Speech & Voice Experience

Insurance Release

PATIENT NAME:

_____

FIRST NAME M.I. LAST NAME

Date of Birth:	Guarantor's SS#:
Street Address:	Gender:
City:	State/ Zip Code:
Home Phone:	Email:
Employer:	Alternate Phone:

Primary Physician:	Practice Name:
Phone:	Fax:
Street Address:	State / Zip Code

PRIMARY INSURANCE INFORMATION:

Insurance Company:	Effective Date:
ID #:	Group #:
Subscriber's Name:	Relationship to Patient:

Our policy is: payment to be made at the time services are rendered. We accept cash, check, or major credit cards (Visa, MasterCard, and Discover). (please initial) _____

All appointments must be canceled by noon the day prior to your appointment to avoid charges. Our cancellation fee is $50.00 and cannot be billed to insurance. This applies to all missed and / or forgotten appointments. _____

Patient treatment plans are individualized based on patient needs. The following codes are commonly not covered by some insurance policies: 97532, 97533, 97535. If your insurance does not cover these codes, we will charge a reduced rate of $20 for each service rendered. _____

Returned checks and accounts with balances over 30 days old may be subject to additional collection fees and interest. _____

I agree to promptly pay all charges when billed for services rendered and accept legal responsibility for any and all charges for the patient above.

Guarantor's Signature: _____ Date: _____

Patient Authorization:

I, _____, hereby authorize The Language Experience to apply for benefits on my behalf for covered services rendered. I release payment from: _____ (Insurance Company). I certify that the information I have reported with regard to my insurance coverage is correct and further authorize release of any necessary information including medical information for this or any related claim, to the above billing, (or in case of Medicare Part B Benefits to the Social Security Administration and Health Care Financing Administration) and / or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing. I request that payment of authorized medical benefits be made either to me or on my behalf to the above named provider for any service furnished to me or physician supplier.

_____

SIGNATURE DATE:

APPOINTMENT POLICY

Welcome to the Language & Voice Experience and thank you for the trust you have placed in our company! In order to ensure on-time and consistent appointments to all patients, we must enforce the following appointment policy. Please take the time to familiarize yourself with the following information.

Your speech-language pathologist reserves your appointment time for you or your family member. If you are unable to keep your therapy appointment, you must call/email your clinician to cancel by ***12 noon the day prior*** to your appointment (including weekends). If you do not give your clinician the required notice of cancellation, **you will be responsible for paying a $50.00 fee.** (**please initial here**)_____

For evaluation appointments, you must contact our office by ***12 noon 2 days prior*** to your appointment (including weekends). If you do not give the required notice of cancellation, **you will be responsible for paying a $150.00 fee.** ***This charge must be paid before your evaluation can be rescheduled.*** (**please initial here**)_____

If a patient **cancels more than 25%** of their scheduled appointments, or **misses two (2) appointments** without calling the office, they will be **subject to forfeiture** of their preferred weekly appointment time. **If the patient is late** to their appointment with less than 10 minutes remaining, this will be considered a late cancellation and will be charged accordingly. Make-up sessions will be permitted as the therapist's schedule allows. (**please initial here**)_____

Insurance can be confusing and a time-consuming task for everyone. Although we may participate with your insurance company our primary relationship is with you, our patient. **YOU** are ultimately responsible for knowing and understanding your policy, benefits, exclusions and limitations, as well as the need for referrals or prescriptions. ***If for any reason, your insurance company does not pay for services rendered by our practice, you, the patient are solely responsible for the balance,*** unless your insurance company advises us otherwise. (**please initial here**)_____

We will be closed in observance the following holidays:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day and the Friday after Thanksgiving
- Christmas Day

In the event of inclement weather, we follow **Montgomery County District Court** closing policies. If you are in doubt about your scheduled appointment, please call our office and follow the prompts to listen to the message regarding "Office Closings."

We, at the Language Experience & Voice Experience truly care about our patients and families. Our door is always open should you have any questions or comments.

_____	_____	_____
Please print name	Signature	Date

Your Privacy Rights

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.

Effective date:

Speech & Voice Experience is required by law to keep your health information safe. This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes
- insurance information

A government rule requires that you get a copy of this privacy notice. This rule is called the Health Insurance Portability and Accountability Act, or HIPAA for short. We will ask you to sign a paper saying that you have been given this notice.

Read this notice at any time to see how your health information can be used and who can see it.

How Your Health Information May be Used or Shared

We may use or share your health information without your permission for the following reasons:

- **Treatment**. We may share information with doctors and other health care providers who care for you. For example, if your doctor orders speech therapy, we will share the results of our treatment with that doctor.
- **Payment.** We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for services. This may include sharing important medical information. We may share information to:
    - get the insurance company's permission to start treatment
    - get permission for more treatment
    - get paid for the treatment you receive
- **Health Care Operations.** We may be use and share your health information to run the clinic and make sure all patients receive good care. For example, we may use your health information to:
    - see how well our services are working
    - see how well our staff is doing

- see how we compare to other clinics
- make our services better
- help others study health care services

Your Health Information May Also Be Used or Shared Without Your Permission for:

- **Abuse and Neglect.** We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- **Appointment Reminders.** We will use your information to remind you of upcoming appointments. Reminders may be sent in the mail, by email, or by phone call or voicemail message. If you do not wish to get reminders, please tell your speech-language pathologist.
- **As Required by Law.** We will share your information when we are told to do so by federal, state, or local law. We will also share information if we are asked by the police or courts.
- **Government Functions.** Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
- **Information about a Person Who Has Died.** We may share information with the coroner, medical examiner, or a funeral director, as needed.
- **Marketing.** We may use your information to let you know of other services that might be of interest to you.
- **Public Health Risks.** We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.
- **Regulatory Oversight.** We may use or share your information to report to agencies overseeing health care. This may include sharing information for audits, licensure, and inspections.
- **Research**. We may share your health information with researchers to be included in their research project. Information will only be shared for projects that have been through a special approval process. These projects have rules to protect your privacy, too.
- **Threats to Health and Safety.** Your health information may be shared if it is believed that it will prevent a threat to your health and safety or the health and safety of others.
- **Worker's Compensation.** We will share your information with Worker's Compensation if your case is being considered as a work-related injury or illness.

When Your Permission is needed to Use or Share your Health Information

You must give us permission to use or share your health information for any situation that is not listed in this notice. You will be asked to sign a form, called an authorization, to allow us to use or share your information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get the information back that we shared with your permission.

Your Privacy Rights

You have the right to:

- **Ask us not to share your information.** You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
- **Ask us to contact you privately.** You can ask us to only contact you in a certain way or at a certain place. For example, you may want us to call you but not email. Or you may want us to call you at work and not at home. You must ask us in writing. We will do all we can to do as you ask.
- **Look at and copy your health information**. You have the right to see your health information and get a copy of that information. You have a right to see treatment, medical, and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
- **Ask for changes to your health information**. You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.
- **Get a report of how and when your information was used or shared.** You can ask us to tell you when your information was shared and who we shared it with. There are some rules about this:
    - You need to ask us in writing.
    - You must tell us the dates you are asking about and if you want a paper or electronic copy.
    - You may get information going back 6 years, but it cannot be for earlier than April 14, 2003. This is the date when the government privacy rules took effect.
- **Get a paper copy of this privacy notice.** You can get a paper copy of this notice at any time. You can get a copy even if you have already signed the form saying you have seen this notice.
- **File complaints.** You can file a complaint with us or with the government if you think that
    - your information was used or shared in a way that is not allowed
    - you were not allowed to look at or copy your information
    - any of your rights were denied

Who is Covered by This Notice

The people that must follow the rules in this notice are:

- All speech-language pathologists and audiologists working at [insert practice name here]
- Anyone who is allowed to add health information to your file, including students and other staff
- Any volunteers who may help you while you are in this clinic

Changes to the Information in This Notice

We may change this notice at any time. Changes may apply to information we already have in your file and any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

Complaints

You may file a complaint if you think we did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. To find out more about filing complaints, go to www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. All complaints must be in writing. You will not get in trouble for filing a complaint.

Contacts

If you have any questions about this notice or your privacy rights, please ask your speech-language pathologist or contact [insert contact name and information here].

Speech & Voice Experience

Acknowledgement That You Have Received Our Privacy Notice

Speech & Voice Experience is required by law to keep your health information safe. This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes
- insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared. It also tells you how you can look at and comment on your information.

By signing this page, you are saying that you have been given a copy of our privacy notice.

_____ _____

Your name Date

_____ _____

Print your name if you are not the patient Relationship to patient

Speech & Voice Experience

Lifetime Authorization

PATIENT/CLIENT NAME: _____

The patient/client/legal guardian authorizes The Language Experience staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/client/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

I authorize release of medical records to any insurance carrier or entity that may be responsible for all or portions of the charges incurred. I assign benefits to the organization furnishing the services and authorize such to submit a claim to Medicare and/or other insurance for payment.

The patient/client/legal guardian agrees to pay for all charges NOT paid by insurance or health plan. In the even collection action is undertaken, the patient/client/legal guardian will incur all costs associated with collection, including attorney fees.

I hereby release this organization and any of its employees or contract workers from any liability that may be incurred from the loss or damage of valuables and personal items that I have kept in my possession while in the facility.

SIGNED: _____ DATE: _____

TITLE OR RELATIONSHIP:

_____

If signed by other than the beneficiary, state the reason the patient was unable to sign:

_____

Witness: _____ Date: _____ Time: _____