

Alaska Speech & Hearing Clinic

2401 East 42nd Avenue, Ste #101 Anchorage, AK 99508-5228 (907) 562-4550

Patient or Child's Name: _____ Date of Birth: _____

Please Print

CONSENT FOR EVALUATION

_____(Initial) I give permission for my child to be evaluated and treated by Alaska Speech and Hearing Clinic (ASHC). The information obtained during the evaluation is confidential and will only be shared per our privacy practices.

_____(Initial) I have received a copy of the Notice of Privacy Practices.

RESPONSIBILITY FOR PAYMENT/AUTHORIZATION TO BILL INSURANCE

_____(Initial) Alaska Speech and Hearing Clinic has agreed to submit bills directly to the insurance provider. Please note that we will only submit our bills twice and then we will bill the family. The patient/family must pay for all deductibles and co-payments at time of service. It is the responsibility of the family to pay all outstanding bills not covered by their insurance based on policy coverage of speech and language therapy and audiology services. I authorize ASHC to bill my insurance carrier directly and agree to be responsible for all amounts not covered by the insurance company (exclusion: Tricare/Medicaid). I also agree to allow ASHC to release any medical records that are requested by the insurance carrier for payment of service. I understand that my insurance is billed for me as a courtesy, I am responsible for furnishing all insurance information and any changes in policy or coverage. All insurance policies must be listed whether they have coverage for our services or not. Bills not paid in a reasonable length of time could be sent to a collection agency. Patients will then be responsible for not only their balance due but also all collection agency, attorney and court fees. If your insurance company denies payment, your entire balance is due at once. Please check your EOB's when they arrive in the mail from your insurance companies.. Please note that bills sent to the collection agency could negatively affect your credit rating. We are not a bank and unable to extend credit.

NO SHOW/LATE POLICY

_____(Initial) Due to a growing number of missed appointments without prior cancellation or being excessively late for appointments (more than 15 minutes) we will now be billing the patient or family for any missed appointment without prior cancellation (At least 24 hours in advance) unless unexpected medical (i.e. sick child). If a patient/family shows up more than 15 minutes late without prior notification, we will not see the child and the patient/family will be responsible for the full price of the missed appointment. We make every effort to see patients on time and if a family is late, it impacts our schedule for the remainder of the day. The charge will be the full price of the scheduled appointment.

SICK PATIENTS

_____(Initial) We see many children throughout the day who are medically fragile. We would appreciate your consideration before bringing your child to the clinic if they are not feeling well. A simple cold or flu bug for one child may be a simple illness but to another could create major medical problems. If your child is showing signs of illness (see on back, signs of illness), please call and cancel your appointment. If you cannot reach a person in the clinic, please leave us a message.

RELEASE OF INFORMATION

I grant permission for ASHC to release and receive medial records, evaluations, progress notes, plans of care and other information with the following people or agencies:

I have read and understand fully the contents of the above initialed agreements and releases as shown and agreed on by my signature here below.

Patient/Guardian Signature

Date

Please Print Full Name