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Acct #:_____ Guar Acct #:_____ Date:_____

Attached: ❑ Hospice/HHA/NH/SNF Facility Info Form ❑ Accident/Injury Information Form ❑ ABN Form Send Demo info to EHR: ❑ Yes ❑ No

CLIENT INFORMATION

Client: _____ (Last / First / Middle) Date of Birth: _____

Race: ☐ Caucasian/White ☐ African American/Black ☐ Unknown ☐ Decline to specify ☐ Other:_____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Decline to specify

Home #:_____ Work #:_____ Ext:_____ Cell #:_____

Email:_____ Date of Birth:_____ Social Security #:_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Preferred Language: ☐ English ☐ Spanish ☐ Unknown ☐ Decline to specify ☐ Other:_____

Current Employer:_____

Prior Name:_____ Patient & Resp Party are the same? ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION

ONLY COMPLETE IF OTHER THAN PATIENT, THIS IS WHERE STATEMENT/BILL IS SENT AFTER INSURANCE DISPOSITION

Responsible Party: _____ (Last / First / Middle) Title: Mr./Mrs./Other: _____ Suffix: Jr./Sr./Other:_____
(Employer Info if work related)

Mailing Address: _____ _____ (Zip) _____ (City) _____ (State)

Home #: _____ Work #:_____ Ext:_____ Cell #:_____

Email: _____ Date of Birth:_____ Social Security #:_____

Relationship to Patient: ☐ Biological Parent ☐ Adoptive Parent ☐ Custodian/Caregiver ☐ Other:_____

Sex: ☐ Male ☐ Female Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Current Employer: _____

Employment Status: ☐ Fulltime ☐ Self Employed ☐ Part Time ☐ Not Employed ☐ Unknown ☐ Retired ☐ Military Active

By signing this,

_____ Initial I hereby acknowledge THE EMERGE CENTER (PRACTICE) has the right to use and disclose protected health information (PHI) for treatment, payment and health care operations, and that I have received the *Notice of Privacy Practices for Protected Health Information (NOPP)*. I understand I have the right to restrict how my PHI is used or disclosed, and that the PRACTICE is not required to agree to any restriction, but if an agreement is reached, the PRACTICE is bound by the agreement.

_____ Initial I hereby authorize THE EMERGE CENTER to evaluate and recommend any testing and/or additional treatment. I understand I have the right to refuse any such recommendations/treatment.

_____ Initial I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility. I verify all above information is true and accurate as of the below indicated date. I hereby authorize the listed insurance companies to pay directly to THE EMERGE CENTER benefits due on my behalf, if any, as provided in the above unexpired policy.

_____ Initial I give my consent for Emerge to send text messages or emails to my mobile/cell phone number and email provided. I understand these messages may include, but are not limited to, appointment reminders, health updates, and other important information related to my or my child's care.

Signature: _____ Date:_____ Witness Signature:_____ Date:_____

Printed Name: _____ ☐ Patient ☐ Responsible Party

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Patient Name: _____ **Date:** _____

Do you have difficulty hearing in situations when speaking with one other person?	☐ Always	☐ Sometimes	☐ Never
Do you have difficulty hearing while watching TV?	☐ Always	☐ Sometimes	☐ Never
Do you have difficulty hearing in situations with a small group of several people?	☐ Always	☐ Sometimes	☐ Never
Do experience dizziness, pain, or ringing in your ears?	☐ Always	☐ Sometimes	☐ Never
Do family members/coworkers/friends remark about your missing what they said?	☐ Always	☐ Sometimes	☐ Never
Do you find it difficult to understand women and/or children when they are speaking?	☐ Always	☐ Sometimes	☐ Never
**Questions adapted from Patient SAC Survey.			

Check any of the following that apply to your IMMEDIATE FAMILY MEMBERS:

- ☐ Deafness
- ☐ Meniere's Disease
- ☐ Balance Issues
- ☐ Sudden Hearing Loss
- ☐ Chronic Middle Ear Issues
- ☐ Otosclerosis
- ☐ Congenital Hearing Loss
- ☐ Auditory Processing Issues
- ☐ Cochlear Implant

Check any of the following that apply to YOU:

- ☐ Chronic Middle Ear Issues
- ☐ Excessive Earwax
- ☐ Sensitivity to Sounds
- ☐ Meniere's Disease
- ☐ Loss of Consciousness
- ☐ Memory Problems
- ☐ Vision Issues
- ☐ Rubella
- ☐ Balance Issues/Vertigo
- ☐ Ear Surgery
- ☐ Fluctuating Hearing Loss
- ☐ Auditory Processing Issues
- ☐ Diabetes
- ☐ Skin Allergies
- ☐ Measles
- ☐ Cochlear Implant
- ☐ Tinnitus (ringing/buzzing)
- ☐ Ear Pain, Pressure, or Fullness
- ☐ Otosclerosis
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Poor Dexterity
- ☐ Mumps
- ☐ Sudden Hearing Loss

Have you been exposed to noises such as:

- ☐ Industrial Machinery
- ☐ Construction Work
- ☐ Drills, Saws, or Compressors
- ☐ Lawncare Equipment
- ☐ Gunfire
- ☐ Loud Music
- ☐ High Pitched Drills or Electronics
- ☐ Aircraft Engines
- ☐ Carpentry Tools
- ☐ Motors
- ☐ Tractors/Other Farm Equipment
- ☐ Explosives

Date & Location of most recent hearing test: _____

Please list any current medications: _____

_____

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Consent for Assessment and Treatment

Client Name _____ Client Date of Birth _____

I voluntarily consent to the assessment and the treatment offered by the Emerge Center. I give my permission for the staff of the Emerge Center to perform the following service(s):

Testing/ assessment and/or treatment from staff of the Emerge Center in the following departments:

- ☐ Speech Therapy assessment and/or treatment
- ☐ Audiology Services
- ☐ Psychological assessment and/or treatment
- ☐ Applied Behavior Analysis therapy
- ☐ Occupational Therapy assessment and/or treatment
- ☐ Specialized consultation:_____
- ☐ Other: _____

This consent is for
- ___ Myself
- ___ My family member (Name _____)
- ___ Other (Explain: _____)

I have been informed that I, my family member, or the interdict will receive testing and/or treatment from Emerge Center. These procedures may involve, but are not limited to: tests of cognitive, speech/language, perceptual, physical, memory, and social/emotional functioning. I understand that during the interview-intake process, I will be asked about the symptoms and history related to my, my family member's, the interdict's present problem. I have been informed about confidentiality and its limits.

Further (initial in each blank to indicate that you have read the item and consent to the statement):

___I understand that services will be provided by employees of the Emerge Center and its Contractors and that, upon my signature, my, my family member's, the interdict's confidential information may be discussed among Emerge Center employees in pursuit of the highest quality of assessment and/or treatment.

___I understand that this consent may be rescinded or modified at any time with a written request to the Emerge Center.

___I understand that these services may include direct, face-to-face contact, interviewing, records review, consultation with other professionals, and other related activities necessary to support these services.

___I understand that there will be no exchange of printed or verbal information outside the Emerge Center without an appropriate release of information that I review and sign.

___I understand and agree to, for professional training purposes, supervised students observing and/or participating in the rendering of my, my family member's, the interdict's services.

___ As part of the student/clinician training process, for reasons related to safety, and/or for consultation with other professionals under Emerge Center, I understand and agree to the live monitoring or taping for review upon a later date as needed, the video recording of the provision of services for which I am herein providing my consent

___ I consent to telehealth service performed by an Emerge Center provider when scheduled. During telehealth services:

- Nonmedical technical personnel may be present to aid in video transmission. I will be informed of any other people who are present at the telehealth encounter.
- Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associate with the telehealth service

___I understand all information client information strictly confidential. The legal exceptions are:

- The client, parent/guardian or legal representative authorizes a release of information with a signature
- To comply with a court order
- There is suspicion of abuse or neglect involving a child, elder, or vulnerable person.
- The client presents as a danger to self or others
- Record review as requested by insurance carrier provided authorization has been obtained.

_____ _____

Signature of Individual or Personal Representative by Law Date

_____

Personal Representative's Relationship/Authority

_____ _____ _____

Signature of Emerge Center Representative Date

NOTE: If the individual is a competent major, he or she is to sign, or make his or her mark on the first line. If the individual is a minor, incompetent major, or unable to sign, the parent, guardian, or correspondent is to sign on the first line and fill in the second line

NOTICE OF PRIVACY PRACTICES

This notice describes how medical or other identifying information obtained by our practice about you may be used and disclosed and how you can get access to this information. Please review this statement carefully and keep a copy to take home.

The Emerge Center is required by professional ethics and federal law to keep confidential all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally. You, the client, have significant rights to understand in order to control how your health information is used. This agency may be penalized if we misuse your personal health information.

Who Will Follow This Notice All employees, independent contractors, officers and directors of The Emerge Center must abide by this notice.

How We May Use and Disclose Your Personal Health Information

We may use and disclose your personal health information only for each of the following purposes: treatment, payment, & health care operations. Examples are given for each purpose, but they are not intended to imply that they are the only uses in that category.

- Treatment means providing, coordinating or managing the services you have requested. Example: If we order a hearing aid for you, we may disclose the results of your audiogram.
- Payment means such activities as obtaining reimbursement for services, determining your eligibility for insurance coverage, billing or collection activities and utilization review. Example: If you are eligible for Medicaid, we will send an invoice for your services to them for payment.
- Health Care Operations include the business aspects of running our practice, such as conducing quality assessment and improvement activities, auditing our financial statements, etc. Example: Independent auditors must review agency invoices against payment of those invoices.
- The Emerge Center will not share your opt-in to an SMS campaign with any third party for purposes unrelated to providing you with the services of that campaign. We may share your Personal Data, including your SMS opt-in or consent status, with third parties that help us provide our messaging services, including but not limited to platform providers, phone companies, and any other vendors who assist us in the delivery of text messages.

Other Uses & Disclosures of Protected Health Information Requiring Your Written Authorization

We may disclose personal health information

- as required by law or statute, including disclosure to public health or designated authorities charged with preventing or controlling disease, injury or disability; licensing & regulatory agencies, authorities investigating domestic violence or abuse or neglect;
- in response to a subpoena or court order;
- to a coroner or medical examiner for identification of a body;
- to the extent allowed by federal law, to other providers' treatment and healthcare operations activities.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures of protected health information not covered by this notice or by other applicable laws will be made only with your written authorization. If you give us authorization to use or disclose any of your protected health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose that information for the reasons previously covered by your written authorization. However, we would be unable to take back any disclosures already made with your authorization, and we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information You may exercise any of the following rights with respect to your protected health information by presenting a written request to the CEO of The Emerge Center:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. We reserve the right to charge you for the net cost of copying your records.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.
- If you believe your privacy rights have been violated, you may file a complaint with the Executive Director of The Emerge Center or with the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or denied service for filing a complaint.

The Emerge Foundation on behalf of the Emerge Center may notify you of fundraising opportunities. You have the right to opt-out of receiving such fundraising communications. If you do not want to receive these communications you can send us an email at giving@emergela.org with the words "Opt Out" in the subject line. Be sure to include your name or the name of the patient (if you are the patient's parent or acting in loco parentis). If it is more convenient, you can call us at (225) 343-4232 ext. 1911 and leave a message with the patient's name stating that you wish to "Opt Out" of receiving fundraising communications. If you decide to Opt-Out of receiving fundraising communications you cannot be denied treatment and that will not affect payment.

This notice is effective as of January 1, 2025. We are required to abide by its terms. Within the provisions of law, we reserve the right to change the terms of this notice and to make the new terms effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practices from our office if such a change should occur. To request more information or file a complaint regarding these practices with the Department of Health &

Human Services, Office of Civil Rights, 200 Independence Ave., S.W., Washington, D.C. 20201 or Phone Toll Free: 1-877-696- 6775

Client Name: _____ _____

Parent/ Legal Guardian Name: _____

Parent/ Legal Guardian Signature: _____ Date:_____

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Terms and Conditions

By using Emerge Center's services, including signing up for text message communications, you expressly consent to collecting, using, and sharing your personal information as outlined in our Privacy Policy. You acknowledge that you have read, understood, and agree to our Terms of Service and Privacy Policy, including the terms related to data collection, communication, and security.

You further consent to receive text messages from Emerge Center. You may choose to stop receiving text messages from Emerge Center at any time. To opt out, simply reply to any text message you receive from us with the word 'STOP'. The phone number from which you send 'STOP' will immediately be removed from the messaging list and no further text messages will be sent. You may reply "HELP" for additional help if needed.

By subscribing to Emerge Center's text messaging service, you agree to receive informational messages related to healthcare. The frequency of messaging will vary based on your engagement with our organization. Message and data rates may apply. You can opt out of receiving these messages at any time by following the instructions provided in each message. The Emerge Center is not responsible for any delays, failures in delivery, or any other issues related to the transmission or receipt of text messages. Delivery of text messages is subject to effective transmission by your mobile carrier and is not guaranteed by Emerge Center.

By subscribing to our SMS services, you acknowledge and agree that Emerge Center will not be liable for any damages, losses, or injuries arising from or related to the use or failure to receive any text messages, including but not limited to, delays, non-delivery, or technical issues. Your use of our SMS services is at your own risk, and we provide our services on an 'as-is' basis without any warranties of any kind, express or implied.

The Emerge Center is committed to protecting the security of your personal information. We implement industry-standard security measures to safeguard your data against unauthorized access, use, or disclosure. However, it is also your responsibility to protect the confidentiality of your account information, and any credentials associated with your use of our services. You agree to notify Emerge Center immediately of any unauthorized use of your account or any other security breach. Emerge Center will not be liable for any loss or damage arising from your failure to protect your account or personal information adequately. By using our services, you acknowledge and accept that no data transmission over the Internet or mobile networks can be guaranteed to be 100% secure, and therefore, you use our services at your own risk.

Questions or concerns may be directed to: The Emerge Center at 225-343-4232.

Mobile Phone Number(s): _____

Client Name: _____ _____

Parent/ Legal Guardian Name: _____

Parent/ Legal Guardian Signature: _____ Date:_____

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Permission to Email Confidential Information

We strive to communicate with parents and caregivers through the best method possible. For many families, email is a preferred method for communication. If you allow us to email with you through your designated email listed below, please sign and date. Please be aware that confidentiality cannot be assured via e-mail.

E-mail address(es): _____

_____

Parent name/s: _____

Parent Signature: _____

Child's Name: _____

Date: _____