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Adult Admission Form

TODAY'S DATE: _____

PATIENT INFORMATION:

Social Security Number: _____ Sex: ❑ Male ❑ Female

Patient Name:_____ Date of Birth: _____

Street Address: _____

City_____State _____ Zip: _____

Home Phone Number: _____ Other/Cell Phone: _____

Reminder Call Preference: ❑ Home Phone ❑ Cell Phone

E-Mail Address: _____Marital Status: ❑ Single - ❑ Married - ❑ Separated - ❑ Divorced - ❑ Widowed _____

Employment Status: ❑ Full Time - ❑ Part Time - ❑ Not Employed - ❑ Retired

Employer: _____ Phone Number: _____

Parent/Guardian (if under 18): _____

Next of Kin Not Living With You:_____Phone:_____

Street Address: _____

City_____State _____ Zip: _____

Referring Physician/Primary Care: _____

Insurance Information: PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD/CARDS

Primary Insurance: _____ **Phone:** _____

ID Number: _____**Group Number**: _____

Subscriber Name: _____**Date of Birth**: _____

Relationship to Patient: ❑ Self - ❑ Spouse - ❑ Child SSN:_____

Secondary Insurance: _____ **Phone:** _____

ID Number: _____**Group Number:** _____

Subscriber Name: _____**Date of Birth:** _____

Relationship to Patient: ❑ Self - ❑ Spouse - ❑ Child

Release of benefits and information: I hereby authorize my insurance benefits be paid directly to the practitioner. I am financially responsible for any balance due. I authorize the practitioner or insurance company to release any information required for any claims. I understand that simple interest will be added to any unpaid balance after 60 days of 1.3%.

Signature of patient or responsible party_____

Date:_____Relationship to Patient:_____

To Be Completed by Speech-Language Pathologist:

ICD-10: _____**CPT:**_____

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Welcome to Harbor Speech Pathology! We are happy to assist you with any questions you may have. Please take a few moments to read the following information.

Insurance: We accept most major insurance plans. As a courtesy to you, we will call your insurance company to verify your coverage for therapy in our office. Benefits quoted by an insurance representative are not a guarantee of payment and at times, can be quoted incorrectly. We encourage you to call your insurance company prior to your first appointment to verify that you are covered for therapy in our office.

Evaluation: Depending on age and abilities, we spend between 30 minutes and 1 hour with patients for the first appointment to determine the treatment plan and present levels of functioning. The evaluation generally involves a detailed intake, a speech and language, cognitive, voice or swallow assessment, goals and objectives to target if needed. Please understand that the unpaid balance is your responsibility.

Treatment: We are able to accommodate our patients with appointments times from 9:00 a.m. to 5:00 p.m., Monday through Thursday. We do our best to find a regular appointment time (weekly or bi-weekly, if desired) for each patient with one of our therapists.

Cost of Supplies: Occasionally, with your consent, we will order supplies to be used in your therapy sessions and at home. In the case that your insurance company does not cover these expenses, you will be responsible for the bill.

Financial Policy: Insurance co-pays are due at time of service. It is the policy of our office to bill all claims to your insurance company as a courtesy to you. The responsibility for payment of your account remains with you at all times, including closed or rejected Labor and Industries claims.

Your insurance policy is a contract between you and the insurance company. In many instances your insurance will cover only a portion of the charges. You should be aware that you are responsible for the balance of your bill. If your claim is denied, you will be responsible for the entire charge. If no insurance is available, private payment is due at the time of service. We accept personal checks, all major credit cards, and cash payments.

Referrals/Prescriptions: It is Harbor Speech Pathology's policy to have a referral or prescription on file for all patients, regardless of your insurance company's requirements. It is your responsibility to obtain one from your primary care physician and make sure we have it at the time of service.

I HEREBY AGREE TO FULL RESPONSIBILITY FOR ALL EXPENSES INCURRED BY OR IN THE ACCOUNT OF _____.

I AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO HARBOR SPEECH PATHOLOGY FOR SERVICES RENDERED. I AGREE THAT I WILL PAY ANY REMAINING BALANCE NO LATER THAN 30 DAYS FOLLOWING THE INSURANCE PAYMENT.

_____ _____

Signature of patient or authorized representative Date

5202 Olympic Drive NW, Suite 100 Gig Harbor, WA 98335 P (253) 851- 0007 F (253) 514-8261
1230 Bay Street, Suite 100 Port Orchard, WA 98366 P (360) 876-1717 F (253) 514-8261
info@harborspeech.com I harborspeech.com

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Cancellation Policy

Dear Valued Patient,

We realize that coming to us for treatment requires a substantial investment in time on your part. We have adequate staff on hand to allow 30-60 minutes for each appointment. This does mean that if you cancel an appointment without adequate notice, we may not be able to fill your appointment time. If you arrive late for your appointment you will miss part of your treatment for that day.

We charge a fee of **$50.00** if an appointment is canceled without 24-hour notice. This charge is NOT covered by insurance and will be your direct responsibility. This is much less than the value of an appointment. It is not intended to be punitive but rather to offset part the cost of having a therapist scheduled.

Thank you for your understanding with this policy as we provide you with quality services.

Sincerely,

Channa Beckman, M.A., CCC-SLP / CBIS
Harbor Speech Pathology

I have read and understand Harbor Speech Pathology's cancellation policy.

_____ _____

Signature Date

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CONSENT FOR DISCLOSURE
WRITTEN AND VERBAL COMMUNICATIONS

I, _____, hereby authorize and request Harbor Speech Pathology or its representatives to:

( ) Release information to ( ) Obtain information from ( ) Exchange information with the following individual(s):

_____

_____

_____

_____

Regarding: _____ Date of Birth: _____

INFORMATION TO BE RELEASED:	YES	NO
Progress reports	_____	_____
Evaluations of treatment participation	_____	_____
Medical history/Social history	_____	_____
Alcohol and other drug history	_____	_____
Psychological/Psychiatric testing, evaluation and reports	_____	_____
Other (specify) _____	_____	_____

_____

I understand that my records are protected under the Federal (42CFR) and State (RCW 71.05.390) confidentiality Law and Regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires automatically as specified below or in 90 days without such specification. This information released may be obtained via mail, telephone, fax, or in person.

Specification of the date, event, or condition upon which this consent expires: _____

_____ _____
PATIENT/ GUARDIAN /SIGNIFICANT DATE

_____ _____
WITNESS DATE

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PATIENT NOTIFICATION OF PRIVACY POLICIES (HIPAA AUTHORIZATION)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT 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. **Harbor Speech Pathology, P.S.** is dedicated to ensuring the privacy of your records. In serving our patients, we create records regarding treatment and services that are provided in order to have accurate information and ensure the appropriateness and efficiency of treatment services. Federal law requires us to strictly protect any personally identifying information of our patients. This notice discloses our policies regarding the storage, use, and sharing of confidential patient information. **PLEASE REVIEW THIS NOTICE CAREFULLY.**

Harbor Speech Pathology, P.S. 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 HIPPA for short. We will ask you to sign a paper acknowledging that you have been given this notice.

Your Health Information May Be Used or Shared <u>without</u> your permission for the following reasons:

1. **Treatment:** We may share your information with doctors or other health care providers who care for you. For example, if your doctor orders speech therapy, we may share the results of our treatment with that doctor.

2. **Payment:** We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for therapy 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

3. **Health Care Operations:** We may 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 and private practices
- Make our services better
- Help others study health care services

Your health information may also be used or shared <u>without</u> 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. If you wish to get text message reminders, please ask the front desk.
- **As Required by Law:** We will share your information when we are told to 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.
- **Health-Related Benefits and Services:** 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.
- **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.

PATIENT NOTIFICATION OF PRIVACY POLICIES (HIPAA AUTHORIZATION)

Worker's Compensation: We will share your information with Worker's Compensation if your case is being considered as a work-related injury.

When Your Permission is Needed to Use or Share Your Health Information

You must give us your permission to use or share your health information for any situation that is not listed on this notice. You will be asked to sign a form to allow us to 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 in writing.
- **Look at and copy your health information:** You have the right to see your health information and get a copy of that information at any time. You have the 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 whom 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 six (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.
- **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 of this notice are:

- All speech-language pathologists at **Harbor Speech Pathology, P.S..**
- Anyone who is allowed to add health information to your file.
- Any volunteers who may help you while you are at 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. All complaints must be in writing. You will not get in trouble for filing a complaint.

If you have any other questions about this notice or your privacy rights, please ask our office staff.

I HAVE READ AND UNDERSTAND THE PRIVACY POLICIES DISCLOSED IN THIS NOTICE.

_____	_____	_____
Patients Name	Patient/ Legal Guardian Signature	Date