APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION

(PLEASE PRINT ALL INFORMATION)

Name:____ **Date of Birth:**______________________

SEX: ◯ Male ◯ Female

ETHNIC GROUP/RACE; ◯ White ◯ Black ◯ Hispanic

◯ Asian or Pacific Islander ◯ American Indian or Alaskan Native

Address:____**Home Phone:**_________________________

City:__________________________________ **Zip:**____________**Mobile Phone:**_________________________

SPOUSE/PARENT/GUARDIAN INFORMATION

Spouse:____________________________________ **Parent/Guardian:**__________________________________

Address:____________________________________ **Address:**____

City:__________________________**Zip:**__________ **City:**_______________________________**Zip:**__________

FINANCIAL INFORMATION/CERTIFICATION

ALL household members MUST provide Income Verification. Documents accepted are either the most recently filed 1040 Tax Return or current Social Security Benefit Statement. If you do not have either of these documents, please call our office at 727-312-3881 or email clinic@ familyhearinghelp.org before submitting this application.

If you are submitting electronically, please submit verification here:

There is/are ____________(Total #) person/people in my household.
TOTAL GROSS HOUSEHOLD INCOME (before taxes) $___________________________ for the **past year**.

I certify that the information contained in this application for assistance is true to the best of my knowledge. I understand that **Sertoma Speech & Hearing Foundation of Florida, Inc. (Sertoma)** may verify any of the above information. I understand that Sertoma has the right to cancel my assistance and collect full fees for services in the event of finding any information fraudulently submitted while I am involved with any of their programs in accordance with **Florida Statute 817.50**, which states that, "Whoever shall, willfully and with intent to defraud, obtain or attempts to obtain goods, products, merchandise, or services from any healthcare provider in this state commits a felony in the third degree."

____ ______________________________________

Patient/Guardian Signature **Date**

Completed application/Income Verification can also be sent to one of the following:
Email: clinic@familyhearinghelp.org Fax: 727-807-6172 or
USPS Mail: Sertoma Speech & Hearing Foundation 5211 US Hwy 19, Ste 200 New Port Richy, FL 34652

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By my signature below, I understand that I have certain rights to privacy regarding my protected health information. I understand that **Sertoma Speech & Hearing Foundation of Florida, Inc. (Sertoma)** can and will use my health information for purposes of my treatment, payment for treatment and health care operations. I understand that Sertoma may use and share my protected health information for other purposes as described in the **HIPAA Notice of Privacy Practices (Notice)**. I understand that Sertoma has the right to change the Notice from time to time and I can review and obtain a current copy of the Notice at any time.

This form must be renewed one year from the Date of Signing listed below

Date of Signing: ____________________________

Patient Name: ____

Patient Date of Birth (MM/DD/YYYY): ____

Patient/Patient's Representative Signature: ____

IF YOU ARE SIGNING AS THE PATIENT'S REPRESENTATIVE:

Print your name: ____

Describe your authority: ____

Internal Use Only:

Good Faith Effort to Obtain Acknowledgement Form

Patient Name: ____ Date: _____________________

I attempted to obtain the patient's (or their representative's) signature on this Notice of Privacy Practices Acknowledgement Form, but was unable to do so as documented below:

Reason: ____

Printed Name: ____________________________ Signature: ________________________________

AUTHORIZATION TO RELEASE PATIENT INFORMATION

In accordance with HIPAA regulations, we are required to have a signed consent form on file before releasing any patient information to anyone other than the patient. If you wish to allow or deny the release of your medical and/or financial information to any individual or facility, please complete and sign this form. **You have the right to revoke your consent in writing at any time, except where we have already made disclosures in reliance on your prior consent. I authorize Sertoma Speech & Hearing Foundation of Florida, Inc. (Sertoma) to speak with, discuss appointments, as well as release my records and any requested information to the individuals/facilities listed below:**

Name/Facility____Relationship to Patient__________________________

Address____Phone Number_________________________

Name/Facility____Relationship to Patient__________________________

Address____Phone Number_________________________

Name/Facility____Relationship to Patient__________________________

Address____Phone Number_________________________

Additionally, I authorize Sertoma to release information regarding my share of Cost for services to the following individual(s), group(s), or individual(s) associated with the below group(s) and/or Insurance Company(ies):

____

AUTHORIZATION REGARDING PHONE MESSAGES

(Please check all that apply)

- ☐ I authorize Sertoma to leave a detailed message on the authorized phone number(s) listed below regarding appointments only.
- ☐ I authorize Sertoma to leave a detailed message on the authorized phone number(s) listed below regarding medical treatment, test results, or financial information.
- ☐ I authorize Sertoma to leave a message with anyone who answers the authorized phone Number(s) listed below.
- ☐ I authorize Sertoma to text this authorized **mobile phone number**______________________ with information regarding appointments, medical treatment, test results, or financial information.
- ☐ Sertoma may only leave messages on the authorized phone number(s) listed with the following person(s).

Authorized person______________________________________Authorized phone number___________________________

Authorized person______________________________________Authorized phone number___________________________

****

Authorizations on this form are for Patient (Print Name)____

Patient/Spouse/Guardian Signature (Circle One)_____________________________________**Date**______________

SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC. RELEASE OF INFORMATION FOR PATIENT CARE, EDUCATIONAL, PROMOTIONAL, AND FUNDRAISING PURPOSES

FOR ADULT PATIENTS

I understand that release of information regarding my care and treatment may assist others with training, education, or research. I have been asked by **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** for permission to use any and all records of my care and treatment that may be used for patient care purposes, in training, education, and research.

I further understand that photographs, movies, or videotapes may be taken of my care and treatment and authorize the use of said photographs, movies, or videotapes for the purposes of training, education, and research provided that no disclosure of my name be in any presentation or publication.

I hereby understand that information regarding my care and treatment and the photographs, movies, and videotapes taken of my care and treatment may be used by **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** in promotional materials and for publicity purposes.

I hereby authorize **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** to utilize my records, photographs, movies, or videotapes for publicity purposes and further authorize the same to publish all or portions of said records, photographs, movies, and videotapes for said purposes. I authorize, for the purposes of publicity, release of my name and information regarding care and treatment.

I further understand that **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** in releasing this information for the purposes set forth above shall have NO responsibility of liability for the use of said information by **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** from any and all liability or claim that might arise in understanding any filming or in the use of the records, photographs, movies or videotapes of me, ____.

(PRINT PATIENT'S FIRST AND LAST NAME)

I AGREE TO ALL OF THE ABOVE

Date:______________________________

______________________________ ______________________________

Patient Printed Name **Patient Signature**

SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC. RELEASE OF INFORMATION FOR PATIENT CARE, EDUCATIONAL, PROMOTIONAL, AND FUNDRAISING PURPOSES

FOR PEDIATRIC PATIENTS

I (we) understand that release of information regarding my (our) child's care and treatment may assist others with training, education, or research. We have been asked by **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** for permission to use any and all records of my (our) child's care and treatment that may be used for patient care purposes, in training, education, and research.

I (we) further understand that photographs, movies, or videotapes may be taken of my (our) child's care and treatment and authorize the use of said photographs, movies, or videotapes for the purposes of training, education, and research provided that no disclosure of my (our) child's name be in any presentation or publication.

I (we) hereby understand that information regarding my (our) child's care and treatment and the photographs, movies, and videotapes taken of my (our) child's care and treatment may be used by **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** in promotional materials and for publicity purposes.

I (we) hereby authorize **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** to utilize my (our) child's records, photographs, movies, or videotapes for publicity purposes and further authorize the same to publish all or portions of said records, photographs, movies, and videotapes for said purposes. I (we) authorize, for the purposes of publicity, release of my (our) child's name and information regarding care and treatment.

I (we) further understand that **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** in releasing this information for the purposes set forth above shall have NO responsibility of liability for the use of said information by **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** from any and all liability or claim that might arise in understanding any filming or in the use of the records, photographs, movies or videotapes of my (our) child, ____.

(PRINT CHILD'S FIRST AND LAST NAME)

I AGREE TO ALL OF THE ABOVE

Date:______________________________

____ ____

Patient's Parent/Guardian Printed Name **Patient's Parent/Guardian Signature**