Acct #:_____ Guar Acct #:_____ Date:_____

Attached: ❑ Hospice/HHA/NH/SNF Facility Info Form ❑ Accident/Injury Information Form ❑ ABN Form Send Demo info to EHR: ❑ Yes ❑ No

## PATIENT INFORMATION

Patient:_____ Title: Mr./Mrs./Other:_____ Suffix: Jr./Sr./Other:_____
(Last / First / Middle)

Mailing Address:_____ _____ _____ _____
(Zip / City / State)

Physical Address:_____ _____ _____ _____
(Zip / City / State)

Home #:_____ Work #:_____ Ext:_____ Cell #:_____

Email:_____ Date of Birth:_____ Social Security #:_____

Sex: ☐ Male ☐ Female ☐ Unknown ☐ Other Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Preferred Language: ☐ English ☐ Spanish ☐ Unknown ☐ Decline to specify ☐ Other:_____

Race: ☐ Caucasian/White ☐ African American/Black ☐ Unknown ☐ Decline to specify ☐ Other:_____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Decline to specify

Current Employer:_____

Employment Status: ☐ Fulltime ☐ Self Employed ☐ Part Time ☐ Not Employed ☐ Unknown ☐ Retired ☐ Military Active

Student: ☐ Full Time ☐ Part Time ☐ N/A Prior Name:_____

Emergency Contact (EC) Name:_____ Relationship:_____

Home #:_____ Work #:_____ Cell #:_____

Have you seen a Physician at this practice within the past 3 years? ❑ Yes ❑ No If yes, which Physician?_____

Pharmacy:_____ Address:_____ Phone #:_____

Blood Type:_____ Notification Method: ☐ Mail ☐ Email ☐ Phone ☐ Text Patient & Resp Party are the same? ☐ Yes ☐ No

Referred By:_____

Do you have an advanced directive (living will, durable power of attorney)? ☐ Yes ☐ No → If 'Yes', provide copy:_____ _____
(Rec'd By / Date)

Is this an Accident or Injury? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No

If 'Yes' to either question, request and complete an Accident/Injury Information Form

Are you currently a Hospice or Home Health Care patient or are you in a Nursing Home or Skilled Nursing Facility? ☐ Yes ☐ No

If 'Yes', request and complete a Hospice/HHA/NH/SNF Facility Information Form and ask about an ABN Form.

Are you or have you been incarcerated within the last year? ☐ Yes ☐ No → If 'Yes', please provide:

Facility Name:_____ Release Date:_____

## RESPONSIBLE PARTY INFORMATION

*ONLY COMPLETE IF OTHER THAN PATIENT, THIS IS WHERE STATEMENT/BILL IS SENT AFTER INSURANCE DISPOSITION*

Responsible Party:_____ Title: Mr./Mrs./Other:_____ Suffix: Jr./Sr./Other:_____
(Employer Info if work related) (Last / First / Middle)

Mailing Address:_____ _____ _____ _____
(Zip / City / State)

Home #:_____ Work #:_____ Ext:_____ Cell #:_____

Email:_____ Date of Birth:_____ Social Security #:_____

Sex: ☐ Male ☐ Female Relationship to Patient:_____ Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Current Employer:_____

Employment Status: ☐ Fulltime ☐ Self Employed ☐ Part Time ☐ Not Employed ☐ Unknown ☐ Retired ☐ Military Active

## INSURANCE INFORMATION

***Scan/Copy Card***

| **PRIMARY:** | **SECONDARY:** |
|---|---|
| Relationship to Insured: ☐ Self ☐ Child ☐ Mate ☐ Other | Relationship to Insured: ☐ Self ☐ Child ☐ Mate ☐ Other |
| Insured: ☐ Patient ☐ Rsp Party ☐ Other | Insured: ☐ Patient ☐ Rsp Party ☐ Other |
| Insured Name: | Insured Name: |
| Social Security #: DOB: | Social Security #: DOB: |
| Group #: Policy#: | Group #: Policy#: |
| Eff Date: Exp Date: | Eff Date: Exp Date: |
| Contact: | Contact: |
| Phone: | Phone: |
| PCP (Name/Phone): | PCP (Name/Phone): |

By signing this,

_____ (Initial) I hereby acknowledge THE EMERGE CENTER (PRACTICE) has the right to use and disclose protected health information (PHI) for treatment, payment and health care operations, and that I have received the *Notice of Privacy Practices for Protected Health Information (NOPP)*. I understand I have the right to restrict how my PHI is used or disclosed, and that the PRACTICE is not required to agree to any restriction, but if an agreement is reached, the PRACTICE is bound by the agreement.

_____ (Initial) I hereby authorize THE EMERGE CENTER to evaluate and recommend any testing and/or additional treatment. I understand I have the right to refuse any such recommendations/treatment.

_____ (Initial) I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility. I verify all above information is true and accurate as of the below indicated date. I hereby authorize the listed insurance companies to pay directly to THE EMERGE CENTER benefits due on my behalf, if any, as provided in the above unexpired policy.

Signature:_____ Date:_____ Witness Signature:_____ Date:_____

Printed Name:_____ ☐ Patient ☐ Responsible Party

Name:_____ Date:_____

| | |
|---|---|
| ☐ ALWAYS ☐ OMETIMES ☐ NEVER | Are there situations in which you find it difficult to hear clearly? |
| ☐ ALWAYS ☐ OMETIMES ☐ NEVER | Do you have to strain to understand conversations? |
| ☐ ALWAYS ☐ OMETIMES ☐ NEVER | Do you have problems hearing over the telephone? |
| ☐ ALWAYS ☐ OMETIMES ☐ NEVER | Do you have trouble hearing a conversation when two or more people are talking at the same time? |
| ☐ ALWAYS ☐ OMETIMES ☐ NEVER | Do you have trouble hearing a conversation in a noisy background such as a restaurant or a group gathering? |
| ☐ ALWAYS ☐ OMETIMES ☐ NEVER | Do you have dizziness, pain or ringing in your ears? |
| ☐ ALWAYS ☐ OMETIMES ☐ NEVER | Do family members or coworkers remark about you missing what is being said? |
| ☐ ALWAYS ☐ OMETIMES ☐ NEVER | Do people complain that you turn the TV volume up too high? |
| ☐ ALWAYS ☐ OMETIMES ☐ NEVER | Do you find it hard to hear someone when they talk in a soft voice or whisper? |
| ☐ ALWAYS ☐ OMETIMES ☐ NEVER | Do you find understanding women and children particularly challenging? |

Circle any of the following that apply to your **immediate family members**:

☐ Deafness
☐ Meniere's Disease
☐ Balance Problems
☐ Sudden Onset Hearing Loss
☐ Chronic Middle Ear Problems
☐ Otosclerosis
☐ Congenital Hearing Loss
☐ Auditory Processing Issues
☐ Cochlear Implant

Circle any of the following that apply to **YOU**:

☐ Chronic Middle Ear Problems
☐ Excessive Earwax
☐ Sensitivity to Sounds
☐ Meniere's Disease
☐ Loss of Consciousness
☐ Memory Problems
☐ Vision Problems
☐ Rubella
☐ Noise Exposure
☐ Balance Problems/Vertigo
☐ Ear Surgery
☐ Fluctuating Hearing Loss
☐ Auditory Processing Issues
☐ Diabetes
☐ Skin Allergies
☐ Measles
☐ Cochlear Implant
☐ Tinnitus
☐ Ear Pain, Pressure or Fullness
☐ Otosclerosis
☐ Head Injury
☐ Heart Disease
☐ Poor Dexterity
☐ Mumps
☐ Sudden Onset Hearing Loss

If you circled Noise Exposure please circle any of the noises you have been exposed to:

☐ Industrial Machinery
☐ Construction Work
☐ Drills, Saws, or Compressors
☐ Lawncare Equipment
☐ Gunfire
☐ Loud Music
☐ High Pitched Drills or Electronics
☐ Aircraft Engines
☐ Carpentry Tools
☐ Motors
☐ Tractors or Other Farm Equipment
☐ Explosives

Date and location of most recent hearing evaluation:_____

Please list any current medications:_____
_____


**Authorization for Release of Information**

Client Name: _____ DOB:_____

I understand that this authorization is voluntary. I understand that I may revoke this consent at any time by sending a written notice to The Emerge Center. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the agency named above.

I hereby authorize the Emerge Center to:

☐ Exchange with ☐ Release to ☐ Obtain from **the parties I have indicated below**

I authorize the Emerge Center to exchange/ release/ obtain information in the following manner:

☐ Verbally only ☐ in written form only ☐ both verbally and in writing

**Persons/ organization receiving/ communicating the information**:

Name _____

Address_____

_____

Phone Number (_____) _____ ext: _____

This consent is valid for 1 year from the date on this form or a date specified in the notes section:

Notes: _____

_____

Signature of Client or Legal Guardian Date

_____

Address City State ZIP

_____

Printed name of client/guardian Relationship if not the parent

**NOTICE OF PRIVACY PRACTICES**
**THE EMERGE CENTER**

**This notice describes how medical or other identifying information obtained by our practice about you may be used and disclosed and how you can get access to this information. Please review this statement carefully and keep a copy to take home.**

The Emerge Center is required by professional ethics and federal law to keep confidential all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally. You, the client, have significant rights to understand in order to control how your health information is used. This agency may be penalized if we misuse your personal health information.

**Who Will Follow This Notice**

All employees, independent contractors, officers and directors of The Emerge Center must abide by this notice.

**How We May Use and Disclose Your Personal Health Information**
We may use and disclose your personal health information only for each of the following purposes: **treatment, payment, & health care operations.** Examples are given for each purpose, but they are not intended to imply that they are the only uses in that category.

- **Treatment** means providing, coordinating or managing the services you have requested. Example: If we order a hearing aid for you, we may disclose the results of your audiogram.
- **Payment** means such activities as obtaining reimbursement for services, determining your eligibility for insurance coverage, billing or collection activities and utilization review. Example: If you are eligible for Medicaid, we will send an invoice for your services to them for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducing quality assessment and improvement activities, auditing our financial statements, etc. Example: Independent auditors must review agency invoices against payment of those invoices.

**Other Uses & Disclosures of Protected Health Information Requiring Your Written Authorization**
**We may disclose personal health information**

- as required by law or statute, including disclosure to public health or designated authorities charged with preventing or controlling disease, injury or disability; licensing & regulatory agencies, authorities investigating domestic violence or abuse or neglect;
- in response to a subpoena or court order;
- to a coroner or medical examiner for identification of a body;
- to the extent allowed by federal law, to other providers' treatment and healthcare operations activities.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

**(OVER)**

**Uses and Disclosures of Protected Health Information Requiring Your Written Authorization**
Any other uses and disclosures of protected health information not covered by this notice or by other applicable laws will be made only with your written authorization. If you give us authorization to use or disclose any of your protected health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose that information for the reasons previously covered by your written authorization. However, we would be unable to take back any disclosures already made with your authorization, and we are required to retain our records of the care we have provided you.

**Your Individual Rights Regarding Your Medical Information**
You may exercise any of the following rights with respect to your protected health information by presenting a written request to the Executive Director of The Emerge Center:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. We reserve the right to charge you for the net cost of copying your records.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.
- If you believe your privacy rights have been violated, you may file a complaint with the Executive Director of The Emerge Center or with the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or denied service for filing a complaint.

The Emerge Foundation on behalf of the Emerge Clinic may notify you of fundraising opportunities. You have the right to opt-out of receiving such fundraising communications. If you do not want to receive these communications you can send us an email at giving@emergela.org with the words “Opt Out” in the subject line. Be sure to include your name or the name of the patient (if you are the patient’s parent or acting in loco parentis). If it is more convenient, you can call us at (225) 343-4232 ext. 1911 and leave a message with the patient’s name stating that you wish to “Opt Out” of receiving fundraising communications. If you decide to Opt-Out of receiving fundraising communications, you cannot be denied treatment and that will not affect payment.

This notice is effective as of August 12, 2019. We are required to abide by its terms. Within the provisions of law, we reserve the right to change the terms of this notice and to make the new terms effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practices from our office if such a change should occur.

To request more information or file a complaint regarding these practices with the Department of Health & Human Services, Office of Civil Rights, 200 Independence Ave., S.W., Washington, D.C. 20201 or Phone Toll Free: 1-877-696-6775

Client/Guardian Signature _____Date: _____

Client/Guardian Name _____

Minor Client Name _____


**Permission to Email Confidential Information**

We strive to communicate with parents and caregivers through the best method possible. For many families, email is a preferred method for communication. If you allow us to email with you through your designated email listed below, please sign and date. Please be aware that confidentiality cannot be assured via e-mail.

E-mail address(es): _____

_____

Parent name/s: _____

Parent Signature: _____

Child's Name:_____

Date: _____

the emerge CENTER
for communication, behavior, and development

# Consent for Assessment and Treatment

Client Name _____ Client Date of Birth _____

I voluntarily consent to the assessment and the treatment offered by the Emerge Center. I give my permission for the staff of the Emerge Center to perform the following service(s):

Testing/ assessment and/or treatment from staff of the Emerge Center in the following departments:

☐ Speech Therapy assessment and/or treatment

☐ Audiology Services

☐ Psychological assessment and/or treatment

☐ Applied Behavior Analysis therapy

☐ Occupational Therapy assessment and/or treatment

☐ Specialized consultation:_____

☐ Other: _____

This consent is for
___ Myself
___ My family member (Name _____)
___ Other (Explain: _____)

I have been informed that I, my family member, or the interdict will receive testing and/or treatment from Emerge Center. These procedures may involve, but are not limited to: tests of cognitive, speech/language, perceptual, physical, memory, and social/emotional functioning. I understand that during the interview-intake process, I will be asked about the symptoms and history related to my, my family member's, the interdict's present problem. I have been informed about confidentiality and its limits.

Further (initial in each blank to indicate that you have read the item and consent to the statement):

___I understand that services will be provided by employees of the Emerge Center and its Contractors and that, upon my signature, my, my family member's, the interdict's confidential information may be discussed among Emerge Center employees in pursuit of the highest quality of assessment and/or treatment.

___I understand that this consent may be rescinded or modified at any time with a written request to the Emerge Center.

___I understand that these services may include direct, face-to-face contact, interviewing, records review, consultation with other professionals, and other related activities necessary to support these services.

___I understand that there will be no exchange of printed or verbal information outside the Emerge Center without an appropriate release of information that I review and sign.

___I understand and agree to, for professional training purposes, supervised students observing and/or participating in the rendering of my, my family member's, the interdict's services.

___ As part of the student/clinician training process, for reasons related to safety, and/or for consultation with other professionals under Emerge Center, I understand and agree to the live monitoring or taping for review upon a later date as needed, the video recording of the provision of services for which I am herein providing my consent

___ I consent to telehealth service performed by an Emerge Center provider when scheduled. During telehealth services:

- Nonmedical technical personnel may be present to aid in video transmission. I will be informed of any other people who are present at the telehealth encounter.
- Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associate with the telehealth service

___I understand all information client information strictly confidential. The legal exceptions are:

- The client, parent/guardian or legal representative authorizes a release of information with a signature
- To comply with a court order
- There is suspicion of abuse or neglect involving a child, elder, or vulnerable person.
- The client presents as a danger to self or others
- Record review as requested by insurance carrier provided authorization has been obtained.

_____ _____

Signature of Individual or Personal Representative by Law Date

_____

Personal Representative's Relationship/Authority

_____ _____ _____

Signature of Emerge Center Representative Date

NOTE: If the individual is a competent major, he or she is to sign, or make his or her mark on the first line. If the individual is a minor, incompetent major, or unable to sign, the parent, guardian, or correspondent is to sign on the first line and fill in the second line