

Last Name _____ First Name _____ MI _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ SS # _____ Birthdate _____
 Age _____ Referred by: _____ **Primary Doctor** _____
 AmeriGroup _____ WellCare _____ Medicaid/Peach Care _____

BELOW IS FOR INFORMATION ON PARENT OR GUARDIAN.

Mother's Last Name _____ First Name _____ MI _____ Birthdate _____
 Mother's Employer _____ Work Phone _____ SS# _____
 Father's Last Name _____ First Name _____ MI _____ Birthdate _____
 Father's Employer _____ Work Phone _____ SS# _____
 Home Address _____ City _____ State _____ Zip _____

E-mail _____

INSURANCE INFORMATION

Primary Insurance Plan Name _____ Relationship to Patient _____
 Policy # _____ Group # _____
 Insured (Name on Card) _____ **Their Birthdate** _____
 Secondary Insurance _____ Policy # _____ Group # _____
 Insured (Name on Card) _____ **Their Birthdate** _____

Consent to Treat, Insurance Assignments, Financial agreement, Authorization to Release Information, Privacy Notice

1. Consent - to allow evaluation and treatment as deemed necessary by the provider. _____ **(initials)**
2. Assignment of Insurance/Release information – In consideration of services rendered, I transfer and assign payment to LSHC. I authorized release of medical/clinical information to process such claim. _____ **(initials)**
3. Financial agreement – I understand that I am responsible for any and all charges for services. I also agree to pay any collection/attorney fees in the event of default. _____ **(initials)**
4. Medicare/Medicaid – authorization to release information and payment and certify that the information given in applying for payment under Title XVIII/XIX of the Social Security Act is correct. _____ **(initials)**
5. Payment responsibility – I understand that insurance claims may be filed as a courtesy. I understand that it is my responsibility to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID BY THE INSURANCE WITHIN A REASONABLE PERIOD, NOT TO EXCEED 60 DAYS. _____ **(initials)**
6. Patient Consent for Use and Disclosure of Protected Health Information
 - With my consent, Looper Speech and Hearing Center may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Looper's Notice of Privacy Practices for a more complete description of such uses and disclosures.
 - I have the right to review the Notice of Privacy Practices prior to signing this consent.
 - Looper Speech and Hearing Center reserves the right to revise its Notice of Privacy Practices at anytime. A copy will be given on your next visit.
 - With my consent, Looper Speech and Hearing Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.
 - With my consent, Looper Speech and Hearing Center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
 - With my consent, Looper Speech and Hearing Center may e-mail any items that assist the practice in carrying out TPO.
 - I have the right to request that Looper Speech and Hearing Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By initialing, I am consenting to Looper Speech and Hearing Center's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Looper Speech and Hearing Center may decline to provide treatment to me. _____ (initials)
The privacy notice is posted and copies are available.

Signature of Patient or Legal Guardian

Print name of Patient or Legal Guardian

Patient's Name (print)

Date

RELATIONSHIP TO PATIENT _____

I authorize Looper Speech and Hearing Center to discuss Protected Health Information with:

Name

Relationship

Signature of Patient or Legal Guardian

Print name of Patient or Legal Guardian

Patient's Name

Date

****How did you hear about Looper? ___ Doctor ___ TV ___ Radio ___ Newspaper ___ Friend ___ Phonebook**

FINANCIAL ASSISTANCE

I do not have insurance. I have very limited income. I am requesting financial assistance based upon the sliding scale:

FINANCIAL INFORMATION

MONTHLY INCOME: SOURCE: _____ AMOUNT: _____

SOURCE: _____ AMOUNT: _____

SOURCE: _____ AMOUNT: _____

NUMBER OF PEOPLE LIVING IN HOUSEHOLD: _____

PROVIDE DOCUMENTATION

I give permission for a representative of Looper Speech and Hearing Center to verify the information provided on this form for the purpose of validating my request for financial assistance.

PATIENT, PARENT, OR GUARDIAN'S SIGNATURE

DATE

FOR OFFICE USE ONLY: PERCENTAGE APPROVED _____ % LSHC REPRESENTATIVE _____