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the speech, hearing, and learning center

29 North Academy Street | Greenville, SC 29601
p 864.331.1400 f 864.331.1416
www.clarityupstate.org

PEDIATRIC INITIAL QUESTIONNAIRE

Date: _____ Form Completed By: _____ Relationship to Child: _____

Child's Name: _____
(First) (Middle) (Last) ("Nick Name")

Date of Birth: _____ Gender: _____ Grade: _____

Name of School: _____ School District: _____

Primary Care Physician: _____

Referring provider if different from primary care physician: _____

What are your reasons for seeking help for the child at this time?

When did you first become concerned about the child?

What are the most positive features about the child?

Family Information

Is the child adopted? □ No □ Yes

Mother's Name: _____ Father's Name: _____

Occupation _____ Occupation _____

Highest Grade Completed _____ Highest Grade Completed _____

Who does the child live with (Include siblings and ages? _____

If any immediate family members (for example, parent, sibling, etc.) are living elsewhere, please list:

Age	Sex	Relationship to this Child	Frequency of contact

Language(s) spoken/heard in the home: _____

Pregnancy History

Was the child's mother under doctor's care during the pregnancy? □ No □ Yes

During the pregnancy, did the mother take any medications or drugs (other than vitamins/iron), drink alcohol or smoke cigarettes? □ No □ Yes

If yes, please describe _____

Any complications during the pregnancy or delivery? □ No □ Yes

If yes, please describe _____

Any specialized treatment provided to baby during and/or following delivery? □ No □ Yes

If yes, please describe _____

Was the child born prematurely? □ No □ Yes If yes, what was the gestational age at delivery? ____weeks

Birth weight: ____lbs ___oz Length of hospital stay following delivery: _____ Mother _____ Baby

Check any of the following which occurred during your baby's first month of life:

□ Breathing Problems □ Infection □ Birth Defect □ Excessive Vomiting
□ Jaundice (yellow) □ Excessive Crying □ Feeding Difficulty □ Injury

Developmental History:

Communication/Speech/Language: ☐ Seems/ed early ☐ Seems/ed on time ☐ Seems/ed late

If concerns, please describe _____

Motor Skills: ☐ Seems/ed early ☐ Seems/ed on time ☐ Seems/ed late

If concerns, please describe _____

Do you have concerns for the child's social development? □ No □ Yes

If yes, please describe _____

Do you have concerns for the child's emotional development? □ No □ Yes

If yes, please describe _____

Do you have concerns for the child's behavior? □ No □ Yes

If yes, please describe _____

Do you have any additional concerns for the child's development? □ No □ Yes

If yes, please describe _____

 Patient's Name _____

Health History: Has the child had any of the following?

Convulsions, seizures, fainting spells? □ No □ Yes
If yes, please indicate when and describe _____

Vision or eye problems? □ No □ Yes

If yes, when was the last time the child's vision has been screened or evaluated? _____

If yes, does the child wear glasses or contacts? □ No □ Yes, Please specify _____

Hearing Problems? □ No □ Yes

If yes, when was the last time the child's hearing has been screened or evaluated? _____

If yes, does the child have hearing aid(s)? □ No □ Yes

Did the child pass their newborn hearing screening? □ No □ Yes

Recurrent Ear Infections? □ No □ Yes
If yes, please indicate when and describe _____

Have PE tubes been inserted? □ No □ Yes
If yes, at what age(s) and how many times? _____

Allergies □ No □ Yes
If yes, what is the child allergic to? _____

Any surgeries, serious illnesses, injuries (including head injuries), or accidents? □ No □ Yes
If yes, please indicate when and describe _____

Has the child ever been hospitalized overnight? □ No □ Yes
If yes, when and why? _____

Has the child ever been given a diagnosis? □ No □ Yes
If yes, please indicate when and state diagnosis(es) _____

Please list any current health concerns: _____

Is the child taking any medications? □ No □ Yes
If yes, please list: _____

Does or has the child received any of the following services? If yes, please describe (when, how long, what for):

BabyNet / Early Intervention □ No □ Yes : _____

Speech/language therapy □ No □ Yes : _____

Occupational therapy □ No □ Yes : _____

Physical therapy □ No □ Yes : _____

Counseling □ No □ Yes : _____

 Patient's Name _____

Educational History

What schools has the child attended? (please list in chronological order beginning with nursery/preschool)

Are you worried about the child's school progress? □ No □ Yes
If yes, please describe _____

Does the child receive extra help at school? □ No □ Yes
If yes, please mark any supports the child has received:
□ Tutoring □ RtI □ 504 □ Special Education (IEP) □ Other _____

Has the child ever had any testing done by the school system or elsewhere? □ No □ Yes
If yes, please describe _____

Family History: Is there a family history of the following?			If yes, list who has/d these concerns
Learning Difficulties	□ No	□ Yes :	
Reading	□ No	□ Yes :	
Written Language	□ No	□ Yes :	
Mathematics	□ No	□ Yes :	
Attention Problems	□ No	□ Yes :	
Hyperactivity/Impulsivity	□ No	□ Yes :	
Anxiety	□ No	□ Yes :	
Depression	□ No	□ Yes :	
Autism Spectrum Disorder	□ No	□ Yes :	
Intellectual Disability	□ No	□ Yes :	
Depression	□ No	□ Yes :	
Bipolar Disorder	□ No	□ Yes :	
Schizophrenia/Delusions/Hallucinations	□ No	□ Yes :	
Language/Speech Delay	□ No	□ Yes :	
Any genetic syndrome	□ No	□ Yes :	
Conduct Problems	□ No	□ Yes :	
Drug/Alcohol Problems	□ No	□ Yes :	
Seizure Disorder	□ No	□ Yes :	
Motor or Vocal Tics	□ No	□ Yes :	
Hearing Loss	□ No	□ Yes :	
Visual Problems	□ No	□ Yes :	
Muscular problems/weakness	□ No	□ Yes :	
Other (Please specify)	□ No	□ Yes :	

Additional Comments: _____

_____

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PEDIATRIC PSYCHOLOGY AND LEARNING QUESTIONNAIRE

Date: _____ Form Completed By: _____ Relationship to Child: _____

Child's Name: _____
(First) (Middle) (Last) ("Nick Name")

Date of Birth: _____ Gender: _____ Grade: _____

Name of School: _____ School District: _____

Primary Care Physician: _____

Referring provider if different from primary care physician: _____

What are your primary concerns regarding the child and what specific questions you would like addressed?

Family History

At what age did the child come into the current living situation? _____

Have there been any recent changes or stresses in the family/home? □ No □ Yes
If yes, please describe: _____

Has there been any DSS involvement concerning the child? □ No □ Yes
If yes, please describe: _____

Please list any other adults in the child's life who provide support in caring for the child? (family friends, neighbors, school personnel, people in religious or community organizations, etc): _____

Medical History

Does the child have any difficulties with sleeping or eating? □ No □ Yes
If yes, please elaborate _____

On school nights, what time does the child usually go to sleep and what time do they usually wake to get ready for school? _____

On non-school nights, does the child's bedtime vary? If so, please describe _____

How much screen time (for example, cell phone, tablet, computer, tv, video games, etc.) does the child usually have per day? _____

Are there any medications that the child is currently taking or has taken in the past that you felt were especially beneficial or that had negative effects? □ No □ Yes
If yes, please elaborate _____

Any other medical information about the child you wish to share? □ No □ Yes
If yes, please share _____

Educational History

Has the child ever repeated a grade? □ No □ Yes
If yes, which and for what reason? _____

Does the child like to attend school? □ No □ Yes
If no, please describe _____

Has the school contacted you about concerns (e.g., speech, academic, social, emotional, behavioral)? □ No □ Yes
If yes, please describe _____

What are the child's academic strengths?

□ Reading phonics/decoding	□ Reading Comprehension	□ Reading Fluency	□ Math Calculation
□ Communicating ideas/learning in writing	□ Punctuation/Capitalization	□ Spelling	□ Math Reasoning
□ Communicating ideas/learning orally	□ Listening / Following Directions	□ Focus	□ Memorizing
□ Perseverance	□ Completing assignments on time	□ Organization	□ Study Skills
□ Handwriting	□ Other: _____		

In what areas does the child have more difficulty?

□ Reading phonics/decoding	□ Reading Comprehension	□ Reading Fluency	□ Math Calculation
□ Communicating ideas/learning in writing	□ Punctuation/Capitalization	□ Spelling	□ Math Reasoning
□ Communicating ideas/learning orally	□ Listening / Following Directions	□ Focus	□ Memorizing
□ Perseverance	□ Completing assignments on time	□ Organization	□ Study Skills
□ Handwriting	□ Other: _____		

Is homework completion a concern? □ No □ Yes
If yes, please describe _____

If the child has/had an IEP for special education services (or support services if attending a private school):

Why were these services initiated (e.g., speech, reading difficulty)? _____

When did he/she first begin receiving services? _____

What services does/did he/she receive? _____

If any (or all) services been discontinued, which and when? _____

Additional Comments/Concerns About Educational History:

_____

_____

_____

_____

_____

_____

 Child's Name _____

Social, Emotional, and Behavioral History

Please list the things the child does well: _____

What does the child enjoy doing in his/her free time? _____

Do you have concerns for how the child interacts with adults or other children? □ No □ Yes
If yes, please describe _____

_____

Do you have any concerns for the child's sensory processing? □ No □ Yes
If yes, please describe _____

_____

Do you have any concerns for the child's response to changes in routine? □ No □ Yes
If yes, please describe _____

_____

Has the child ever experienced any traumatic events? (physical abuse, sexual abuses, witnessed domestic violence, car accident, fire or natural disaster, etc.) □ No □ Yes
If yes, please describe _____

_____

Does the child have a history of using/abusing alcohol or other substances? □ No □ Yes
If yes, briefly describe (substance used, length of time, amount, outcome, etc.): _____

_____

Has the child ever been hospitalized or admitted at a residential treatment facility for psychiatric reasons? If yes, please briefly describe _____ □ No □ Yes

Has the child ever engaged in any self-harming behaviors (cutting, burning, carving, head banging, etc.)? □ No □ Yes
If yes, please briefly describe _____

Has the child ever made suicidal statements or attempts? □ No □ Yes
If yes, please briefly describe _____

Additional Comments/Concerns: (If needed, please use the backside of this page)

_____

_____

_____

_____

_____

_____

_____

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INFORMED CONSENT FOR EVALUATION AND THERAPEUTIC SERVICES

Welcome to the Psychology and Learning Department at Clarity. This agreement contains important information about our services and your rights and responsibilities as a client. It is important that you read this document carefully before participating in the evaluation and/or therapeutic services. After you have read this document, please sign your name on the last page to accept the terms of this document.

CONSENT FOR SERVICES

As a legally consenting individual, I agree to permit the clinicians of the Psychology and Learning Department at Clarity to provide therapeutic services (such as, learning therapy, coaching, or counseling) and/or conduct a comprehensive psycho-educational/psychological evaluation on myself or my child, as applicable.

I understand that therapeutic services may be provided by a person who holds at least bachelor's degree and has received specialized training in learning disabilities, special education, reading, psychology, counseling, elementary education with concentration in special education or reading, secondary education with concentration is special education or reading. When required by law due to the nature of services rendered (that is, coaching or counseling), services are provided by a licensed psychologist, a licensed professional counselor, post-doctoral fellow under the direct supervision of a licensed psychologist, or psychology trainee under the direct supervision of a licensed psychologist.

I understand that evaluations are provided by a licensed psychologist, post-doctoral fellow, or psychology trainee under the direct supervision of a licensed psychologist. A post-doctoral fellow is an individual who has a doctoral degree in psychology and is in the process of completing the year-long supervisory period that is required prior to becoming a licensed psychologist. A psychology trainee is an individual who has not yet obtained a doctoral degree in psychology but is obtaining training required for the completion of a doctoral degree in psychology.

I understand that participation in therapeutic services and/or an evaluation is entirely voluntary and I or my child can withdraw consent at any time without penalty. However, I understand that Clarity may be unable to provide feedback of the test results if testing is terminated, and that I will still be responsible for payment of any testing, scoring, and evaluation time provided up until termination.

CONFIDENTIALITY

I understand that communication between a client and clinician are protected by both federal and state law. Records of services in the Psychology and Learning Department are confidential and will not be released in an individually identifiable form without my prior consent unless required by law. I understand that in many situations, Clarity can only release information about services rendered in the Psychology and Learning Department to others if I sign a written authorization form that meets certain legal requirements imposed by state and federal privacy regulations. Clarity will follow applicable state laws and professional standards in the storage, maintenance, retention, and destructions of clinical records. Please see the HIPAA Privacy Notice, which explains HIPAA and how it applies to your personal health information in greater detail.

I agree that for training purposes, evaluation sessions may be observed by supervisors or trainees (such as, a postdoctoral fellow). I also authorize the use of clinical case discussion and review of records for the purpose of training or consultation with other providers within Clarity, who are also legally bound to keep the information confidential.

I understand that Clarity must be in compliance with child abuse reporting laws and court mandated rulings regarding release of confidential information or any provision of psychological services. Situations in which Clarity is legally obligated to take action and may reveal some personal health information including, but are not limited to, filing a report with the appropriate government agency when they have reasonable cause to suspect abuse, abandonment, or neglect of a child under 18 or a vulnerable adult, protective action if it is believed that a client represents a clear and immediate threat to another person or themselves, or receipt of a subpoena from a court proceeding.

AUTHORIZATION FOR INFORMED CONSENT FOR EVALUATION AND THERAPEUTIC SERVICES

I fully understand and accept the terms of this consent.

_____	_____
Signature of Client (representative or parent/guardian if a minor)	Date
_____	_____
Print Name (representative or parent/guardian if a minor)	Relationship to Client (if not client)
_____	_____
Client's Name	Client's Date of Birth

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POST-DOCTORAL FELLOW ACKNOWLEDGEMENT

I understand that Laura Rogers, Ph.D. is a Post-Doctoral Fellow in School Psychology and she will be providing psychological services (that is, an evaluation or treatment) to myself or child (if client is a minor). A post-doctoral fellow is an individual who has a doctoral degree in psychology and is in the process of completing requirements for licensure as a psychologist in the state of South Carolina. As such, Dr. Rogers is under the direct supervision of Elizabeth Shands, Ph.D., a licensed psychologist.

_____ _____
Signature of Client (representative or parent/guardian if a minor) Date

_____ _____
Print Name (representative or parent/guardian if a minor) Relationship to Client (if not client)

_____ _____
Client's Name Client's Date of Birth

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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. ****

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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.

I understand that I am responsible for filing insurance for psychological and psycho-educational evaluation services. This includes letting Clarity's business office know if my insurance company requires pre-authorization **prior-to** the start of the evaluation so necessary forms can be submitted to my insurance company. Following the evaluation feedback session, I will be given appropriate paperwork, so I can submit a claim to my insurance company. I understand that Clarity **is not in network** with any insurance company for ***pyshcological and psycho-educational services.*** I am responsible for all costs associated with these services up front.

I understand that Clarity is contracted with some insurance companies for counseling services. If Clarity is an in-network provider for my insurance company, Clarity will file insurance on my behalf after collecting required co-pays and/or coinsurance payments.

I understand that if Clarity is not an in-network provider for my insurance company for counseling services, I will be responsible for all costs associated with these services up front. This includes letting Clarity's business office know if my insurance company requires preauthorization **prior-to** the start of counseling so necessary forms can be submitted to my insurance company. After each counseling session, I will be given appropriate paperwork, so I can submit a claim to my insurance company.

_____ _____
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 my not cover your service.

_____ _____
Signature of Patient or Parent/Guardian Date

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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. ****

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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)		
_____ Initial if authorized	Patient (or Personal Representative)'s Mailing Address: _____ City: _____ State: _____ Zip: _____	
_____ Initial if authorized	Patient (or Personal Representative)'s Home Phone Number #_____ ☐ Ok to leave message?	Description of Information to be provided: ☐ Appointment Information ☐ Financial Information ☐ Other _____
_____ Initial if authorized	Other Phone Numbers for Patient (or Personal Representative): #_____ (Cell) ☐ Ok to leave message? #_____ (Work) ☐ Ok to leave message? #_____ (Other) ☐ Ok to leave message?	Description of Information to be provided: ☐ Appointment Information ☐ Financial Information ☐ Other _____
_____ Initial if authorized	Primary Email _____ Relationship to Patient: _____	Description of Information to be provided: ☐ Appointment Information ☐ Financial Information ☐ Report from Evaluation/Screening ☐ Treatment Progress ☐ Other _____
_____ Initial if authorized	Secondary Email _____ Relationship to Patient: _____	Description of Information to be provided: ☐ Appointment Information ☐ Financial Information ☐ Report from Evaluation/Screening ☐ Treatment Progress ☐ Other _____

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*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

_____ Initial if authorized

School or Employer: _____

Description of Information to be provided:
- ☐ Date/Time of Appointment(s)
- ☐ Report from Evaluation/Screening
- ☐ Treatment Progress
- ☐ Other _____

_____ Initial if authorized

SC Children's Rehabilitative Services

Description of Information to be provided:
- ☐ Date/Time of Appointment(s)
- ☐ Report from Evaluation/Screening
- ☐ Treatment Progress
- ☐ Other _____

_____ Initial if authorized

SC BabyNet Agency: _____

Description of Information to be provided:
- ☐ Date/Time of Appointment(s)
- ☐ Report from Evaluation/Screening
- ☐ Treatment Progress
- ☐ Other _____

_____ Initial if authorized

Other (Please give name and relationship):

_____
Name Relationship

Description of Information to be provided:
- ☐ Date/Time of Appointment(s)
- ☐ Report from Evaluation/Screening
- ☐ Treatment Progress
- ☐ Other _____

Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

_____ Initial if authorized

Other (Please give name and relationship):

_____
Name Relationship

Description of Information to be provided:
- ☐ Date/Time of Appointment(s)
- ☐ Report from Evaluation/Screening
- ☐ Treatment Progress
- ☐ Other _____

Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

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):

_____

For Office Use Only: Receiving Employee_____ Date Received_____

[ ] Scanned and Copy given to patient/client

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 disclosure 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 with 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

70 years of clarity
the speech, hearing, and learning center

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