

PROVIDENCE 
SPEECH AND HEARING CENTER

Dear New Patient:

Welcome to Providence Speech and Hearing Center! In order to make the check-in process easier, **please complete the enclosed forms and bring with you on your appointment.**

Your appointment is scheduled for _____ at _____
Date Time

**PLEASE LEAVE ADDITIONAL CHILDREN AT HOME
PLEASE BE AWARE THERE IS CONSTRUCTION IN THE AREA**

Please plan to arrive 15 minutes early so that the requested information can be verified. If you arrive late for your appointment it is probable that you will have to be re-scheduled.

If you are with an out-of-network PPO, or if you are receiving a service that is not covered by your insurance, your responsibility is ESTIMATED to be \$ _____ for this appointment.

Please bring:

- * your insurance card
- * your co-payment or estimated amount as noted above (**this must be paid prior to services being rendered**)
- * if you use hearing aids, please bring them with you
- * previous hearing test results and reports (if available)

If you have secondary insurance, insurance claims counseling is offered.

There is a map on the other side of this letter. 1 hour free parking is available in the St. Joseph's Outpatient Parking Structure, located just to the north of the Providence Building (see map). Park in the structure, and walk down the sidewalk to the SOUTH side of the Providence Building to enter the clinic. You will see a children's playground, and a sign for the Speech and Hearing Center. Do NOT enter the north entrance, as you cannot get to the Speech and Hearing Center through that door.

If you need to cancel or change your appointment please call AT LEAST 48 hours in advance so that your time may be given to another patient. Late cancellations (less than 24 hours) or no-shows will be billed to you.

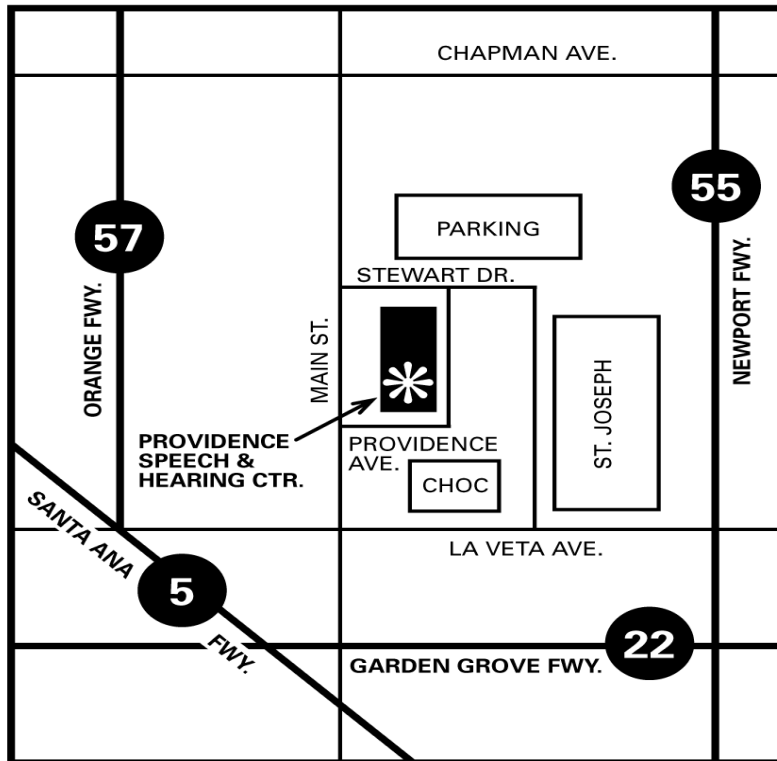
As a provider of Rehabilitation & Audiological Services, we adhere to and enforce Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. These Acts prohibit federally-funded programs from discriminating against persons on the basis of race, color or national origin (Title VI), mental or physical disability (Section 504), or age(Age Discrimination Act) in the provision of services.

If you have any questions please call the scheduling department at (714)923-1521.

We look forward to seeing you!

1301 Providence Ave., Orange, California 92870
(714) 639-4990 Fax (714) 744-3841

PROVIDENCE
Speech and Hearing Center
Providence Building
1301 Providence Avenue
Orange, CA 92868
(714) 639-4990



Providence Speech and Hearing Center is located on the campus of St. Joseph Hospital and Children's Hospital of Orange County (CHOC) in the heart of Orange County and is freeway accessible from the 22 and 5 freeways. The nearest major cross streets are Main and LaVeta.

The entrance to the Center is at the south end of the Providence Building.

PROVIDENCE SPEECH & HEARING CENTER
PATIENT INFORMATION



{Please Print}

Last Name: _____ First Name: _____

Address: _____ Apt.#: _____

City: _____ State: _____ Zip Code: _____

Home phone#: () _____ Work phone#: () _____

Cell Phone #: () _____ E-Mail _____

Date of Birth: _____ Age: _____ Sex: _____

Social Security#: _____ Driver's License#: _____

Ethnicity: ___ Asian ___ Black/African Amer. ___ Amer. Indian/Alaska Native ___ Latin/Hispanic
___ Pacific Islander ___ White/Caucasian ___ Other

How Did You Hear About Us? Please indicate from choices below.

Newspaper Event Direct Mail Friend Web Site Senior Center Other

What is the name of the Physician that referred you Providence? _____

RESPONSIBLE PARTY

Last Name: _____ First Name: _____

Relationship to patient: _____

Address: _____ Apt.#: _____

City: _____ State: _____ Zip Code: _____

Home phone#: () _____ Work phone#: () _____

E-Mail home: _____ E-Mail Work: _____

Date of Birth: _____ Age: _____ Sex: _____

Social Security#: _____ Driver's License#: _____

INSURANCE INFORMATION

Insured Name: _____ Date of Birth: _____

Insurance company name: _____ Subscriber: _____

Complete Insurance Address: _____

Policy/Group#: _____ Employer: _____

Check one: HMO PPO EPO POS

SECONDARY INSURANCE (MEDICARE PATIENTS ONLY)

Check one: Supplemental or Retirement Plan

Insured Name: _____ Date of Birth: _____

Insurance company name: _____ Subscriber: _____

Complete Insurance Address: _____

Policy/Group#: _____ Employer: _____

Check one: HMO PPO EPO POS

I hereby assign to Providence Speech and Hearing Center all monies to which I am entitled for charges(s) related to the service(s) provided. I understand that I am financially responsible to Providence Speech and Hearing Center for charges not covered by this assignment. Also, I authorize the release of any information in order to process claims.

Signature: _____ Date: _____

RELEASE OF INFORMATION

I, the undersigned, hereby authorize Providence Speech and Hearing Center to provide medical information or records to:

Person or Physician: _____ Phone: _____

Address: _____ Apt.# _____

City: _____ State: _____ Zip code: _____

Signature of representative to patient: _____

I, the undersigned, hereby authorize Providence Speech and Hearing Center to provide medical information or records to:

Person or Physician: _____ Phone: _____

Address: _____ Apt.# _____

City: _____ State: _____ Zip code: _____

Signature of representative to patient: _____

I, the undersigned, hereby authorize Providence Speech and Hearing Center to provide medical information or records to:

Person or Physician: _____ Phone: _____

Address: _____ Apt.# _____

City: _____ State: _____ Zip code: _____

Signature of representative to patient: _____

I, the undersigned, hereby authorize Providence Speech and Hearing Center to provide medical information or records to:

Person or Physician: _____ Phone: _____

Address: _____ Apt.# _____

City: _____ State: _____ Zip code: _____

Signature of representative to patient: _____

CONSENT TO RELEASE MEDICAL HISTORY

Patient Name:

Date of Birth:

City:

State:

Date:

To Whom is My Concern:

This authorizes all physicians, hospitals, and medical attendants to furnish any and all medical records, history and information to Providence Speech and Hearing Center, or to any representative of Providence Speech and Hearing Center, concerning my medical condition. This authorization also includes examination of all hospital records, x-ray film, and furnishing of any information including opinions. You are further requested not to disclose such information to any other person without written authority to do so.

All prior authorization is hereby cancelled.

Patient / Parent / Legal Guardian



PROVIDENCE SPEECH AND HEARING CENTER
FINANCIAL POLICY
STATEMENT OF FINANCIAL RESPONSIBILITY

Thank you for using Providence Speech and Hearing Center as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must read and sign this policy before being seen.

ALL COPAY AND DEDUCTIBLE MONIES ARE DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD AND AMERICAN EXPRESS

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. All charges incurred are the responsibility of the patient or their guarantor. We will bill your insurance company as a courtesy. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. If your insurance company has not paid your account within 60 days the balance will automatically be billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Benefit inquiries and authorizations are not a guarantee of payment by your insurance company.

OVERPAYMENT

Our policy is collect a payment of 50% of charges at the time of service for non provider insured patients, unless other arrangements have been made. If you feel you have overpaid please feel free to contact our billing department so we can research and process any refunds do to you. All refunds are processed in the same manner as payment was received. If any credits on your account are do to insurance overpayments a refund will be made to the insurance company

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Prearranged contract rates will be honored.

MINOR PATIENTS

The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard or American Express, or payment by cash or check at time service has been provided.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of the missed session. Please help us serve you better by keeping scheduled appointments.

INTEREST

We reserve the right to charge interest in the amount of 10% as provided by state law.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

Name Printed

Signature of Patient or Responsible Party

Date

Signature of Co-Responsible Party

Date

Providence
Speech and Hearing Center
ELIGIBILITY CERTIFICATION

Blue Shield HMO
California Care HMO
CareAmerica HMO
Cigna HMO
FHP HMO
Health Plan of America HMO

Health Net HMO
TakeCare/Lincoln National HMO
PacifiCare HMO
PruCare HMO
Secure Horizons HMO

Other _____

“I, _____, understand that I am eligible for
(Name of member)
benefits on or as of _____ through my _____
(Effective date) (Own/spouse/parent)
employment at _____. I understand that _____
(Name of employer) (Name of IPA)
is the medical group chosen for all members of the contract under which I am covered.

I am aware that if the above is not true, I (or the person financially responsible for me)
am responsible for all charges related to services provided to me. I agree that if the
above is not true, I (or the person financially responsible for me) will pay in full all such
charges.”

Subscriber's Name _____

Signature of patient/responsible party _____ Date _____

Address _____

Phone _____

SS/Certificate Number _____

Group Number _____