Center for Vocal Health

Privacy Practices

Below is information on how Center for Vocal Health will use/disclose your health information. Center for Vocal Health is required by law to make a concerted effort to protect patient information and privacy. Center for Vocal Health will alert patients of any suspected breach of information if applicable. Center for Vocal Health will provide a copy of your medical records from our clinic upon request. If you have any questions, requests, or complaints, please alert the manager on duty.

Patients Legal Name_____

Signature _____

Date_____

Authorization of Health Information

By signing below, I authorize Center for Vocal Health, Inc. to use and disclose my medical, financial, and all other personal health information for the purposes of providing me with treatment, collecting payment, and discussing my information with other staff to accomplish this.

Patient's Legal Name _____

Preferred Name _____ Pronouns _____

Signature of Patient _____
Legal Guardian (if applicable)_____

Date_____

(This authorization automatically expires one year after the signature date above)

I authorize Center for Vocal Health to share and discuss my information with the following person in addition to the healthcare professionals related to my care:

Name_____

Relationship_____

(Updated 9/19/2023)

Center for Vocal Health

Practice Policies - Payment

Patient copays are due at time of service.

If you have a deductible plan, Center for Vocal Health will bill your insurance for the provided services. A portion of your deductible will be collected at the time of service.

You are responsible for all insurance copays, coinsurance, deductibles, and/or any other expenses not paid to Center for Vocal Health by your insurance.

Our office will file the claims with insurance carriers with whom we have contracts, however, the guarantor is responsible for all fees, regardless of insurance coverage.

Time with our patients is very important to us. Consistent attendance at your scheduled therapy sessions is required for progress in therapy. Out of the courtesy to your treating therapist, other patients, and our office staff we require **a 24 hour notice for cancellations**. Cancellations not made within the timeframe and no-show appointments will result in **a $50 fee**.

You will be responsible for these charges as insurance companies do not pay for no-shows or late cancellations.

Accounts more than 90 days past due may be turned over to a collection agency.

I have read all of the above information and understand and agree to all provisions therein regarding responsibility for payment.

Patient/Guardian Signature_____ Date _____

(Updated 9/19/2023)