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

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

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 _____

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ADULT PSYCHOLOGY QUESTIONNAIRE

Date: _____ Person(s) Completing Form: _____

Has the patient been to this agency before? □ No □ Yes If yes, when? _____

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

Date of Birth: _____ Gender: _____

Occupation: _____ Highest Level of Education Completed: _____

Primary Care Physician: _____

Referring provider if different from primary care physician: _____

What is the patient's primary language? _____

Is this the patient's native language? □ No □ Yes
If no, what is the patient's native language? _____

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

Social History

Current Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Does the patient have children? □ No □ Yes
If yes, how many? _____ Names and ages: _____

Have there been any significant changes/stresses in the patient's family/home within the past year? □ No □ Yes
If yes, please describe _____

Please describe any significant friendships/relationships:

What hobbies/interests/activities does the patient enjoy?

How old was the patient's mother when she had the patient? _____ Was the patient adopted? □ No □ Yes

Were there any problems with the patient's mother's pregnancy with the patient? □ No □ Yes
If yes, please state _____

Were there any problems associated with her delivery with the patient? □ No □ Yes
If yes, please state _____

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

Did the patient have any delays in the patient's early development (e.g., walking, talking)? □ No □ Yes
If yes, please state _____

Has the patient received any diagnoses that are developmental (e.g., ADHD, Learning Disorder, Dyslexia, Autism) or psychological (e.g., anxiety, depression) in nature? □ No □ Yes
If yes, please state _____ _____

Has the patient ever been hospitalized? □ No □ Yes
If so, briefly describe (when, where, reason why) _____

Were there any significant stressors during the patient's childhood (for example, parental divorce, moves)? □ No □ Yes
If yes, please state _____

Has the patient experienced any traumatic events as an adult (for example, physical abuse, sexual abuse, domestic violence, etc.)? □ No □ Yes
If yes, please describe _____

Has the patient ever been seen by a psychiatrist, psychologist or counselor? □ No □ Yes
If yes, briefly describe_____

Has the patient ever engaged in any self-harming behaviors? □ No □ Yes
If yes, briefly describe_____

Does the patient have a history of suicidal ideation or attempts? □ No □ Yes
If yes, briefly describe_____

Does the patient have a history of violence (physical aggression, destruction of property, threats to harm others, etc.)? □ No □ Yes
If yes, briefly describe_____

Does the patient have a history of involvement with the legal system? □ No □ Yes
If yes, briefly describe_____

Has the patient or those close to the patient ever had concern for the patient's alcohol consumption or substance use? □ No □ Yes
If yes, briefly describe_____

Educational History

What schools did the patient attend from preschool through high school?

 Patient's Name _____

Did the patient's parents or teachers have concern for the patient's learning or attention during childhood? If yes, please describe _____ □ No □ Yes

Did the patient ever repeat a grade? If yes, which and for what reason? _____ □ No □ Yes

Did the patient have received tutoring, have an IEP or receive accommodations at any time from preschool through high school? If yes, please describe _____ □ No □ Yes

As a child did the patient like to attend school? If no, why? _____ □ No □ Yes

What schools has the patient attended since high school? Please state course of study and any degree(s)/certificate(s) attained.

Has the patient received any accommodations and/or tutoring while completing coursework after high school? If yes, please describe _____ □ No □ Yes

As an adult, does the patient like taking/attending classes? If no, please describe _____ □ No □ Yes

As an adult, has the patient had to repeat any courses? If yes, please state course(s) and reason(s) _____ □ No □ Yes

What are the patient's <u>academic strengths</u>?

□ Reading phonics/decoding	□ Reading Comprehension	□ Reading Fluency	□ Math Calculation
□ Written Expression	□ Punctuation/Capitalization	□ Spelling	□ Math Reasoning
□ Oral Expression	□ Listening / Following Directions	□ Focus	□ Memorizing
□ Perseverance	□ Completing assignments on time	□ Organization	□ Study Skills

□ Other: _____

Please check if and when the patient has had ***significant difficulty*** with the following during their lifetime:

	Preschool	Elementary School	Middle School	High School	Post High School	Current
Reading phonics/decoding						
Reading Comprehension						
Reading Fluency						
Math Calculation or Math Reasoning						
Oral Expression						
Listening / Following Directions						
Written Expression						
Punctuation/Capitalization						
Spelling						
Focus						
Memorizing						
Perseverance						
Completing assignments on time						
Organization						

 Patient's Name _____

Study Skills						

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 :	

If you have additional questions or concerns, please write them below, using an additional piece of paper, if needed.

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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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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

DEPOSIT ACKNOWLEDGEMENT
FOR PSYCHOLOGICAL/PSYCHO-EDUCATIONAL EVALUATIONS

I acknowledge that if I cancel my child's evaluation within (2) weeks of the appointment, and choose not to reschedule the appointment, the deposit will be forfeited. (This policy applies to canceled appointments- not appointments that must be rescheduled due to illness or family emergency.) I further acknowledge that I or my child will be allowed only one reschedule before my deposit is forfeited (this does not apply if Clarity Staff cause the reschedule.)

_____ _____
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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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)		
_____ 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 _____