BOISE SPEECH and HEARING CLINIC
208.793.7006 | 13075 W Persimmon Lane Suite 120 Boise, ID 83713 | frontdesk@boiseshc.com

WELCOME TO OUR OFFICE

This information sheet is designed to answer questions you may have regarding your care. We take great pride in the training, knowledge and capabilities of our staff and we want you to know that we are dedicated to giving you quality care.

OFFICE HOURS

Regular office hours are 8:00 am to 5:00 pm Monday through Friday. We will make every effort to see your at the scheduled time. In order to maintain other patients' schedules, your promptness is appreciated. We believe strongly in the value of your time and will do our best to keep you from having to wait.

CANCELLATIONS

Because of frequent last minute cancellations, it has become necessary to require 24 hour notice before any missed appointments. This will allow us to schedule other patients who are waiting for appointment times and it will also prevent unnecessary time spent in preparation for a missed appointment. **Patients may be billed a fee of $25.00 for "no-show" or appointments which are missed and not canceled 24 hours priors to the scheduled time.** We have a 24 hour answering service; therefore, calls made to cancel or reschedule an appointment may be made at anytime by calling (208) 793-7006 For the benefit of other patients in need of our services, any patient who missed two (2) sessions without advance notice will be notified that they will be discharged from our service after one (1) more absence for which the therapist is not given at least 24 hours' notice.

PAYMENT POLICY

Co-pays and fees are due and payable at the time of visit. If you are scheduled twice weekly, for your convenience, you may pay once a week. We bill insurance on a daily basis. Your co-pay and deductible are due at the time of your appointment. We will be happy to discuss other payment arrangements if needed. If you have any questions regarding these arrangements or your account, please contact our office.

ONLINE STATEMENTS

Statements are sent out vial Email to the primary email documented in your file. **We will no longer print statements.** The email will come from Chatterton Speech and Therapy DBA Boise Speech and Hearing Clinic. Please check your email. Due dates for all payments will the 15th of the month.

Your signature indicates that you have read and understand our office policies. If you have any questions, please do not hesitate to ask.

_____ _____

Signature Date

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PATIENT INFORMATION

Patient's Name: _____

Occupation (if applicable): _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Contact Number: _____ Birthday: _____ Age: _____

Primary Email: _____

Father/ Spouses's Name: _____

Employer: _____ Occupation: _____

Email: _____ Cell Phone: _____

Mother/ Spouse's Name: _____

Employer: _____ Occupation: _____

Email: _____ Cell Phone: _____

Primary Care Physician: _____

Referred By: _____ Referred For: _____

Insurance Co: _____ Policy #: _____ Group #: _____

Policy Holder (PH): _____

DOB of Policy Holder: _____ SSN of Policy Holder: _____

For Confirmations, please check one: Call ☐ Text ☐ Email ☐ Cell Provider _____

Main reason for visit: _____

_____

Previous Speech Therapy? _____ Where? _____

I hereby affirm that the above information is accurate and correct to the best of my knowledge. I understand that this information is considered private medical record and that a full explanation of my rights regarding this information is included in the "Notice of Privacy Practices."

_____ _____

Signature Date

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RECORDS RELEASE AND MARKETING AUTHORIZATION

I hereby authorize the Boise Speech and Hearing Clinic to provide such services as Hearing and Speech Evaluation, Speech Therapy, and other Related Services for my overall Speech and Hearing Health as deemed necessary. I understand that if insurance, including Medicare and Medicaid, does not cover the cost of said services, that I will be responsible for the payment of such.

I hereby authorize the release of all pertinent information including diagnosis, examination records, and treatment records to authorized persons. These records will be help in strict confidence and are not available to unauthorized persons, as outlined by the Health Insurance Portability and Accountability Act (HIPPA) and explained in the Boise Speech and Hearing "Notice of Privacy Practices" document.

I understand that my personal information is private and that I have the right to prevent such information from being used for marketing purposes as outlined in the "Notice of Privacy Practices." I further acknowledge that I am free to change my preference regarding whether or not to receive marketing materials at any time.

- ☐ I consent
- ☐ I do not consent

I understand that photos, videos, testimonials, and case studies of patients can be used for educational and marketing purposes. By checking the indicated box below, I give Boise Speech and Hearing Clinic permission to the the above mentioned information for these purposes. All steps will be taken by Boise Speech and Hearing Clinic to maintain the privacy and anonymity of patients in marketing and educational activities. All materials gathered by Boise Speech and Hearing Clinic employees are property of Boise Speech and Hearing Clinic, and patients are not entitled to compensation of any kind I also understand that I am able to revoke this permission in writing at any time, except in actions already taken by Boise Speech and Hearing Clinic.

- ☐ I consent
- ☐ I do not consent

I have read and understood the above information and also acknowledge that I have had an opportunity to view and/ or receive a copy of the "Notice of Privacy Practices."

_____ _____

Signature Date