BOISE SPEECH *and* HEARING CLINIC

208.793.7006 | 8601 W. Emerald St, Suite 150 Boise, ID 83704 | 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 you 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 any time 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 monthly 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

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EVALUATION RESERVATION POLICY

Boise Speech and Hearing Clinic strives to maximize each patient's potential. Careful planning and time goes into preparing for an evaluation. There is a waiting list for current evaluation slots.

Please be advised that when booking your evaluation appointment we will ask for your credit/debit card number and you will be charged a deposit of **$50 (fifty dollars)** to hold your time slot. After you complete your scheduled evaluation and we bill your insurance, this deposit will be used towards your patient balance or any future sessions. If your insurance covers 100% of your evaluation and session charges, the deposit will be refunded to you after we receive your insurance payment.

If you must reschedule your evaluation appointment, you must do so at least **48 hours** (two days) before your appointment. The fee for less than 48 hours notice is **$50 (fifty dollars), a full forfeiture of your deposit**.

If you cancel your evaluation appointment and choose not to reschedule, **your credit/debit card will be charged $250 (two hundred fifty dollars).**

If you fail to show up for your scheduled evaluation and have not given us any notice, **your credit/debit card will be charged $250 (two hundred fifty dollars)**.

I hereby authorize Chatterton Speech Therapy (doing business as Boise Speech and Hearing Clinic) to charge my credit/debit card in the amount of $50 to hold my time slot and agree to the terms and conditions explained above.

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Signature Date