FSU | L.L. SCHENDEL SPEECH & HEARING CLINIC
COMMUNICATION SCIENCE & DISORDERS

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Client's Name: _____ **Client's DOB:** _____

Parent's Name (if client is a minor): _____ **Clinic Number:** _____

PHONE NUMBER ***EMAIL:***

_____

LEAVING MESSAGES

Can messages regarding your appointment(s) be left on your answering machine/voicemail? ___ Yes ___ No

AUTHORIZATION TO COMMUNICATE VIA EMAIL and TEXT Messages

Transmitting confidential patient information by email has a number of risks that clients should consider before using email.

I authorize the clinic to contact me via email/text message about my appointments. ___ Yes ___ No

I authorize the clinic to send reports or other documents via email. ___ Yes ___ No

I authorize **The Florida State University Speech and Hearing Clinic**, Tallahassee, FL, to use or disclose the above named client's protected health information. The following information may be disclosed: Please indicate preference with an X

-----Audiological records	------Speech records	-----Any/all records.

Name/Relationship _____Phone #_____

Address: _____ City: _____ State: _____ Zip Code: _____

Indicate report mailing preference: E-MAIL or REGULAR MAIL

Name/Relationship: _____Phone #_____

Address: _____ City: _____ State: _____ Zip Code: _____

Indicate report mailing preference: E-MAIL or REGULAR MAIL

Name/Relationship: _____Phone #_____

Address: _____ City: _____ State: _____ Zip Code: _____

Indicate report mailing preference: E-MAIL or REGULAR MAIL

Name/Relationship: _____Phone #_____

Address: _____ City: _____ State: _____ Zip Code: _____

Indicate report mailing preference: E-MAIL or REGULAR MAIL

_____I will pick up the copies myself (Please bring picture ID to pick up.)

If additional authorizations are needed, please fill out another sheet.

ACCREDITATION

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is NOT conditioned on my signing this Authorization. However, The Speech and Hearing Clinic may condition the provision of healthcare for the purpose of disclosing to a third party protected health information specifically created for that third party, or for participating in research-related treatment upon my agreement to use and disclose this information.

By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorization to The Speech and Hearing Clinic to disclose my records, and that I may revoke this Authorization at any time by providing a written notice to The Speech and Hearing Clinic to the attention of the Clinic Director, except if this Authorization was obtained as a condition of obtaining insurance coverage. In order for the revocation of this authorization to be effective, The Speech and Hearing Clinic must receive the revocation in writing.

The revocation shall be effective except to the extent that The Speech and Hearing Clinic has already used or disclosed information in reliance on the Authorization. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. **Please refer to the *Notice of Health Information Privacy Practices* for more detailed information**. Unless otherwise revoked, this authorization will expire one year from the date of signature or in less than a year, as indicated: _____. After this date, The Speech and Hearing Clinic can no longer use or disclose the client's protected health information without first obtaining a new authorization form.

- **I fully understand and accept the terms of this authorization.**

  Signature _____ Date _____

- **The above authorization is given on this client's behalf as the client is a minor or is unable to sign for the following reasons:** _____

  Signature: _____ Date _____
  Relative / Guardian / Personal Representative

For Office use only: **Processed by: _____ Date: _____**

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CONSENT FOR DIAGNOSTIC AND TREATMENT SERVICES

Client's Name: _____ **Client's DOB:** _____

Parent/Legal Guardian's Name (if client is a minor): **Clinic Number:** _____

I,_____, HEREBY AUTHORIZE Florida State University Speech and Hearing Clinic audiologists, speech-language pathologists, or students under the direct supervision of licensed certified personnel, to conduct requested services at the Florida State University Speech and Hearing Clinic.

I understand that any evaluation and treatment will be completed by a licensed and certified audiologist or speech-language pathologist or by a student under direct supervision.

I understand that evaluations and treatment may be completed using telepractice. I also understand telepractice involves the communication of my medical information both orally and visually.

I have the right to withhold or remove consent at any time without affecting my right to future care or treatment.

I agree that for training and research purposes, therapy or evaluation sessions may be observed by clinical educators, faculty, student clinicians, and associated team members.

I agree that sessions may be audio-recorded, videotaped or stored in an electronic format, and recordings of sessions may be used for training, supervision, research, or for educational purposes in professional settings. I also authorize the use of clinical case discussion and review of records for professional and/or teaching purposes.

Information obtained during the course of service(s) will remain confidential, to the extent allowed by law. My participation in service(s), as well as that of my child or family member, is voluntary and I or my child or family member can withdraw from the service(s) at any time.

I understand my clinician must be in compliance with child abuse reporting laws and court mandated rulings regarding release of confidential information.

I acknowledge that I have read and fully understand the above explanation of the consent for diagnostic and treatment services, all questions have been satisfactorily answered, and I give my permission for participation in these services.

I know that I may contact Dr. Tricia Montgomery (Director of Clinical Education) at 850-644-9143, my clinical supervisor at 850-644-2238 at the L. L. Schendel Speech and Hearing Clinic, or a representative of the Human Subjects Committee at 850-644-8633 for answers to questions about service, research, or rights.

- **AUTHORIZATION FOR CONSENT:** I fully understand and *consent to engaging in telepractice with the FSU Speech and Hearing Clinic* as a part of my therapy process. Telepractice will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

_____ Date: _____
Signature of Client (representative or parent/legal guardian if a minor)
Authority of Representative to Act on Behalf of Client _____

- **AUTHORIZATION FOR CONSENT:** I fully understand and accept the terms of this *Consent for Diagnostic and Treatment Services*.

_____ Date: _____
Signature of Client (representative or parent/legal guardian if a minor)
Authority of Representative to Act on Behalf of Client _____

- **AUTHORIZATION FOR CONSENT:** *I consent to be contacted regarding future research opportunities.*

_____ Date: _____
Signature of Client (representative or parent/legal guardian if a minor)
Authority of Representative to Act on Behalf of Client _____

- **AUTHORIZATION FOR CONSENT:** I acknowledge that I have received The Speech and Hearing Clinic *Notice of Health Information Privacy Practices.*

_____ Date: _____
Signature of Client (representative or parent/legal guardian if a minor)
Authority of Representative to Act on Behalf of Client _____

Client safety and security Policy for minors (children under the age of 18)

For initial evaluations and first therapy sessions, we require parent/guardian or other authorized individual over the age of 18 to stay with the client the entire time. Based upon the safety and needs of the client, we reserve the right to request that someone remain on premise the entire time during subsequent sessions.

I authorize my child to participate in clinical services at the FSU Speech & Hearing Clinic without parental supervision. In the case of an emergency, I authorize the FSU Speech & Hearing Clinic to act as a surrogate to make decisions in my absence, contacting me immediately to inform me of the incident. I waive my right to pursue legal action in such cases.

_____ _____
Parent/Guardian Printed Name Parent/Guardian Signature

_____
Date

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FSU SPEECH & HEARING CLINIC FINANCIAL POLICY

Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, sign in at the front desk and present your current insurance card. This is your verification of the correct
   Insurance and consent to bill them on your behalf.
   a. If we do not participate in your insurance plan, **payment in full is expected from you at the time of your office visit.** We are happy to provide you with a receipt so that you may file for reimbursement from your insurance company.
   b. **Co-Payments are due at time of service.** You are responsible for any/all co-payments, deductibles, and co-insurances.
   c. *We accept several health insurance plans and some Medicaid HMOs*. Please check with our front office staff **before your appointment** to determine whether your health insurance plan is one that is accepted by our clinic, and any documentation that will be needed for your appointment (e.g., an order from your physician).
   d. If the insurance company that you designate is incorrect, **you will be responsible for payment of the visit** and for submitting the charges to your correct insurance plan.
2. It is your responsibility to understand your benefit plan. It is your responsibility to know:
   - if a written referral or prior authorization is required to see a speech pathologist or audiologist,
   - if preauthorization is required prior to you/your family member receiving services, and
   - What services are covered by your insurance? Not all services we offer are covered by all insurances.
3. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you.
4. After your insurance has paid, **you are responsible for any balance on your account.**
5. **Payment for an office visit is to be paid at the time of the visit.**
   - Any outstanding account balance greater than 30 days will be charged a $5 re-bill fee every 30 days unless other arrangements have been made previously***. Unpaid balances exceeding 90 days with no effort to make payment will result in dismissal from the clinic's caseload.***
6. If you do not have insurance or we do not accept your insurance plan, and if you find that our regular fees would cause a financial hardship, please ask for an Adjusted Rate Application. **You must submit all requested documentation to be considered for an adjusted rate, and submitting an application does not guarantee that you will be approved.**

I HAVE READ AND UNDERSTAND THIS POLICY, AGREE TO COMPLY, AND ACCEPT THE RESPONSIBILITY FOR ANY PAYMENT THAT BECOMES DUE AS OUTLINED IN THIS DOCUMENT.

SEMESTER: _____ **Charge Per Session:** _____ **Your initials:** _____

Client Name (PRINTED): _____

Signature (Responsible party): _____

_____	_____	_____
Responsible party member's name	Relationship	Date