1100 Washington Avenue, Suite 317 T: (412) 489-5527
Carnegie, PA 15106 F: (412) 489-5726

CLIENT INTAKE FORM

1. CLIENT The client is the person who is receiving the equipment or services.

Client Name (Last, First, MI):	Client Date of Birth:
Status: ☐Married ☐Single ☐Other ☐Employed	
Sex: ☐Male ☐Female	SSN:
Does the client currently own a communication device? ☐Yes ☐No	
Make/Model:	Date of Purchase:
Current Place of Residence (Check all that apply): ☐Home ☐Skilled Nursing Facility ☐Assisted Living ☐Custodial Care Facility ☐Group Home ☐Hospice Program ☐Other: _____	
Physical Address: Name of Facility (if applicable): _____	
Mailing Address: ☐ Same as Physical Address	

Phone:	Alt. Phone:	Email:

2. CONTACT / CLIENT ADVOCATE The contact/client advocate is the person who is assisting the client or emergency contact

Name:	
Relationship to Client: ☐Spouse ☐Parent ☐Legal Guardian ☐Other: _____	
Address:	

Phone:	Alt. Phone:	Email:

Does this person have legal/financial responsibility over the patient? ☐Yes ☐No

3. TREATING PHYSICIAN The treating physician is the medical doctor who has prescribed the requested equipment.

Name:	UPIN (Universal Personal ID #):
Address:	

Phone:	Alt. Phone:	Fax:

NPI #:	State License #:

4. DIAGNOSIS Please list all diagnoses and date of onset, if applicable, below.

Is diagnosis a result of an accident? ☐Yes ☐No	Date of accident:

5. PRIMARY INSURANCE If the primary insurance is Medicare or Medicaid, just fill in the ID number below and proceed to secondary insurance.

Subscriber Name:	Policy Holder & Relationship:	Policy Holder DOB:
Name of Insurance:		
Member ID #:	Group #:	Phone #:
Billing Address:		

6. SECONDARY INSURANCE If the secondary insurance is Medicare or Medicaid, just fill in the ID number below.

Subscriber Name:	Policy Holder & Relationship:	Policy Holder DOB:
Name of Insurance:		
Member ID #:	Group #:	Phone #:
Billing Address:		

7. REASON FOR REFERRAL

How did you hear about the ICAN™ Clinic of The AAC Institute?

8. CONSENT AND RELEASE I hereby consent to treatment by, and authorize insurance benefits to be paid directly to The AAC Institute. I agree that I am responsible to pay 1.) for services not covered by my insurance company, 2.) co-payments and deductibles, and 3.) any expenses associated with the collection of a debt owed to them by me (i.e., Attorney fee, court cost or collection agency fee). I also consent to the release of the pertinent medical information to my insurance carrier(s) for the purpose of processing health care claims.

Signature of Responsible Party

Witness

Date

Date

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Cancellation Policy

Failure to keep your scheduled appointment with the ICAN™ Talk Clinic hinders our ability to provide the best care to our patients.

We ask that you show consideration by calling at least 24 hours prior to your appointment if you are unable to attend. **Please call (412) 489-5527 to notify us of your cancellation.**

Repeated late cancellations or no-shows are disruptive to the optimal delivery of service to you and our other patients. As a result, there will be a cancellation charge for every no-call, no-show appointment. You will be billed for the full price of the service, including those individuals who are having funding for services through insurance. Three cancellations or now shows will result in discontinuing services at the ICAN™ Talk Clinic. Cancellations due to illness or family emergency are excluded from this policy.

I understand the ICAN™ Talk Clinic's appointment cancellation policy and understand my responsibility to plan appointments accordingly and notify ICAN™ Talk Clinic appropriately if I have difficulty fulfilling my scheduled appointments.

Patient/Parent Signature

Date

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Privacy Notice Acknowledgement

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the ***Health Insurance Portability and Accountability*** act of 1996 (HIPAA), we are required to supply you a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of AAC Institute/ICAN Talk Clinic's ***Notice of Privacy Practices for Protected Health Information***.

_____ _____
Patient Name Printed Date

_____ _____
Patient Signature Authorized Provider Representative

_____ _____
Personal Representative Printed Personal Representative Signature

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Photo/Media Release

Name of Child/Adult: _____

Name of Parent/Guardian of Child (if minor): _____

I/we _____ hereby grant to the AAC Institute and/or ICAN™ Talk Clinic and persons action for or through them the right to reproduce, assign, or distribute photographs, films, videotapes, and sound recordings of myself/my child for use in materials they may crate. This permission includes the following:

- Printed advertisements in publications including photographs of myself/my child
- Quotations from myself/my child/other family members, caregivers, therapists, speech language pathologists, or others concerned with the care of myself/my child
- A printed case history of myself/my child to be prepared by the AAC Institute which may be widely disseminated, including being place on the AAC Institute website
- Video clips or still photographs of myself/my child to be placed on the AAC institute website
- Educational venues such as conferences, in-service training, or college courses

_____ _____
Name (Print) Date

_____
Signature

_____
Guardian/Parent

AAC Institute Clinic dba ICAN Talk Clinic
Personal Representative Designation Form

Dear Patient:

We understand that you wish to appoint a personal representative to act on your behalf as described below. In regard to this matter, the privacy of your health care information is important to us. In the spaces below, provide the requested information about yourself (the client) and the person you are designating to act as a personal representative concerning your health care information. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

Note that, subject to the disclaimers in the following paragraph, this form can be used to document the following types of personal representative activities on behalf of the patient: 1) making appointments for health care services; 2) discussions with health care providers about routine tests and treatments (do not require informed consent); and 3) access to medical records as necessary to have discussions with health care providers about routine tests and treatments.

Note that this form is <u>not applicable and cannot be used</u> for any behavioral health patients or for any patient when major health care decisions are involved, including, but not be limited to: 1) procedures/services that require informed consent (and withdrawal of consent if applicable); 2) admissions to and discharges from nursing homes or other long-term care facilities; 3) donation of organs, body parts, or body for medical purposes, including the authorization of an autopsy; and, 4) continuation or withdrawal of life support. For major health care decisions, a formal power of attorney or living will is recommended.

Read this form carefully and then fill it out completely by printing or typing. If printing, use a pen.

This personal representative designation only applies to the following AAC Institute Clinic dba ICAN Talk Clinic

1. Required Information

Client's Name:	Clients's Date of Birth:	Client's Phone:
Client's Address:		
Name of Client's Personal Representative:		Personal Representative Phone:
Personal Representative Address:		Relationship to client:
Any limitations on issues your personal representative may discuss? Yes _____ No _____ If yes, please specify:		
Expiration date for this designation (unless/until you specify in writing the expiration, this form will remain in effect indefinitely or until patient expires):		

2. Required Signatures

Personal Representative Signature:_____Date: _____

Client Signature: _____ _____Date: _____

Please return this completed form by mail to: AAC Institute Clinic 1100 Washington Ave Suite 317 Carnegie, PA 15106 or by fax to: 412-489-5726

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Request for Medical Records

Patient Name: _____

Address: _____

Phone: _____

SSN: _____

I, _____, authorize the release of my medical records from _____ located at _____ to _____.
Release of information includes permission to provide:

☐ All records including therapeutic notes, reports, testing results, and other pertaining documentation.

*Note that if these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

☐ Specified document(s): _____

☐ Written communication between ICAN™ Talk Clinic and _____

☐ Phone or video conferencing between ICAN™ Talk Clinic and _____

These records are for the services provided during the follow date(s):

☐ All times the patients was seen at the facility.

☐ Between the dates _____ to _____.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of Patient | Date

_____ _____

Printed Name of Patient Representative | Representative's Authority to Sign for Patient

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Consent for Language Sample Collection, Analysis, and Use and Request for Expeditious Communication

Introduction

People who rely on AAC indicate that the two most important things to them are:

1.) Being able to say exactly what they want to say, and
2.) Being able to say it as fast as possible.

Communication that honors these and other values is most readily achieved through the collection and analysis of language samples.

The ASHA (American Speech-Language-Hearing Association) Scope of Practice for Speech-Language Pathologists (SLPs) is the very definition of the profession in the United States. It includes the expectation that all SLPs collect data, measure outcomes, and provide services in accordance with the principles of evidence-based practice. Language sample collection is the very foundation of compliance with these expected professional practices.

_____ provides services in compliance with ASHA standards. Therefore, language samples are collected and analyzed as a normal component of service delivery. This is done using audio recording, video recording, and/or data recording. Recorded language samples may be analyzed here or sent to others for analysis, either by physical or electronic means. They will be stored, conveyed, and otherwise treated with confidence. If you are willing to have either the language samples or their analyses anonymously shared with others for educational or promotional or research purposes, that may be done.

Due to the potential for claims of invasion of privacy, we ask that you read and sign this consent form.

Consent

I have read and understand the above information on language sample collection and analysis.

I agree to the recording, transmission, and storage of language samples using (check those for which permission is granted):

□ Audio Recording □ Data Recording
□ Video Recording □ Direct Transcription

I agree that these samples will have all personal identification removed and may be used for (check those for which permission is granted):

□ Clinical Service Delivery
□ Promotional Purposes (advertising, catalog, etc.)
□ Research purposes (analysis by other researchers, etc.)

OR

□ I prefer not to have language samples collected and analyzed and acknowledge that this may result in compromised communication performance. Initial _____

Request

□ It is important to me that services be provided in a timely manner. Therefore, I request that the most expeditious forms of communication and service delivery be used and hereby consent to the use of those forms (email, Internet, telephone, voicemail, video-telephone, tele-rehabilitation methods, fax, postal mail, courier, and others) for communication of all information, including protected health information.

_____ _____

(Print Name/Signature) Date

(Parent or Guardian if under age 18 years)

Name _____

Address _____

_____

_____

Telephone _____

Email _____

(These items will be maintained in confidence and not be part of any disseminated data.)

Subject No. (entered by administrator) _____