

### ADULT HEARING HISTORY AND CURRENT FUNCTIONING

Date: \_\_\_\_\_ Person(s) Completing Form: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
(First) (Middle) (Last) ("Nick Name")

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

#### Medical History

When were your hearing difficulties first noticed? \_\_\_\_\_

Did it happen gradually or suddenly? \_\_\_\_\_

What other symptoms occurred around the same time? \_\_\_\_\_

Possible causes of hearing loss? \_\_\_\_\_

Is there a family history of hearing loss?  No  Yes

If yes, please describe \_\_\_\_\_

Have you been seen by a physician for suspected hearing loss?  No  Yes

If yes, please state by whom, any diagnoses and treatments recommended: \_\_\_\_\_

#### Have you had or do you currently have any of the following?

Dizzy spells or loss of balance?  No  Yes

If yes, please state when, how often, and describe the dizziness if possible:

\_\_\_\_\_

Ear Infection(s)?  No  Yes

If yes,  Left  Right  Both

Ear Surgery?  No  Yes

If yes, when? \_\_\_\_\_ By Whom? \_\_\_\_\_

Ear Pain?  No  Yes

If yes,  Left  Right  Both

When and How Often? \_\_\_\_\_

Ear Drainage or Running Ears?  No  Yes

If yes,  Left  Right  Both

When and How Often? \_\_\_\_\_

Do your ears ring or do you have other head noises  No  Yes  
 If yes,  Left  Right  Both  
 How Often? \_\_\_\_\_

Do your ears feel full?  No  Yes  
 If yes,  Left  Right  Both

Do you (please check those that apply)?

- Feel like people mumble?  Need the TV louder than other noises?
- Have trouble understanding conversation?
  - In quiet from a distance?
  - In quiet even when near to the speaker?
  - In background noise?

**Noise History**

Have you ever worked in a noisy job (include military service)?  No  Yes

If yes, what type of job did you do? \_\_\_\_\_

For how long? \_\_\_\_\_

Did you use hearing protection (earplugs/ear muffs)?  No  Yes

If yes, for how long? \_\_\_\_\_

Do you or have you ever used guns?  No  Yes

If yes, how often? \_\_\_\_\_

**Current Functioning**

How well do you currently hear in the following environments?

	<b>Well</b>	<b>Fair</b>	<b>Poor</b>
One-to-one conversations			
Quiet room (1 to 2 people)			
Small group (4 to 6 people)			
Large social gatherings			
At the work place			
Watching television			
During religious services			
Meetings/lectures			
In the car			
Outdoors			
On the telephone			

**What is your experience with hearing aids? (Please check all that apply)**

- I have never used or visited a Hearing Health Care Professional to ask about a hearing aid(s).
- I have been to another Hearing Health Care Professional to gather information regarding my hearing difficulties, but have not tried or purchased a hearing aid(s).
- I have tried a hearing aid(s). but returned the instrument(s).
- I have a hearing aid(s) but only wear it occasionally or not at all.
- I have a hearing aid(s) and wear it regularly in the \_\_\_\_\_ Right Ear and/or \_\_\_\_\_ Left Ear.

**Please rank the following in terms of importance in a hearing aid (1 to 4 with 4 being the most important):**

\_\_\_\_\_ Overall Sound Quality      \_\_\_\_\_ Reliability      \_\_\_\_\_ Style/Appearance      \_\_\_\_\_ Cost

**On a scale of 1 to 10, how motivated are you regarding doing something about your hearing loss? (Please check one)**

- 1-2 Not Motivated
- 3-4 Somewhat Motivated
- 5-6 Motivated
- 7-8 Very Motivated
- 9-10 Extremely Motivated

**If you have additional questions or concerns, please write them below:**

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## ADULT INITIAL QUESTIONNAIRE

Date: \_\_\_\_\_ Person(s) Completing Form: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
(First) (Middle) (Last) ("Nick Name")

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed

Occupation: \_\_\_\_\_ Highest Level of Education Completed: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Referring provider if different from primary care physician: \_\_\_\_\_

Who recommended the patient for this appointment?

What are your reason(s) for seeking services at Clarity, Inc at this time?

When did the patient (or someone else) first notice these concerns and what did the patient (or someone else) feel led to/caused these concerns?

### **Personal Medical History**

Did the patient have any serious illnesses, injuries (including head) or medical problems as a child?  No  Yes

If yes, please state \_\_\_\_\_

Has the patient had any serious illnesses, injuries (including head) or medical problems as an adult?  No  Yes

If yes, please state \_\_\_\_\_

Is the patient currently being treated for?  Diabetes  Heart Condition  High Blood Pressure

Kidney Disease  Other \_\_\_\_\_

Please list any medications the patient is currently taking and why?

Does the patient or others think the patient has a hearing problem?  No  Yes

If yes, please state \_\_\_\_\_

## NOTICE OF CLARITY'S OFFICE POLICY

**Clarity, Inc.** participates with many insurance companies and we will submit your claim to all carriers that we participate with. Please be advised that your individual health insurance policy is a contract between you and your insurance company, and **Clarity Inc.** is not a party to that contract. Be advised that some of your services **MAY NOT** be covered by your individual insurance policy. By presenting for care, you agree that you will be financially responsible for all services and charges, regardless of your insurance status. Should any provided services not be covered by your insurance, **WE WILL NOT ALTER YOUR CLAIM, CHANGE YOUR DIAGNOSIS, OR REPORT A DIFFERENT SERVICE THAN WHAT WAS PERFORMED IN ORDER THAT YOUR INSURANCE WILL COVER THE CHARGE. YOU WILL BE RESPONSIBLE FOR THE BALANCE.** The ONLY exception to this is that, should the correction be due to a clerical error in original service entry. We accept most major credit cards. Copies of all insurance cards AND a photo ID are required prior to any services being rendered or insurance claims being submitted on your behalf. **Your signature below acknowledges your acceptance of Clarity's office policy as well as your financial responsibility for any charges not covered by the insurance carriers you have listed below. Please see the Business Office for a copy of this agreement.**

### 2020 PATIENT INFORMATION

**Patient's Name**

**Patient's Date of Birth**

**Patient's Address**

**City, State, Zip**

**Email Address**

**Home Phone**

**Cell Phone**

**Work Phone**

**Primary Care Physician Name**

**PCP Phone**

**Emergency Contact Name**

**Relationship to Patient**

**Emergency Contact Address**

#### **PRIMARY INSURANCE CARRIER**

**Policy Holder Name**

**Policy Holder Address** (if different from above)

**Policy Holder Date of Birth**

#### **SECONDARY INSURANCE CARRIER**

**Policy Holder Name**

**Policy Holder Address** (if different from above)

**Policy Holder Date of Birth**

Permission for client's picture to be taken and used as part of their electronic chart:  yes  no  
(This picture is for internal use only)

**Are you interested in receiving more information about the following services:**

Hearing & Audiology  Speech-Language Therapy  Psychological Evaluations  Counseling

**Would you like to receive emails from Clarity about services and upcoming events?**  yes  no

#### **ACKNOWLEDGEMENT:**

*I have read the above 'Notice of Clarity's Office Policy' and willingly authorize medical evaluation and treatment, as well as any release of any medical information for medical/insurance purpose concerning any and all charges for services rendered by **Clarity, Inc.** in regards to the above mentioned patient.*

\_\_\_\_\_  
Printed Name of Financially Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Responsible Party

**\*\* PLEASE BRING COMPLETED FORM ALONG WITH INSURANCE IDENTIFICATION CARD AND A GOVERNMENT ISSUED PHOTO ID TO THE BILLING OFFICE UPON CHECK IN. \*\***

## **Notice of Clarity's Office Policies**

### **Insurance Disclosure**

Please read and sign the following. If you have any questions about this form, please contact Clarity: The Speech, Hearing, and Learning Center at (864) 331-1400.

Clarity, Inc. participates with many insurance companies and we will submit your claim to all carriers that we participate with. Please be advised that your individual health insurance policy is a contract between you and your insurance company, and Clarity Inc. is not a party to that contract. Be advised that some of your services **MAY NOT** be covered by your individual insurance policy. By presenting for care, you agree that you will be financially responsible for all services and charges, regardless of your insurance status. Should any provided services not be covered by your insurance, **WE WILL NOT ALTER YOUR CLAIM, CHANGE YOUR DIAGNOSIS, OR REPORT A DIFFERENT SERVICE THAN WHAT WAS PERFORMED IN ORDER THAT YOUR INSURANCE WILL COVER THE CHARGE. YOU WILL BE RESPONSIBLE FOR THE BALANCE.** The **ONLY** exception to this is that, should the correction be due to a clerical error in original service entry. We accept most major credit cards. Copies of all insurance cards AND a photo ID are required prior to any services being rendered or insurance claims being submitted on your behalf.

**Your signature below acknowledges your acceptance of Clarity's office policy as well as your financial responsibility for any charges not covered by your health insurance. Please see the Business Office for a copy of this agreement.**

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient's Date of Birth

**I authorize the release of any medical or other information to the insurance company that is necessary to process my insurance claim(s).**

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

**If there are any changes to your or your child's insurance between now and the time of your appointment, please notify us because your new insurance may not cover your service.**

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

### **Late Cancellation and no-show policy:**

If for any reason, you are unable to keep this appointment, we request you call us 24 hours in advance at (864) 331-1400 to cancel or reschedule. If **two** appointments (in any six month time period) are missed or cancelled with less than 24 hours notice, we will reschedule the appointment **after** a six month waiting period from the time of the missed appointment.

I acknowledge that I understand the policy for late cancellations and no shows:

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

### **Photography Permission**

**Permission for client's picture to be taken and used as part of their electronic chart:**  yes  no

(This picture is for internal use only)

**Are you interested in receiving more information about the following services:**

Hearing & Audiology  Speech-Language Therapy  Psychological Evaluations  Learning Intervention  Counseling

**Would you like to receive emails from Clarity about services and upcoming events?**  yes  no

**\*\* PLEASE BRING COMPLETED FORM ALONG WITH INSURANCE IDENTIFICATION CARD AND A GOVERNMENT ISSUED PHOTO ID TO THE BILLING OFFICE UPON CHECK IN. \*\***



29 N. Academy Street Greenville, SC 29601 Phone: 864.331.1400

## COMPOUND AUTHORIZATION

*The purpose of this authorization is to meet the patient's request for information disclosures and uses. This authorization shall be in enforce for six years, until the patient/client reaches the age of majority (18 years of age) or until this authorization is revoked by the patient or the patient's personal representative.*

### PATIENT INFORMATION

\_\_\_\_\_  
Patient's last name                      Patient's first name                      Patient's middle name

\_\_\_\_\_  
Patient's date of birth

**Verification method:** Clarity, Inc. will verify the identity of a person requesting protected health information and the authority of any such person to have access to protected health information if the identity or the authority of such person is not known to Clarity, Inc. Please provide a word/phrase that Clarity, Inc. can ask for to verify identity:

\_\_\_\_\_.

### Patient's Verification code

*This authorization form permits Clarity, Inc. to use or disclose protected health information listed in the description section below to the entity or person listed for the patient listed above:*

Communicating Directly with Patient or Personal Representative (as defined by HIPAA)		
<small>Initial if authorized</small>	Patient (or Personal Representative)'s Mailing Address: _____ City: _____ State: _____ Zip: _____	
<small>Initial if authorized</small>	Patient (or Personal Representative)'s Home Phone Number # _____ <input type="checkbox"/> Ok to leave message?	Description of Information to be provided: <input type="checkbox"/> Appointment Information <input type="checkbox"/> Financial Information <input type="checkbox"/> Other _____
<small>Initial if authorized</small>	Other Phone Numbers for Patient (or Personal Representative): # _____ (Cell) <input type="checkbox"/> Ok to leave message? # _____ (Work) <input type="checkbox"/> Ok to leave message? # _____ (Other) <input type="checkbox"/> Ok to leave message?	Description of Information to be provided: <input type="checkbox"/> Appointment Information <input type="checkbox"/> Financial Information <input type="checkbox"/> Other _____
<small>Initial if authorized</small>	Primary Email _____ Relationship to Patient: _____	Description of Information to be provided: <input type="checkbox"/> Appointment Information <input type="checkbox"/> Financial Information <input type="checkbox"/> Report from Evaluation/Screening <input type="checkbox"/> Treatment Progress <input type="checkbox"/> Other _____
<small>Initial if authorized</small>	Secondary Email _____ Relationship to Patient: _____	Description of Information to be provided: <input type="checkbox"/> Appointment Information <input type="checkbox"/> Financial Information <input type="checkbox"/> Report from Evaluation/Screening <input type="checkbox"/> Treatment Progress <input type="checkbox"/> Other _____



Communications **FROM** Clarity will be sent as encrypted messages. Emails sent **TO** Clarity by you (the patient/client or personal representative of the client) may be unencrypted as this is not a standard feature of most email providers. Please be aware that email communications can be intercepted during transmission or misdirected. Your use of email to communicate Protected Health Information or other information of a confidential nature to us indicates that you acknowledge and accept the possible risks associated with such communication.

**Communications with Others**

School or Employer: _____ Initial if authorized	Description of Information to be provided: <input type="checkbox"/> Date/Time of Appointment(s) <input type="checkbox"/> Report from Evaluation/Screening <input type="checkbox"/> Treatment Progress <input type="checkbox"/> Other _____
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SC Children's Rehabilitative Services _____ Initial if authorized	Description of Information to be provided: <input type="checkbox"/> Date/Time of Appointment(s) <input type="checkbox"/> Report from Evaluation/Screening <input type="checkbox"/> Treatment Progress <input type="checkbox"/> Other _____
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SC BabyNet Agency: _____ Initial if authorized	Description of Information to be provided: <input type="checkbox"/> Date/Time of Appointment(s) <input type="checkbox"/> Report from Evaluation/Screening <input type="checkbox"/> Treatment Progress <input type="checkbox"/> Other _____
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Other (Please give name and relationship): _____ Initial if authorized Name _____ Relationship _____ Address: _____ City: _____ State: _____ Zip: _____ Phone Number: _____	Description of Information to be provided: <input type="checkbox"/> Date/Time of Appointment(s) <input type="checkbox"/> Report from Evaluation/Screening <input type="checkbox"/> Treatment Progress <input type="checkbox"/> Other _____
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Other (Please give name and relationship): _____ Initial if authorized Name _____ Relationship _____ Address: _____ City: _____ State: _____ Zip: _____ Phone Number: _____	Description of Information to be provided: <input type="checkbox"/> Date/Time of Appointment(s) <input type="checkbox"/> Report from Evaluation/Screening <input type="checkbox"/> Treatment Progress <input type="checkbox"/> Other _____
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**Rights of the Patient**

- I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.
- I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
 Date                                      Signature of Patient or Personal Representative (as defined by HIPAA)                                      Relationship to patient (if other than patient)

Description of Personal Representative's Authority (Attach necessary documentation):  
 \_\_\_\_\_

## Notice of Privacy Practices for the office of CLARITY, Inc.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### Protected Health Information

“Protected Health Information” (also referred to as PHI) is health information created or received by your health care provider that contains information that may be used to identify you, such as demographic data. It includes written or oral information that relates to your past, present, or future mental health; provision of health care to you; and your past present, or future payment for health care.

### Uses and disclosures to carry out treatment, payment, and health care operations

**Treatment-** CLARITY, Inc. may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

**Payment-** CLARITY, Inc. may use or disclose your protected health information for billing, claims management, collection activities, or obtaining payment.

**Health Care Operations-** CLARITY, Inc. may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. CLARITY, Inc. may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities. CLARITY, Inc. may use or disclose your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business.

CLARITY, Inc. may use or disclose protected health information to remind you of your appointment, to give you information about treatment alternatives, or other health related benefits or services. If you do not wish to receive appointment reminders or the information about treatment alternatives, other health related benefits, services, you may notify our office and you will receive no further information.

CLARITY, Inc. may contact you for our **own** fundraising activities. If you do not want to receive fundraising communication, you may opt-out at any time. Each communication will contain methods to be used to opt-out of further communication. If you opt-out, you will receive no further fundraising communications. If at any time you wish to receive fundraising communication you wish to receive the communication again, you can contact our practice.

### Authorized Uses or Disclosures

The following uses or disclosures require a **valid** authorization as defined by the HIPAA standards.

**Uses or Disclosures for Psychotherapy Notes-** CLARITY, Inc. will require written authorization for most uses and disclosures of psychotherapy notes, where applicable.

**Uses or Disclosures for Marketing Purposes-** CLARITY, Inc. will require an authorization for uses and disclosures of protected health information used in marketing.

**Disclosures for a Sale of Protected Health Information-** CLARITY, Inc. will require an authorization for any disclosures that would constitute a sale of protected health information.

For any other use or disclosure, you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

### Uses or disclosures requiring an opportunity for the individual to agree or object

For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

### Uses and disclosures for which an authorization or opportunity to agree or object is not required

The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

**Uses and disclosures required by law-** CLARITY, Inc. may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

**Uses and disclosures for public health activities-** CLARITY, Inc. may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

**Disclosures about victims of abuse, neglect or domestic violence-** CLARITY, Inc. may disclose protected health information about an individual whom CLARITY, Inc. reasonably believes to be a victim of abuse, neglect, or domestic violence.

**Uses and disclosures for health oversight activities-** CLARITY, Inc. may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.

**Disclosures for judicial and administrative proceedings-** CLARITY, Inc. may, in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.

**Disclosures for law enforcement purposes-** CLARITY, Inc. may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.

**Uses and disclosures about decedents-** CLARITY, Inc. may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.

**Uses and disclosures for cadaveric organ, eye or tissue donation purposes-** CLARITY, Inc. may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

**Uses and disclosures for research purposes-** CLARITY, Inc. may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.

**Uses and disclosures to avert a serious threat to health or safety-** CLARITY, Inc. may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

**Uses and disclosures for specialized government-** CLARITY, Inc. may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.

**Disclosures for workers' compensation-** CLARITY, Inc. may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

### **Patient rights under HIPAA**

The following information describes your rights under the HIPAA Standards. CLARITY, Inc. requires that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, **except as in the Right of Restriction section.**

### **Right of an individual to request a restriction of uses and disclosures**

CLARITY, Inc. will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section.

Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service. We will agree to this restriction as long as your payment is honored. If payment is not honored, we are not obligated to continue to abide by the requested restriction.

### **Confidential communication requirements**

CLARITY, Inc. will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.

### **Access of individuals to protected health information**

An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost-based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the end of this document.

### **Amendment of protected health information**

An individual has the right to ask to have CLARITY, Inc. amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

### **Accounting of disclosures of protected health information**

An individual has a right to receive an accounting of disclosures of protected health information made by CLARITY, Inc. in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12-month period. There will a reasonable cost-based fee for additional requests.

### **Right of Breach Notification**

An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

### **Copy of this notice**

You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

### **Our Duties**

CLARITY, Inc. is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

CLARITY, Inc. is required to abide by the terms of the notice currently in effect.

CLARITY, Inc. is required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. Revised Notices will be available and posted at our office(s) and posted on our web site, if applicable.

### **Complaints**

If at any time you feel we have violated your HIPAA rights, please contact our Privacy Officer or the Secretary of Health and Human Services. CLARITY, Inc. will not retaliate against any individual for filing a complaint.

### **Contact**

You have the right to file a complaint with our Privacy Officer at the address and phone number at the top of this notice, or with the Office of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323.

Effective Date of the Notice is November 16, 2018



29 N. Academy Street, Greenville, SC 29601 Phone: 864.331.1400 [WWW.Clarityupstate.Org](http://WWW.Clarityupstate.Org)

**Acknowledgement of Receipt of Notice of Privacy Practice for CLARITY, Inc.**

**PATIENT INFORMATION FOR:**

\_\_\_\_\_  
Patient's last name                      Patient's first name                      Patient's middle name

\_\_\_\_\_  
Patient's date of birth

**I hereby acknowledge that I have received the Notice of Privacy Practices for CLARITY, Inc.**

\_\_\_\_\_  
Date                      Signature of patient or personal representative  
(as defined by HIPAA)                      Relationship to patient (if other than patient)

\_\_\_\_\_  
Description of Personal Representative and please attach a copy of documentation if applicable.

**For Office Use Only:**

**Documentation of "Good Faith" Attempt to get acknowledgement signature.**

- Minor patient was accompanied to the appointment by someone other than their parent or legal guardian. A copy of the *Notice of Privacy Practice for CLARITY, Inc.* will be mailed to the patient's parent(s) or legal guardian with a request to sign the Acknowledgement of Receipt document.
- The documentation was mailed to the patient, but Acknowledgement of Receipt was not returned to us.
- Document presented to patient, but patient refused to sign.
- Patient presented in an emergency situation and there was no time to give the Notice or receive a signature. Attempt to give the Notice and get Acknowledgement of Receipt will be handled as soon as possible.
- Documentation was presented to the patient, but a communication failure prevented us from receiving an Acknowledgement of Receipt.
- Other \_\_\_\_\_

Employee preparing document: \_\_\_\_\_ Date: \_\_\_\_\_  
Employee Signature \_\_\_\_\_