Patient Financial Responsibility Statement

The UA Speech and Hearing Center is a fee-for-service clinic. Speech-language services and audiological services are provided by or under the direct supervision of certified speech-language pathologists and audiologists.

**Address Change:** It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information.

**Co-payments:** Co-payments are collected at the time of check-in. We accept cash, check, and most major credit cards.

**Billing:** If you owe additional money after your visit, you can expect to receive a statement. Statements are mailed out on a monthly basis. Payment is expected within 10 days of receipt of your statement.

**Failure to Pay:** Clients who ignore statements and fail to pay their balance risk negative credit ratings and possible dismissal from the center. Past due accounts may hinder your ability to have appointments scheduled.

**Fees:** Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment may result in a charge of $50 for missed evaluations and $25 for missed treatment sessions. If you must cancel an appointment, we require a minimum of 24 hours' notice.

**Guarantor:** Any client over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your balance in full and negotiate repayment with them outside of our office. This policy includes individuals negotiating divorce agreements.

**Insurance:** Our center contracts with many insurance plans. It is important for you to be an informed consumer, who understands the specifications of your insurance policy. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorization, and limits on therapy charges regardless of whether or not our clinicians participate. Before your appointment, please review the coverage of your plan to know what is in-network and what is not. If your plan requires pre-certification, please make sure you have provided all necessary documentation before the appointment.

As a courtesy to you, we will bill your insurance company directly for services rendered. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to making it your responsibility. However, please be advised that you are ultimately financially responsible for payment of services rendered. If you do not present a current insurance card, you will be responsible for payment in full. Insurance plans and Medicare consider some services to be "non-covered," in which case you are responsible for payment in full. If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith.

**Medicare Clients:** Medicare may not cover some of the services that your clinician recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

**Minors and Dependents:** Parents and guardians are responsible for payments for their dependents at the time services are rendered. Minors and dependents must present a valid insurance card if a claim is to be filed. The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our clinic in the middle of marital disputes. It is your responsibility to work out payment of your child's care between the custodial and noncustodial parent.

**Referrals and Authorizations:** Please be aware that your insurance may require a referral or authorization in advance of the appointment of service. If a referral or authorization is not obtained before care is provided, you will be responsible for the cost of the care. When in doubt contact your plan directly for clarification.

**Refunds:** A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our office.

**Self-Pay Clients:** Self-pay clients should be prepared to pay at the time of each visit.

I understand the above policy. I may also request a copy of the SHC's Billing Policy for more details.

Client Name: 

Your Name: 

Signature: 

Client File #: 

Relationship: 

Date: 


Permission to Contact

I authorize the Speech and Hearing Center to leave messages for me regarding clinical services as specified below. These messages may include appointment reminders, schedule changes, or other private health information, including information about evaluation or treatment. It is your responsibility to notify us should this information change. **You do not have to check any of these options if they do not apply to you, or if you do not want us to communicate with you at these different locations.**

**Circle yes or no**

I give my permission for the Speech and Hearing Center to call me

Yes  No  at home

Yes  No  at work

Yes  No  on my cell phone

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I give my permission for the Speech and Hearing Center to leave a message

Yes  No  on my answering machine

Yes  No  on my voice mail

Yes  No  with the person who answers if I am unavailable

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I give my permission for the Speech and Hearing Center

Yes  No  to leave a message with appoint/schedule information

Yes  No  to leave message with more detailed information

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I give my permission for the Speech and Hearing Center

Yes  No  to mail written information to my home

Yes  No  to FAX to this number

Yes  No  to email information to email address:

(  ) encrypted  (  ) unencrypted - client has been informed of risk

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I authorize following person(s) to have access to my Speech and Hearing Center records:

Person:  ___________________________________  Relationship:  ____________________________

Person:  ___________________________________  Relationship:  ____________________________

**Confidentiality:** It is our goal to keep you informed of your or your child’s progress and test results. If you would like to discuss this information in a private location away from the waiting area, please inform your clinician. We will make every effort to respect the confidential nature of your services.

Client Name (Print):  ___________________________________  Date:  __________________________

Legal Representative Name (Print):  ___________________________________

Signature:  ___________________________________

Valid until discharged from services unless otherwise specified.

Revised 1/18
Permission to Treat

I understand that the Speech and Hearing Center is a teaching clinic and that services are often provided by students under the supervision of a state licensed and nationally certified speech-language pathologist or audiologist.

MY PERMISSION IS GIVEN FOR DIAGNOSTIC AND INTERVENTION SERVICES AS DEEMED ADVISABLE BY MEMBERS OF THE SPEECH AND HEARING CENTER CLINICAL TEAM.

Client Name ___________________________ Date ___________________

Your Name ___________________________ Relationship __________________

Signature ___________________________
Our Notice of Health Information Practices is summarized below. Please review it carefully and sign it. Return this form to your clinician. The full version is available upon request or in our waiting room, and is yours to keep if you would like to have it. You can also access the Notice online at http://cd.ua.edu/speech-and-hearing-center/hipaa/.

The Notice explains when we might use/disclose your clinical information, and includes some of the following examples:

- when you give us permission to disclose your clinical information
- to aid in your treatment or to persons involved in your clinical care or the payment for such
- to help us or other healthcare providers get paid for services provided to you
- to improve our clinical care operations
- for use by businesses with whom we contract to help provide administrative support, but only if they agree in writing to keep your information private
- to public health agencies, governmental agencies, or other entities or persons when required or authorized by law or when required or permitted to do so by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Since the Speech and Hearing Center is a training facility for students majoring in Communicative Disorders, it is common practice for evaluation or therapy sessions to be observed or recorded for the following teaching and collaborative purposes:

- review by the clinician and clinical supervisor to evaluate the clinician’s performance
- review by the clinician and clinical supervisor to evaluate the client’s progress and adjust services if needed
- review by clinical supervisors for collaboration on how to better serve you or your child
- review by other students enrolled in clinic or Department of Communicative Disorders classes for teaching purposes.

If you do not want to be recorded or do not want your child to be recorded for these purposes, you must inform your clinician. You will be given a form to sign stating that recordings are not to be made. It will be placed in your client file.

Clinical sessions will be observed by authorized individuals who have undergone training regarding Speech and Hearing Center clients’ right to confidentiality. Observation is required for students enrolled in various aspects of clinical training. It is also required as part of the teaching/learning process for student clinicians and clinical supervisors. It is sometimes recommended practice for parents to be engaged in the clinical process. Parents, with permission of the clinical supervisor, will at times observe their child’s therapy.

The Notice also explains some of your rights under HIPAA, including but not limited to, your:

- right to ask that information about you not be disclosed to certain persons
- right to restrict disclosure of your clinical information to your health plan when you pay out of pocket in full for a healthcare item or clinical procedure
- right to ask that we communicate differently with you to ensure your privacy
- right to look at and get a copy of most of your clinical information in our records
- right to request that we correct clinical information in your record that is wrong or misleading
- right to be notified when a breach of your clinical information has occurred
- right to have us tell you to whom we have disclosed your clinical information
- right to make a complaint with our Privacy Officer or the Secretary of the U.S. Department of Health and Human Services.

I acknowledge that I have been given an opportunity to review this facility’s Notice of Health Information Practices, that I understand what kind of information is contained in the Notice, that I am entitled to have my own personal copy of the Notice, and that a copy is available for me to have.

Client Name (Print): __________________________ Date: __________________________

Legal Representative Name (Print): __________________________________________

Signature: __________________________

Revised effective 9/23/2013
Adult Case History Form

Thank you for choosing the University of Alabama’s Speech & Hearing Center to help you with your speech and language needs. To help us prepare and conduct a thorough evaluation, we would like for you to fill out the following information. Please be as accurate as possible. The information given here will be treated confidentially.

Date: ______________________

I. General Information

Gender: __________________ Date of Birth: _______________ Age: ______________

Preferred Pronoun: __________________

Preferred Language: __________________

Name of person completing this form: __________________ Relationship to client: __________________

Client's legal name: __________________ Client’s preferred name (if different): __________________

Address: ________________________________________________________________

(Street) __________________ (City) __________________ (St.) __________________ (Zip) __________________

Home Phone: __________________ Cell Phone: __________________ SSN: __________________

Occupation: __________________ Employer/School: __________________

II. Referral Information

Who referred you to this clinic? __________________

Reason for referral: __________________

III. Education History

Name of last school attended: __________________

Highest degree earned: __________________

Date earned: __________________

IV. Family History

Ethnicity (please circle one)

- African American  - Hispanic  - American Indian
- Caucasian  - Asian  - Multi-Racial

Relationship Status: __________________

Name of spouse/significant other: __________________

Children

Name: __________________ _______________ Age: __________________

Name: __________________ _______________ Age: __________________

Name: __________________ _______________ Age: __________________

Emergency Contact: __________________ __________________ Relationship: __________________

Address of Emer. Cont.: __________________ Phone # of Emer. Cont.: __________________

Is there any history of speech, language, or hearing difficulties in your family? If so, please describe: __________________
VI. Present Communication Status

Please describe your present speech, language, and hearing, including any difficulties you are experiencing:

__________________________________________

__________________________________________

Have you ever received a speech and language evaluation? (please circle one): Yes No
If yes, by whom and when? ____________________________________________

Results of previous evaluation: _______________________________________

__________________________________________

Have you ever had speech or language therapy? (please circle one): Yes No
If yes, by whom and when? ____________________________________________

When did the communication problem first begin? ______________________

(Please circle one) Has the problem: Remained the same Gradually worsened Worsened quickly

Describe the severity of the disorder: __________________________________

Overall, I would rate my communication as (please circle one): Excellent Good Fair Poor

Comments: _________________________________________________________

What do you consider to be your greatest communication problem at this time?

__________________________________________

Please list all activities you enjoy:

__________________________________________

__________________________________________

__________________________________________

Do you have any other comments that may be helpful to us in planning your evaluation?

__________________________________________

__________________________________________

__________________________________________