

Patient Consent and Acknowledgement

General Consent for Medical Treatment

I authorize Voicewize to examine, test and treat me for my medical condition. I am aware that the practice of medicine is not an exact science, and I understand that no guarantees have been made to me regarding the result of evaluation and treatment. _____ (initial)

Assignment of Benefits

Voicewize may receive payment for patient care from insurance companies, Medicare and/or other third-party programs. I agree to have my insurance company or other third-party payment program make payments directly to Voicewize (a.k.a. Entertaining Diversity, Inc.) and to let the speech-language pathologist and/or Voicewize submit claims and required treatment information to my insurance company or other third party payment program for my care and receive payments directly. _____ (initial)

I agree that I am responsible for understanding the benefits covered under my insurance plan and that I must pay all charges, co-payments, and deductibles that are not covered by my insurance company or third party payment program, even if I had believed the charge would be covered at the time of service or was unaware of my plan's deductible and co-pay requirements. _____ (initial)

I understand that I am responsible for knowing the referral and pre-authorization requirements of my own health plan and for obtaining referrals and pre-authorizations for treatment as necessary prior to attending my visit(s). If I do not obtain appropriate referrals and pre-authorizations, I understand that I am responsible for full payment for services rendered. _____ (initial)

Permission to Communicate

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician, your referring physician and other community care providers including mental health providers, and your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care. _____ (initial)

Trainees

Your speech-language pathologist may engage in training of graduate level clinicians. These clinicians in training may be involved in your care. Professional staff supervises trainees in accordance with professional standards. _____ (initial)

My questions have been answered. I agree to the information in this form.

Patient (or person authorized to sign for patient)

Date

Notice of Privacy Practices

Our Responsibilities

Voicewize (a.k.a., Entertaining Diversity, Inc.) is required by law to:

- * Maintain the privacy of your medical information
- * Provide a Notice of Privacy Practices explaining our duties and privacy practices
- * Abide by the terms of the notice currently in effect

We reserve the right to change privacy practices, and to make the new practices applicable to all information we maintain.

Your Rights

You have the right to:

- * Request that we restrict how we use or disclose your medical information (We may not be able to comply with all requests)
- * Request that we use a specific telephone number, address or email address to communicate with you
- * In writing, request to inspect and copy your medical information (fees may apply)
- * In writing, request an amendment to your medical information (We may not be able to comply with all requests e.g., if the information was not created by us or if amendment would create factual inaccuracy in a medical record).
- * In writing, request an accounting of how your medical information was disclosed (excludes disclosures for treatment, payment or healthcare operations, and those for which you have given authorization.)

What information is kept in your medical record?

Any information related to your evaluation or care. This may include, symptoms, medical history, examination and test results, diagnoses, past, current and future treatment plans.

Why is this information kept?

The information in your medical record is used to plan your care, to communicate between professionals treating you, provide a legal record of your care, provide documentation of services received for third-party payers, to educate health professionals, to provide a source of information for public health officials, to improve quality of service.

How do we use medical information?

We use your medical information to treat you, to obtain payment for services, and to conduct health care operations. Examples of how we use your information include:

Treatment

We keep a record of each visit. This record may include your test results, diagnoses, medications and your response to medications or other therapies. This allows your speech-language pathologist to provide the best care to meet your needs. This information may be disclosed to people who are involved in managing your health care e.g., family members, home health services, support agencies, your primary care physician, your referring physician and other medical professionals involved in your care.

Payment

We document the services and supplies you receive at each visit so that you, your insurance company or another third party can pay us. We may tell your health plan about upcoming treatment or services that require its prior approval. We may also give information to someone who helps to pay for your care.

Health Care Operations

Medical information is used to improve the services we provide, to train staff and students, for business management, for quality improvement, and for customer service.

Other Uses

We may also use information to:

- Provide appointment reminders
- Recommend treatment alternatives
- Tell you about health benefits and services
- Communicate with family or friends involved in your care
- For purposes required by law (e.g., public health, lawsuits/disputes, worker's compensation, law enforcement)

Information we share

There are other times when we are permitted or required to disclose medical information without your signed permission. Examples of these situations are to protect victims of abuse or neglect or to avert serious threat to public health or safety. Any other use or disclosure may only be done with your signed authorization. You may revoke your authorization at any time by contacting our office.

If you have questions, please contact Barbara M Wilson Arboleda at 781-329-2262.

All complaints will be thoroughly investigated, and you will not suffer retaliation for filing a complaint. You may also file a complaint with the Office of Civil Rights in Washington, DC.

Telephone Communication

___ May we leave a voicemail message regarding appointment times? (Initial on line)

___ May we leave a voicemail message regarding medical information? (Initial on line)

What telephone number would you like us to use for these purposes? _____

Electronic Communications

___ May we communicate with you via email for appointment reminders and scheduling?

___ May we communicate with you via email to provide medical information? (Initial on line)

___ May we communicate your information to other medical professionals via email to facilitate your care?

What email address would you like us to use for these purposes? _____

Patient (or individual responsible for patient)

Date

Missed Appointment Policy

*Voice therapy is a medical service, not a class or lesson.
If you do not attend, your insurance may revoke benefits.*

You must provide at least 24-hours notice to change or cancel your therapy visit except in the case of a sudden serious illness or other medical emergency.

For ALL other late cancellations or "no shows" for your appointment you will be charged a cancellation/no show fee.

The cancellation/no show fee is \$35 per incident and will be due at the time of your next therapy visit.

If you are not sure whether you will be able to attend your session, don't wait until the last minute to call. Contact your clinician and they will advise you as to how to proceed.

In order to cancel or change your visit, please call or e-mail your clinician

Brockton office (508) 559 - 7237

Dedham office (781) 329 - 2262

Chelmsford office (781) 256 - 5557

barbara@voicewize.com

lezli@voicewize.com

jen@voicewize.com

nancy@voicewize.com

jordan@voicewize.com

Patient Signature

Date

Parent Signature (if applicable)

Voicewize Financial Policy

If you have medical insurance, we are committed to helping you utilize your maximum allowable benefits. Understand, however, that your treatment plan will be designed to treat your medical condition, not to fit within specific benefit limits. Therefore it is important for you to understand our payment policy.

1. Payment for services is due on each visit for charges incurred up through your last visit. We accept cash, checks, and most major credit cards.
2. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility. We will do our best to assist you in understanding your policy.
4. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If financial problems arise that affect timely payment of your account, please contact us promptly to arrange for a payment program.
4. Medicare patients are responsible for the yearly deductibles, services that exceed the outpatient therapy cap and unless a supplemental insurance plan is in place for 20% of the cost of services.
5. All patients are responsible for informing us of any change of insurance company or changes to their plan and any change to their primary care physician.

Signature: _____

Date: _____