{Please Print} **PATIENT INFORMATION** (Información del Paciente, por favor imprenta)

Last Name (Apellido): ____________ First Name (Nombre): ____________
Address (Domicilio): ____________ Apt. #: ____________
City (Cuidad): ____________ State (Estado): ____________ Zip Code (Zona Postal): ____________
Home Phone # (Nu. De Teléfono): ____________ Work Phone # (Nu. De Teléfono Trabajo): ____________
Cell phone # (Nu. Celular): ____________ E-mail (Correo Electrónico): ____________
Date of Birth (Fecha de Nacimiento): ____________ Age (Edad): ____________ Sex (Sexo): ____________
Social Security # (Seguro Social): ____________ Driver's License # (Un. Licencia de Conducir): ____________

RESPONSIBLE PARTY (Persona Responsable)

Last Name (Apellido): ____________ First Name (Nombre): ____________
Address (Domicilio): ____________ Apt. #: ____________
City (Cuidad): ____________ State (Estado): ____________ Zip Code (Zona Postal) ____________
Home Phone # (Nu. De Teléfono): ____________ Work Phone # (Nu. De Teléfono Trabajo): ____________
Cell phone # (Nu. Cellular): ____________ E-mail (Correo Electrónico): ____________
Date of Birth (Fecha de Nacimiento): ____________ Age (Edad): ____________ Sex (Sexo): ____________
Social Security # (Seguro Social): ____________ Driver's License # (Nu. Licencia de Conducir): ____________

INSURANCE INFORMATION (Información de Seguro)

Insured Name (Nombre del Asegurado): ____________ Date of Birth (Fecha de Nacimiento): ____________
Insurance company name (Nombre de la aseguranza) ____________ Policy (Póliza)/Group(Grupo)#: ____________
Complete Insurance Address (Dirección completa de Seguros) ____________
Subscriber # (Nu. Suscriptor): ____________ Employer (Empleador): ____________
Check one (Marque uno): ☐ HMO ☐ PPO ☐ EPO ☐ POS
Primary Care Physician (Doctor Primario):____________ Phone (Telefono):____________
Address (Domicilio):____________

SECONDARY INSURANCE (Información de Seguro Segundo)

Check one (Marque uno): ☐ Supplemental (Supplimental) or ☐ Retirement Plan (plan de jubilación)
Insured Name (Nombre del Asegurado): ____________ Date of Birth (Fecha de Nacimiento): ____________
Insurance company name (Nombre de la aseguranza) ____________ Policy (Póliza)/Group(Grupo)#: ____________
Complete Insurance Address (Dirección completa de Seguros) ____________
Subscriber # (Nu Suscriptor): ____________ Employer (Empleador): ____________
Check one (Marque uno): ☐ HMO ☐ PPO ☐ EPO ☐ POS

Ethnicity, please check one (Etnicidad, por favor marque uno):

☐ Asian ☐ Black/African Amer. ☐ Amer. Indian/Alaska Native ☐ Latino/Hispanic ☐ Pacific Islander ☐ White/Caucasian
☐ Other ____________

US Armed Services veteran status, check if applicable (EE.UU. Fuerzas Armadas condición de veteran, marque el que aplica):
☐ Patient/self (Paciente/si mismo) ☐ Patient's parent/guardian (Padre/s de paciente/guardian) ☐ Patient's spouse (Conyuge de paciente)

How did you hear about us? Please indicate from choices below (¿Cómo se entero acerca de nosotros? Por favor, indique las opciones de más abajo)
☐ Newspaper (periódico) ☐ Event (evento) ☐ Direct Mail (correo directo) ☐ Friend (amistad) ☐ Website (sitio web)
☐ Senior Center (centro de ancianos) ☐ Other (otro) ____________

What is the name of the Physician that referred you? (¿Cual es el nombre del médico que lo refirió? ____________

I hereby assign to Providence Speech and Hearing Center (PSHC) all monies to which I am entitled for charges related to the service(s) provided. I understand that I am financially responsible to PSHC for charges not covered by this assignment. Also, I authorize the release of any information in order to process claims. (El que firme, comprende que todos los cargos incurridos por mi o mis dependientes por servicios presentados son mi responsabilidad financiera. Todos los cargos de la corte, abogados o comisión necesaria para colectar esta cuenta serán agados por mí. Le doy permiso a esta agencia de comunicarse con mis empleadores. Al grado que sea necesario para determinar la responsabilidad de los pagos y obtener compensación, o autorizó la revelación de partes del expediente de este paciente.)

Signature (Firma): ____________ Date (Fecha): ____________

CONSENT TO RELEASE MEDICAL/EDUCATIONAL HISTORY

CONSENTIMIENTO PARA CEDER HISTORIAL MÉDICA Y EDUCACIONAL

Patient Name/Nombre del Paciente	**Date of Birth/**Fecha de Nacimiento
City/Cuidad	**State/**Estado
Date/Fecha	

To Whom It May Concern *(A Quién Corresponda)***:**

This authorizes all physicians, hospitals, medical attendants, school districts personnel (E.G., SLP, Psychologists, Teachers) to furnish any and all medical records, educational records, history and information to Providence Speech and Hearing Center, or to any representative of Providence Speech and Hearing Center, concerning my medical condition. This authorization also includes examination of all hospital records, x-ray film, IEP documents, audio evaluations or screenings, prior evaluations, OT or PT report and furnishing of any information including opinions. You are further requested not to disclose such information to any other person without written authority to do so. *(Esto autoriza a todos los médicos, hospitales, asistentes-medico, personal del distrito escolar (EG, SLP, Psicólogos, Maestros) a proporcionar cualquier y todos los expedientes médicos, expedientes educacionales, historial y la información a el Centro Providence del Habla y Audiencia, o a cualquier representante del Centro Providence del Habla y Audiencia en relación con mi condición médica. Esta autorización también incluye la exanimación de todos los expedientes del hospital, de rayos X, documentos de IEP, evaluaciones de audio o detecciones, evaluaciones previas, reportes de OT o PT y el suministro de cualquier información, incluyendo opiniones. Le pedimos además no revelar esta información a cualquier otra persona sin autorización escrita para hacerlo).*

All prior authorization is hereby cancelled. *(Toda autorización previa queda cancelada).*

Patient / Parent / Legal Guardian
Paciente / Padre de familia / Tutor legal

Revised 9/20/13

Who do you authorize to receive copies of records? Please complete one section for each physician, facility, or for yourself. (A quien le autoriza que reciba copias de registros médicos? Por favor complete una sección para cada médico, facilidad, o para usted mismo.)

I, the undersigned, hereby authorize Providence Speech and Hearing Center to provide medical information or records to (Yo, el abajo firmante, le autorizo a Providence Speech and Hearing Center proveer información o documentación medica a):

Facility or Physician (Instalación o el médico): ______________________ Phone # (Nu. de Teléfono): ________________

Address (Dirección): ____ Ste: ____________________

City (Cuidad): __________________________ State (Estado): ______________ Zip Code (Código postal): _________

Signature of representative to patient (Firma del representante del paciente): ______________________________________

I, the undersigned, hereby authorize Providence Speech and Hearing Center to provide medical information or records to (Yo, el abajo firmante, le autorizo a Providence Speech and Hearing Center proveer información o documentación medica a):

Facility or Physician (Instalación o el médico): ______________________ Phone # (Nu. de Teléfono): ________________

Address (Dirección): ____ Ste: ____________________

City (Cuidad): __________________________ State (Estado): ______________ Zip Code (Código postal): _________

Signature of representative to patient (Firma del representante del paciente): ______________________________________

I, the undersigned, hereby authorize Providence Speech and Hearing Center to provide medical information or records to (Yo, el abajo firmante, le autorizo a Providence Speech and Hearing Center proveer información o documentación medica a):

Facility or Physician (Instalación o el médico): ______________________ Phone # (Nu. de Teléfono): ________________

Address (Dirección): ____ Ste: ____________________

City (Cuidad): __________________________ State (Estado): ______________ Zip Code (Código postal): _________

Signature of representative to patient (Firma del representante del paciente): ______________________________________

I, the undersigned, hereby authorize Providence Speech and Hearing Center to provide medical information or records to (Yo, el abajo firmante, le autorizo a Providence Speech and Hearing Center proveer información o documentación medica a):

Facility or Physician (Instalación o el médico): ______________________ Phone # (Nu. de Teléfono): ________________

Address (Dirección): ____ Ste: ____________________

City (Cuidad): __________________________ State (Estado): ______________ Zip Code (Código postal): _________

Signature of representative to patient (Firma del representante del paciente): ______________________________________

Revised 9/20/13

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Summary
By law, we are required to provide you with our **Notice of Privacy Practices** (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

Use and Disclosure of your Health Information:

1. To comply with requests from public health authorities and health oversight agencies which are required by law to collect health information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
5. If you are a member of U.S. or foreign military forces, including veterans, and if required by the appropriate authorities.
6. To federal government officials for intelligence and national security activities required by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. We are required by law to maintain the confidentiality of your health information as prescribed by HIPAA. These HIPAA guidelines are summarized above for your information and understanding. A full copy of the Center's privacy policies is available for review upon request.

If you have any questions about this Notice of Privacy Practices or Providence Speech and Hearing Center's health information privacy policies, please contact Robyn Belz at the phone number listed below.

Effective Date of this Notice: ___________________________________(write date you received this notice)

Contact Person: Privacy Officer, C/O Providence Speech and Hearing Center
1301 Providence Avenue, Orange CA 92868
Phone Number: (714) 639-4990

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of the Center's Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me any updates to this Notice of Privacy Practices should it be amended, modified, or changed in any way."

Patient Name (please print) ____

Patient or Representative Signature____________________________ Date _______________

Patient refused to sign ____

Patient was unable to sign because ____

PSHC Representative Name ____

Revised 8/7/2014

HIPAA AUTHORIZATION TO USE HEALTH INFORMATION FOR FUNDRAISING AND MARKETING ACTIVITIES

Purpose of this Form:
A federal law known as the Health Insurance Portability and Accountability Act (HIPAA) protects how your health information is used. HIPAA does not allow your health information to be used or released for certain purposes without your written permission. State laws also protect how your health information may be used.

Providence Speech and Hearing Center ("Providence") is dedicated to providing high quality patient care. As a nonprofit organization, Providence relies on the generosity of donations from patients and others to continue to fulfill its clinical care mission. Providence periodically contacts patients and others to inform them of new programs, services and initiatives that may be of interest or are supported by our fundraising efforts.

By signing this form, you are allowing your health care providers (for example, speech language pathologist, audiologist) to release your health information for the marketing and fundraising efforts described in this form. You will be given a signed copy of this authorization.

How Your Health Information Will Be Used:
This authorization permits Providence clinical staff and marketing and fundraising personnel to use your contact and other demographic information and the name(s) of your Providence treating physicians and information about your health care, to identify programs and initiatives that are likely to interest you, such as programs relating to your care and treatment, and to contact you about them for fundraising purposes and to include you on mailing lists. Providence will not provide this information to unrelated parties for their own marketing and fundraising.

How long will this authorization be in effect?
This authorization will remain in effect for ten (10) years from the date of signature. Once your authorization expires, we may need your signature again.

What if I don't want to sign, or later change my mind?
Signing this form is entirely voluntary. If you don't sign, this will not affect Providence's clinical treatment of you, or your eligibility for benefits. If you change your mind at any time, you can revoke (cancel) this authorization by providing a written notice of revocation to Providence Speech and Hearing Center, 1301 W. Providence Avenue, Orange, CA 92868, stating that you are revoking your authorization regarding fundraising and/or marketing. It will be effective upon receipt.

Are the individuals who receive my health information pursuant to this authorization permitted to use or disclose it for other purposes?
No. Providence policies and California law prohibit anyone who receives your health information pursuant to this authorization from using or releasing it for other purposes except with your written authorization or as specifically required or permitted by law. Federal privacy protections are narrower and may not apply to everyone who receives your health information, but California law would still apply.

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about Providence's use of my health information described in this form. I hereby knowingly and voluntarily authorize Providence to use such information for the purposes described above.

____ ________________________

Signature of Individual Date

If Individual is unable to sign this Authorization, please complete below:

____ ________________________

Signature of Legal Guardian/Legal Relationship/ Personal Representative Date

FINANCIAL POLICY
STATEMENT OF FINANCIAL RESPONSIBILITY

Thank you for using Providence Speech and Hearing Center as your health care provider.

We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must read and sign this policy before being seen.

ALL COPAY AND DEDUCTIBLE MONIES ARE DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS, VISA/MASTERCARD AND AMERICAN EXPRESS

REGARDING PAYMENT: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. All charged incurred are the responsibility of the patient or their guarantor. We will bill your insurance company as a courtesy. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. If your insurance company has not paid your account within 60 days, the balance will automatically be billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and /or other medical insurance. Benefit inquiries and authorizations are not a guarantee of payment by your insurance company.

OVERPAYMENT: Our policy is to collect a payment of 50% of charges at the time of service for non-provider insured patients, unless other arrangements have been made. If you feel you have overpaid, please contact our Billing Department so we can research and process any refunds due to you. All refunds are processed in the same manner as payment was received. If any credits on your account are due to insurance overpayments, a refund will be made to the insurance company.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our geographic area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Prearranged contracts will be honored.

MINOR PATIENTS: The adults accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to an approved credit plan, such as a Visa, MasterCard, or American Express, or paid by cash or check at time of service.

MISSED APPOINTMENTS: Unless canceled 24 hours in advance, our policy is to charge for missed appointments at the rate of the missed session. Please help us serve you better by keeping scheduled appointments.

INTEREST: We reserve the right to charge interest in the amount of 10% as provided by state law.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

______________________________	______________________________
Patient's Name (printed)	Signature of Patient or Responsible Party
______________________________	
Date	

Revised 8/7/14

Corporate Office: 1301 Providence Ave., Orange, CA 92868 ♦ (714) 639-4990 ♦ Fax (714)744-3841 ♦ www.pshc.org