



PATIENT NAME: \_\_\_\_\_

**PLEASE READ CAREFULLY, COMPLETE NECESSARY SECTIONS, INITIAL, CHECK ALL THAT APPLIES, AND SIGN BELOW**

\_\_\_\_\_ **FINANCIAL POLICY (Private-Pay or Insurance Patients)**

All professional services rendered are charged to the patient. There is no guarantee of payment from any insurance company. Necessary forms will be completed to help expedite insurance carrier payment. However, this service, regardless of authorization, may or may not be covered. For this, the patient is responsible for all fees regardless of insurance coverage and must pay the entire balance, if there has been no response from your insurance company within 60 days.

**RESPONSIBLE PARTY: (IF NOT PATIENT)**

NAME: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

If your account is turned over to collections for reimbursement, a 30% fee will be charged to your balance, to cover the collection process. You will also be responsible for any attorney or court fees that may be charged in seeking retribution.

\_\_\_\_\_ **INSURANCE AUTHORIZATION/ASSIGNMENT (Check each box)**

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize CSHC to deposit checks made in my name.
- I authorize CSHC to disburse with the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- This assignment will stay in effect as long as care is given, unless terminated by patient.

**By initialing above, I agree and understand, with complete clarity, the policies I have read above. The signature below will remain in effect indefinitely, unless terminate by either the patient or Charlotte Speech & Hearing Center. – ALL SECTIONS MUST BE INITIALED!!**

\_\_\_\_\_  
Patient's (Guardian's, if under 18) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's (Guardian's, if under 18) Name

# **!!!PLEASE KEEP FOR YOUR RECORDS!!!**

## **NOTICE OF PRIVACY PRACTICES**

Charlotte Speech & Hearing Center is required by law to protect the privacy of your personal health information, provide this notice about information practices and follow the information practices that are described herein.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

Charlotte Speech & Hearing Center uses your personal health information primarily for treatment, obtaining payment for treatment, and evaluating the quality of care we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health benefits that could be of interest to you. We may also use or disclose your personal health information without prior authorization for public health and auditing purposes, research studies, or for emergencies. We also provide information required by law.

### **YOUR INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. We will consider all such requests on a case-by-case basis, but the Center is not legally required to accept them.

### **CONCERNS AND COMPLAINTS**

If you are concerned that Charlotte Speech & Hearing Center may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Executive Director at the address below. You may file a written complaint to the US Department of Health and Human Services. We will not retaliate against you for filing a complaint.

**Charlotte Speech and Hearing Center**  
**Attn: Executive Director**  
**210 E. Woodlawn Road, Suite 150**  
**Charlotte, NC 28217**

This notice was published and becomes effective January 1, 2009.

### **DISCRIMINATION POLICY**

The Charlotte Speech & Hearing Center is fully committed to policies of non-discrimination. It is the practice of the center to prevent any form of discrimination, harassment, or prejudicial treatment on the basis of race, color, religion, national origin, sex, age, sexual orientation, or status of disabled individual or disabled veteran.

*\*Borrowed from the Civil Rights Act of 1964 and the American with Disabilities Act*

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# PRIVACY NOTICE ACKNOWLEDGMENT

Patient's Name: \_\_\_\_\_

Parent/Guardian's Name (If patient is under the age of 18):  
\_\_\_\_\_

I certify that I received a copy of this Center's Privacy Practices and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanation provided to me and I am confident that the facility is committed to protecting my health information. This acknowledgement will remain in effect indefinitely, unless otherwise revoked by a written, dated request.

\_\_\_\_\_  
Patient/Parent/Guardian Signature Please Print Name Date

\_\_\_\_\_  
Witness Signature (Office Personnel) Date

## **COMPLETE THIS SECTION IF YOU ARE A COURT ORDERED REPRESENTATIVE (POWER OF ATTORNEY, GUARDIAN AD LITEM, FOSTER PARENT)**

I certify that I am an authorized representative of \_\_\_\_\_ (Patient). I am the patient's \_\_\_\_\_ (Legal Authority/Relationship) and I have received the Privacy Notice on behalf of this individual and that the facility provided me with the opportunity to review this document and ask questions to assist me in understanding his/her rights. I am satisfied with the explanation provided to me and I am confident that the facility is committed to protecting my health information. This acknowledgement will remain in effect indefinitely, unless otherwise revoked by a written, dated request.

\_\_\_\_\_  
Representative Signature Please Print Name (Representative) Date

\_\_\_\_\_  
Witness Signature (Office Personnel) Date

## **ACCESS TO CHART (ACCOUNT)**

The following people are allowed to receive information, including test results, treatment and/or financial aspects, unless otherwise stated, on my account with Charlotte Speech & Hearing Center:

	PERSON'S NAME	RELATIONSHIP TO PATIENT
1.	_____	_____
2.	_____	_____
3.	_____	_____

If additional space is needed, please continue on the back of this sheet of paper.

### **FOR OFFICE USE ONLY**

If signature of acknowledgment has not been obtained from the patient/parent or guardian, please explain your efforts to obtain the acknowledgment and the reasons you could not obtain it.

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

\_\_\_\_\_  
Office Personnel Signature Date