# Adult Patient Profile

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td></td>
</tr>
<tr>
<td>DOB:</td>
<td></td>
</tr>
<tr>
<td>Person Completing Form:</td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td></td>
</tr>
<tr>
<td>Emergency Contact:</td>
<td></td>
</tr>
<tr>
<td>Phone No.:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City &amp; Zip:</td>
<td></td>
</tr>
<tr>
<td>Home Phone:</td>
<td></td>
</tr>
<tr>
<td>Cell Phone:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

Is it ok for us to leave a message regarding your treatment at the following #s?  
Home: ☐ Yes ☐ No  Cell: ☐ Yes ☐ No

# Reasons for Rehabilitation

**Diagnosis/Conditions/Reasons you are seeking rehabilitation services:**  
__________________________________________________________  
__________________________________________________________________________  
__________________________________________________________________________

**Your Primary goal for therapy is to be able to?**  
__________________________________________________________  
__________________________________________________________________________  
__________________________________________________________________________

**Things you would like to do at home that you cannot do right now (e.g., talking on the phone, daily activities, hobbies, etc.)**  
__________________________________________________________________________  
__________________________________________________________________________  
__________________________________________________________________________

**Activities you would like to do in the community that you cannot do right now (e.g., public speaking, going out to eat, etc.)**  
__________________________________________________________________________  
__________________________________________________________________________  

# Health History

**Do you have (or have you had) any of the following conditions?** Please check all that apply.  

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Stroke</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Lung Disease</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Cancer</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Head Injury</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thyroid Disorder</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Headaches/Migraines</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Concussion</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel Issues</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Seizures</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Asthma/Hay Fever</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Swallowing Issues</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Other:</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

**Are you or could you be pregnant?**  
☐ Yes  ☐ No
How would you describe your general health? □ Good □ Fair □ Poor If fair/poor, please explain:
_________________________________________________________________________________________________________________________________________________

Have you recently been or have you ever been hospitalized related to the condition for which you are seeking treatment? □ Yes □ No If yes, please provide the following information:
When: ______________________ Where: __________________________________________
How Long (Admit/Discharge Dates):
______________________________________________________________________________________________

Have you experienced significant weight change (loss or gain) in the past 6 months?
□ Loss □ Gain □ No Change □ N/A □ Yes □ No
If yes, how many pounds? ______________
Was the change in weight intentional or expected? □ N/A □ Yes □ No
List any dietary restrictions (diabetic, food allergies, etc.):
______________________________________________________________________________________________

Are there any other health problems that you would like us to know about? □ Yes □ No
If yes, please explain:
______________________________________________________________________________________________

Do you use a wheelchair, walker, or other assistive device for mobility? □ Yes □ No
If yes, identify which type of device:
______________________________________________________________________________________________

Do you have any balance problems? □ Yes □ No

Do you have left or right sided weakness? □ Yes □ No □ N/A □ Yes □ No If yes, which side:
______________________________________________________________________________________________

Have you had any previous surgeries? □ Yes □ No □ N/A □ Yes □ No If yes, please explain below.

<table>
<thead>
<tr>
<th>Surgery/Procedure</th>
<th>Month/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
</tbody>
</table>

Do you have any allergies? □ Yes □ No □ N/A □ Yes □ No If yes, please list any allergies and the reaction you experience to each below (e.g., allergies to medications, latex, foods, products, etc.)

<table>
<thead>
<tr>
<th>Allergen</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
</tbody>
</table>
Medications:

Are you currently taking any medication?  □ Yes  □ No  If yes, please list below.

1.  6.  
2.  7.  
3.  8.  
4.  9.  
5.  10.  

Previous Therapies:

<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th>Dates</th>
<th>Agency</th>
<th>Name of Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological/Counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Rehab</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Special Needs: (Please check all that apply)

Vision:  □ No Problems  □ Glasses/Contact Lenses  □ Visual Difficulties  □ Glasses for Reading  □ Require Enlarged Print

Communication:  □ No Problems  □ Difficulty Reading  □ Difficulty Writing  □ Communication Needs/Devices/Assist, please specify: ______________________________________________________  ______________________________________________________

Hearing:  □ No Problems  □ Hearing Aid(s)  □ Difficulty Hearing

Living Situational/Level of Independence:

Home Type:  □ Mobile/Trailer  □ Single Level  □ Split Level  □ Multi Story  □ Apt./Condo/Townhouse  □ Other: ________________________________  # of Steps to Main Living Space: ___________________

Live With:  □ Spouse or Significant Other  □ Grown Children  □ Friend(s)  □ Alone  □ Caregiver  □ Assisted Living  □ Long-Term Care Facility  □ Other: _______________________________________

Independence: Please rate your ability to perform the activities below, using the letters  I = Independent  A = Assistance

Bathing/Grooming _______ Dressing _______ Household Chores _______ Stairs _______ Driving _______

Education/Work History:

□ _____ Grade  □ High School Diploma  □ Assoc. Degree  □ Bachelor’s Degree  □ Master’s Degree  □ Post Graduate

I learn best by:  □ Discussion  □ Demonstration  □ Written Language  □ Videos  □ Other: ________________________________

Is there any information or education that you would like your therapist to provide to you?  □ Yes  □ No

If yes, please explain:  ____________________________________________________________________________________

Work Status:  □ Full Time  □ Part Time  □ Unemployed  □ Medical Leave  □ Retired

Occupation: ________________________________  Do you have any vocational concerns?  □ Yes  □ No
**Psychosocial History:**

**Marital Status:**
- Single   □
- Married □
- Divorced □
- Widowed □

**Children (how many):** ____________  **Ages:** ________________________________

Is there anything in your home environment that causes concern(s) for your safety or for other family members?
- Yes □  No □  If yes, please explain: ____________________________________________

Do you have any special cultural, religious, or spiritual practices that you would like us to recognize/address while here?
- Yes □  No □  If yes, please explain: ____________________________________________

**Are you experiencing any of the following:**
- Loss of interest in previously enjoyed activities □
- Feelings of Hopelessness □

**Below are words to describe your personality and behavior.** Circle all that apply and underline all that you had before your accident/stroke/diagnosis.

<table>
<thead>
<tr>
<th>Happy</th>
<th>Aggressive</th>
<th>Depressed</th>
<th>Enthusiastic</th>
<th>Friendly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warm</td>
<td>Independent</td>
<td>Energetic</td>
<td>Distractible</td>
<td>Jealous</td>
</tr>
<tr>
<td>Tense</td>
<td>Prefers to be Alone</td>
<td>Dependent</td>
<td>Affectionate</td>
<td>Relaxed</td>
</tr>
<tr>
<td>Critical</td>
<td>Easily Fatigued/Tired</td>
<td>Directive</td>
<td>Can’t Sleep</td>
<td>Impatient</td>
</tr>
<tr>
<td>Shy</td>
<td>Vigorous</td>
<td>Calm</td>
<td>Irritated</td>
<td>Angry</td>
</tr>
</tbody>
</table>

List description(s) not listed above: ________________________________________________

**Personal Interests/Activities:**

What are your favorite leisure activities/hobbies? ______________________________________

What are your favorite TV shows? ___________________________________________________

What magazines/books/newspapers do you read? ______________________________________

Do you like to talk on the phone?  □ Yes □ No

Do you use the internet/email?  □ Yes □ No

Is there anything else you would like us to know that would help us to best serve your needs?
__________________________________________________________________________________
__________________________________________________________________________________
Consent for Participation

I ________________________________, give permission for the faculty and students of the Idaho State University Speech and Language Clinic to use information gathered from my participation in educational training. I understand that students, under the supervision of fully licensed and certified faculty clinicians, will be observing and conducting my treatment and/or evaluation as part of the student’s education, and direct supervision may occur onsite or via secure remote access from a different location. In addition, I also understand that students in the educational process will be reviewing my evaluation and treatment results and records.

I understand that the treatment and/or evaluation will be observable by patient family members through the group observation area. I am aware that other parents, guardians, and family members will also be in the observation sessions and may be able to see or hear my child’s and/or family member’s therapy session.

I understand that as part of the treatment and/or evaluation process, aspects of the process will be videotaped for the educational process of the student, for analysis of patient communication, and for educational activities within the department. These videotapes will be used in the treatment and/or assessment process and will be destroyed when the information gathering process is complete or will be kept in a secure location within the department.

I understand that I can withdraw from my participation at any time during this experience and revoke my permission to use the information pertaining to my case. If I elect to withdraw and revoke my permission, I will inform the Clinic Director and the Department Chairperson of this action in writing. I further understand that a copy of this form will be given to me upon my request, and the original will be kept on file in the Department of Communication Sciences & Disorders.

The Idaho State University Speech and Language Clinic does not discriminate against any person on the basis of race, religion, color, creed, national origin, disability, age, gender, sexual orientation, gender identity, genetic information, veteran status or any other status protected by federal, state or local law in admission, treatment, or participation in its programs, services and activities.

________________________________________
Print Name of Patient

________________________________________
Signature of Patient or Personal Representative               Date

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent    ☐ Guardian    ☐ Power of Attorney    ☐ Other: __________________________________________
Consent for Participation in Publicity Endeavors

I authorize that my protected health information in the form of photographs and video clips may be used by the Idaho State University Speech and Language Clinic for publicity purposes. The photographs and/or video clips may be on the ISU Speech and Language Clinic website, at job fairs, recruiting endeavors, and other events to recruit students to, or promote the professions of speech-language pathology, audiology, deaf education, and sign language studies for the Department of Communication Sciences & Disorders, and Education of the Deaf at Idaho State University.

The photographs and video clips may be used for the following purposes:

- To recruit professionals into the fields of speech-language pathology, audiology, deaf education, and sign language studies.
- To promote the Department of Communication Sciences & Disorders, and Education of the Deaf.
- To inform potential patients of the services offered at the ISU Speech and Language Clinic at Idaho State University.

This authorization will be used by the Department of Communication Sciences & Disorders, Education of the Deaf at Idaho State University for a period not to exceed 10 years from the date of this authorization.

I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to ISU’s Privacy Officer:

**ISU Privacy Officer:** James Francel  
921 S. 8th Avenue, Stop 8410  
Pocatello, ID 83209  
(208) 282-3022  
Email: franjam5@isu.edu

I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

__________________________________________________________
**Print Name of Patient**

__________________________________________________________
**Signature of Patient or Personal Representative**  
**Date**

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent  ☐ Guardian  ☐ Power of Attorney  ☐ Other: ________________________________

Updated: 08/27/19
Authorization to Obtain
Emergency Medical Treatment

I authorize the Idaho State University Speech and Language Clinic to obtain emergency medical treatment at any hospital for the individual listed below. I agree to be fully responsible for any costs related to the said treatment, and to hold harmless Idaho State University of any such costs.

Print Name of Patient

Signature of Patient or Personal Representative

Date

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent  ☐ Guardian  ☐ Power of Attorney  ☐ Other: ________________________________
Acknowledgement of Receipt of Notice of Privacy Practices

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices.

I acknowledge that I have received a copy of the ISU Speech and Language Clinic Notice of Privacy Practices.

____________________________
Print Name of Patient

____________________________
Signature of Patient or Personal Representative

Date

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent  ☐ Guardian  ☐ Power of Attorney  ☐ Other: ________________________________

Please Note: It is your right to refuse to sign this Acknowledgement.

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices.

1. Does the patient have a copy of the Notice of Private Practices?  ☐ Yes  ☐ No

2. If you answered “No” above, please explain why the patient did not sign acknowledgment form:

☐ Patient/individual refused to sign _______________________ (Date of Refusal).
☐ Communication barriers prohibited obtaining an acknowledgement.
☐ Legal representative not available.
☐ Patient bypassed registration.
☐ An emergency situation prevented ISU from obtaining an acknowledgement.
☐ Other: _______________________________________________________________________

__________________________
Completed By: __________________________

Signature

Date
Patient Authorization to Release Protected Health Information (PHI)

Patient Name: ___________________________ DOB: ___________________________
Address: ___________________________ Phone No.: ___________________________
__________________________________________________

I authorize ISU’s Speech and Language Clinic and any of their affiliated entities, employees, agents, or associated health care practitioners to use or disclose the patient’s protected health information (PHI) as described below:

1. I authorize the use and disclosure of my PHI to be RELEASED to the following entity:

   Name: ___________________________
   Address: ___________________________
   Phone: ___________________________ Fax: ___________________________
   ☑ Records from: ________________ to: ________________
   Records to be released: Other: ___________________________________________________________
   ☐ Evaluation Reports ☐ X-Ray Reports ☐ Laboratory Tests / Reports
   ☐ Progress Notes ☐ X-Ray Films ☐ Consultation Reports
   ☐ Discharge Summary ☐ Pathology Reports ☐ History and Physical Exam

2. I authorize the use and disclosure of my PHI to be OBTAINED from the following entity:

   Name: ___________________________
   Address: ___________________________
   Phone: ___________________________ Fax: ___________________________
   ☑ Records from: ________________ to: ________________
   Records to be released: Other: ___________________________________________________________
   ☐ Evaluation Reports ☐ X-Ray Reports ☐ Laboratory Tests / Reports
   ☐ Progress Notes ☐ X-Ray Films ☐ Consultation Reports
   ☐ Discharge Summary ☐ Pathology Reports ☐ History and Physical Exam

If the information includes records or information from another health care provider or entity, that information:
☐ SHOULD or ☐ SHOULD NOT be released under this Authorization. This Authorization applies only to the information indicated above. Additional information shall require another Authorization.

3. The disclosure is for the following purpose (check one and complete as needed):
   ☐ Patient Request ☐ Continuity of Care ☐ Legal ☐ Other: ___________________________

Updated: 08/28/19
I acknowledge that the information to be released MAY INCLUDE information protected by federal and state laws.

The ISU Speech and Language Clinic will send information ONLY to the above address or fax number. Any disclosure of the patient’s PHI to another person or entity will require another authorization.

This Authorization is valid for one (1) year from the date set forth below. It may be revoked at any time in writing to ISU’s Privacy Officer below prior to the expiration of such 90-day period. Revocation of this authorization shall not affect releases to the revocation.

**ISU Privacy Officer:** James Francel  
921 S. 8th Avenue, Stop 8410  
Pocatello, ID 83209  
(208) 282-3022  
Email: franjam5@isu.edu

I may refuse to sign this authorization, which will not affect my treatment or payment for health care at the ISU Speech and Language Clinic.

After your PHI (medical records) are released by your authorization, the possibility exists that your PHI will no longer be subject to the protection of federal privacy regulations and may be re-disclosed by the recipient.

I certify that I have the authority to approve the requested release of information and sign this authorization.

______________________________________________  
**Patient or Personal Representative Signature**

______________________________________________  
**Printed Name**

______________________________________________  
**Date of Request**
Notice of Disclosure

The purpose of the ISU Speech and Language Clinic is to provide training for graduate students. Graduate students observe, evaluate, and treat clients under the direct supervision of a licensed faculty clinician. While all services provided are supervised under program guidelines developed by the American Speech-Language-Hearing Association (ASHA), these services are often considered non-covered by insurance as defined below.

- **Medicare / Medicaid Participants**: We understand that you may have recently completed therapy under a certified plan of care with another speech therapist. We further understand that, even if your prior therapist has concluded that you have completed the course of therapy under that plan of care, you would like to continue working with our speech therapy students on the skills you have learned, to improve your general welfare, and to support the training mission of the Speech and Language student training program.

Since the Medicare / Medicaid program does not cover services furnished under the policies and procedures of the student training program, you will be personally responsible for the fee established by ISU for the services provided by students in training. No Medicare / Medicaid payment may be made and, accordingly, no claims will be submitted to Medicare / Medicaid for these services.

- **Private Insurance**: Under our current insurance contracts, services furnished under the policies and procedures of the student training program are considered non-covered. Therefore, you will be personally responsible for the fee established by ISU for the services provided by students in training. No insurance payment may be made and, accordingly, no claims will be submitted to your insurance for these services.

While participating in the student training program, you will receive periodic evaluations by students under the supervision of their instructors as part of their training. If those evaluations reveal that your condition may warrant further evaluation by your physician and qualify as covered services under a new speech therapy plan of care, we would recommend that course of action to you and refer you to another clinic.

Regular attendance is critical to our student’s learning experience. Patients with excessive cancellations and/or no shows will be discharged from our program.

Current fees for services furnished in the student training program are as follows:

<table>
<thead>
<tr>
<th>Poverty Level (At or Below)</th>
<th>Discount</th>
<th>Per Visit TX Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 100%</td>
<td>80%</td>
<td>$5</td>
</tr>
<tr>
<td>100% - 200%</td>
<td>60%</td>
<td>$10</td>
</tr>
<tr>
<td>200% - 300%</td>
<td>40%</td>
<td>$15</td>
</tr>
<tr>
<td>300% - 400%</td>
<td>0%</td>
<td>$25</td>
</tr>
</tbody>
</table>

As a client of the ISU Speech and Language Clinic, I understand that my insurance will not be billed for student services and that I will not submit a claim for these non-covered services. I also understand the attendance policy and will strive to attend regularly. I also understand that payments are required monthly to participate in the program.

---

*Print Name of Patient*

*Signature of Patient or Personal Representative*  
*Date*

Updated: 08/27/19
ISU Speech and Language Clinic
Sliding Fee Income Scale
FY 2020

<table>
<thead>
<tr>
<th>Poverty Level*</th>
<th>0 - 100%</th>
<th>100% - 200%</th>
<th>200% - 300%</th>
<th>300% - 400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Size</td>
<td>80%</td>
<td>60%</td>
<td>40%</td>
<td>No Discount</td>
</tr>
<tr>
<td>1</td>
<td>0-$12,490</td>
<td>$12,490 - $24,980</td>
<td>$24,980 - $37,470</td>
<td>$37,470</td>
</tr>
<tr>
<td>2</td>
<td>0-$16,910</td>
<td>$16,910 - $33,620</td>
<td>$33,620 - $50,730</td>
<td>$50,730</td>
</tr>
<tr>
<td>3</td>
<td>0-$21,330</td>
<td>$21,330 - $42,660</td>
<td>$42,660 - $63,990</td>
<td>$63,990</td>
</tr>
<tr>
<td>4</td>
<td>0-$25,750</td>
<td>$25,750 - $51,500</td>
<td>$51,500 - $77,250</td>
<td>$77,250</td>
</tr>
<tr>
<td></td>
<td>(0 – $12.38/hr)</td>
<td>($12.38 – $24.76/hr)</td>
<td>($24.13 – $37.14/hr)</td>
<td>($37.14+/hr)</td>
</tr>
<tr>
<td>5</td>
<td>0-$30,170</td>
<td>$30,170 - $60,340</td>
<td>$60,340 - $90,510</td>
<td>$90,510</td>
</tr>
<tr>
<td>6</td>
<td>0-$34,590</td>
<td>$34,590 - $69,180</td>
<td>$69,180 - $103,770</td>
<td>$103,770</td>
</tr>
<tr>
<td>7</td>
<td>0-$39,010</td>
<td>$39,010 - $78,020</td>
<td>$78,020 - $117,030</td>
<td>$117,030</td>
</tr>
<tr>
<td>8</td>
<td>0-$43,430</td>
<td>$43,430 - $86,860</td>
<td>$86,860 - $130,290</td>
<td>$130,290</td>
</tr>
</tbody>
</table>

*Based on 2019 Federal Poverty Guidelines (http://aspe.hhs.gov/poverty)
*Gross Annual Income

**Evaluation** = $75 / 1 per year

**Therapy** = $25 / visit

<table>
<thead>
<tr>
<th>Poverty Level (At or Below)</th>
<th>Discount</th>
<th>Per Visit TX Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 100%</td>
<td>80%</td>
<td>$5</td>
</tr>
<tr>
<td>100% - 200%</td>
<td>60%</td>
<td>$10</td>
</tr>
<tr>
<td>200% - 300%</td>
<td>40%</td>
<td>$15</td>
</tr>
<tr>
<td>300% - 400%</td>
<td>0%</td>
<td>$25</td>
</tr>
</tbody>
</table>

- Evaluations will be charged one time per year and are also subject to the discount table with a minimum charge of $25 / $40 / $60 / $75.
- **Monthly payments are required** for continued participation in the discount program unless otherwise approved due to special circumstances.
- Accounts must be paid in full prior to participation in the following semester.
- Accounts over 90 days will be sent to collections and all discounts will be removed.
- Questions should be directed to Cindy Rock, 208-373-1743
Application for Fee Assistance

<table>
<thead>
<tr>
<th>Contact Information:</th>
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</thead>
<tbody>
<tr>
<td>Patient Name:</td>
</tr>
<tr>
<td>DOB:</td>
</tr>
<tr>
<td>Street Address:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>City and State:</td>
</tr>
<tr>
<td>Zip Code:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Household:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number in Household:</td>
</tr>
<tr>
<td>Self</td>
</tr>
<tr>
<td>Spouse or Partner</td>
</tr>
<tr>
<td>Child</td>
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<td>Child</td>
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<td>Child</td>
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<table>
<thead>
<tr>
<th>Income:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Monthly Income BEFORE Taxes <em>(Include both spouses if working)</em></td>
</tr>
<tr>
<td>Other Income <em>(Unemployment, Social Security, Child Support, etc.)</em></td>
</tr>
<tr>
<td>TOTAL MONTHLY INCOME:</td>
</tr>
<tr>
<td>TOTAL ANNUAL INCOME:</td>
</tr>
</tbody>
</table>

Required Income Documentation: *(must be received within 2 weeks of first visit)*

**Employed:** Most recent tax return or most recent pay stubs (2)

**Unemployed:** Public Assistance check stub/copy; Social Security check stub or Letter of Award; Certification Letter from Medical Assistance or Department of Social Services

*I certify that the income and household composition information is true and correct to the best of my knowledge. I agree to notify Idaho State University of any income changes that may affect my eligibility in this program.*

__________________________  __________________________
Patient/Guardian Signature:  Date:

Clinic Use Only: Cindy Rock (208) 373-1743

<table>
<thead>
<tr>
<th>Sliding Scale Discount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
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</tbody>
</table>

Approved By:  Date:

Updated: 08/27/19
Notice of Privacy Practices

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, SIGN THE ACKNOWLEDGEMENT OF RECEIPT, AND GIVE TO THE RECEPTIONIST.

Protecting Your Personal and Health Information

Our clinic is committed to protecting the privacy of its patients’ personal and health information. Applicable Federal and State laws require us to maintain the privacy of our patients’ personal and health information. This Notice explains our clinic’s privacy practices, our legal duties, and your rights concerning your personal and health information. In this Notice, your personal and health information is referred to as “health information” and includes your name, age, address, income or other financial information. We follow the privacy practices described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until replaced.

How We Protect Your Health Information

We protect your health information by:

• Treating all of your health information that we collect as confidential.
• Stating confidentiality policies and practices in our medical and clinical staff handbooks as well as disciplinary measure for privacy violations.
• Restricting access to your health information only to those medical and clinical staff who need to know your health information in order to provide our services to you.
• Only disclosing your health information that is necessary for an outside service company to perform its function on our behalf, and the company has by contract agreed to protect and maintain the confidentiality of your health information.
• Maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information.

Uses and Disclosures of Your Health Information

We will use and disclose health information about you for treatment, payment and health care operations. For example:

• Treatment: We may provide another physician or subsequent healthcare provider who is treating you with copies of various reports of your health information that should assist him or her with your treatment.
• Payment: We may use and disclose your health information to obtain payment for services we provide to you.
• Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training and educational programs, accreditation, certification, licensing, or credentialing activities.
• Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Updated: 08/27/19
• **To Your Family and Friends:** We must disclose your health to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

• **Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

• **Marketing Health-Related Services:** We will not use your health information for marketing without a written authorization from you.

• **Required by Law:** We may use or disclose your health information when we are required to do so by law, including, but not limited to, court or administrative orders, subpoenas, discovery requests, or other lawful process.

• **Abuse or Neglect:** We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

• **National Security:** We may disclose to military authorities the health information of Armed forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

• **Appointment Reminders:** We may also use health information about you to call, leave a voice message, text, email, or send a postcard or letter to you as a reminder about an appointment.

• **Research:** Under certain limited circumstances, we may use and disclose health information about you for research purposes. All research projects, however, are subject to a special approval process.

**Rights You Have Regarding the Use and Disclosure of Your Health Information**

You have the right to request all of the following:

• **Access to Your Health Information:** You have the right to request a copy of your health information. A nominal fee may be charged for providing copies. However, this right does not include the following types of records: psychotherapy notes; records compiled in reasonable anticipation of a court action or administrative action or proceeding; and protected health information whose release is prohibited by federal or state laws. Access to your records may also be limited if it is determined that by providing the information it could possibly be harmful to you or another person. If access is limited for this reason, you have a right to request a review of that decision.

• **Amendment:** You have the right to request in writing an amendment to your health information. The request must identify which information is incorrect and an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial which will be added to the information of the original request. If your original request is approved, we will make reasonable effort to include the amended information in future disclosures. (Amending a record does not mean that any portion of your health information will be deleted.

• **Accounting or Disclosures:** If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.
• **Restriction Requests:** You have the right to request that the clinic place additional restrictions on uses and disclosures of your health information. We may not be able to accept your request, but if we do, we will uphold the restriction unless it is an emergency.

• **Confidential Communication:** You have the right to request that communication regarding your health information be done in an alternate way or be sent to an alternate location.

• **Electronic Notice:** If you received this notice by accessing a web site or by email, you are also entitled to have a paper copy which is available by request from the clinic or department.

**Changes to this Notice**

We reserve the right to change our privacy practices and terms of this Notice at any time, as permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make such changes, we will update this Notice and post the changes in the waiting room or lobby of the facility. You may also request a copy of the Notice at any time.

**Questions and Complaints**

For questions regarding this notice or our privacy practices, please contact our office.

If you are concerned that your privacy rights may have been violated, you may contact either of the people listed below to make a complaint. You may also make a written complaint to the U.S. Department of Health and Human Services whose address can be provided upon request.

If you choose to make a complaint with us or the U.S. Department of Health and Human Services, we will not retaliate in any way.

**ISU Clinic Operations:** Cindy Rock, Clinics Director of Operations 1311 E. Central Dr. Meridian, ID 83642 (208) 373-1743 rockcind@isu.edu

**ISU Privacy Officer:** James Francel, HIPAA Privacy & Security Officer Office of General Counsel 921 S. 8th Ave, Stop 8410 Pocatello, ID 83209 (208) 282-3022 franjam5@isu.edu