



**330 S Madison Ave Suite 106  
Bainbridge Island WA 98110  
(206) 451-4308**

### **General Communication**

We do our best to communicate with our patients. The following are some important procedures with our office:

- There is a \$50 no-show fee for all patients. Please see our cancelation policy for more information.
- A 3.29% convenience fee will be added to all credit and debit card payments. No fees will be added to payments made by check or cash.
- Our clinicians do their best to show up on time, and we appreciate the same courtesy. We understand that Agate Pass Bridge traffic can back up (especially during the morning commute, and annual bridge cleaning in February). If you will be more than 5 minutes late, please call our office (206-451-4308) or text (206-348-3829) to let our office know.
- Sometimes our clinicians need to take a day off. This means our patients may occasionally be seen by one of our other certified clinicians due to a sick day or planned vacation. In this event, another clinician will be provided for you, or when possible, we will offer a time that you can reschedule with your primary clinician. If we need to change your appointment in any way, we will try to contact you as soon as possible. We understand that change can be difficult, for both adults and children. If you have a preference of an alternate clinician, please let us know. It is our goal to keep you on schedule and moving forward with your progress.
- Please like us on Facebook (The Aubin Aphasia Speech & Language Center, LLC). Please check Facebook, or call our office if weather (i.e., snow or ice) may be a factor. Our office will still be open during power outages. We will also post recommended websites, book selections, or articles of interest.

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***Patient/ Personal Representative Signature Date***



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### **Cancellation Policy**

If you need to change or cancel your appointment, we are happy to do that for you - provided that you let us know 24 hours in advance. However, if you cancel your appointment with less than 24 hours-notice, or simply fail to show up for your appointment, we will charge you a cancellation fee of \$50.00. This fee is not paid by your insurance. We believe this policy allows you flexibility in scheduling, yet is still fair to our therapists.

I have reviewed the above cancellation policy for The Aubin Aphasia Center, and understand that I will be billed for missed appointments or appointments cancelled with less than 24 hours-notice.

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***Patient/ Personal Representative Signature***



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**330 S Madison Ave Suite 106**  
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**(206) 451-4308**

**Protected Health Information**

**Date :** \_\_\_\_\_

**Patient Name (first, middle, last):** \_\_\_\_\_

**Birthdate:** \_\_\_\_\_

I authorize the following individuals to receive healthcare related information which may be Protected Health Information (PHI) regarding my treatment from The Aubin Aphasia Speech & Language Center:

**Name Phone Relationship**

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*(Please use separate sheet of paper if more space is necessary)*

This authorizes the above individuals to share healthcare information with The Aubin Aphasia Speech & Language Center, LLC as well as receive. Information will be kept confidential and will not be shared with unauthorized individuals. Information may be shared via phone calls, written handouts/copies, emails, or text messaging.

This authorization is to remain valid until otherwise notified in writing.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

### Insurance Benefits

Primary Insurance: \_\_\_\_\_

Primary Insured Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Primary Insured Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I, the undersigned, agree to assign my insurance benefits to be paid directly to The Aubin Aphasia Center for medical services rendered. I understand that I am financially responsible for all charges, whether paid or not by insurance and will be fully responsible for payment, if coverage is declined or absent. These charges can include your visit copays, coinsurance, and annual deductibles. I hereby release all information necessary to secure payment of benefits. authorize the use of this signature on my insurance Submission.

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***Patient/ Personal Representative Signature***

***Date***



## Your Information. Your Rights. Our Responsibilities.

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.**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

<b>Get an electronic or paper copy of your medical record</b>	<ul style="list-style-type: none"><li>• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.</li><li>• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee</li></ul>
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<p><b>Ask us to correct your medical record</b></p>	<ul style="list-style-type: none"> <li>• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.</li> <li>• We may say “no” to your request, but we’ll tell you why in writing within 60 days</li> </ul>
<p><b>Request confidential communications</b></p>	<ul style="list-style-type: none"> <li>• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.</li> <li>• We will say “yes” to all reasonable requests.</li> </ul>
<p><b>Ask us to limit what we use or share</b></p>	<ul style="list-style-type: none"> <li>• You can ask us <b>not</b> to use or share certain health information for treatment, payment, or our operations.</li> <li>• We are not required to agree to your request, and we may say “no” if it would affect your care.</li> </ul> <p>ice or health care item out of-pocket in full, you can ask us not to share that purpose of payment or our operations with your health insurer.</p> <ul style="list-style-type: none"> <li>• We will say “yes” unless a law requires us to share that information.</li> </ul>
<p><b>Get a list of those with whom we’ve shared information</b></p>	<ul style="list-style-type: none"> <li>• You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.</li> <li>• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.</li> </ul>
<p><b>Get a copy of this privacy notice</b></p>	<ul style="list-style-type: none"> <li>• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.</li> </ul>
<p><b>Choose someone to act for you</b></p>	<ul style="list-style-type: none"> <li>• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.</li> <li>• We will make sure the person has this authority and can act for you before we take any action.</li> </ul>
<p><b>File a complaint if you feel your rights are violated</b></p>	<ul style="list-style-type: none"> <li>• You can complain if you feel we have violated your rights by contacting us using the information on the back page.</li> <li>• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or visiting <a href="http://www.hhs.gov/ocr/privacy/hipaa/complaints/">www.hhs.gov/ocr/privacy/hipaa/complaints/</a>.</li> <li>• We will not retaliate against you for filing a complaint</li> </ul>

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

<p><b>In these cases, you have both the right and choice to tell us to:</b></p>	<ul style="list-style-type: none"> <li>• Share information with your family, close friends, or others involved in your care</li> <li>• Share information in a disaster relief situation</li> <li>• Include your information in a hospital directory</li> </ul> <p><i>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. We may also share your information when needed to lessen a serious and imminent threat to health or safety.</i></p>
<p><b>In these cases we never share your information unless you give us written permission:</b></p>	<ul style="list-style-type: none"> <li>• Marketing purposes</li> <li>• Sale of your information</li> <li>• Most sharing of psychotherapy notes</li> </ul>
<p><b>In the case of Fundraising</b></p>	<ul style="list-style-type: none"> <li>• We may contact you for fundraising efforts, but you can tell us not to contact you again</li> </ul>

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

<p><b>Treat you</b></p>	<ul style="list-style-type: none"> <li>• We can use your health information and share it with other professionals who are treating you.</li> </ul> <p><i>Example: A doctor treating you for an injury asks another doctor about your overall health condition.</i></p>
<p><b>Run our organization</b></p>	<ul style="list-style-type: none"> <li>• We can use and share your health information to run our practice, improve your care, and contact you when necessary.</li> </ul> <p><i>Example: We use health information about you to manage your treatment and services.</i></p>
<p><b>Bill for your services</b></p>	<ul style="list-style-type: none"> <li>• We can use and share your health information to bill and get payment from health plans for other entities.</li> </ul> <p><i>Example: We give information about you to your health insurance plan so it will pay for your services.</i></p>

**How else can we use or share your health information?** We are allowed or required 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](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

<b>Help with public health and safety issues</b>	<ul style="list-style-type: none"> <li>• We can share health information about you for certain situations such as: <ul style="list-style-type: none"> <li>• Preventing disease</li> <li>• Helping with product recalls</li> <li>• Reporting adverse reactions to medications</li> <li>• Reporting suspected abuse, neglect, or domestic violence</li> <li>• Preventing or reducing a serious threat to anyone’s health or safety</li> </ul> </li> </ul>
<b>Do research</b>	<ul style="list-style-type: none"> <li>• We can use or share your information for health research</li> </ul>
<b>Comply with the law</b>	<ul style="list-style-type: none"> <li>• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.</li> </ul>
<b>Respond to organ and tissue donation requests</b>	<ul style="list-style-type: none"> <li>• We can share health information about you with organ procurement organizations</li> </ul>
<b>Work with a medical examiner or funeral director</b>	<ul style="list-style-type: none"> <li>• We can share health information with a coroner, medical examiner, or funeral director when an individual dies</li> </ul>
<b>Address workers’ compensation, law enforcement, and other government requests</b>	<ul style="list-style-type: none"> <li>• We can use or share health information about you: <ul style="list-style-type: none"> <li>• For workers’ compensation claims</li> </ul> </li> </ul>
<b>Respond to lawsuits and legal actions</b>	<ul style="list-style-type: none"> <li>• For law enforcement purposes or with a law enforcement official</li> <li>• With health oversight agencies for activities authorized by law</li> <li>• For special government functions such as military, national security, and presidential protective services</li> </ul> <ul style="list-style-type: none"> <li>• We can share health information about you in response to a court or administrative order, or in response to a subpoena.</li> </ul>

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

**Changes to the Terms of This Notice** We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.