ASU SPEECH AND HEARING CLINIC – CLIENT GENERAL ACKNOWLEDGEMENT AND AGREEMENT

By signing below on page two of this document, I certify that I have reviewed this document and agree as follows:

1) Notice of Privacy Practices Acknowledgement

I understand that ASU Speech and Hearing Clinic follows the guidelines as stated in its Notice of Privacy Practices. I acknowledge that I have received, or been given access to, a copy of the ASU Speech and Hearing Clinic Notice of Privacy Practices which can be found at http://shs.asu.edu/clinics

2) Conditions of Treatment

I consent to the usual and customary medical evaluation and treatment relating to hearing and/or speech which may be performed on me at ASU Speech and Hearing Clinic. I understand that the services may be provided by a student clinician under the supervision of a speech-language pathologist or audiologist certified by the American Speech-Language Hearing Association. I understand that my medical records will be kept for a minimum of six (6) years following the last date of treatment.

3) Financial Agreement

I understand that all services rendered to me at ASU Speech and Hearing Clinic will have fees associated with them. If payments for these fees are not covered by a third party, I understand that I will be responsible for payment at the time services are rendered.

I understand that my complete insurance information must be provided to ASU Speech and Hearing Clinic at the time the service is rendered or no later than 48 hours after my appointment in order to bill my insurance company.

I hereby authorize ASU Speech and Hearing Clinic to furnish information to insurance carriers concerning my illness, condition and treatment, and I hereby irrevocably assign to ASU Speech and Hearing Clinic all payments for medical services rendered to me or my dependents.

4) Privacy Options

a) Opt-Out Option for Family Members I understand that unless I Opt-Out, ASU Speech and Hearing Clinic may share minimally necessary medical information with properly identified family members in order to assist in medical care and billing. If I Opt-Out, ASU Speech and Hearing Clinic staff will not share information with family even when requested by family members. I also understand that I can change my choice of sharing information in the future by notifying ASU Speech and Hearing Clinic in writing. If I am under 18, I understand that I cannot Opt-Out of sharing medical information with my parents or legal guardians.

☐ I certify that I am 18 years or older and I choose to OPT-OUT of sharing of private medical information with family members for medical care and/or billing purposes.
b) Additional/Alternative Designee to Receive Medical Information

☐ I choose the following additional and/or alternative person(s) to receive my medical information for medical care and/or billing purposes as deemed necessary or otherwise appropriate by ASU Speech and Hearing Clinic.

Name: ___________________________ Relationship: ___________________________

Address: __________________________________________________________________

Contact Phone #:________________________

Name: ___________________________ Relationship: ___________________________

Address: __________________________________________________________________

Contact Phone #:________________________

c) Alternative Methods of Communication

ASU Speech and Hearing Clinic can utilize many methods to communicate with patients including communicating verbally, through the mail, and telephonically. By default, I understand that ASU Speech and Hearing Clinic will not utilize unsecure email unless I choose to Opt-IN to this method of communication.

☐ I choose to OPT-IN to allow unsecure email communication with me. I understand ASU Speech and Hearing Clinic will still determine the best method of communication depending on the nature of the information.

Email- __________________________@________________________

________________________________________  __________________________

Patient Signature                                      Date