School of Allied Health Professions
Patient Registration/Update

☐ New Patient ☐ Update

Last Name | First Name | Middle Name

☐ Female ☐ Male ___/___/___ Date of Birth ___-___-___ Social Security Number

Patient's Street Address | City | State | Zip | (___) Phone Number

Responsible Person's Name | Relationship to Patient | E-mail address

Responsible Person's Address | City | State | Zip | (___) Phone Number

___/___/___ Responsible Person's Date of Birth ___-___-___ Responsible Person's Social Security Number

Emergency Contact Name | Relationship | (___) Phone Number

Primary Insurance

Insurance Company Name | ID # | Group #

Insurance Company Address | City | State | Zip | (___) Phone Number

Relationship to Subscriber | Subscriber Name | Subscriber Social Security #

Subscriber's Employer

Secondary Insurance

Insurance Company Name | ID # | Group #

Insurance Company Address | City | State | Zip | (___) Phone Number

Relationship to Subscriber | Subscriber Name | Subscriber Social Security #

Subscriber's Employer

LSU Health NEW ORLEANS
School of Allied Health Professions

Patient Consent for Treatment

I do hereby voluntarily consent to such treatment as is deemed necessary by the clinician. I hereby release Louisiana State University Health Sciences Center and its personnel from any responsibilities resulting from illness, ill effect, or reaction from the treatment ordered by my physician.

I have read all of the above, and I certify that I understand its contents.

_____ _____
Patient's Signature Date

_____ _____
Other Authorized Signature Date

_____ _____
Relationship of Authorized Signature Reason Patient Cannot Sign

LSU Health
NEW ORLEANS
School of Allied Health Professions

Patient Guarantee and Authorizations

In consideration for and to cause Louisiana State University Health Sciences Center School of Allied Health Professions Clinics to treat _____ (print patient name) as a private patient, the **undersigned hereby unconditionally guarantees payment of all cost charges and expenses** of the Louisiana State University Health Sciences Center School of Allied Health Professions Clinics to apply for benefit on my behalf for covered services rendered by the LSU School of Allied Health Clinics, and request all payments be made to "LSUHSC." Furthermore, **I understand and agree any unpaid balance not covered by my insurance policy will be paid directly by me.**

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care procedures. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I have read all of the above, and I certify that I understand its contents.

_____
Patient's Signature

_____
Other Authorized Signature

_____
Relationship of Authorized Signature

_____
Date

_____
Date

_____
Reason Patient Cannot Sign

LSU Health NEW ORLEANS
School of Allied Health Professions

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of
(Patient's name – please print)
the Notice of Privacy Practices of LSUHSC-New Orleans on this date.

_____ Date: _____
Signature – Patient or Patient's Representative

Health Care Provider's Documentation of Good Faith Effort to Obtain Acknowledgement of Receipt

If the Acknowledgement could not be obtained prior to the date of first service to the patient, or, in an emergency situation, as soon as reasonably practicable after the emergency has resoled, describe below the efforts made to obtain the written Acknowledgement and the reasons why the written Acknowledgement could not be obtained. If the patient refused to provide the written Acknowledgement, please so state.

Efforts to obtain written Acknowledgement:

_____

_____

_____

_____

Reasons written Acknowledgement could not be obtained:

_____

_____

_____

_____ Date: _____
(Signature of healthcare provider)

_____
(Printed name of healthcare provider)

Revised 04/2023

Notice of Privacy Practices Protected Health Information

This Notice Describes How Your Medical/Dental Information May Be Used and Disclosed and How You Can Get Access to this Information. Please Review it CAREFULLY.

The law requires us to make sure your medical information is kept private. It also requires us to give you this notice of our legal duties and privacy practices to tell you what we can do with the medical information about you. To better understand this law, you may want to read it. It is in Title 45 of the Code of Federal Regulations, Part 164. In the unlikely event that the information we have about you should be obtained by someone who is not supposed to have it, the law requires us to notify you. We are required to follow the practices outlined in this notice. We have the right to change this notice and our privacy practices in the future. Any changes made will apply to all of the medical information we have about you at this time. If we make a change, we will put up a notice in our building. We will also give you a copy of the new notice if you ask for it. You can also read about these changes on the computer at this website: www.lsuhsc.edu.

HOW YOUR MEDICAL/DENTAL INFORMATION MAY BE USED: In general, we may use your medical information in a number of ways:

To provide patient care to you. Your medical information may be used by the doctors, nurses and other professionals who are treating you. For example, your medical information is used to help them find out your problems or condition, and to decide the best way to treat you. Appointment Reminders. We may use your medical information to contact you to remind you of appointments, and to give you information about other treatment options, or other health – related benefits and services that may be of interest to you.

Appointment reminders. We may use your medical information to contact you to remind you of appointments, and to give you information about other treatment options or other health-related benefits and services that may be of interest to you.

To obtain payment. Your medical information may also be used by our business office to prepare your bill and process payments from you as well as from any insurance company, government program or other person who is responsible for payment.

For our health care operations. Your medical information may be used to review the quality and appropriateness of the care you receive. We may also use your medical information to put together information to see how we are doing and to make improvements in the services and care we give you. In some cases we may have students, trainees, or other health care personnel, as well as some non-health care personnel, who come to our facility to learn under the guidance of faculty to practice or improve their skills.

To create de-identified databases. We may use your medical information for the purpose of removing your personal information that tells anyone who you are, and putting it into a computer program. Your information may be completely de-identified where all identifying information is removed or partially de-identified but includes information such as gender and zip codes. This information is often used for research purposes. If your information is partially de- identified, it is called a "limited data set."

Fundraising. We may use your medical information to raise funds for our organization directly or to raise funds for our organization through an institutionally – related foundation or business associate. You may receive communications about these fundraising activities. You have the right to request that you not be contacted by us for purposes of fundraising and we must agree to your request.

HOW YOUR MEDICAL/DENTAL INFORMATION MAY BE DISCLOSED: In addition to using your medical information, we may disclose all or part of it to certain other people. This includes giving your information to:

You. In order to get your medical information, you will need to fill out an authorization form. You may also have to pay for the cost of some or all of the copies.

People You Authorize. If you tell us that you want us to give your medical information to someone, we will do so. You will need to fill out an authorization form. We must obtain your written authorization before disclosing information you may have shared with one of our psychiatrists, psychologists or counselors in a private session, or to use your information to market our services, or to sell your information. We must obtain your authorization to use or disclose your information in any way that is not otherwise described in this notice. You may stop this authorization at any time. We are not allowed to force you to give us permission to give your medical information to anyone. We cannot refuse to treat you because you stop this authorization.

Payers. We have the right to give your medical information to insurance companies, government programs such as Medicare and Medicaid, and their contractors who process your claims, as well as to others who are responsible for paying all or part of the cost of treatment provided to you. For example, we may tell your health insurance company what is wrong with you and what treatment is recommended or has been given to you.

Business Associates. Business Associates are companies or people we contract with to do certain work for us. Examples include billing services, information auditors, attorneys and specialized people providing management, analysis, utilization review or other similar services to us. Another example is giving health information to a Business Associate so that they can create a de-identified database. All Business Associates are required to agree to take reasonable steps to protect the privacy of your medical information.

Limited Data Set Recipients. If we use your information to make a "limited data set," we may give the "limited data set" that includes your information to others for the purposes of research, public health action or health care operations. The persons who receive the "limited data set" are also required to agree to take reasonable steps to protect the privacy of your medical information.

The Secretary of the U.S. Department of Health and Human Services. The Secretary has the right to see your records in order to make sure we follow the law.

Public Health Authorities. We may disclose your medical information to a public health authority responsible for preventing or controlling disease, maintaining vital statistics or other public health functions. We may also give your medical information to the Food and Drug Administration in connection with FDA-regulated products.

Law Enforcement Officers. We may reveal your medical information to the police. We may also give your medical information to persons whose job is to receive reports of abuse, neglect or domestic violence. And, if we believe that releasing this information is needed to prevent a serious threat to the health or safety of a person or the public, we are permitted to reveal your medical information.

Health Oversight Agencies. We may give your medical information to agencies responsible for health oversight activities, such as investigations and audits, of the health care system or benefits programs, as allowed by law.

Courts and Administrative Agencies. We may reveal your medical information as required by a judge for a legal issue.

Coroners and Administrative Agencies. If you die, we may reveal medical information about your death to coroners, medical examiners and funeral directors, as allowed by law.

Tissue Donation and Organ Transplant Services. We may reveal your medical information to agencies that are responsible for obtaining tissue donations and obtaining and transplanting organs.

Research. We may reveal your medical information in connection with certain research activities. With your authorization, we may disclose pertinent information such as your name, social security number, study name, and dates of participation to our Accounts Payable department to issue human subjects research incentive payments.

Specialized Governmental Functions. We may disclose your medical information for certain specialized governmental functions, as allowed by law. Such functions include:

- Military and veteran activities
- National security and intelligence activities
- Proactive services to the President and others
- Medical suitability determinations; and
- Correctional institutions and other law enforcement custodial situations.

Required by Law. We may also reveal your medical information in any other circumstances where the law requires us to do so.

OBJECTIONS TO USES AND DISCLOSURES: In certain situations, you have the right to object before your medical information can be used or revealed. This does not apply if you are being treated for certain mental or behavioral problems. If you do not object after you are given the chance to do so, your medical information may be used:

Patient Directory. In most cases, this means your name; room number and general information about your condition may be given to people who ask for you by name. Also, information about your religion may be given to members of the clergy, even if they do not ask for you by name.

Family and Friends. We may disclose to your family members, other relatives and close personal friends, any medical information that they need to know if they are involved in caring for you. For example, we can tell someone who is assisting with your care that you need to take your medication or get a prescription refilled or give them information about how to care for you. We can also use your medical information to find a family member, a personal representative or another person responsible for your care and to notify them where you are, about your condition or of your death. If it is an emergency or you are not able to communicate, we may still give certain information to persons who can help with your care.

Disaster Relief. We may reveal your medical information to a public or private disaster relief organization assisting with an emergency.

YOUR RIGHTS REGARDING YOUR MEDICAL/DENTAL INFORMATION: You may also have the following rights regarding your medical information:

You have the right to ask us to treat your medical information in a special way, different from what we normally do. Unless it is one of the uses or disclosures to which the law gives you the right to object, we do not have to agree with you. If we do agree to your wishes, we have to follow your wishes until we tell you that we will no longer do so. However, you have the right to request restrictions on disclosures of information about a health care item or service for which you have paid in full out of pocket. We must agree to your request as long as the requested restriction applies to seeking payment or our health care operations and not required by law.

You have the right to tell us how you would like us to send your information to you. For example, you might want us to call you only at work or only at home. Or you may not want us to call you at all. If your request is reasonable, we must follow your request.

You have the right to look at your medical information and, if you want, to get a copy of it. We can charge you for a copy, but only a reasonable amount. Your right to look at and copy your medical records is based upon certain rules. For example, we can ask you to make your request in writing, or, if you come in person, that you do so at certain times of the day.

You have the right to ask us to change your medical information. For example, if you think we made a mistake in writing down what you said about when you began to feel bad, you can tell us. If we do not agree to change your record, we will tell you why, in writing, and give you information about your rights.

You have the right to be told to whom we have given your medical information in the six years before you ask. This does not apply to all disclosures. For example, if we gave someone your medical information so that they could treat you or pay for your care, we do not have to keep a record of that.

You have the right to get a copy of this notice at no charge.

You have the right to complain to us or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights.

If you have a complaint or concern, please call our

24 hour Hotline: (504) 568-2347

Your call will be handled by our Privacy Officer.
You may remain anonymous and all calls are kept confidential.

For further information about your rights or
about the uses and disclosures of your medical information, please call

The Office of Compliance Programs at: (504) 568-5135

to speak with either our Compliance or Privacy Officer.

Or write to:

LSUHSC New Orleans
Office of Compliance Programs
433 Bolivar Street, Room 807
New Orleans, LA 70112

Or email:

nocompliance@lsuhsc.edu

This notice is effective as of 4/13/2003 and revised as of 9/23/2013

LSU Health NEW ORLEANS
School of Allied Health Professions

Consent to Photograph, Videotape, Audiotape

I give permission to Louisiana State University Health Sciences Center (LSUHSC) to photograph, videotape, or audiotape me and/or my child, _____, during evaluation and treatment sessions. I understand that these may be used for teaching, professional presentations or for publication. Photographs and tapes will be the property of the department and will be held in confidence. In some instances, the name of you or your child may be used.

Please indicate any restrictions below or strike out and initial any exclusions.

_____

_____

_____

_____

Name: _____

Address: _____

_____

Phone: _____

_____ _____

Signature **Date**

LSUHSC Allied Health Clinics
1900 Gravier St. | 411 S. Prieur St.
New Orleans, LA 70112

Telemedicine/Telehealth
The practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data by a physician using an interactive telecommunication technology that enables a physician and a patient at two locations separated by distance to interact via a two-way video and audio transmissions simultaneously.

Telehealth Consent Form

1. I understand that my health care provider wishes me to engage in a telehealth session/appointment.

2. I understand that a telehealth session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

3. I understand that my medical records will be created and maintained according to the same standards as in an in-person visit. The records will reflect that the encounter occurred by telehealth. Confidential and subject to all applicable state and federal laws and regulations relative to privacy and security of health information.

4. I understand that my provider will discuss with me an overview of:

    a. Technical issues relative to encryption,
    b. Protocol for technical failure,
    c. Limits to confidentiality in electronic communication,
    d. Emergency Plan for clients in settings with/without available clinical staff,
    e. Protocol for documentation and storage of client information,
    f. Conditions for which a telehealth session may be terminated, and
    g. Protocol for referral or coordination of care with other health care providers.

5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth session if it is felt that the videoconferencing connections are not adequate for the situation. I will provide an alternative contact number and my location in case there are interruptions in services or technical difficulties with my telehealth session.

6. I have had a direct conversation with my provider, during which I had the opportunity to ask questions about this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

7. Though my provider and I may be in direct, virtual contact through the Telehealth Zoom Service, neither LSUHSC AH nor the Telehealth Service (Zoom) provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

8. Telehealth by LSUHSC Allied Health is NOT an Emergency Service and in the event of an emergency or urgent matter, I will use a phone to call 911.

10. I do not assume that my provider has access to any or all of the technical information in the Telehealth session - or that such information is current, accurate or up-to date. I will not rely on my health care provider to have any of this information in the Telehealth service.

11. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

12. I understand that if I am a new patient, I will be required to show my photo ID for verification/ security and if I am a caregiver for a minor child that will be receiving services, I understand that my child will be asked to state their name and age.

13. I understand that once the telehealth scheduling link is used for the scheduled appointment, I will not be able to use the link for future sessions. I understand that I will request future appointments by contacting the office via phone or email.

By signing this form, I certify:

• That I have read or had this form read and/or had this form explained to me.
• That I fully understand its contents including the risks and benefits of the procedure(s).
• That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____
Signature of Client/Patient

_____ _____
Printed Name of Client/Patient Date

_____
Provider Signature

_____ _____
Provider Printed Name Date

If client/patient is a minor:
I,_____ give permission for _____to conduct a telehealth session/appointment, with my child_____

Guardian's signature_____ Date_____

Relationship to minor_____

LSU Health NEW ORLEANS
School of Allied Health Professions

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Information (Please PRINT)

First Name:	Last Name:	
Middle Initial:	Date of Birth: _____/ _____/ _____ (MM/DD/YYYY)	
Street Address:		
City:	State:	Zip Code:
Home Phone Number: ( )	Cell Phone Number: ( )	
Email address (optional):		

I hereby authorize: LSUHSC Speech and Hearing Clinic

Address: **1900 Gravier St. 9th Floor New Orleans, LA 70112**
Phone Number: 504-566-4346 Fax Number: 504-568-4352
Email Address: comdfrontoffice@lsuhsc.edu

To:

❑ **Received information from**:

Address: Phone number: Fax number :

❑ **To release information from**:

Address: Phone number: Fax number:

Health Information to be used and/or disclosed under this authorization:

❑ Photographs, Videotapes	❑ Complete Health Record	❑ Itemized Bill
❑ Consultation reports	❑ Discharge Summary	❑ Complete Billing record
❑ Diagnosis & Treatment Codes	❑ History and Physical	❑ Progress Notes

❑ Other:_____

The below information will **NOT** be released unless you specifically authorized by initialing below: **Please initial ALL that apply**			
AIDS or HIV test results:		Behavioral Health Information:	
Alcohol/substance abuse treatment:			

Purpose of the use and/or disclosure:

❑ Continued Care ❑ Legal ❑ Insurance ❑ At my request ❑ Other:

Acknowledgement of Understanding:

- I understand that I may withdraw my authorization in writing at any time except to the extent that action has been taking in reliance on this statement. Withdrawal must be made in writing and presented or mailed to the LSUHSC-NO Child & Family Counseling Clinic at the address listed above.
- I understand that if I do not sign this form, my health care and the payment of my health care will not be affected.
- I understand that signing this form is voluntary. LSUHSC-NO Child & Family Counseling Clinic may not condition treatment, payment, enrollment in health plans, or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.
- I understand that once LSUHSC-NO Child & Family Counseling Clinic discloses my PHI to the recipient, LSUHSC-NO Child & Family Counseling Clinic cannot guarantee that the recipient will not redisclose my PHI to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my PHI.
- I understand that I may inspect or copy the information to be used or disclosed, as provided by 42 CFR 164.524
- I understand there is a charge for photocopies and records provided on electronic media, as permitted by Louisiana law, unless copies are sent directly to another healthcare provider.
- I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting.

Signature of patient or Legal Representative:	Date:
Printed Name of Patient or Legal Representative:	Relationship to Patient:
Representative's Authority to Act for Patient: ***(Attach supporting documentation)***	

LSU Health NEW ORLEANS
School of Allied Health Professions

IMPORTANT INFORMATION ABOUT COMPLETING THE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NOTICE TO PATIENTS:
Please read this notice carefully and follow instructions for completing the authorization to release of your protected health information.

Important Information about Authorization:
The authorization will terminate on the date indicated on the Authorization or when revoked in writing by the patient

LSUHSC-NO Speech and Hearing Clinic
1900 Gravier Street 9tht Floor
New Orleans, LA 70112

Phone Number: (504)568-4348
Fax Number: (504)568-4352
Email:COMDFrontOffice@lsuhsc.edu

Instructions for Completing Authorization:

1. Complete all sections on the "AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION" form. Incomplete forms will not be accepted (**mandated by the Federal Guidelines for HIPAA**).
2. Form must be completed by patient or authorized patient representative, with appropriate identification.
3. If patient is deceased, did not expire at this facility, and you are the next of kin, please include a copy of the death certificate.
4. Please send (mail, fax, or email) your completed Authorization to Release Protected Health Information form TO the appropriate location listed above
5. If you have any questions regarding the release of your medical information, please contact your provider at the LSUHSC-NO Speech and Hearing Clinic; at the location listed above.

LSU Health NEW ORLEANS
School of Allied Health Professions

Speech Language Pathology Prompt Pay Discount Program

Our services are provided to the public at competitive rates. We are participating providers with several insurance companies including Medicare, Medicaid, and private health insurance companies. We also have a semester fee program for those who meet criteria outlined below.

To provide patients with a mechanism to pay for Speech Therapy services *denied* by the client's insurance carrier, the SAHP Clinics have implemented a Prompt Pay Discount Program.

A patient is eligible for the Prompt Pay Discount Program based on the following:

To find out if you qualify for The Prompt Pay Discount Program contact your Speech Language Pathologist or the Clinic Manager for more information.