FINANCIAL POLICY FOR ROCHESTER HEARING AND SPEECH CENTER (non-Medicaid)

Please read this entire document carefully. You must sign this form before we proceed with your care. Please address any concerns to our financial team.

Our primary goal is to provide the highest quality of healthcare, and in a gentle, efficient an enthusiastic manner. We will do our best to help you plan your investment in your hearing health based on your needs.

Please bring cash, check or credit card with you at the time of treatment.

Delinquent balances over 90 days old will be sent to collections. PLEASE NOTE THAT YOU WILL BE RESPONSBILE FOR ALL FEES INCURRED TO ATTEMPT TO COLLECT ON YOUR ACCOUNT.

A returned check fee of $35.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the return fee must be paid in full by either cash or credit card.

MISSED/ CANCELLED/ BROKEN APPOINTMENTS

We REQUEST 24 hours in advance for rescheduling your appointment. Missed/no show appointments without a 24 hour prior notification will have a charge of $25.00 added to your account. If you have (3) three missed/no show appointments you will be discharged from our practice. We understand that certain unforeseen circumstances may arise and they can be discussed with the Office Manager.

Co-pays are due at time of service, if you do not make a payment by end of business day you will be charged a $10.00 late fee.

OFFICE POLICY FOR PATIENTS WITH INSURANCE

Please bring your insurance card and any other information you may have from your insurance carrier to each appointment. Also, please let us know immediately of any changes in your insurance carrier or policy.

Your treatment plan is individually based on one's diagnosis, and is not based on your insurance benefits or lack of benefits. We make the best decision based on your needs.

We will always do our best to help maximize your insurance benefits.

Although we file your claims as a courtesy, your insurance policy is a contract between you, your employer and your insurance company. We may or may not be a participating provider for your insurance carrier.

_____ (initial here)

Rev: 4/26/18

Not all services are a covered benefit in all contracts. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. **We cannot act as a mediator with your carrier or employer.**

As a courtesy to all of our insured patients, we will file your insurance claims. You are responsible on the day of treatment for uncovered expenses.

Your claim will be filed immediately and all benefits are expected to be paid within 30-45 days. The filing of an insurance claim does not relieve you of your responsibility on your account. If the claim is not cleared by your carrier the unpaid portion will then become your responsibility. A statement will be then issued to you.

I understand and accept the financial policies listed above. I understand if I have any questions I can speak to a billing associate or the Office Manager. I agree to pay for all services rendered to avoid any additional fees. I understand that I am financially responsible for any and all charges of treatment and incurred fees, whether or not paid by insurance and I agree to pay for such charges in full. I also hereby authorize the release of pertinent medical information to the insurance carrier(s).

X_____ _____ _____

Patient (or parent of minor), POA, Legal Guardian Signature | Staff Initial | Date

X_____ _____

Please Print Name (from above signature) | Client Name

Rev: 4/26/18

ROCHESTER HEARING AND SPEECH CENTER

1000 Elmwood Avenue #400, Rochester, NY 14620 // Phone: (585) 271-0680 // Fax: (585) 442-4114
3199 W. Ridge Road, Rochester, NY 14626 // Phone: (585) 723-2140 // Fax: (585) 723-3557
1170 Ridge Road, Webster, NY 14580 // Phone: (585) 286-9373 // Fax: (585) 872-8075

Client Information ***(person receiving services)*** **Today's Date:** _____

Name: _____
Last *First* *Middle*

Phone: (home/cell) _____ (work) _____

Sex: ☐(M) ☐(F) Birthdate: _____

Home Address: _____
Street *Apt. No.*

_____
City *State* *Zip* *County*

Email address: _____

Emergency Contact: _____
Name *Phone Number* *Relationship*

How did you hear about Rochester Hearing and Speech Center?

☐ Insurance ☐ RHSC Website ☐ RHSC Internet Ad ☐ RHSC Radio Ad ☐ RHSC TV Ad

☐ Social Media ☐ Print Publication ☐ Community Based Site Visit ☐ RHSC Employee Referral

☐ Friend/Family ☐ EI/CPSE/CSE ☐ Physician Referral: _____
Name of Doctor

☐ Other: _____

Primary Care Physician Information:

Physician Name: _____

Address: _____

Telephone: (____) _____

Insurance Information:

Medicare ***(Social Security System)***

Medicare No.: _____
(i.e., 99999999A9)

Subscriber Name: _____

Medicaid ***(NYS Dept. of Social Service)***

Medicaid CIN No.: _____
(i.e., AB00000C)

2 Digit Sequence Number: _____

Social Worker Name/Case Worker: _____

Phone No.: (___) _____

Primary Health Insurance

Insurance Company Name:

Client ID No.: _____
(i.e., 222222222-02)

Subscriber Name: _____

Relationship to Client: _____

Subscriber Employer: _____

Specialist Co-Pay Amount: _____

Annual Deductible: _____

CLIENT REGISTRATION FORM (con'd.)

CLIENT NAME:_____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employment Status: ☐Full Time ☐Part Time ☐Unemployed ☐Retired ☐N/A

Client Employer: _____ **Occupation:** _____

.....

Meaningful Use for Medicaid/Medicare and Grant Funding Data

Rochester Hearing and Speech Center is funded in part by the United Way of Greater Rochester, as well as other private foundations, and for these funding purposes, the following information is gathered for statistical reports only, is voluntary, and is not shared by client name.
Rochester Hearing and Speech Center also provides services under the auspices of Medicaid and Medicare, and these entities require documented attempt to gather data on race, ethnicity, and language. This information is strictly voluntary, and confidential.

If any area is unchecked, it will be assumed that you do not wish to report.

For Medicaid/Medicare and/or Grant Funding:

ETHNICITY: (check one)
☐Hispanic ☐Latino ☐Not Hispanic or Latino
☐Unreported

RACE: (check one)
☐White or Caucasian ☐Black or African American ☐Asian ☐Pacific Islander
☐Native American or Alaskan Native ☐Native Hawaiian ☐Multi-racial ☐Other
☐Unreported

PRIMARY LANGUAGE: _____

The following information is requested for purposes of Grant Funding only:

Household Income:

☐Less than $15,000 ☐$15,000 to $24,999 ☐$25,000 to $44,999
☐$45,000 to $74,999 ☐$75,000 or greater ☐Unknown

Number of people in the household: _____

ROCHESTER HEARING AND SPEECH CENTER
1000 Elmwood Avenue #400 Rochester, NY 14620 (585) 271-0680
3199 W. Ridge Road Rochester, NY 14626 (585) 723-2140
1170 Ridge Road Webster, NY 14580 (585) 286-9373

CHILD QUESTIONNAIRE

Date:_____

Name of Person completing this form:_____

Relationship to Child:_____

Please complete as much as possible.

Information about your child:

Client's Name:_____
(Last) (First) (M.I.) (nickname)

Age:_____ Birthdate:_____ Sex: M_____ F_____

REFERRAL INFORMATION

Please state in your own words any concerns you have about your child's development which prompted this evaluation:

_____

_____

_____

BIRTH INFORMATION

1. Describe mother's general health during pregnancy _____

_____

_____

2. Describe mother's illnesses, accidents, or difficulties during pregnancy: _____

_____

_____

3. Medications/alcohol/drugs used during pregnancy, please describe: _____

_____

_____

4. How long was the pregnancy? _____ Baby's birth weight:_____

5. Did child/mother experience any of the following during labor and delivery or after delivery? (Check all that apply.)

- ☐ difficult/long labor
- ☐ Ceasarean section
- ☐ evidence of birth injury
- ☐ birth defects
- ☐ difficulty breathing
- ☐ intensive care nursery
- ☐ Rh problems
- ☐ seizures
- ☐ jaundice (yellowish skin color)
- ☐ cyanosis (bluish skin color)
- ☐ infection
- ☐ Other _____

Please explain: _____

_____

DEVELOPMENTAL HISTORY

1. At what age did your child:
   sit alone?_____ crawl? _____walk alone?_____ complete toilet training?_____

2. Overall development seems to be:
   ☐ Somewhat faster than most children.
   In what areas? _____
   ☐ Somewhat slower than most children.
   In what areas?_____
   ☐ About the same as most children.

3. Sleep: ☐ sleeps through the night Bedtime_____ Wake time_____
   ☐ naps If yes, what hours? _____

   If there are concerns with your child's sleep, what helps them get to sleep:
   ☐music ☐bath before bed ☐heavy covers ☐ white noise ☐Other: _____

MEDICAL INFORMATION:

GENERAL HEALTH:

1. Describe the general health of the child: _____

2. What medication(s) is the child presently taking? _____

   _____

   For how long? _____

3. Has your child been immunized for:

Yes	No		Yes	No	
☐	☐	poliomyelitis	☐	☐	mumps
☐	☐	measles	☐	☐	diphtheria
☐	☐	rubella			

4. Has your child had any of the following? (Check all statements that apply)

Check	Age		Check	Age	
☐	_____	failure to thrive	☐	_____	chicken pox
☐	_____	mumps	☐	_____	high fever
☐	_____	scarlet fever	☐	_____	seizures
☐	_____	measles -10 or 3 days	☐	_____	frequent colds
☐	_____	pneumonia	☐	_____	tonsils removed
☐	_____	meningitis	☐	_____	adenoids removed
☐	_____	head injuries	☐	_____	operations
☐	_____	allergies	☐	_____	Other:_____
☐	_____	asthma			

Comments:_____

_____

5. Describe any other serious illnesses, injuries, operations or physical problems and treatment

_____

VISION:

1. Are there concerns about your child's sight?_____
2. Has vision been tested?_____ Where?_____
   When?_____ Results?_____
3. If your child wears glasses, since what age? _____

DENTAL HEALTH:

1. Are there concerns about your child's teeth or mouth?_____
   Describe:_____
2. Dentist's name:_____

COMMUNICATION

1. How does your child communicate most of the time?

☐ cries or whines
☐ makes sounds or babbles
☐ points and gestures
☐ uses single words (bye-bye, hot)
☐ puts words together (Daddy come, where ball)
☐ uses complete sentences (Mommy is going. I want my ball.)

2. Please check all statements that apply to your child.
- ☐ I think my child's speech and language are all right for his/her age.
- ☐ My child does not seem to understand spoken instructions.
- ☐ S/he only understands when others show what is wanted.
- ☐ My child has not yet started to talk.
- ☐ S/he talks a little, but not as much as other children the same age.
- ☐ S/he can't explain what s/he wants very well.
- ☐ S/he is difficult to understand.
- ☐ S/he mispronounces sounds or words.
- ☐ S/he often hesitates, holds on to, or repeats sounds or words.
- ☐ My child's voice is nasal/harsh/too loud.

3. At what age did your child first use:

_____ real words (hi, cookie, juice)
_____ two word combinations (bye-bye Daddy)
_____ short sentences (gimme more of that)

4. Family history of speech, hearing or learning problems? (check) _____ Yes _____ No

If yes, please explain:_____

_____

5. Is there a language other than English spoken in the home on a regular basis? (This includes American Sign Language.) If yes, please describe and give frequency of use:

_____

_____

HEARING:

1. Describe any concerns about hearing: _____

_____

_____

2. Has your child's hearing been tested? _____ Yes _____ No
   If yes, when was the testing done, who did it, and what were the results?
   When:_____ Who:_____
   Results:_____

3. My child's hearing seems better in the: ☐ left ear ☐ right ear ☐ both the same

4. My child's hearing seems to be:
- ☐ normal
- ☐ normal, but doesn't understand what is heard
- ☐ poor only when the child is congested or has an ear infection
- ☐ poor all the time

5. Check all statements which apply to your child's hearing:

- ☐ Has no difficulty hearing
- ☐ Child wears a hearing aid
- ☐ Child doesn't always answer when called from another room
- ☐ Doesn't always look to find sounds such as a telephone, siren, doorbell, or voice
- ☐ Child hears a loud voice much better
- ☐ Can hear better if the child watches your face
- ☐ Insists on having the TV turned up loud
- ☐ Child's teacher says that s/he has trouble following verbal directions
- ☐ Child frequently says "Huh?" or "What?"

6. Does anyone related to your child have a permanent hearing loss which began in childhood or early adulthood? ☐ Yes ☐ No

If yes, explain:_____

7. How many ear infections has your child had?_____

When was the first?_____ Most recent?_____

What type of treatment was given?_____ By which doctor?_____

8. Check any problems with your child's ears, past and present:

- ☐ fluid present in ears. When?_____
- ☐ excessive wax ☐ drainage from ears ☐ earaches
- ☐ tubes in ears; when inserted:_____
- ☐ other:_____

MOTOR SKILLS

1. Which of the following describe your child's motor skills (answer for 2 years or older.)

☐ Has no difficulty with motor skills

Check all that apply:

- ☐ Appears stiff, awkward, or clumsy when moving
- ☐ Unable to maintain a squat position when playing
- ☐ Difficulty propelling a riding toy and/or a tricycle
- ☐ Loses balance or trips when walking on uneven surfaces
- ☐ Cannot jump up with two feet or step over low objects
- ☐ Difficulty or hesitancy in climbing up and/or down stairs, alternating feet
- ☐ Difficulty with catching, kicking or throwing a ball
- ☐ Falls frequently
- ☐ Walks on toes
- ☐ Difficulty with walking
- ☐ Cannot stand on one foot

- ☐ Weak grasp or tight grasp on crayon
- ☐ Difficulty picking up and/or playing with small manipulatives (beads, blocks, Duplos)
- ☐ Avoids or has difficulty using both hands for activities
- ☐ Jerky or tremor-like motions in hands when drawing or playing with small objects
- ☐ Cannot point with index finger
- ☐ Difficulty releasing objects accurately (such as putting objects into a container)
- ☐ Dislikes or avoids coloring or drawing
- ☐ Difficulty using scissors
- ☐ Difficulty assembling puzzles

☐ Other motor concerns (please describe)

_____

_____

2. Preferred hand: ☐ left ☐ right ☐ does not have a preferred hand

SELF-HELP SKILLS

1. My child can do the following:

☐ undress	☐ dress self	☐ wash hands	☐ brush teeth
☐ finger feed	☐ use spoon well	☐ use fork well	☐ drink from cup
☐ unzip coat	☐ button clothes	☐ toilet trained	

2. Is your child a picky eater? _____ yes _____ no

If yes, explain: _____

_____

3. Does you child have any feeding/swallowing concerns:

☐ Overstuffs mouth
☐ History of gagging/vomiting with food
☐ Difficulty chewing
☐ Sucking through a straw
☐ Other: _____

BEHAVIOR

1. How would you describe your child's personality? _____

_____

_____

2. Does your child have problems in these areas: (check all statements that apply)

☐ Most often ignores others	☐ Difficult to take to busy places, e.g., mall, grocery store
☐ Frequent temper tantrums	☐ Constantly moving ("on the go")
☐ Often fights with other children	☐ Difficulty stopping one activity and moving to another
☐ Hard to discipline	☐ Fearful of movement (playground equipment/stairs)
☐ Often breaks or destroys things	☐ Difficulty calming when upset
☐ Constantly demands adult attention	☐ Appears anxious in new situations
☐ Difficulty separating from mother	☐ Overly sensitive to smells, sounds, touch, or messy materials
☐ Easily frustrated	☐ Risk taker; poor safety awareness
☐ Mouths objects	☐ Self-injurious behaviour (bangs head, bites self)

☐ Difficulty concentrating or staying with one activity
☐ Other: _____

Explain or additional comments on child's behavior: _____

_____

3. How is your child disciplined? _____

_____

Are these methods effective? _____

_____

4. In your opinion, does your child appear to have an unusually high activity level?
☐ Yes ☐ No

Explain/describe _____

_____

_____

EDUCATIONAL INFORMATION:

1. Present School/Daycare: _____ If in school, what grade? _____
School District: _____
2. How well does your child do in school? ____ good ____ average ____ poor
3. If your child is not doing well in school, please describe: _____

_____

SPECIAL SERVICES:

Describe any special testing, treatment or therapy your child has had in the past or is currently receiving.
(Examples: speech, psychological, developmental, neurological)

Type of Evaluation/Service: _____ Type of Evaluation/Service: _____

_____ _____

Date: _____ Date: _____

Location: _____ Location: _____

Results: _____ Results: _____

Treatment: _____ Treatment: _____

* *

PERSONS LIVING IN HOUSEHOLD:

NAME	AGE	RELATIONSHIP TO CHILD
1.		
2.		
3.		
4.		
5.		
6.		

Father's Name: _____ Date of Birth: _____
Last *First*

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Current Marital Status: ___ Single ___ Married ___ Separated

Education Level Completed: ___ High School/GED ___ College Graduate ___ Other _____

Mother's Name: _____ Date of Birth: _____
Last *First*

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Current Marital Status: ___ Single ___ Married ___ Separated

Education Level Completed: ___ High School/GED ___ College Graduate ___ Other _____

PLEASE SIGN ATTACHED CONSENT FORMS

ROCHESTER HEARING AND SPEECH CENTER
1000 Elmwood Avenue, Suite 400, Rochester, NY 14620-3096 // Phone: (585) 271-0680
3199 W. Ridge Road, Rochester, NY 14626 // Phone: (585) 723-2140
1170 Ridge Road, Webster, NY 14580 // Phone: (585) 286-9373

Consent for Clinical Services

Client Name: _____ Client Date of Birth: _____

I, _____, consent for the above named client to
(Client or Parent/Guardian/Person Authorized to Consent)
receive professional services at Rochester Hearing and Speech Center. I understand that Rochester Hearing and Speech Center is a provider of services within the disciplines of Audiology, Speech Language Pathology, Occupational Therapy, Physical Therapy, Special Education, Psychology and/or Hearing Aid Dispensing.

I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing.

_____
Signature of Client *or* Parent/Guardian/Person Authorized to Consent

_____ _____
Printed Name Date Signed

_____
Relationship to Client

Drafted 3/2017, Revised 6/14/17

ROCHESTER HEARING AND SPEECH CENTER

Consent to Use and Disclose Protected Health Information for Evaluation, Treatment, Payment and Health Care Operations

Name: _____ Date of Birth:_____
(Please print)

I understand that my signature on this consent is required in order for me to receive services from Rochester Hearing and Speech Center. In addition, I authorize the use and disclosure of my Protected Health Information (PHI) by Rochester Hearing and Speech Center's staff for purpose of evaluation, treatment, payment and health care operations.

I understand that this information may be used or disclosed by Rochester Hearing and Speech Center to

* plan my care and treatment;
* communicate among various health care professionals who are involved in my care or treatment;
* obtain payment for care provided by Rochester Hearing and Speech Center or for the payment activities of another health care provider or entity;
* provide information to my health insurance company or plan;
* assess and review the quality of my care. Further information on uses and disclosures of PHI is included in Rochester Hearing and Speech Center's Notice of Privacy Practices.

As part of RHSC's comprehensive services, we will release the findings of your reports to those professionals involved in your care. Reports will automatically be sent to the physician listed and to referral sources. To send these reports, we must have your authorization to do so. This authorization will be valid through this specific course of treatment.

Please list any other specific individuals/facilities you would like information shared/sent to. (ex. relatives, day care providers, etc.):

_____ _____

If there are any restrictions, please indicate:

_____ _____

I understand that I may cancel this authorization at any time by submitting a written request and that the release of HIV-related information requires additional authorization.

Payment, excluding that covered by insurance, is due at the time of service. If, for any reason, your insurance refuses to pay us for all or part of the service, you will be billed for the service provided. Payment will be due within 30 days of billing. If payment is not received within 30 days, your account will be forwarded to a collection agent, and further services will not be provided until your account is satisfied.

_____ _____
Signature Date

_____ _____
Parent or Legal Guardian (Print) Relationship

ROCHESTER HEARING AND SPEECH CENTER

1000 Elmwood Avenue #400 Rochester, NY 14620 (585) 271-0680
3199 W. Ridge Road, Rochester, NY 14626 (585) 723-2140
1170 Ridge Road, Webster, NY 14580 (585) 286-9373

My signature below acknowledges that I have received a copy of Rochester Hearing and Speech Center's Notice of Privacy Practices and the Clients' Bill of Rights.

Rochester Hearing and Speech Center accepts the following insurances: Excellus, MVP, NYS Empire, United Health Care, Aetna

_____ _____

Client/*Child Name (*Print*) Date

_____

Client Signature

*If child:

**or Legal Guardian/POA

_____ _____

Parent or Legal Guardian (*Print*) Date

_____ _____

Signature Relationship to Client/*Child

For Facility Use Only:

Rochester Hearing and Speech Center made a good faith effort to obtain the above referenced individual's written acknowledgement of receipt of the above.

_____ _____

Staff Member Date

S/F: 338A NPP Acknowledgement
Rev. 8/15

September 1, 2013

ROCHESTER HEARING AND SPEECH CENTER
1000 Elmwood Avenue
Rochester, New York 14620
(585) 271-0860

PRIVACY NOTICE

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.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy and security of protected Health Information
- Give you this notice of our legal duties and privacy practices regarding Health Information about you
- Follow the duties and privacy practices described in this notice

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose Health Information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Privacy Officer whose contact information is provided on page 4 of this notice.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose Health Information to make sure the audiology or occupational therapy care you receive is of the highest quality.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us.

SPECIAL SITUATIONS:

We are allowed to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Research. We can use or share your Health Information for health research as required or allowed by federal and state laws.

Respond to Organ and Tissue Donation Requests. We can share Health Information about you with organ procurement organizations.

Work with a Medical Examiner or Funeral Director. We can share Health Information about you with a coroner, medical examiner or funeral director when an individual dies.

Respond to Lawsuits and Legal Actions. We can share Health Information about you in response to a court order, administrative order or subpoena, as required or allowed by federal and state laws.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law. We may also use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report child abuse or neglect; report problems with products; notify people of recalls of products they may be using. We will only make this disclosure if you agree or when required or authorized by law.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Data Breach Notification Purposes. We may use or disclose your Health Information to provide legally required notices of unauthorized access to or disclosure of your Health Information.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; or (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Personal Representatives. We may disclose your Health Information to, or according to the direction of a person who under applicable law, has the authority to represent you in making decisions related to your health. For example, we may disclose your Health Information to a legal guardian, health care agent or other person who by law is allowed to make health care decisions for you in the event you should become unable to make your own health care decisions.

USES AND DISCLOSURES THAT GENERALLY REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Health Information that directly relates to that person's involvement in your health care.

Share Information in a Disaster Relief Situation. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest or to lessen a serious and imminent threat to health or safety.

Fundraising. We may contact you for fundraising efforts, but you can tell us not to contact you again.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Health Information will be made only with your written authorization:

1. Uses and disclosures of your Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Health Information
3. Psychotherapy notes generally require a written authorization, but psychotherapy notes as defined by the Health Insurance Portability and Accountability Act ("HIPAA") are not kept by this Practice.

Other uses and disclosures of Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Health Information under the authorization, but disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation. The contact information for our Privacy Officer is located on page 4 of this notice.

YOUR RIGHTS:

You have the following rights regarding your Health Information:

Right to Inspect and Obtain Information. You have a right to inspect and obtain a paper or electronic copy of your Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records. To inspect and/or obtain a paper or electronic copy of your Health Information, you must make your request, in writing, to our Privacy Officer whose contact information is located on page 4 of this notice. We usually have up to 30 days to make your Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other costs associated with your request. We may deny your request in certain limited circumstances. If we do deny your request, you may have the right to appeal. If you have been denied the right to inspect or obtain a copy of your Health Information and wish to appeal, please contact our Privacy Officer whose contact information is provided on page 4 of this notice.

Right to Get Notice of a Breach. You have the right to be promptly notified if a breach occurs that may have compromised the privacy or security of your Health Information.

Right to Amend. If you feel that Health Information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our office. To request an amendment, you must make your request, in writing, to our Privacy Officer whose contact information is provided on page 4 of this notice.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request to our Privacy Officer whose contact information is provided on page 4 of this notice.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request a restriction, you must make your

request, in writing, to our Privacy Officer whose contact information is provided on page 4 of this notice. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full, and no other law requires us to share that information.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer whose contact information is provided on page 4 of this notice. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.rhsc.org. To obtain a paper copy of this notice, request a copy from the receptionist or direct your request in writing to our Privacy Officer whose contact information is provided on page 4 of this notice.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**

To file a complaint with our office, contact our Privacy Officer, Kathy Gilman, Rochester Hearing and Speech Center, 1000 Elmwood Ave Suite 400, Rochester NY 14620. All complaints must be made in writing.

To file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights, send a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201, or call 1-877-696-6775 or visit www.hhs.gov/ocr/privacy/hipaa/complaints/.