clarity

PATIENT INFORMATION FORM

Date

PATIENT INFORMATION

Patient's Last Name | Patient's First Name | Patient's Middle Name | Suffix | Preferred name

Date of Birth

☐ Male ☐ Female

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Another _____

Race: ☐ Caucasian (White) ☐ American Indian ☐ African American (Black) ☐Hispanic ☐ Asian ☐ Multiracial ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Refused/Declined Primary Language: _____

Home address: _____ City: _____ State: _____ Zip: _____

Mail to address: _____ City: _____ State: _____ Zip: _____
(If different from home address)

Home Phone: ( ) _____ ☐ This is the primary number for patient.

Cellphone: ( ) _____ ☐ This is the primary number for patient.

Primary Email Address: _____

EMERGENCY CONTACT (Pediatric Patients, please list someone other than parents/guardians)

Name: _____ Home Phone: ( ) _____ Relation to Patient: _____

PARENT/GUARDIAN INFORMATION (Pediatric patients only)

Parent/Guardian 1 (If the address and/or phone numbers are the same as patient, please indicate same.)

Name: _____ _____ _____ _____
Last | First | Middle | Nickname

Date of birth: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____
Month/Day/Year

Home address: _____ City: _____ State: _____ Zip: _____
(If different from the patient)

Employer: _____ Work Phone: ( ) _____ Ext.

Parent/Guardian 2 (If the address and/or phone numbers are the same as patient, please indicate same.)

Name: _____ _____ _____ _____
Last | First | Middle | Nickname

Date of birth: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____
Month/Day/Year

Home address: _____ City: _____ State: _____ Zip: _____
(If different from the patient)

Employer: Work Phone: ( ) Ext.

RESPONSIBLE PARTY

The Responsible Party is the person who is financially responsible for the patient's account and who will receive all account statements to their address.

Last Name | First Name | Middle Name | Relation to Patient

Home Phone: ( ) _____ Cell Phone: ( ) _____
(If different from the patient) (If different from the patient)

Mail to address: _____ City: _____ State: _____ Zip: _____
(If different from the patient)

Social Security Number:

THIS IS A TWO PAGE FORM

Clarity, Inc. | 29 North Academy Street | Greenville, SC 29601 | PH: 864-331-1400 | FAX: 864-331-1416

Patient Name: _____ _____ _____ Date of Birth: _____
Last First Middle Month/Day/Year

☐ **Check here if no insurance. Skip to authorizations (below).**

PRIMARY INSURANCE INFORMATON (Please present insurance card and ID to Business Office)

Subscriber: This is the person who carries the insurance. If the subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: _____ Subscriber's date of birth: _____
Month/Day/Year

Patient relationship to subscriber: _____

If address and phone number is same as patient, please indicate same.

Address: _____ City, State, ZIP: _____ Home Phone: ( )

Insurance co. name: _____ Phone: _____

Policy/Cert #: Group no.: Effective Date:

SECONDARY INSURANCE INFORMATON (Please present insurance card and ID to Business Office)

Subscriber: This is the person who carries the insurance. If the subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: _____ Subscriber's date of birth: _____
Month/Day/Year

Patient relationship to subscriber: _____

If address and phone number is same as patient, please indicate same.

Address: _____ City, State, ZIP: _____ Home Phone: ( )

Insurance co. name: _____ Phone: _____

Policy/Cert #: Group no.: Effective Date:

AUTHORIZATIONS

I authorize evaluation and treatment and I authorize release of information for insurance/medical purposes concerning evaluation and/or treatment serivces provided to me by Clarity, Inc. I hereby also authorize payment from my insurance company to Clarity, Inc. for services rendered. In addition, I authorize audio recording for the purpose of accurate scoring during the provision of evaluation services.

Signature Relation to Patient Date

ACCEPTANCE OF PAYMENT POLICIES AND FINANCIAL RESPONSIBILITY

I understand that some services provided by Clarity, Inc. may not be covered by my insurance and that I will be responsible for any amount not covered by my insurance at the time of service. I understand that it is my responsibility to notify Clarity, Inc. if my insuranve coverage changes and that I will be financially responsible for any noncovered services. I understand that Clarity, Inc. will collect all applicable copays, deductibles, coinsurance, and fees for services not covered by my insurance at the time services are rendered.

If a deposit is required for scheduled services I understand that if I cancel the appointment(s) within (2) weeks of the appointment(s) and choose not to reschedule the appointment(s), the deposit will be forfeited. This policy does not apply to appointments that must be rescheduled due to illness or family emergency. I further acknowledge that only one reschedule will be allowed before my deposit is forfeited (this does not apply if Clarity, Inc. has to reschedule the appointment).

Signature Relation to Patient Date

LATE CANCELLATION AND NO-SHOW POLICY

*I understand that if for any reason I am unable to keep a scheduled appointment, I must contact Clarity at least 24 hours in advance at **(864) 331-1400** to cancel or reschedule. If **two** appointments (in any six-month period) are missed or cancelled with less than 24 hours' notice, Clarity will reschedule the appointment **after** a six-month waiting period from the time of the missed appointment.*

Signature Relation to Patient Date

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Privacy Practices and Authorization for Disclosure of Medical Information

The privacy of your medical information is important. We will only share information about the services you receive at Clarity, Inc. with person(s) you designate and via the mean(s) you specify. This authorization shall be in enforce for six years, until the patient 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 Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

PATIENT'S VERIFICATION CODE

Clarity, Inc. will verify the identity of a person requesting protected health information. Please provide a word/phrase that Clarity, Inc. can ask for to verify identity: _____

SHARING INFORMATION WITH OTHERS

Please CHECK the information below that you authorize Clarity, Inc. to give out for the above patient, and list who has permission to receive this information other than the patient's parents/legal guardians.

☐ Results of Evaluations ☐ Appointment Information ☐ Billing Information ☐ Treatment Information

_____ Name of person that has permission to receive the above patient information _____ Relationship to Patient

_____ Name of person that has permission to receive the above patient information _____ Relationship to Patient

COMMUNICATION BY PHONE

I authorize Clarity, Inc. to leave a voice message on the phone number below regarding: Check ONLY ONE

☐ All Information including appointments, general information, updates, billing etc.

☐ Appointment information ONLY

( ) _____ Phone Number _____ Relationship to Patient

COMMUNICATION BY EMAIL

Please be aware that email communications can be intercepted during transmission or misdirected. Your use of and authorization for the use of email to communicate Protected Health Information or other information of a confidential nature with Clarity, Inc. indicates that you acknowledge and accept the possible risks associated with such communication. **Please CHECK the information below that you authorize Clarity, Inc. to release about above patient via email and the email address(es) you authorize Clarity, Inc. to send Protected Health Information.**

☐ Results of Evaluations ☐ Appointment Information ☐ Billing Information ☐ Treatment Information

_____ Email Address _____ Name of the account owner for this email address _____ Relationship to Patient

_____ Email Address _____ Name of the account owner for this email address _____ Relationship to Patient

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 below. 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. Information received by this office is for our own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or obtain a copy of the protected health information disclosed as described in this document. I can do this by written notification to the address below.

I authorize disclosure of the information listed above by the means specified and I have read and received a copy of the Notice of Privacy Practices for Clarity, Inc.

_____ Signature _____ Relation to Patient _____ Date