



QUESTIONS ABOUT AUDITORY PROCESSING DISORDER (APD) TESTING

What is APD?

Auditory processing is not how well a person hears, but instead what the brain does with what a person hears. An individual can get a perfect score on a hearing test yet still have extreme difficulty with auditory processing. Many term this a listening disorder, joking “He hears what he wants to hear.” But in reality, auditory processing disorders can cause reading and spelling problems, in addition to difficulty following multi-step directions and remembering details from a story.

Individuals with auditory processing difficulties will present with specific symptoms. Often, they will act as if they have a hearing issue even when they pass every hearing test that is given. There are specific indicators that help you determine if auditory processing issues are present.

Of all the processing disorders, this one is most often missed or misdiagnosed. Many times, children are misdiagnosed with ADD or ADHD when they actually suffer from an auditory processing disorder.

Who can diagnose APD?

Only an audiologist with special training in APD can diagnose an auditory processing disorder. Psychologists and speech language pathologists may SCREEN for this, but diagnosis is not in their scope of practice.

I suspect my child has APD. Do I really need a diagnosis?

Yes. There are different types of APD that have similar symptoms but respond very differently to treatment and accommodations. What helps one type of APD can make things worse for another type of APD. Measurement and diagnosis is also important to monitor the effectiveness of treatment. If we can’t define and measure performance it is impossible to determine progress.

Who can be tested for APD?

A comprehensive test battery is appropriate for children age 7 years and older. Children must be able to tolerate headphones and repeat words and sounds. Reading and writing are not required for this test. Difficulties with attention (ADHD) will interfere with testing unless well controlled.

Does insurance pay for this?

We are out of network with all insurance plans. Insurance is a contract between you and the insurance plan you have chosen. Our services will all be considered out of network and subject to your deductible and out of network fee schedules. While we are happy to file your insurance claim, payment is expected in full at the time of service and your insurance company will reimburse you directly within your plan guidelines.

It is your responsibility to contact your insurance to determine what your benefits are.
The following CPT codes are commonly used during this testing:

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92552	Pure tone, air conduction	\$45.00
92556	Speech recognition, discrimination	\$50.00
92550	Tympanometry and acoustic reflex testing	\$45.00
92558	DPOAE	\$30.00
92620	APD evaluation testing, 60 minutes	\$400.00
92621	APD testing, report writing, 60 minutes	\$200.00
92626	Feedback session with parents, 60 min.	\$150.00

What is the average price of APD testing?

In general, APD testing will usually run \$770-\$920. This includes a review of medical records from other specialists, 2 hours of in-office testing, report, and a follow up conference to go over results. If you cannot afford testing there are payment options. However, the final report will not be released until payment is received in full.

Why is this testing so expensive?

APD testing is very time consuming. There is no cookie cutter approach. This means time spent in testing (2 hours in the office) plus at least 1-2 hours scoring data and writing an individualized report and 1 hour of time with the family to go over all the results. There are other providers who may charge less, but *be sure you are comparing apples to apples*. We have found that these providers may only complete testing that looks at one or two areas of processing and use the same list of recommendations for each patient. This is not best practice and helpful for treatment.

What tests do you do?

Tests are chosen to be sure we cover all areas of processing. Attention is assessed with the ACPT or IVA-QS. Auditory memory is assessed with the Digit Memory Span. Dichotic listening is assessed with the SSW, Competing sentences, and dichotic digits test. Phonemic synthesis looks at decoding. Monaural low redundancy skills are assessed with the filtered words and time compresses sentences test. Temporal processing tests include gap detection, pitch pattern sequence, and duration pattern sequence testing. Speech in noise is assessed with the BKB-SIN or Quick-SIN.

Is there treatment for APD?

Treatment of APD generally focuses on three primary areas: changing the learning or communication environment, recruiting higher-order skills to help compensate for the disorder, and remediation of the auditory deficit itself. The primary purpose of environmental modifications is to improve access to auditorily presented information. Suggestions may include use of electronic devices that assist listening, teacher-oriented suggestions to improve delivery of information, and other methods of altering the learning environment so that the child with APD can focus his or her attention on the message.

Direct treatment of APD seeks to remediate the disorder itself. There exist a wide variety of treatment activities to address specific auditory deficits. Some may be computer- assisted, others may include one-on-one training with a therapist. Sometimes home-based programs are appropriate whereas others may require children to attend therapy sessions in school or at a local clinic. Once again, it should be emphasized that there is no one treatment approach that is appropriate



for all children with APD. The type, frequency, and intensity of therapy, like all aspects of APD intervention, should be highly individualized and programmed for the specific type of auditory disorder that is present.

How do I schedule an appointment?

You can request a referral from your physician or refer yourself. The office phone number is 704-412-7975 or you may contact the office via email at mkarp@audiologycharlotte.com.



PERSONAL HISTORY - PEDIATRIC

Today's Date: _____

Date of Birth: _____ Age: _____

Full Name: _____

Preferred Name: _____ ☐ Male ☐ Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

E-mail Address: _____

Parent's /Guardian Name: _____

Name	Occupation	Age	Cell Number

Other Children in family: _____

Name	Age	Grade Level	Any Speech Hearing or Medical Problems?

Languages spoken at home: _____

Family Physician: _____ Physician Phone Number: (____) _____

How did you hear about our practice? ☐ Physician ☐ Counselor/Therapist ☐ School ☐ Self ☐ Friend

☐ Website ☐ Google ☐ Other: _____

What are your main concerns or reasons for this evaluation? _____

At what age was your child's problem noted? By Whom? _____



Please list persons (family members, doctors, etc.) with whom you give us permission to discuss your health information, send reports, and schedule future appointments:

- Referring Physician - _____
- Primary Care Physician - _____
- Other Physician - _____
- Family Member (s) - _____
- Other - _____

MEDICAL HISTORY

Please check the following behaviors that may be pertinent to this child.

- ☐ History of hearing loss.
- ☐ Pre or Perinatal complications (i.e. low birth weight, difficulty breathing, head trauma, high fever, seizures, jaundice, etc.)
- ☐ History of allergies, asthma, reactive airway disease (RAD), frequent colds/upper respiratory infections.
- ☐ History of Attention Deficit Hyperactivity Disorder (ADHD). If so:

What age was your child diagnosed? _____

Diagnosed by: _____ Profession: _____

Is your child receiving medication for ADHD? _____

How long does it take to see the medication's effect? _____

Has any other specialist seen your child? (Describe)

☐ Counselor _____

☐ Psychologist _____

☐ Special Education Therapist _____

☐ Tutor _____

☐ Developmental Pediatric Specialist _____

☐ Behavioral Psychologist _____

☐ Speech /Language Pathologist _____

☐ Occupational Therapist _____

☐ Physical Therapist _____



Has your child or a family member been diagnosed with a learning disorder? _____

Has any other family member been diagnosed with ADHD or an APD? _____

Please check all medical symptoms that apply:

	Left Ear	Right Ear	Both	Dates of occurrence:
Ear Pain				
Ear Infections				
Ear popping				
Ear Surgery				
Ear Tubes				
Ear Drainage				
Ears Ringing				
Trauma (Head/ Ear)				
Ear Deformity				
Dizziness or unsteadiness				

Has your child had any of the following? Please check all of those that apply.

- | | | |
|---------------------------------------------------|-------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Asphyxia | <input type="checkbox"/> Hyperbilirubinemia |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Head/Neck Deformity | <input type="checkbox"/> CMV |
| <input type="checkbox"/> Craniofacial abnormality | <input type="checkbox"/> Syndrome abnormality | <input type="checkbox"/> Bacterial Meningitis |
| <input type="checkbox"/> Ototoxic Medication | <input type="checkbox"/> Mechanical ventilation | <input type="checkbox"/> Maternal Substance abuse |
| <input type="checkbox"/> Fever over 104 | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

If checked above please describe: _____



Please check all medical symptoms and conditions that apply:	YES	NO
Eye problems (such as blurred or double vision or pain)		
Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues)		
Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations)		
Respiratory issues (such as shortness of breath, cough, wheezing)		
Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain):		
Musculoskeletal issues (such as joint pain, swelling, recent trauma)		
Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness):		
Psychiatric issues (such as depression, anxiety, compulsions)		
Endocrine symptoms (such as frequent urination, hot flashes)		
Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands)		
Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency)		

List any operations _____

Other chronic illnesses _____

Any drug or other allergies (including latex/plastics) _____

Please list all current medications or attach a list:

NAME	DOSE (MG)	FREQUENCY (Example: 1 a day)	DELIVERY METHOD (Example: Oral , Shot, Eye drops)

Has your child taken medication today? _____



Today's Date: _____

Full Name: _____

Date of Birth: _____ Age: _____

LISTENING SKILLS

- ___ 1. Says "huh" or "what" frequently.
- ___ 2. At times, appears to have a hearing loss.
- ___ 3. Frequently asks for directions to be repeated.
- ___ 4. Responds in a slow or delayed manner.
- ___ 5. Responds too quickly to situations without waiting for instructions.
- ___ 6. Misunderstands what is said most of the time.
- ___ 7. Appears as if he/she is not paying attention.
- ___ 8. Exhibits a low tolerance for noise.
- ___ 9. Easily distracted in noise.
- ___ 10. Communication is enhanced when visual information is provided with audition.
- ___ 11. Displays some/extreme difficulty when provided with lengthy/complex information.
- ___ 12. Difficulty in understanding speech sounds.
- ___ 13. Does not understand the verbal message, especially in background noise.
- ___ 14. Often "hears" a similar word (bath vs. math).
- ___ 15. Shows difficulty in differentiating musical instruments or notes.

ACADEMIC SKILLS

School: _____ Grade _____

Left Handed _____ Right Handed _____ Ambidextrous _____

What are your child's strongest subjects in school? _____

Does your child have any difficulties with any subjects at school? _____

If, yes, describe: _____



- ___1. Displays inconsistency in school performance.
- ___2. Rushes through homework or classroom work without realizing errors were made.
- ___3. Unmotivated to learn new concepts.
- ___4. Tests reveal better *performance* results than *verbal* results.
- ___5. Performs well in a one-to-one situation.
- ___6. Is disruptive in class.
- ___7. Interrupts peers or teachers.
- ___8. Performance improves in a structured environment.
- ___9. Displays weak reading/writing or spelling skills.
- ___10. Has difficulty explaining a story or idea.
- ___11. Does not complete tasks or is not organized with tasks.
- ___12. Appears unusually fatigued toward the end of the school day.
- ___13. Displays weak comprehension ability.

ADDITIONAL

- ___1. (Requires/required) articulation therapy.
- ___2. (Requires/required) language therapy.
- ___3. Seems to enjoy novel situations.
- ___4. Difficulty in turn taking situations.
- ___5. Fidgets with hands or feet.
- ___6. Appears forgetful during daily routines.
- ___7. Loses items necessary to complete daily activities.
- ___8. Remembers final directions better than initial directions.
- ___9. Exerts more concentration than usual.
- ___10. Reverses letters or sounds when writing or speaking.
- ___11. Poor at drawing geometrical shapes.



STUDENT NAME _____

FISHER'S AUDITORY PROBLEM CHECKLIST

FORM COMPLETED BY: _____

RELATIONSHIP TO CHILD: _____

Please place a check mark before each item that is considered to be a concern by the observer:

- ___ 1. Has a history of hearing loss.
- ___ 2. Has a history of ear infection(s).
- ___ 3. Does not pay attention (listen) to instruction 50% or more of the time.
- ___ 4. Does not listen carefully to directions—often necessary to repeat instructions.
- ___ 5. Says “Huh?” and “What?” at least five or more times per day.
- ___ 6. Cannot attend to auditory stimuli for more than a few seconds.
- ___ 7. Has a short attention span. (If this item is checked, also check the most appropriate time frame)

___ 0-2 minutes ___ 5-15 minutes ___ 2-5 minutes ___ 15-30 minutes

- ___ 8. Daydreams – attention drifts – not with it at times.
- ___ 9. Is easily distracted by background sound(s).
- ___ 10. Has difficulty with phonics.
- ___ 11. Experiences problems with sound discrimination.
- ___ 12. Forgets what is said in a few minutes.
- ___ 13. Does not remember simple routine things from day to day.
- ___ 14. Displays problems recalling what was heard last week, month, year.
- ___ 15. Has difficulty recalling sequence that has been heard.
- ___ 16. Experiences difficulty following auditory directions.
- ___ 17. Frequently misunderstands what is said.
- ___ 18. Does not comprehend many words-verbal concepts for age/grade level.
- ___ 19. Learns poorly through the auditory channel.
- ___ 20. Has a language problem, (morphology, syntax, vocabulary, phonology).
- ___ 21. Has an articulation (phonology) problem.
- ___ 22. Cannot always relate what is heard to what is seen.
- ___ 23. Lacks motivation to learn.
- ___ 24. Displays slow or delayed responses to verbal stimuli.
- ___ 25. Demonstrates below average performance in one or more academic areas.

Scoring: Four percent credit for each numbered item not checked.

Number of items not checked ___ x 4 = ___

S.I.F.T.E.R.**SCREENING INSTRUMENT FOR TARGETING EDUCATIONAL RISK***by Karen L. Anderson, Ed.S., CCC-A*

STUDENT _____ TEACHER _____ GRADE _____

DATE COMPLETED _____ SCHOOL _____ DISTRICT _____

The above child is suspect for hearing problems which may or may not be affecting his/her school performance. This rating scale has been designed to sift out students who are educationally at risk possibly as a result of hearing problems. Based on your knowledge from observations of this student, circle the number best representing his/her behavior. After answering the questions, please record any comments about the student in the space provided on the reverse side.

1. What is your estimate of the student's class standing in comparison of that of his/her classmates?	UPPER 5	4	MIDDLE 3	2	LOWER 1	ACADEMICS	<input type="checkbox"/>
2. How does the student's achievement compare to your estimation of her/her potential?	EQUAL 5	4	LOWER 3	2	MUCH LOWER 1		
3. What is the student's reading level, reading ability group or reading readiness group in the classroom (e.g., a student with average reading ability performs in the middle group)?	UPPER 5	4	MIDDLE 3	2	LOWER 1		
4. How distractible is the student in comparison to his/her classmates?	NOT VERY 5	4	AVERAGE 3	2	VERY 1	ATTENTION	<input type="checkbox"/>
5. What is the student's attention span in comparison to that of his/her classmates?	LONGER 5	4	AVERAGE 3	2	SHORTER 1		
6. How often does the student hesitate or become confused when responding to oral directions (e.g., "Turn to page . . .")?	NEVER 5	4	OCCASIONALLY 3	2	FREQUENTLY 1		
7. How does the student's comprehension compare to the average understanding ability of her/her classmates?	ABOVE 5	4	AVERAGE 3	2	BELOW 1	COMMUNICATION	<input type="checkbox"/>
8. How does the student's vocabulary and word usage skills compare with those of other students in his/her age group?	ABOVE 5	4	AVERAGE 3	2	BELOW 1		
9. How proficient is the student at telling a story or relating happenings from home when compared to classmates?	ABOVE 5	4	AVERAGE 3	2	BELOW 1		
10. How often does the student volunteer information to class discussions or in answer to teacher questions?	FREQUENTLY 5	4	OCCASIONALLY 3	2	NEVER 1	CLASS PARTICIPATION	<input type="checkbox"/>
11. With what frequency does the student complete his/her class and homework assignments within the time allocated?	ALWAYS 5	4	USUALLY 3	2	SELDOM 1		
12. After instruction, does the student have difficulty starting to work (looks at other students working or asks for help)?	NEVER 5	4	OCCASIONALLY 3	2	FREQUENTLY 1		
13. Does the student demonstrate any behaviors that seem unusual or inappropriate when compared to other students?	NEVER 5	4	OCCASIONALLY 3	2	FREQUENTLY 1	SCHOOL BEHAVIOR	<input type="checkbox"/>
14. Does the student become frustrated easily, sometimes to the point of losing emotional control?	NEVER 5	4	OCCASIONALLY 3	2	FREQUENTLY 1		
15. In general, how would you rank the student's relationship with peers (ability to get along with others)?	GOOD 5	4	AVERAGE 3	2	POOR 1		

TEACHER COMMENTS

Has this child repeated a grade, had frequent absences or experienced health problems (including ear infections and colds)? Has the student received, or is he/she now receiving, special services? Does the child have any other health problems that may be pertinent to his/her educational functioning?

The S.I.F.T.E.R. is a SCREENING TOOL ONLY

Any student failing this screening in a content area as determined on the scoring grid below should be considered for further assessment, depending on his/her individual needs as per school district criteria. For example, failing in the Academics area suggests an educational assessment, in the Communication area a speech-language assessment, and in the School Behavior area an assessment by a psychologist or a social worker. Failing in the Attention and/or Class Participation area in combination with other areas may suggest an evaluation by an educational audiologist. Children placed in the marginal area are at risk for failing and should be monitored or considered for assessment depending upon additional information.

SCORING

Sum the responses to the three questions in each content area and record in the appropriate box on the reverse side and under Total Score below. Place an **X** on the number that corresponds most closely with the content area score (e.g., if a teacher circled 3, 4 and 2 for the questions in the Academics area, an X would be placed on the number 9 across from the Academics content area). Connect the **X**'s to make a profile.

CONTENT AREA	TOTAL SCORE	PASS	MARGINAL	FAIL
ACADEMICS		15 14 13 12 11 10	9 8	7 6 5 4 3
ATTENTION		15 14 13 12 11 10 9	8 7	6 5 4 3
COMMUNICATION CLASS PARTICIPATION		15 14 13 12 11	10 9 8	7 6 5 4 3
SOCIAL BEHAVIOR		15 14 13 12 11 10 9	8 7	6 5 4 3
		15 14 13 12 11 10	9 8	7 6 5 4 3



Acknowledgement

Treatment, Consent, and Billing Agreement

Health Insurance Portability & Accountability Act (HIPPA) Acknowledgement

Authorization for Treatment and Procedures: I hereby agree to and give consent to be treated by *Audiology & Hearing Services of Charlotte, PLLC*.

(initial here) HIPPA Acknowledgement: By initialing this section and signing below, I acknowledge that I have had access to *Audiology & Hearing Services of Charlotte, PLLC*'s notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available upon request.

(initial here) Participation in Insurance Products: By initialing this section and signing below, I relieve *Audiology & Hearing Services of Charlotte, PLLC* of any responsibility in reference to nonparticipation in the insurance or if my services were to be performed by another entity.

(initial here) Release of Information: By initialing this section and signing below, I give permission to *Audiology & Hearing Services of Charlotte, PLLC* to disclose all or any part of my medical records to any of my other treating health care providers as needed for treatment purposes. *Audiology & Hearing Services of Charlotte, PLLC* will release information as permitted by law and/or HIPPA regulations.

(initial here) Educational and/or Marketing Information: By initialing this section and signing below, I authorize *Audiology & Hearing Services of Charlotte, PLLC* to send me educational and/or marketing information on the products and services offered by *Audiology & Hearing Services of Charlotte, PLLC*. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

(initial here) Financial Responsibility By initialing this section and signing below, I agree to accept the financial policies of *Audiology & Hearing Services of Charlotte, PLLC*. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

Printed Name: _____

Signature of Patient or Guardian: _____

Date: _____



Late Policy

Late Policy

If a patient is late for an appointment we ask that you call and let us know you are on your way. However, if you are more than 15 minutes late you will have to reschedule your appointment and will be considered a "No-Show".

Cancellation of Appointment(s) / No-Shows

Patients wanting to cancel an appointment are asked to call the office 24 hours in advance. The charge for not canceling within a 24-hour notice is \$25.00, which will be charged to your account and is not payable by any insurance company.

Patients who "No-Show" with no previous notification three times for scheduled appointments may be discharged from the practice.

Informed consent /Agreement:

- ☐ I have been informed of and understand the Clinic's late policy.
- ☐ I have been informed of and understand the Audiology & Hearing Services of Charlotte No Show/ Late Cancellation Policy. I understand that a no-show or late cancellation will result in a \$25.00 Charge that is not covered by any insurance. I understand that three consecutive no show or late Cancellations may result in dismissal from the Clinic.

Signature of Patient / Guardian: _____ Date: _____