THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

Audiology and Speech Clinics at UT Conference Center

Note new location!

600 Henley Street, Suite 213
GPS Address: 601 Locust Street
Knoxville, Tennessee 37996
Phone: 865-974-5453

PATIENT NAME: _____

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____

The UTHSC Audiology and Speech Clinics at UT Conference Center are an educational and research facility in the Department of Audiology and Speech Pathology. The services we provide include evaluations and treatment for children and adults with hearing loss. Graduate students in audiology or speech in the department provide the services under the supervision of the department's licensed audiologists and speech-language pathologists. Evaluations normally are 1 to 1 ½ hours in length.

INSURANCE

We will file a claim with all insurance providers (primary and secondary) for all patients. Please be aware that some insurance providers do require the patient to get an Out-of-Network authorization from the primary care doctor before being seen at our facility. Medicare and most health insurance companies will pay for the diagnostic procedures in our clinics, but will not cover the cost of hearing aids or fitting fees. Medicare requires that we collect 20% of testing charges due on date of service. ***Payment is expected at the time of service (including co-pays) by visa, master card, discover, check or cash.***

FEES

The clinic charges for each procedure that is performed. ***If you were referred by the VA, they will pay for all visits.***

REDUCED RATES

For speech patients, we offer reduced rates to those who qualify based on a sliding fee scale. It depends on the number of people in the home and the gross household income. If you feel that you may qualify for a reduced rate, please bring either a complete copy of your last year's tax return or, if you do not file a tax return, the last 3 months of your bank statements. You may also call us at (865) 974-5453 with questions.

CANCEL/RESCHEDULE POLICY

If you are unable to keep your scheduled appointment, you are expected to call the clinic and cancel at least 24 hours prior to your appointment. If you do not call to cancel or to reschedule, the missed appointment will be counted as a "No-Show Appointment." After two "No-Shows," we may be unable to reschedule an appointment for you. In this packet, we have included a more detailed description of our policy.

UTHSC Audiology Clinic
Patient Registration

Patient Name _____
(Last) **(First)** **(Middle)**

Address _____
City State Zip

Patient Age _____ Home Phone _____ Cell Phone _____

Patient Sex: M F Patient DOB _____ Social Security # _____

Emergency Contact _____
(Name) (Phone) (Relationship)

Parent/Guardian/Spouse Information

Name _____ Relationship _____ SS# _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Home Phone _____

Employer _____ Work/Cell Phone _____

Name _____ Relationship _____ SS# _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Home Phone _____

Employer _____ Work/Cell Phone _____

Insurance Information

Primary Insurance _____ Secondary Insurance _____

Subscriber Name: _____ Subscriber Name: _____

Policy/ID # _____ Group # _____ Policy/ID # _____ Group # _____

Insured's DOB _____ Insured's DOB _____

Insured SS # _____ Insured SS # _____

Pt.'s Relation to Insured _____ Pt.'s Relation to Insured _____

The above information is true to the best of my knowledge. I authorize this medical treatment facility to furnish information to my insurance carriers concerning my illness and treatments to process my claim and I authorize my insurance benefits to be paid directly to **UT Audiology Clinic.** I understand that I am financially responsible for any balance.

Signature _____ Date _____

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

Medication List

Please list below all **medications, supplements, vitamins, etc**. that you are currently using. Be sure to include the dosage and method. You may also attach a list for your convenience.

Name of medication	Dosage (amount & how often)	Method (oral, injection, patch)

Do you currently use tobacco products (within the past 24 months)? Circle one - Yes or No

If Yes, what type and how often? _____

Printed Name: _____ Signature: _____

Date Completed: _____

Date Updated: _____Initials: _____ **Date Updated: _____Initials: _____**

Date Updated: _____Initials: _____ **Date Updated: _____Initials: _____**

*******THE SECTION BELOW TO BE FILLED OUT BY PROVIDER*******

_____ (1036F) – No

_____ (4004F) – Yes, and patient received tobacco cessation intervention (counseling, pharmacotherapy, or both)

_____ (4004F-8P) – Yes, but did not receive tobacco cessation intervention (counseling, pharmacotherapy, or both) or screening not performed (reason not specified)

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(P) 865-974-5453
(F) 865-974-1792

Exchange of Information

Patient's Name _____ **Date of Birth** _____

A copy of your results will be sent to the referring physician. I hereby authorize the *University of Tennessee* Hearing and Speech Center to receive **and/or** release information to the additional names listed below. You will need to provide **both name and address**. Everyone listed will also receive a copy of your medical report.

Primary Care Doctor * required

Name
Address
City State Zip

Name
Address
City State Zip

Name
Address
City State Zip

Name
Address
City State Zip

Name
Address
City State Zip

Name
Address
City State Zip

Signature of patient, parent or guardian

Date

Signature of staff

Date

Date Updated: _____ Initials: _____
Date Updated: _____ Initials: _____

Date Updated: _____ Initials: _____
Date Updated: _____ Initials: _____

THE UNIVERSITY OF TENNESSEE
HEALTH SCIENCE CENTER
Department of Audiology and Speech Pathology

CONSENT FOR TREATMENT & CARE
NOTICE OF RECEIPT OF PRIVACY PRACTICES

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified conditions(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you indicate that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your audiologist and/or speech-language pathologist about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your provider, we encourage you to ask questions.

I voluntarily request an audiologist and/or speech-language pathologist, as deemed necessary, to perform reasonable and necessary examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I have been given a copy of the University of Tennessee Health Science Center Department of Audiology and Speech Pathology's (UTHSC ASP) Notice of Privacy Practices that provides a description of health information uses and disclosures. I understand that I have a right to review the notices prior to signing this form. I understand that UTHSC ASP reserves the right to change their notice and practices and that changes will be posted in the office area. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and UTHSC ASP is not required to agree to the restrictions requested. I may revoke this acknowledgement in writing, except to the extent that UTHSC ASP has already taken action.

TO THE PARENT/GUARDIAN OF PATIENT: I give consent for the following adult individuals to bring the patient to UTHSC ASP for any appointment following the initial evaluation and hereby give permission to UTHSC ASP to exchange information with the following individuals. This request will remain in effect until revoked by me in writing.
(Please print)

a) Name: _____ relationship: _____ phone:_____

b) Name: _____ relationship: _____ phone:_____

c) Name: _____ relationship: _____ phone:_____

d) Name: _____ relationship: _____ phone:_____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Date

_____ _____
Signature of Witness Date

_____ _____
Printed Name of Witness Employee Job Title

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

Financial Agreement

Name: _____ Chart #: _____

Date of Birth: _____

I understand that I will be charged on a fee-for-service basis, and I agree to pay this amount. I agree I am responsible for any charges not covered by my insurance or other third party guarantor (i.e., VA, CSS, TEIS). **I understand that payment will be made at the time services are rendered unless the Center staff has documented payment arrangements as follows:**

Please initial only the categories that apply to you.

_____ **MEDICARE** I understand that **Medicare does not cover hearing aid evaluations, hearing aid fittings, earmolds, and hearing aid supplies and accessories.** The Center will file a claim for services provided with Medicare and any Medicare supplemental insurance of which we are informed. I understand that I am responsible for any copays and deductibles not paid by Medicare or Medicare supplemental insurance.

_____ **VETERANS ADMINISTRATION (VA)** I have been referred by the VA. The VA will be billed for all services provided not covered by insurance.

_____ **TENNCARE** The Center will file claims with my TennCare insurance carrier. I am responsible for any deductible and co-payment required by TennCare.

_____ **OTHER INSURANCE** The Center will file claims for services and other charges with my insurance carrier. I am responsible for payment of any deductible and co-payments required by my insurance plan. I understand that payment of deductible and co-payments are due at time of service. I am also responsible for paying any non-covered charges as determined by the insurance company per the EOB. I understand that my insurance policy may not cover hearing aids, ear molds, ear impressions, and hearing aid supplies.

_____ **SCHOOL SYSTEMS** The Center has contracted with _____ School System for the services. I am responsible for any services not covered by the school system contract.

_____ **TEIS/CSS/PCSG** I was referred by Tennessee Early Intervention System (TEIS), Children's Special Services (CSS), or Parent Child Services Group (PCSG). For TEIS and CSS patients, the Center will file claims for the services with my insurance company and will bill any remaining balance to TEIS or CSS. For PCSG patients, services will be billed to PCSG.

_____ **AETNA / UHC** I am aware that the center is out of network with my insurance and that I will have to pay for services on day of appointment. I will be reimbursed should my insurance cover any portion of my visit.

_____ **NO INSURANCE/ SELF PAY** I am aware that I will be responsible for paying all charges on the day of my appointment.

It is my responsibility to inform the Hearing and Speech Center of any changes in my insurance carrier and/or my current address. I understand that any changes to this financial agreement affect only subsequent charges, and that I am responsible for all charges to my account. **I authorize the UT Audiology Clinic to release any medical or other information necessary to process medical claims with third-party guarantors. I authorize payment of any insurance benefits related to these filed claims to be made directly to the UT Audiology Clinic.**

_____ _____

Signature of Client Date

_____ _____

Clinic Staff Date

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Cancellation Policy

Your appointment is a contract with our Clinic. Your advance notice of a cancellation enables us to offer the appointment time to another patient. Please review our cancellation/late policy.

1. If you do not show for 2 appointments in one semester or 3 appointments in one year (without a phone call to cancel the appointment 24 hours in advance of the appointment time), we may not be able to reschedule your appointment.

2. If you are more than 20 minutes late to your scheduled appointment, it will be necessary to re-schedule your appointment and this will count as 1 No-Show appointment.

3. We follow the Knox County Schools inclement weather policy. If Knox County Schools are closed, our clinics will also be closed.

4. If you or your child wakes up sick on the day of your appointment, please call to reschedule no later than 8:00 am.

It is our desire to work with you and/or your child. If you are unable to follow these guidelines, we will be happy to assist you in finding an alternative clinic. If you have any questions, please feel free to ask the clinic reception staff or contact our program liaison at 865-974-1592.

Thank you.

I, _____, have been informed and understand the above UTHSC
(Print Patient Name)
Audiology and Speech Clinic attendance policy.

_____ _____
Patient/Guardian Signature Date

_____
Witness

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

Adult Case History

Please complete the front and back of this form, and bring it with you to your scheduled appointment.

Name: _____ **Date of Birth:** _____ **Date:** _____
Occupation: _____ **Phone:** _____ **Email:** _____

What is the primary reason for scheduling this appointment? _____

Have you noticed that you have difficulty hearing? **NO** **YES**

The onset of your hearing loss was: **Sudden or Gradual**

How long have you noticed difficulty hearing? _____

Have you ever had your hearing tested? **NO** **YES**

If yes, when and where were you tested? _____

What were the findings? _____

Is one ear worse than the other? **NO** **YES** **Left** **Right**

Do you know what caused the difference? _____

Is there a family history of hearing loss? **NO** **YES** Describe: _____

Do you have a history of ear infections? **NO** **YES** **Left** **Right** **Both**

If yes, when was your last infection? _____

Have you ever had ear surgery? **NO** **YES** **Left** **Right** **Both**

If yes, what type of surgery, when and by whom? _____

Do you have any other ear problems(pain, fullness, drainage)? **NO** **YES** Describe: _____

Do you ever have ringing, buzzing, or other noises in your ears? **NO** **YES** **Left** **Right** **Both**

If yes, is the noise constant? **NO** **YES**

How long have you had noise in your ears? _____

Describe the noise? _____

Do you ever feel dizzy? **NO** **YES**

If yes, please describe your dizziness and when it began. _____

_____

Do you know the cause of the dizziness? _____

Have you ever worked in loud noise? **NO** **YES** Describe: _____

Have you ever served in the Military? **NO** **YES** Describe: _____

Do you have any noisy hobbies, (woodworking, shooting, etc.)? **NO** **YES** Describe._____

Did/Do you wear hearing protection? **NO** **YES** Describe._____

Please circle one and indicate age, if applicable.

Sinus/Allergy Problems	**NO**	**YES**	Age____	
Diabetes	**NO**	**YES**	Age____	
Cancer	**NO**	**YES**	Age____	Chemo/Radiation: _____
Kidney Disease	**NO**	**YES**	Age____	
Stroke	**NO**	**YES**	Age____	
High Blood Pressure	**NO**	**YES**	Age____	
Take Blood Thinner	**NO**	**YES**	Age____	
Pacemaker	**NO**	**YES**	Age____	
Concussion/Head Injury	**NO**	**YES**	Age____	
Memory Loss/Dementia	**NO**	**YES**	Age____	

Additional serious illness or injury in the last 2 years _____

_____

Have you ever worn hearing aids? **NO** **YES**

How long have you worn hearing aids? _____

In which ear(s) have you worn hearing aids? **Left** **Right** **Both**

Do you wear hearing aids now? **NO** **YES** **Left** **Right** **Both**

What is the make and model of your current hearing aids? _____

When did you purchase your current hearing aids? _____

The hearing aids have been **Satisfactory** **Unsatisfactory**

Describe_____

Do you have a cochlear implant? **NO** **YES** **Left** **Right** **Both**

Who is your surgeon? _____ Which manufacturer? _____

When were you implanted? **Left** _____ **Right** _____

Medications (see additional form for full medications list)

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

UT Audiology and Speech Clinics
at UT Conference Center
Acknowledgment of Receipt of the Notice of Privacy

I have been given a copy of the Notice of Privacy Practices that provides a description of health information uses and disclosures. I understand that I have the right to review the notices prior to signing this acknowledgment form. I understand that the organization reserves the right to change their notice and practices and that changes will be posted in the office area. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and the University of Tennessee Hearing and Speech Clinics are not required to agree to the restrictions requested. I understand that I may revoke this acknowledgement in writing, except to the extent that the organization has already taken action in the reliance thereon.

Signature of Client or Legal Representative

_____

Date

_____

Revision Effective September 23, 2013

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER
HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Information

Each time you receive health care services from The University of Tennessee Health Science Center ("UT Health Science Center" or "UTHSC"), a record of your treatment is made. This record contains information about your symptoms, examinations, test results, medications you take, your allergies and the plan for your care. We refer to this information as your health or medical record. It is an essential part of the healthcare we provide for you. Your health record contains personal health information and there are state and federal laws to protect the privacy of your health information. This notice is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Uses and Disclosures of Your Health Information

We will use your information for treatment purposes

The UTHSC staff involved in your care will document information in your record about your examination, the care that you receive, the results of that care, and the care planned for you. If you were referred to us from another health care provider, we may send copies of your medical record to the provider who referred you to us so your provider will have updated treatment information about your care.

We will provide your doctors and other healthcare providers who are treating you with copies of various reports that should assist them in treating you.

We may also use health information about you to call you and/or send you a letter to follow up with diagnostic test results and to survey your satisfaction with the services provided.

We will use your health information for payment purposes

A bill will be sent to you or your insurance company. We may include information that identifies you, as well as your diagnoses, procedures, healthcare providers and supplies used. We also may contact your insurance company to determine if they will pay for your health care as part of their certification process.

We will use your health information for regular healthcare operations purposes

UTHSC staff may look at your health information to assess the care and results in your case and others like yours. The UT Health Science Center is a teaching institution, so we may use your health information in the process of educating and training students and resident physicians.

Your right to request restrictions on use and disclosure of your health information

You have the right to request in writing a restriction on the above uses and disclosures of your protected health information for treatment, payment and health care operations; however, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. We may, however, also end the agreement at any time after notifying you in writing of such.

Other Disclosures

Business Associates

There are some services provided in our organization through contracts with business associates and in some instances, their subcontractors. We require the business associate, and any subcontractors they utilize, to protect your health information.

Communication with others involved with your care

We may give to a family member, or other relative, close personal friend or any other person you identify, certain parts of your health information that is directly relevant to that person's involvement in your care or payment related to your care.

Your health information will only be shared if you agree, or are silent when given the opportunity to disagree, or we believe, based on the circumstances and our professional judgment that you do not object.

If you are incapacitated or in an emergency circumstance, we may provide to a family member, or other relative, close personal friend, or any other person accompanying you, certain parts of your health information that is directly relevant to that person's involvement in your care or payment related to your care.

Research

Under certain circumstances, we may use and disclose health information about you from your medical record for research purposes. All such research projects, however, will be subject to a special approval process designed to protect the privacy of your health information.

Required by law

We may disclose health information required by law to the following entities or type of entities that includes, but is not limited to:

- Food and Drug Administration
- Public Health or legal authorities charged with disease prevention
- Correctional institutions
- Workers compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Medicare or Medicaid if requested for an audit or investigation
- Funeral directors, coroners and medical examiners
- National security and intelligence agencies
- Protective services for the president and others
- Law enforcement as required by law or in accordance with a valid subpoena
- Licensing boards
- To avoid a serious threat to the health and safety of a person or the public

Marketing

The UT Health Science Center will **not** use health information in your records for marketing purposes without your written authorization or approval.

Other uses and provided information from your medical

record will be made only with your written authorization or approval.

Patient rights

You have the right to:

- Inspect and obtain a copy of your health record within sixty days of request. There may be a charge to cover the cost of producing your record in hard copy or electronic form.
- Request an amendment of your health records;
- Obtain an accounting of disclosures of your protected health information made after April 14, 2003 for purposes other than treatment, payment, and healthcare operations;
- Request communication of your health information in a certain way or at a certain location. For example, you can ask that we contact you by mail and not by telephone, or that we contact you at a specific telephone number, or that we use an alternative address for billing purposes, or that we not leave messages on certain answering machines. Email communication will be provided only at your written request indicating you understand that email can be an unsecure communication method;
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken; and
- Restrict disclosures to a health plan for services when those services have been paid out-of-pocket in full by the patient, a family member, or another individual.

Our duties

We are obligated to:

- Maintain the privacy of your health information;
- Obtain an authorization for the use and disclosures of psychotherapy notes, marketing, and the sale of protected health information;
- Refrain from selling your protected health information without your individual written authorization;
- Notify you if there has been a breach of your unsecured protected health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect about you through this notice;
- Abide by the terms of the notice currently in effect;
- Notify you in writing if we are unable to agree to a requested restriction;
- Follow reasonable requests you make to communicate with you as you instruct, for example, to contact you at a certain telephone number or address;
- Provide you a paper copy of this notice of privacy practices upon request; and
- With written request, to provide you with a copy of your electronic health record in electronic form and to transmit the copy directly to another person designated by you. An electronic copy may be attached to an email that does not require encryption as long as you have been advised of the risk of transmission of an unencrypted document.

To exercise any of the above rights or to make any of the above requests, your request **must** be in writing.

The University of Tennessee Health Science Center is not required to act immediately except for a request for a copy of your health record and will investigate our abilities to comply with all requests prior to agreeing to the request.

The University of Tennessee Health Science Center reserves the right to change this Notice of Privacy Practices and its policies and procedures for privacy practices at any time and to make the changes effective for all protected health information created or received prior to the new effective date and then currently maintained by the UTHSC. Any revised Notice will be posted in the waiting rooms or patient lobbies of our clinical practices and reasonable efforts will be made to advise you of the change(s) in the Notice, policies and procedures at your next service visit. You may also obtain a copy of the revised Notice upon request.

For More Information or to Report a Problem

If you have any questions about your rights or duties or the UTHSC practices and procedures regarding protected health information, please contact the appropriate office of the facility where you received services.

If you believe your privacy rights have been or are being violated, you may file a complaint by calling the UTHSC HIPAA Privacy Officer's hotline telephone number at (901) 448-1700.

You may file a complaint with the Secretary of the Department of Health and Human Services. Complaints to the Secretary must be filed in writing on paper or electronically and must be made within 180 days of when you became aware of, or should have been aware of, the incident giving rise to your complaints. By law, you cannot be penalized for filing a complaint.

Revised Date—September 22, 2013

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

Patient Questionnaire
Profile of Hearing Aid Benefit*

NAME: _____DATE:_____CHART:_____

This questionnaire is designed to assess your everyday experience with conversation and the sounds around you. Your answers will help the audiologists and staff at UT Audiology Clinic to better understand your individual and unique needs as they work with you to improve your ability to hear.

Please place an "X" in the box that comes closest to your everyday experience. Notice that each choice corresponds to a percentage. You can use this to help you decide on your answer. For example, if the statement is true about 75% of the time, place a mark in the box marked "Generally".

If you have not experienced the situation we described, try to think of a similar situation that you have been in and respond for that situation. If you have no idea, leave that item blank.

Thank you for your participation.

Always = 99%

Almost Always = 87%

Generally=75%

Half-the-time=50%

Occasionally=25%

Seldom=12%

Never=1%

Cox, RM, Alexander GC. The abbreviated profile of hearing aid benefit. Ear Hear. 1995; 16: 176-86.
*Modified with permission.

	Always	Almost Always	Generally	Half-the-time	Occasionally	Seldom	Never
1. When I am in a crowded grocery store, talking with the cashier, I can follow the conversation.							
2. I miss a lot of information when I'm listening to a lecture.							
3. Unexpected sounds, like a smoke detector or alarm bell are uncomfortable.							
4. I have difficulty hearing a conversation when I'm with one of my family at home.							
5. I have trouble understanding the dialogue in a movie or at the theater.							
6. When I am listening to the news on the car radio, and family members are talking, I have trouble hearing the news.							
7. When I'm at the dinner table with several people, and am trying to have a conversation with one person, understanding speech is difficult.							
8. Traffic noises are too loud.							
9. When I am talking with someone across a large empty room, I understand the words.							
10. When I am in a small office, interviewing or answering questions, I have difficulty following the conversation.							
11. When I am in a theater watching a movie or play, and the people around me are whispering and rustling paper wrappers, I can still make out the dialogue.							
12. When I am having a quiet conversation with a friend, I have difficulty understanding.							
13. The sounds of running water, such as a toilet or shower, are uncomfortably loud.							
14. When a speaker is addressing a small group, and everyone is listening quietly, I have to strain to understand.							
15. When I'm in a quiet conversation with my doctor in an examination room, it is hard to follow the conversation.							
16. I can understand conversations even when several people are talking.							
17. The sounds of construction work are uncomfortably loud.							
18. It's hard for me to understand what is being said at lectures or church services.							
19. I can communicate with others when we are in a crowd.							
20. The sound of a fire engine siren close by is so loud that I need to cover my ears.							
21. I can follow the words of a sermon when listening to a religious service.							
22. The sound of screeching tires is uncomfortably loud.							
23. I have to ask people to repeat themselves in one-on-one conversation in a quiet room.							
24. I have trouble understanding others when an air conditioner or fan is on.							

Comments:_____

_____

_____