**Note: This form must be signed, dated and returned before scheduling an appointment.**

**Please recognize that we DO NOT file insurance for the following Evaluation/Treatment sessions:**

* Accent Modification Evaluations and Accent Modification Treatment sessions are Fee for Service and payment is expected at time of service.

**Please recognize that we do file insurance for the following Evaluation/Treatment sessions and you are responsible for finding out if your insurance plan pays for our service and if there are any requirements or limitations:**

* Speech-Language Evaluation/Treatment Sessions.
* Voice Evaluation/Treatment Sessions.
* Tinnitus Evaluation/Treatment Sessions.
* Feeding Evaluation/Treatment Sessions

**You are responsible for checking with your insurance plan to find out if they will pay for our services at our clinic and you will need to find out if your insurance plan requires prior authorization/precertification for our services and if your insurance company has a limit on the number of sessions they will pay for.**

**If your insurance plan requires prior authorization/precertification you will be responsible for getting these services approved and having the approval sent to us before your first visit.**

**Patient or Parent/Guardian Printed Name Patient Name if Someone Else is Responsible for Patient Care**

**Patient or Parent/Guardian Signature**

**Date**

# Acknowledgement of Notice of Privacy Practices

## Reconocimiento del Aviso de las Prácticas de la Privacidad

I have been given the opportunity to review the ETSU Notice of Privacy Practices and understand that the Notice indicates how my protected health information may be used and disclosed and how I gain access to this information. I have also been given the opportunity to receive a copy of the ETSU Notice of Privacy Practices for the further review.

By signing below, I agree to the above-mentioned statement.

*Se me ha dado la oportunidad de repasar el Aviso de las Prácticas de la Privacidad de ETSU y entiendo que el aviso indica cómo se puede usar y revelar mi información médica protegida, y cómo yo puedo tener acceso a dicha información. También, se me ha dado la oportunidad de recibir una copia del Aviso de las Prácticas de la Privacidad de ETSU para mantener para el futuro.*

*Al firmar abajo, juro que la declaración arriba es cierta.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian’s Printed NamePatient or Guardian’s Signatur*e*

*Nombre Escrito del Paciente o del Custodio Firma del Paciente o del Custodio*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If Guardian, relationship to patient) Date

*(Si es el Custodio, cual es la relación Fecha*

*con el paciente?)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Representative’s Printed NamePractice Representative’s Signature

*Nombre Escrito del Representante de la Firma del Representante de la*

*Práctica Práctica*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Patient’s Printed NamePatient’s Signature

*Nombre Escrito del Paciente Firma del Paciente*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Patient’s Date of Birth

*Fecha de Nacimiento del Paciente*

# HIPAA AUTHORIZATION FORM

I acknowledge I have received the ETSU Speech-Language-Hearing Center Notice of Privacy Practices.

I authorize East Tennessee State University Speech-Language-Hearing Center to discuss and/or release my medical information including labs and test results, diagnosis, and treatment discussed to the following persons

Name Relationship to Patient Phone Number

Name Relationship to Patient Phone Number

Name Relationship to Patient Phone Number

**Please circle the answer that applies below: Phone Number**

May we contact you at work? Yes No N/A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave messages at home? Yes No N/A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave messages with relatives at home? Yes No N/A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we call to remind you of your appointment? Yes No N/A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Printed) Date

Signature (Patient or Guardian – if under 18) Relationship

Witness Signature Date

# PATIENT INFORMATION

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial \_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: [ ] Male [ ] Female

Home Phone (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Place: CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ COUNTY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_COUNTRY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race**

White Black/African-American Hispanic Asian Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Language Spoken**

English Spanish Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Will you Need Interpreter Services? YES NO

**Marital Status**

Single Married Widowed Divorced

**Military Status**

N/A Veteran Currently Enlisted

**Female Head of Household**

[ ] Yes [ ] No

**Mother’s Maiden Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*This is ONLY used for verification of identification if someone calls to obtain patient information.

# Patient Education Information

Highest grade completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] N/A [ ] Less than high school [ ] High school diploma [ ] Some college [ ] College graduate [ ] Post graduate

# Patient Employment Information

Employment Status: Part-time Full-time Unemployed

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name: Phone: Relationship:

Emergency Contact Address:

**Primary Care Physician**

Physician Name: Phone:

Food Allergies (please list all):

# PATIENT ACCOUNT GUARANTOR INFORMATION

**Who is responsible for this bill if the insurance doesn’t pay? (if different than patient information)**

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial \_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: [ ] Male [ ]Female

Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name

Employer Address

City/State/Zip

Employer (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION - PRIMARY**

**(If you wish for your insurance to be filed please present all insurance information upon arrival to the clinic)**

[ ] No insurance [ ] Medicare [ ] Medicaid / Tenncare [ ] Other (Employer/Private/Commercial)

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s relationship to patient: [ ] Self [ ] Spouse [ ] Parent [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (specify)

Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Insured’s SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION - SECONDARY**

**(Please present all insurance information upon arrival to the clinic)**

[ ] No insurance [ ] Medicare [ ] Medicaid / Tenncare [ ] Other (Employer/Private/Commercial)

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s relationship to patient: [ ] Self [ ] Spouse [ ] Parent [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (specify)

Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Insured’s SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group/Account #\_\_\_\_\_\_\_\_\_

# AUTHORIZATION AND RELEASE

***I authorize the East Tennessee State University Speech-Language-Hearing Center to evaluate and treat me, and/or my child, or ward. I understand that the evaluation and treatment procedures used by the ETSU Speech-Language-Hearing Center are non-medical in nature. These procedures meet professional and ethical standards of the American Speech-Language-Hearing Association, and they offer no physical or psychological risk. Although the treatment procedures are expected to be beneficial, I understand that no guarantee of success can be expressed or implied.***

***I understand that the ETSU Speech-Language-Hearing Center serves as a training center for students majoring in Speech-Language Pathology or Audiology at East Tennessee State University. For this reason, I authorize the use of student observation, video recording, audio recording, pictures, client data, and discussion for professional research or educational purposes. I understand that no names or identifying information will be used in any of these procedures.***

***I authorize the ETSU Speech-Language-Hearing Center to release any and all clinical information necessary in order to submit my insurance claims to my insurance companies. I also request that my insurance companies pay benefits directly to the ETSU Speech-Language-Hearing Center for services rendered. I understand that the Health Center will refund any overpayments on my account. My right to prepare advance directives (directives about what medical treatment I may want to receive if I became physically or mentally unable to communicate my wishes) has been explained to me.***

**Signature of patient or parent (if minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Farmworker Status**

**Homeless Status**

N/A Street Couch Doubling Up Transitional Housing Shelter

**Employee**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**!OFFICE USE!**

# CLIENT ATTENDANCE POLICY

Clients are encouraged to attend therapy sessions on a regular basis. Regular attendance should enable progress to be made at a more rapid rate than when sessions are missed. In accordance with this, therapy will be terminated if erratic attendance occurs.

When a client cannot attend, please contact the Clinic at (423) 439-4355 or the number designated by your Clinical Instructor. Please state the reason for the absence, prior to the appointment time. Illness, death in the family, emergency, or prearranged excused situations will be considered as reasons for an excused absence. Failure to contact the Clinic will be considered an unexcused absence. The Clinical Instructor may remove the client’s name from our roster and schedule someone from our waiting list in his/her place if more than 1 unexcused absence occurs.

If a client is ill (especially in the contagious stage of an illness), we request that the client remain at home. Please call us regarding the absence.

NOTE TO FAMILIES:

Please do not leave the building during your family member’s therapy time. If the client becomes sick or needs your assistance, we need to have immediate access to you. We cannot be responsible for the client before or after the therapy session; thus, it is essential that you remain in the building.

Your cooperation is greatly appreciated. We want to serve your needs in the best possible way.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Client (Print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party Relationship to Client