Intake Form

SUMMIT VOICE AND SWALLOWING

Name

Patient Name: _____Date of Birth: _____

Pronouns: _____

Email Address: _____

Home Address

Street: _____

City: _____ State: _____ Zip code: _____

Mailing Address

☐ Check if Mailing Address is the same as the Home Address

Street: _____

City: _____ State: _____ Zip code: _____

Emergency Contact

Name: _____

Phone number: _____ Relationship to patient: _____

Home Health Services

Are you currently or have you recently received home health services? ☐ Yes ☐ No

If yes, with which agency? _____

Insurance Information

Primary Insurance: _____

Secondary Insurance (if applicable): _____

Is the patient the Insured? ☐ Yes ☐ No

Name of insured if OTHER than patient: _____

Date of birth of insured if OTHER than patient: _____

Insurance ID number or social security number of insured: _____

Patient Name: _____ Date of Birth: _____

Conditions and Consent for Outpatient Care

In this document, "**Patient**" means the person receiving treatment. "Patient Representative" means any person acting on behalf of the Patient and signing as the Patient's representative. Use of the word "I", "you", "your" or "me" may in context include both the Patient and the Patient Representative. With respect to financial obligations "I" or "me" may also, depending on the context, mean financial guarantor "Guarantor".

"Provider" means Summit Voice and Swallowing ("Summit"), which includes, but is not limited to the staff of Summit: Speech Language Pathologists, speech pathology undergraduate and graduate students, certain other licensed independent practitioners and any authorized agents, contractors, affiliates, successors or assignees acting on their behalf.

1. **Consent to Treatment**. I consent to the procedures which may be performed during this outpatient episode of care, including, but not limited to, diagnostic procedures, treatment, outpatient services rendered as ordered by the Provider. I consent to allowing students as part of their training in health care education to participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at Summit, and understand that these students will be supervised by licensed staff, as necessary.

2. **Consent to Photographs, Videos, Audio Recordings or other Digital Media**. I consent to photographs, videos, audio recordings, other digital media by Summit in any and all of its publications or advertisements including web-based publications, for record-keeping, security purposes, and educational purposes, without payment or other consideration. I understand and agree that all Images will become the property of Summit and will not be returned.

   I hereby irrevocably authorize Summit to edit, alter, copy, exhibit, publish, reproduce or distribute these Images for any lawful purpose. I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image.

   I hereby hold harmless, release, defend and forever discharge Summit and its respective officers, directors, employees and agents from all claims, costs, damages, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of use of the Images.

3. **Consent to Research and Education**. Summit supports the development of knowledge about voice and swallowing by the participation in student education and collection of data for research.

   For the purpose of education, students may participate in provision of speech pathology services under the direction of a qualified and licensed provider. You have the right to choose from whom you receive treatment. If you do not want student participation in your care, please let your provider know.

   Any data collected for research shall be de-identified. De-identification describes the process by which information that identifies a patient (such as names, dates and geographic information) is removed from pertinent health information. De-identified data is no longer considered protected health information and does not fall under the same regulations and restrictions as protected health information. De-identification mitigates privacy risks to patients and therefore can be used in research. The HIPAA Privacy Rule was designed to maintain patient privacy by protecting individually identifiable health information. However, the HIPAA Privacy Rule also states that once data has been de-identified, covered entities can use or disclose it without any limitation. If you would prefer that Summit not use your de-identified data, please let us know prior to services rendered.

4. **Financial Agreement**. I understand that, as a courtesy to me, Summit, or a third party provided, may bill an insurance company offering coverage, but may not be obligated to do so. I agree that the financial responsibility for the services rendered belongs to me, the Patient, and/or Guarantor. I agree to pay for services that are not covered and covered charges not paid in full by insurance coverage including, but not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy

exclusions, or failure to comply with insurance plan requirements. I hereby assign to Summit all money to which I am entitled for medical expenses related to services performed. I authorize Summit to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims.

If I do not have insurance, I understand that I must pay privately. Private payment is due in full at the time of service. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $40.00 returned check fee will be charged for checks returned due to insufficient funds. I understand that no refunds will be made for services rendered at Summit.

5. **Assignment of Benefits**. Patient assigns all of his/her rights and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the Provider and authorizes direct payment to the Provider of any insurance benefits otherwise payable to or on behalf of Patient for the hospitalization or for outpatient services, including emergency services, if rendered. Patient understands that any payment received from these policies and/or plans will be applied to the amount that Patient or Guarantor has agreed to pay for services rendered during this admission and, that Provider will not retain benefits in excess of the amount owed to the Provider for the care and treatment rendered during the admission.

   I understand that any health insurance policies under which I am covered may be in addition to other coverage or benefits or recovery to which I may be entitled, and that Provider, by initially accepting health insurance coverage, does not waive its rights to collect or accept, as payment in full, any payment made under different coverage or benefits or any other sources of payment that may or will cover expenses incurred for services and treatment.

   I hereby **irrevocably appoint** the Provider as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer, employer-sponsored medical benefit plans, third party liability carrier or, any other responsible third party ("Responsible Party") for any and all benefits due me for the payment of charges associated with my treatment. This assignment shall not be construed as an obligation of the Providers to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right.

   I agree to take all actions necessary to assist the Provider in collecting payment from any such Responsible Party should the Provider(s) elect to collect such payment, including allowing the Provider(s) to bring suit against the Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment acknowledge that it is my duty and responsibility to immediately pay any such payments to the Provider(s).

   I assign and transfer to Summit (and any contractors or affiliates) any and all benefits, monies, and sums payable to me for services, accident or bodily injury under any services, accident medical payments/PIP/bodily injury or uninsured/underinsured motorist policy providing for outpatient service payments.

6. **Consent to Telephone Calls, text messages and/or email for Financial Communications**. I agree that, in order for Summit, or Summit's EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Summit or their EBO Servicer and collection agents may contact me by telephone or text message at any telephone number or by email at any email address I have provided or you or your EBO Servicer and collection agents have obtained or, at any number or email forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

7. **Consent to Email, Phone Number, or Text Usage for Healthcare Communications**. If at any time I provide an email, phone number or text address at which I may be contacted, I consent to receiving healthcare, marketing and promotional communications at that email, phone number or text address from the Providers. The other healthcare communications may include but are not limited to communications to the provided numbers, family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. I consent to all communication of information to any person, or individual who is reached at the email, phone number or address provided.

8. **No Show/Late Cancellation Policy**. Please give our office at least 24 hours notice to cancel or reschedule your appointment. Less than 24 hours notice may result in a late fee of $55.00. A "no-show" is missing a scheduled appointment with no notice. A "late-cancellation" is canceling/changing an appointment within 24 hours of an appointment. Any charges related to no-show or cancellations are the responsibility of the patient and will not be billed to insurance.

To cancel or reschedule an appointment, please call Summit Voice and Swallowing at (775) 870-3680. This policy is in effect to ensure that all of our patients have the opportunity to be seen in a timely manner.

I acknowledge that there may be a charge of $55.00 for each no show and/or late cancellation appointment.

Patient Signature:_____ Date: _____

9. **Covid Release of Liability**. Summit Voice and Swallowing ("Provider") has taken recommend precautions to reduce the spread of infectious diseases including COVID-19. Despite these measures, Provider cannot guarantee that patients will not become infected. I am aware that participating in the services provided could increase my risk of exposure to illnesses. It is not yet known if participation in speech pathology evaluation and/or treatment increases risk of COVID-19.

   By signing this release form, I acknowledge and assume the risk that I may become exposed to or infected by COVID-19 or any other resulting illnesses by participating in the evaluation and/or treatment from the Provider. I, on behalf of my past, present and future agents, attorneys, representatives, predecessor, successors, assigns, heirs and executors to fully and forever waive, release, discharge, indemnify and hold harmless Provider, its past, present and future members, officers, agents, representatives, contractors, attorneys, employees, successors and assigns (collectively "Releasees") from any and all matters of liability, claims for damages, causes of action, suits, proceedings, compensation, attorney's fees, costs and expenses of suits, claims and demands whatsoever, which may arise from my participation in Provider's services, including, but not limited to, any and all claims, losses or liabilities for death, personal injury, partial or permanent disability, property damage, medical or hospital bills, including economic losses, which may arise out of or relate to my participation.

   My signature below indicates that I have carefully read this waiver and fully understand its contents. I am aware that this is a release of liability and a contract between myself and provider and/or affiliated organizations on behalf of myself and/or any minor child, sign it of my own free will.

10. **Release of Information**. I hereby permit Summit to release healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information regarding a prior admission(s) at Summit may be made available to other medical facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations.

11. **Notice of Privacy Practices**. I acknowledge that I have received Summit's Notice of Privacy Practices, which describes the ways in which Summit may use and disclose my healthcare information for its treatment, payment, healthcare operations and other prescribed and permitted uses and disclosures. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. I understand that I may contact Summit if I have a question or complaint.

12. **Acknowledgement of Patient Civil Rights and Responsibilities**.
    Summit supports all patients to be treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law. I understand that any complaints or grievances regarding my civil rights may be filed with the Office for Civil Rights by accessing their website at www.hhs.gov/ocr.

13. **Acknowledgement**. I have been given the opportunity to read and ask questions about the information contained in this form, **specifically** including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the Providers.

I, the undersigned, as the Patient or Patient Representative, or, for a minor/incapacitated Patient, as the legal guardian, hereby certify I have read, and fully and completely understand this Conditions and Consent for Outpatient Care, and that I have signed this Conditions and Consent for Outpatient Care knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Patient Signature:_____ Date: _____

Acknowledgment of Receipt of the Notice of Privacy Practices

The law requires Summit Voice and Swallowing to ask you to state in writing that you received their "Notice of Privacy Practices" (the "Notice"). This Notice describes in detail how Summit Voice and Swallowing may use and share your health information, as well as your health privacy rights. You have the right to review the "Notice of Privacy Practices" before signing this acknowledgment. The law does not require you to sign this “acknowledgment of receipt of the notice.” Signing does not mean that you have agreed to any special uses or disclosures of your health records. Refusing to sign the acknowledgment does not prevent a provider or plan from using or disclosing health information as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) permits. By signing this form, you acknowledge that you have received the “Notice."

Patient Signature:_____ Date: _____

Medical Records Release

Physicians/Providers you want Summit to send records to:
I request and authorize Summit or any of its authorized representatives to release the information selected below to the following individual:

Name(s)/Contact Info: _____

Name(s)/Contact Info: _____

Records you want Summit to receive:
I request and authorize Summit to obtain, copy or inspect the following information from:

Name(s)/Contact Info: _____

Name(s)/Contact Info: _____

I understand that I may refuse to sign this authorization and that my refusal will not affect my consent to the use or disclosure of my protected health information for purposes of evaluation, treatment, or payment. I understand that I may revoke this authorization in writing at any time to Summit, except to the extent that information has already been released in response to this authorization. I acknowledge that this release also authorizes Summit to discuss the released information with the authorized party. I agree that a photocopy of this authorization may be used for all purposes the same as the original. This authorization will expire in 12 months unless otherwise revoked.

I understand that the information requested to be released under this authorization is confidential and subject to certain laws which protect my rights as a patient. I understand that Summit has complied with the HIPAA requirements by producing the above requested records in accordance with this authorization and is not responsible for any re-disclosure of my records. I represent that I have the capacity to enter into this authorization and indemnify and save Summit harmless from actions in compliance with this authorization.

Patient Signature:_____ Date: _____

Consent for Nasoendoscopy

I hereby authorize Summit Voice and Swallowing ("Provider") to perform the following procedures/treatments: **Nasoendoscopy.**

Purpose and Benefits:
Nasoendoscopy allows visualization of voice and swallowing mechanisms. I understand that this procedure may need to be completed before, during, and after a course of treatment.

What to Expect:
In order to complete nasoendoscopy, I can expect to sit upright in an exam chair, relax and breathe through my nose, as a small flexible camera (about the width of a straw) is passed through the nose and into the throat. For a swallowing evaluation, I will then be given various colored foods and liquids to swallow. For a voice evaluation, I will be asked to do a variety of voicing tasks. The procedure usually lasts 7-15 minutes.

Possible Risks of Having Procedure:
This procedure is not without risk. The most common risks include, but are not limited to, discomfort, nose-bleeding, tissue irritation/tear, vasovagal response (fainting/syncope), vomiting and/or gagging. I acknowledge that there may be other risks or complications not discussed that may occur.

Risks of Not Having Procedure and Alternatives:
The alternative to nasoendoscopy is 1) videofluoroscopy (x-ray video) for swallowing; 2) rigid stroboscopy for voice; 3) not completing the procedure. I acknowledge that Provider may not be able to diagnose and/or treat my specific problem if I elect not to complete this procedure.

I consent to the procedure and assume the risks associated therewith. As such, I, on behalf of myself, my heirs, successors and assigns, release and discharge Provider of all liability associated with the procedure. I acknowledge that no guarantees have been made to me as to the results of this procedure or any treatment that may be required as a result of this procedure. I understand that the results of this procedure may not result in the resolution of my condition. I have been given the opportunity to ask questions and that all questions have been answered to my satisfaction.

I authorize Provider, to photograph, video and/or use of other mediums for medical, scientific and/or educational purposes provided my identity is not revealed by them.

I have read and fully understand this consent form including the purpose, benefits and risks of the proposed procedure. I voluntarily consent to the performance of the procedure.

Patient Signature:_____ Date: _____