College of Health Solutions
Arizona State University
Speech and Hearing Clinic

PO Box 870102,
Tempe AZ 85287
Tel: 480-965-2373
Fax: 480-965-0076

Last Name:_____

First Name:_____

Date of Birth:_____

ASU SPEECH AND HEARING CLINIC – CLIENT GENERAL ACKNOWLEDGEMENT AND AGREEMENT

By signing below on page two of this document, I certify that I have reviewed this document and agree as follows:

1) Notice of Privacy Practices Acknowledgement

I understand that ASU Speech and Hearing Clinic follows the guidelines as stated in its Notice of Privacy Practices. I acknowledge that I have received, or been given access to, a copy of the ASU Speech and Hearing Clinic Notice of Privacy Practices which can be found at https://asuspeechandhearingclinic.org/about

2) Conditions of Treatment

I consent to the usual and customary medical evaluation and treatment relating to hearing and/or speech which may be performed on me at ASU Speech and Hearing Clinic. I understand that the services may be provided by a student clinician under the supervision of a speech-language pathologist or audiologist certified by the American Speech-Language Hearing Association. I understand that my medical records will be kept for a minimum of six (6) years following the last date of treatment.

3) Financial Agreement

I understand that all services rendered to me at ASU Speech and Hearing Clinic will have fees associated with them. If payments for these fees are not covered by a third party, I understand that I will be responsible for payment at the time services are rendered. We make every attempt to gain accurate information from your insurance company regarding covered benefits and amounts. However, I understand that this is an estimate based on the information provided to us by my insurance company. I understand that my insurer may deny payment for services that the insurer decides are not "medically necessary" or that are "experimental". While ASU Speech and Hearing Clinic will take reasonable steps to appeal these denials, I understand that I am responsible for paying for services/products denied by my insurer.

I understand that my complete insurance information must be provided to ASU Speech and Hearing Clinic at the time the service is rendered or no later than 48 hours after my appointment in order to bill my insurance company.

I hereby authorize ASU Speech and Hearing Clinic to furnish information to insurance carriers concerning my illness, condition and treatment, and I hereby irrevocably assign to ASU Speech and Hearing Clinic all payments for medical services rendered to me or my dependents.

4) Observers and Volunteers

I understand the ASU Speech and Hearing Clinic is a teaching institution that provides educational opportunities to students and also uses volunteers, both of which may be involved in or observe my care.

I understand that I may refuse services from a volunteer or observer at any time by notifying the ASU Speech and Hearing Clinic Staff or my Clinician.

5) Alternative Methods of Communication

ASU Speech and Hearing Clinic can utilize many methods to communicate with patients including communicating verbally, through the mail, and telephonically. By default, I understand that ASU Speech and Hearing Clinic will not utilize unsecure email unless I choose to Opt-IN to this method of communication.

☐ **I choose to OPT-IN to allow unsecure email communication with me. I understand ASU Speech and Hearing Clinic will still determine the best method of communication depending on the nature of the information.**

Email:_____

Signature of Patient, Parent if patient is under 18 or Legally Authorized Representative	**Date of Signature**
Name (printed)	**Relationship of Legally Authorized Representative to Patient**

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ASU SPEECH AND HEARING CLINIC – MARKETING AUTHORIZATION

By signing below, I _____ (please print name) certify that I have reviewed this document and agree as follows:

As a patient of the ASU Speech and Hearing Clinic, you are granted the opportunity to receive various marketing information from selected entities, if you choose to participate.

☐ **I give permission for ASU Speech and Hearing Clinic to share information with me such as newsletters, fundraising information and news about upcoming events, specials, and articles pertaining to services and products in the clinic.**

☐ **I do NOT give ASU Speech and Hearing Clinic permission to share marketing information with me.**

I understand that any authorization to share information granted above will be valid for 1 year and that I can revoke the authorization at any time by notifying ASU Speech and Hearing Clinic.

I understand that ASU Speech and Hearing Clinic may not condition treatment on whether or not I agree to this authorization.

I understand that by granting this authorization, there is a potential that my information may be re-disclosed by the recipient and no longer protected by the federal privacy regulations.

_____

Signature of Patient, Parent if patient is under 18 or Legally Authorized Representative

_____

Relationship of Legally Authorized Representative to Patient

_____

Date of Signature