THE UNIVERSITY OF TENNESSEE
HEALTH SCIENCE CENTER

AUDIOLOGY AND
SPEECH PATHOLOGY

APPOINTMENT INFORMATION

Hearing and Speech Center
1600 Peyton Manning Pass
Knoxville, Tennessee 37996
Phone: 865-974-5451 (voice, VRS)

PATIENT NAME: _____

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____

The Hearing and Speech Center is an educational and research clinic in the Department of Audiology and Speech Pathology. The services we provide include communication evaluations and treatment for children and adults. Graduate students in speech-language pathology in the department provide the services under the supervision of the department's speech-language pathologists. Evaluations normally are 2 hours in length. Therapy sessions are generally 1 hour in length.

INSURANCE

We will file a claim with all insurance providers (primary and secondary) for all patients. Please be aware that some insurance providers do require the patient to get an out-of-network authorization from the primary care doctor before being seen at our facility. Medicare and many health insurance companies will pay for the diagnostic procedures in our clinic, but payment is subject to your deductible and out-of-pocket expenses. Medicare requires that we collect 20% of testing charges due on date of service. ***Payment is expected at the time of service (including co-pays) by visa, master card, discover, check, or cash.***

FEES

The clinic charges for each procedure that is performed. ***If you were referred by the VA, they will pay for all visits.***

REDUCED RATES

We offer reduced rates to those who qualify based on a sliding fee scale. It depends on the number of people in the home and the gross household income. If you feel that you may qualify for a reduced rate, please request a form, and bring one of the following to your appointment: 1) A complete copy of your last year's tax return, or 2) your most current benefits statement letter from the Social Security Administration, or 3) the last 3 months of your bank statements. You may also call us at (865) 974-5451 (voice, VRS) with questions.

ATTENDANCE POLICY

If you are unable to keep your scheduled appointment, you are expected to call the clinic and cancel at least 24 hours prior to your appointment. If you do not call to cancel or to reschedule, the missed appointment will be counted as a "No-Show Appointment." After two "No-Shows," we may be unable to reschedule an appointment for you. In this packet, we have included a more detailed description of our policy.

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER
AUDIOLOGY AND SPEECH PATHOLOGY

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Last Name _____ First Name _____ Middle Initial _____

Address _____ City_____ State _____ Zip _____

DOB _____ Sex _____ Social Security # (SSN) _____

Home Phone _____ Cell Phone _____ Email Address _____

May we periodically send you information from our department to your email address? [ ] Yes [ ] No

Marital Status [ ] Single [ ] Married [ ] Other Language _____

Race [ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American [ ] Native Hawaiian or Pacific Islander [ ] White

Ethnicity [ ] Hispanic or Latino or Spanish Origin [ ] Not Hispanic or Latino or Spanish Origin

Patient Employed? [ ] Yes [ ] No If yes, employer name _____

Student Status [ ] Not a Student [ ] Full-time [ ] Part-time Name of school? _____

Emergency Contact Name _____ Phone _____ Relationship _____

PARENT/GUARDIAN/SPOUSE INFORMATION

1) Name _____ Relationship _____ SSN _____

Address _____ City, State, Zip _____ DOB _____

Employer _____ Work/Cell Phone _____ Home Phone _____

2) Name _____ Relationship _____ SSN _____

Address _____ City, State, Zip _____ DOB _____

Employer _____ Work/Cell Phone _____ Home Phone _____

INSURANCE INFORMATION

Primary Insurance _____

Subscriber's Name _____

Policy/ID# _____ Group # _____

Subscriber's DOB _____

Subscriber's SSN _____

Patient Relationship to Subscriber _____

Secondary Insurance _____

Subscriber's Name _____

Policy/ID# _____ Group # _____

Subscriber's DOB _____

Subscriber's SSN _____

Patient Relationship to Subscriber _____

The above information is true to the best of my knowledge. I authorize this medical treatment to process my claim, and I authorize my insurance benefits to be paid directly to UTHSC clinics, doing business as UT Hearing and Speech Center. I understand that I am financially responsible for any balance.

Signature of Patient or Personal Representative _____ Date _____

THE UNIVERSITY OF TENNESSEE
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MEDICATION LIST

Please list below all medications, supplements, vitamins, etc. that you are currenting using. Be sure to include the dosage and method taken.

Instead completing this form, you may also attach a list, but please make sure it includes all the requested information.

Name of Medication	Dosage (amount and how often)	Method (oral, injection, patch, etc.)

Do you currently use tobacco products (within the past 24 months)?

- ☐ Yes If yes, what type and how often? _____
- ☐ No

_____ _____ _____

Signature of Patient or Personal Representative | Printed Name | Date Completed

Date Updated _____ Initials _____ Date Updated _____ Initials _____

Date Updated _____ Initials _____ Date Updated _____ Initials _____

THE UNIVERSITY OF TENNESSEE
HEALTH SCIENCE CENTER

AUDIOLOGY AND
SPEECH PATHOLOGY

EXCHANGE OF INFORMATION

Audiology Phone: 865-974-5453 Fax: 865-974-1792
Speech-Language Phone: 865-974-5451 Fax: 865-974-4639

Patient's Name ____ Date of Birth _______________

Information about your care will be shared with your referring physician. I hereby authorize the *University of Tennessee Health Science Center* (UTHSC) clinics, doing business as UT Hearing and Speech Center, to receive **and/or** release information to the additional names listed below. Please provide both name and address.

YOUR PRIMARY CARE DOCTOR'S NAME AND ADDRESS IS REQUIRED BELOW
IF THIS PROVIDER IS DIFFERENT FROM YOUR REFERRING PHYSICIAN.

Name ________________________________
Address ______________________________
City _________________ State____ Zip________
Phone ________________________________
Fax __________________________________
What do you want received/released?
[ ] Medical records [ ] Evaluation and treatment reports
[ ] Academic records [ ] Other (describe) ____________

Name ________________________________
Address ______________________________
City _________________ State____ Zip________
Phone ________________________________
Fax __________________________________
What do you want received/released?
[ ] Medical records [ ] Evaluation and treatment reports
[ ] Academic records [ ] Other (describe) ____________

Name ________________________________
Address ______________________________
City _________________ State____ Zip________
Phone ________________________________
Fax __________________________________
What do you want received/released?
[ ] Medical records [ ] Evaluation and treatment reports
[ ] Academic records [ ] Other (describe) ____________

Name ________________________________
Address ______________________________
City _________________ State____ Zip________
Phone ________________________________
Fax __________________________________
What do you want received/released?
[ ] Medical records [ ] Evaluation and treatment reports
[ ] Academic records [ ] Other (describe) ____________

Signature of Patient or Personal Representative ______________________________ Date ____________

Staff ____________________________ Date ____________________________

Date Updated __________ Initials ______ Date Updated __________ Initials ______
Date Updated __________ Initials ______ Date Updated __________ Initials ______

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER
AUDIOLOGY AND SPEECH PATHOLOGY

GENERAL CONSENT & NOTICE OF RECEIPT OF PRIVACY PRACTICES

UTHSC Audiology and Speech Pathology complies with all applicable federal, state, and local laws prohibiting discrimination. We provide services to all patients regardless of race, color, religion, gender, national or ethnic origin, disability, age, sexual orientation, genetic information, citizenship, marital status, employment status, and status as a covered veteran.

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified conditions(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you indicate that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your audiologist and/or speech-language pathologist about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your provider, we encourage you to ask questions.

I voluntarily request an audiologist and/or speech-language pathologist, as deemed necessary, to perform reasonable and necessary examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I have been given a copy of the University of Tennessee Health Science Center Department of Audiology and Speech Pathology's (UTHSC ASP) Notice of Privacy Practices that provides a description of health information uses and disclosures. I understand that I have a right to review the notices prior to signing this form. I understand that UTHSC ASP reserves the right to change their notice and practices and that changes will be posted in the office area. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and UTHSC ASP is not required to agree to the restrictions requested. I may revoke this acknowledgement in writing, except to the extent that UTHSC ASP has already taken action.

Further, I understand that UTHSC ASP serves as a clinical education facility for the undergraduate and graduate students in Audiology and Speech Pathology at the University of Tennessee. For this reason (initial each if you agree/understand):

____**I authorize** both student observation and participation as well as case discussion for professional or educational purposes.

____**I authorize** the use of audio and video recording of evaluation and treatment for therapeutic, professional, or educational purposes. I understand that I will be informed at the time of recordings.

____**I understand** that evaluation and treatment information in my file may be reviewed by authorized individuals for possible research analysis. I understand that no names or identifying information will be used in any of these procedures.

____**I understand** that some therapy sessions may have shared observation spaces and/or be observed by students.

TO THE PARENT/GUARDIAN OF PATIENT: I give consent for the following adult individuals to bring the patient to UTHSC ASP for any appointment following the initial evaluation and hereby give permission to UTHSC ASP to exchange information with the following individuals. This request will remain in effect until revoked by me in writing.

(Please print)

Name: _____ relationship: _____ phone:_____

Name: _____ relationship: _____ phone:_____

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENTS.

_____	_____	_____	_____
Signature of Patient or Personal Representative	Date	Signature of Witness	Date
_____	_____	_____	_____
Printed Name of Patient or Personal Representative	Date	Printed Name of Witness	Date

Revision Effective September 23, 2013

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER
HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Information

Each time you receive health care services from The University of Tennessee Health Science Center ("UT Health Science Center" or "UTHSC"), a record of your treatment is made. This record contains information about your symptoms, examinations, test results, medications you take, your allergies and the plan for your care. We refer to this information as your health or medical record. It is an essential part of the healthcare we provide for you. Your health record contains personal health information and there are state and federal laws to protect the privacy of your health information. This notice is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Uses and Disclosures of Your Health Information

We will use your information for treatment purposes

The UTHSC staff involved in your care will document information in your record about your examination, the care that you receive, the results of that care, and the care planned for you. If you were referred to us from another health care provider, we may send copies of your medical record to the provider who referred you to us so your provider will have updated treatment information about your care.

We will provide your doctors and other healthcare providers who are treating you with copies of various reports that should assist them in treating you.

We may also use health information about you to call you and/or send you a letter to follow up with diagnostic test results and to survey your satisfaction with the services provided.

We will use your health information for payment purposes

A bill will be sent to you or your insurance company. We may include information that identifies you, as well as your diagnoses, procedures, healthcare providers and supplies used. We also may contact your insurance company to determine if they will pay for your health care as part of their certification process.

We will use your health information for regular healthcare operations purposes

UTHSC staff may look at your health information to assess the care and results in your case and others like yours. The UT Health Science Center is a teaching institution, so we may use your health information in the process of educating and training students and resident physicians.

Your right to request restrictions on use and disclosure of your health information

You have the right to request in writing a restriction on the above uses and disclosures of your protected health information for treatment, payment and health care operations; however, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. We may, however, also end the agreement at any time after notifying you in writing of such.

Other Disclosures

Business Associates

There are some services provided in our organization through contracts with business associates and in some instances, their subcontractors. We require the business associate, and any subcontractors they utilize, to protect your health information.

Communication with others involved with your care

We may give to a family member, or other relative, close personal friend or any other person you identify, certain parts of your health information that is directly relevant to that person's involvement in your care or payment related to your care.

Your health information will only be shared if you agree, or are silent when given the opportunity to disagree, or we believe, based on the circumstances and our professional judgment that you do not object.

If you are incapacitated or in an emergency circumstance, we may provide to a family member, or other relative, close personal friend, or any other person accompanying you, certain parts of your health information that is directly relevant to that person's involvement in your care or payment related to your care.

Research

Under certain circumstances, we may use and disclose health information about you from your medical record for research purposes. All such research projects, however, will be subject to a special approval process designed to protect the privacy of your health information.

Required by law

We may disclose health information required by law to the following entities or type of entities that includes, but is not limited to:

- Food and Drug Administration
- Public Health or legal authorities charged with disease prevention
- Correctional institutions
- Workers compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Medicare or Medicaid if requested for an audit or investigation
- Funeral directors, coroners and medical examiners
- National security and intelligence agencies
- Protective services for the president and others
- Law enforcement as required by law or in accordance with a valid subpoena
- Licensing boards
- To avoid a serious threat to the health and safety of a person or the public

Marketing

The UT Health Science Center will **not** use health information in your records for marketing purposes without your written authorization or approval.

Other uses and provided information from your medical

record will be made only with your written authorization or approval.

Patient rights

You have the right to:

- Inspect and obtain a copy of your health record within sixty days of request. There may be a charge to cover the cost of producing your record in hard copy or electronic form.
- Request an amendment of your health records;
- Obtain an accounting of disclosures of your protected health information made after April 14, 2003 for purposes other than treatment, payment, and healthcare operations;
- Request communication of your health information in a certain way or at a certain location. For example, you can ask that we contact you by mail and not by telephone, or that we contact you at a specific telephone number, or that we use an alternative address for billing purposes, or that we not leave messages on certain answering machines. Email communication will be provided only at your written request indicating you understand that email can be an unsecure communication method;
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken; and
- Restrict disclosures to a health plan for services when those services have been paid out-of-pocket in full by the patient, a family member, or another individual.

Our duties

We are obligated to:

- Maintain the privacy of your health information;
- Obtain an authorization for the use and disclosures of psychotherapy notes, marketing, and the sale of protected health information;
- Refrain from selling your protected health information without your individual written authorization;
- Notify you if there has been a breach of your unsecured protected health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect about you through this notice;
- Abide by the terms of the notice currently in effect;
- Notify you in writing if we are unable to agree to a requested restriction;
- Follow reasonable requests you make to communicate with you as you instruct, for example, to contact you at a certain telephone number or address;
- Provide you a paper copy of this notice of privacy practices upon request; and
- With written request, to provide you with a copy of your electronic health record in electronic form and to transmit the copy directly to another person designated by you. An electronic copy may be attached to an email that does not require encryption as long as you have been advised of the risk of transmission of an unencrypted document.

To exercise any of the above rights or to make any of the above requests, your request **must** be in writing.

The University of Tennessee Health Science Center is not required to act immediately except for a request for a copy of your health record and will investigate our abilities to comply with all requests prior to agreeing to the request.

The University of Tennessee Health Science Center reserves the right to change this Notice of Privacy Practices and its policies and procedures for privacy practices at any time and to make the changes effective for all protected health information created or received prior to the new effective date and then currently maintained by the UTHSC. Any revised Notice will be posted in the waiting rooms or patient lobbies of our clinical practices and reasonable efforts will be made to advise you of the change(s) in the Notice, policies and procedures at your next service visit. You may also obtain a copy of the revised Notice upon request.

For More Information or to Report a Problem

If you have any questions about your rights or duties or the UTHSC practices and procedures regarding protected health information, please contact the appropriate office of the facility where you received services.

If you believe your privacy rights have been or are being violated, you may file a complaint by calling the UTHSC HIPAA Privacy Officer's hotline telephone number at (901) 448-1700.

You may file a complaint with the Secretary of the Department of Health and Human Services. Complaints to the Secretary must be filed in writing on paper or electronically and must be made within 180 days of when you became aware of, or should have been aware of, the incident giving rise to your complaints. By law, you cannot be penalized for filing a complaint.

Revised Date—September 22, 2013

THE UNIVERSITY OF TENNESSEE
HEALTH SCIENCE CENTER

AUDIOLOGY AND
SPEECH PATHOLOGY

FINANCIAL AGREEMENT

I understand that I will be charged on a fee-for-service basis, and I agree to pay this amount. I agree I am responsible for any charges not covered by my insurance or other third-party guarantor (e.g., VA, TEIS). I understand that payment will be made at the time services are rendered unless clinic staff has documented payment arrangements as follows:

Please initial only the categories that apply to you.

_____ **MEDICARE** I understand that **Medicare does not cover hearing aid evaluations, hearing aid fittings, earmolds, and hearing aid supplies and accessories**. The clinic will file a claim for services provided with Medicare and any Medicare supplemental insurance of which we are informed. I understand that I am responsible for any copays and deductibles not paid by Medicare or Medicare supplemental insurance.

_____ **VETERANS ADMINISTRATION (VA)** I have been referred by the VA. The VA will be billed for all services provided not covered by insurance.

_____ **TENNCARE** The clinic will file claims with my TennCare insurance carrier. I am responsible for any deductible and co-payment required by TennCare.

_____ **OTHER INSURANCE** The clinic will file claims for services and other charges with my insurance carrier. I am responsible for payment of any deductible and co-payments required by my insurance plan. I understand that payment of deductible and co-payments are due at time of service. I am also responsible for paying any non-covered charges as determined by the insurance company per the EOB. I understand that my insurance policy may not cover hearing aids, ear molds, ear impressions, and hearing aid supplies.

_____ **SCHOOL SYSTEMS** The clinic has contracted with _____ School System for the services. I am responsible for any services not covered by the school system contract.

_____ **TEIS** I was referred by Tennessee Early Intervention System (TEIS). For TEIS patients, the clinic will file claims for the services with my insurance company and will bill any remaining balance to TEIS, in accordance with the child's agreed-upon Individualized Service Plan.

_____ **AETNA / UHC / OTHER OUT-OF-NETWORK** I am aware that the clinic is out of network with my insurance and that I will have to pay for services on day of appointment. I will be reimbursed should my insurance cover any portion of my visit.

_____ **CAC SENIORS** I was referred by Knoxville CAC Seniors Office on Aging. As a Gift of Hearing recipient, I am not responsible for payment to this clinic for services and devices provided for the first year after the Gift of Hearing award.

_____ **NO INSURANCE/ SELF PAY** I am aware that I will be responsible for paying all charges on the day of my appointment.

It is my responsibility to inform UTHSC Audiology and Speech Pathology (ASP) clinics, doing business as *UT Hearing and Speech Center*, of any changes in my insurance carrier and/or my current address. I understand that any changes to this financial agreement affect only subsequent charges, and that I am responsible for all charges to my account. I authorize UTHSC ASP clinics to release any medical or other information necessary to process medical claims with third-party guarantors. I authorize payment of any insurance benefits related to these filed claims to be made directly to the *UT Hearing and Speech Center*.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Staff Date

THE UNIVERSITY OF TENNESSEE
HEALTH SCIENCE CENTER
AUDIOLOGY AND
SPEECH PATHOLOGY

SPEECH-LANGUAGE ATTENDANCE POLICY

Your appointment is a contract with our clinic. Our goal is to provide state-of-the-art assessment and treatment services to you and/or your family. To achieve these goals, we design evidence-based treatment programs for our patients, and we take responsibility for managing those programs so the rate of progress can be determined routinely.

A CRITICAL FACTOR IN SUCCESSFUL TREATMENT IS PATIENT ATTENDANCE.

1. If you do not show for 2 appointments in one semester or 3 appointments in one year (without a phone call to cancel the appointment 24 hours in advance of the appointment time), we may not be able to reschedule your appointment.

2. If you are more than 20 minutes late to your scheduled appointment, it will be necessary to re-schedule your appointment and this will count as 1 No-Show appointment.

3. We follow the Knox County Schools inclement weather policy. If Knox County Schools are closed, our clinics will also be closed. If weather conditions improve and faculty, students, and patients can commute, your speech-language provider will contact you. If UT is closed, our clinic will be closed.

4. If you or your child wakes up sick on the day of your appointment, please call to reschedule/cancel as soon as possible.

Between semesters, we are required to establish new schedules for our patients. Those who have attended regularly will receive first priority for placement in treatment.

It is our desire to work with you and/or your child. If you are unable to follow these guidelines, we will be happy to assist you in finding an alternative clinic. If you have any questions, please feel free to ask the clinic staff.

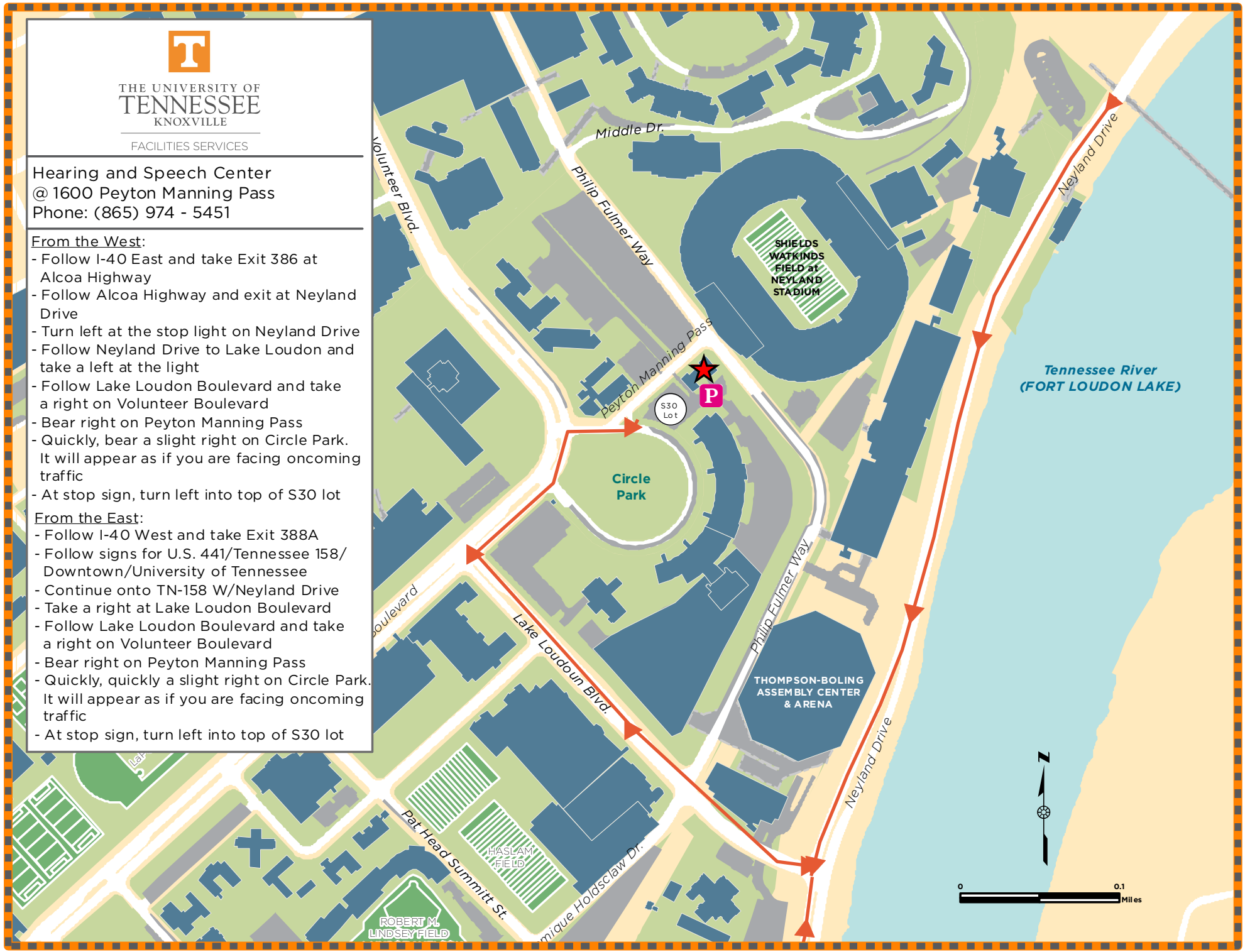
Thank you.

PLEASE SIGN BELOW.

I, _____, have been informed and understand the above attendance policy.
(Print Patient Name)

_____ _____
Signature of Patient/Guardian or Personal Representative Date

_____
Witness


THE UNIVERSITY OF TENNESSEE KNOXVILLE
FACILITIES SERVICES
Hearing and Speech Center
@ 1600 Peyton Manning Pass
Phone: (865) 974 - 5451
From the West:
- Follow I-40 East and take Exit 386 at Alcoa Highway
- Follow Alcoa Highway and exit at Neyland Drive
- Turn left at the stop light on Neyland Drive
- Follow Neyland Drive to Lake Loudon and take a left at the light
- Follow Lake Loudon Boulevard and take a right on Volunteer Boulevard
- Bear right on Peyton Manning Pass
- Quickly, bear a slight right on Circle Park. It will appear as if you are facing oncoming traffic
- At stop sign, turn left into top of S30 lot
From the East:
- Follow I-40 West and take Exit 388A
- Follow signs for U.S. 441/Tennessee 158/ Downtown/University of Tennessee
- Continue onto TN-158 W/Neyland Drive
- Take a right at Lake Loudon Boulevard
- Follow Lake Loudon Boulevard and take a right on Volunteer Boulevard
- Bear right on Peyton Manning Pass
- Quickly, quickly a slight right on Circle Park. It will appear as if you are facing oncoming traffic
- At stop sign, turn left into top of S30 lot
Middle Dr.
Volunteer Blvd.
Philip Fulmer Way
Peyton Manning Pass
Neyland Drive
SHIELDS WATKINDS FIELD at NEYLAND STADIUM
S30 Lot
P
Circle Park
Tennessee River (FORT LOUDON LAKE)
Lake Loudoun Blvd.
Philip Fulmer Way
THOMPSON-BOLING ASSEMBLY CENTER & ARENA
Neyland Drive
Pat Head Summitt St.
HASLAM FIELD
ROBERT M. LINDSEY FIELD
N
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Miles