

PROVIDENCE 
SPEECH AND HEARING CENTER

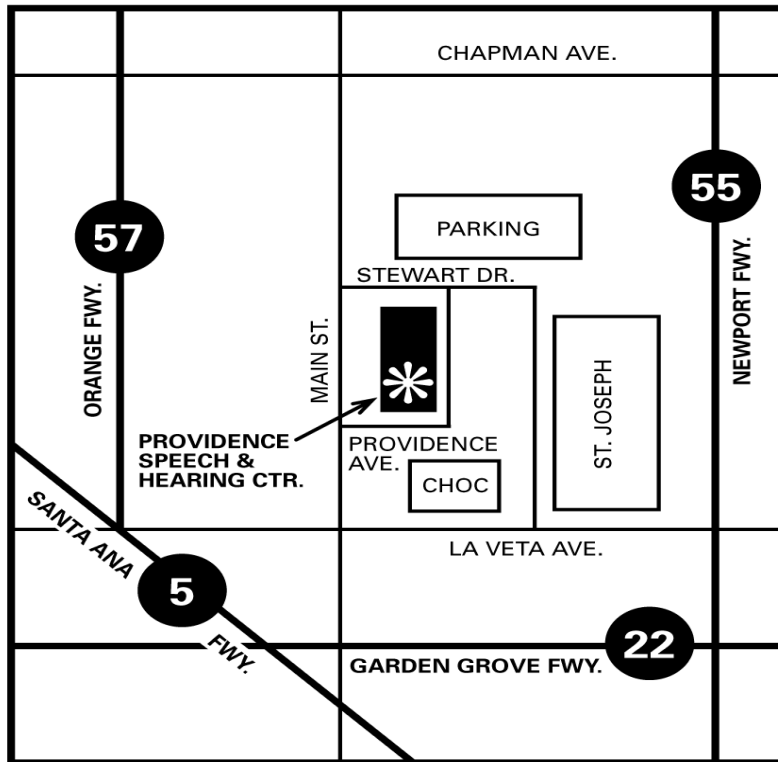
Dear Parent:

Thank you for calling to make an appointment for a speech and language evaluation at Providence Speech and Hearing Center. As you prepare for your visit, we would like to recommend the following:

- ❖ Parents: Plan to bring only the child to be evaluated to the appointment. You and your child will be involved with the evaluation and it will provide us with better information if you are not distracted by other siblings or responsibilities.
- ❖ Please be certain your child has eaten before arriving and bring a snack.
- ❖ Please arrive at least 15 minutes before your scheduled appointment. This will give the receptionist time to start a chart with your paperwork and allow the clinician to start at the scheduled time.
- ❖ The appointment will take between 60 – 120 minutes, so please allow enough time to get to your next destination.
- ❖ One hour of free parking is available in the St. Joseph parking structure on Stewart Ave. We will validate for the second hour. Each additional hour will be charged at \$1.00 per hour. Please be prepared to cover this cost with cash. Parking is not allowed in the circular driveway in front of the Center. See map on back for directions.
- ❖ Remember that you will be responsible for payment at the time services are rendered, unless other **prior** arrangements have been approved.

If you have any questions feel free to contact the Scheduling Department at (714) 923-1521

PROVIDENCE
Speech and Hearing Center
Providence Building
1301 Providence Avenue
Orange, CA 92868
(714) 923-1521



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#: () _____

E-Mail Home: _____ E-Mail Work: _____

Birthdate: _____ Age: _____ Sex: _____

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

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

Newspaper Event Dir Mail Friend Web Site Sen Center Other

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: _____

Birthdate: _____ Age: _____ Sex: _____

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

INSURANCE INFORMATION

Insured Name: _____ Date of Birth: _____

Insurance company name: _____ SS#: _____

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: _____

Complete Insurance Address: _____

Policy/SS#: _____ Group#: _____

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 Speach 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 Speach 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 Speach 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 Speach 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: _____



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 _____

1301 W. Providence Ave, Orange, CA 92868 Phone: (714) 923-1521 Fax: (714) 639-2593

s:\forms\eligibility certification

PROVIDENCE

SPEECH AND HEARING CENTER



Date: _____

To Whom It May Concern:

I,		do hereby authorize	_____	
	Patient / Parent/ Guardian's Name		School District or Physician	

			Address	
			_____	_____
			City	State
			_____	Zip
			_____	_____
			Phone	Fax

To release	_____	medical records to:		
	Patient name			

Providence Speech and Hearing Center
 1301 Providence Avenue
 Orange, CA 92868
 (714) 923-1521 FAX: (714) 639-2593

Signature: _____
Patient or legal guardian if patient under 18 years of age

Date: _____

Print: _____