HASA
CIRS Interpreting @ Gateway School
Hearing and Speech-Language Services

CONSENT FOR TREATMENT:
I hereby authorize the personnel of The Hearing and Speech Agency and Hilgenberg Scottish Rite Center to render to the patient whose name appears on this form such care as they deem necessary and appropriate.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize The Hearing and Speech Agency and Hilgenberg Scottish Rite Center to release my diagnosis and other medical information to the third party payer identified to determine benefits payable. Reports will be sent to me electronically or via fax unless otherwise noted. **Please remove The Hearing and Speech Agency from your SPAM folder**.

ASSIGNMENT OF BENEFITS:
I hereby authorize direct payment to The Hearing and Speech Agency of any insurance otherwise payable to me or the patient. I acknowledge the responsibility for any coinsurance, deductible, and/or other sum not received by The Hearing and Speech Agency from any third party source.

GUARANTEE OF PAYMENT:
I acknowledge financial responsibility for any health insurance deductible, coinsurance or failure for any reason of any insurance carrier to pay The Hearing and Speech Agency's charge in full when rendered. Once the bill has been submitted to the insurance company, changes to procedures or diagnostic codes cannot be made. I also acknowledge that interest may be charged to unpaid balances over 30 days from the date payment is due. In the event that the account is referred for collections, I agree to pay for all collection and attorney fees required to collect any delinquent balance.

PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION (Applies to Medicare Patients Only):
I hereby certify that the information given by me applying for payment under TITLE XVIII and XIX of the Social Security Act of third party payers is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim.

PERSONAL VALUABLES:
Patients are encouraged to leave all valuables at home. The Hearing and Speech Agency is not responsible for the loss of or damage to any personal property the patient has brought into The Hearing and Speech Agency.

PATIENT RIGHTS AND RESPONSIBILITIES:
I have been notified about patient rights and responsibilities including Privacy Practices.

I permit a copy of this authorization to be used in place of the original.

I certify that I understand the contents of this form.

_____

Client Name Guardian Name Client/Guardian Signature Date

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Permission to Obtain and Release Information

Client Name _____ DOB _____

Address _____

Phone _____ Email: _____

Please provide the primary care physician's name, address and contact information below. This is required for all patients with Medical Assistance, but optional for patients with private insurance.

Physician Name _____

Physician Address _____

Phone Number _____ Fax Number _____

If you would like for the evaluation and progress notes to be sent to an additional person or organization, please list below.

Name _____

Address _____

I hereby authorize The Hearing and Speech Agency of Metropolitan Baltimore, Inc. to release pertinent clinical and/or educational information in written and/or oral form regarding evaluation, treatment, or ongoing progress for the above-named person, in the following disciplines:

☐ Speech-Language Pathology ☐ Occupational Therapy ☐ Audiology

☐ I do not want my information or records released to anyone

_____ _____
Client (Parent or Guardian if client is a minor) Date

_____ _____
Witness Date

This consent will be in effect for one year from the date of signature. It may be revoked or revised in writing at any time by the person giving permission on this form or by a minor child who reaches the age of majority during the effective year.

Revised: 1/2017

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FINANCIAL INFORMATION

Financially Responsible Party If Other Than the Patient

Name:_____ Relationship to Patient:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Primary Insurance Information for Policy Holder

Insurance Company:_____ Policy/ID Number (include alpha prefix):_____

Group Number: (include alpha characters) _____Effective Date:_____

Claims Phone Number:_____ Policy Holder Name:_____

Date of Birth:_____ Social Security Number:_____

Relationship to Patient:_____ Employer:_____

Work Phone:_____

Secondary Insurance Information for Policy Holder

Insurance Company:_____ Policy/ID Number (include alpha prefix):_____

Group Number: (include alpha characters) _____Effective Date:_____

Claims Phone Number:_____ Policy Holder Name:_____

Date of Birth:_____ Social Security Number:_____

Relationship to Patient:_____ Employer:_____

Work Phone:_____

Form Completed by:_____ **Relationship to Patient:**_____

Signature:_____ **Date:**_____

Rev. 2/18