THE UNIVERSITY *of* NORTH CAROLINA
GREENSBORO
School *of* Health *and* Human Sciences

UNCG Speech and Hearing Center
Department of Communication Sciences & Disorders

CLIENT INFORMATION

Today's Date ______________________________ Check one: New Client ☐ Returning Client ☐

Client's Name (First/MI/Last): ______________________________

DOB (mm/dd/yyyy): ______________________________ Gender: Male ☐ Female ☐ Other ☐

Address: ______________________________

City: ______________________________ State: ____________ Zip: ____________

Preferred phone for messages: ____________________ Alternative phone: ____________________

Are you a US Citizen? Yes ☐ No ☐ Are you currently a student or employee at UNCG? Yes ☐ No ☐

Are you currently a student or employee at an area college? Yes ☐ No ☐ Where? ____________________

Emergency Contact Person (First/Last): ______________________________

Relationship to Client: ______________ Phone: ______________ Alternative Phone: ______________

Complete this section if the client is under age 18 years or is 18 years and over with a legal guardian.

Legal Guardian (First/Last): ______________________________ Relationship to Client: ____________

Address: [Check here if same as above ☐] ______________________________

City: ______________________________ State: ____________ Zip: ____________

Preferred phone for messages: ____________________ Alternative phone: ____________________

Complete this section if you have Medicare Part B coverage.

The Center requires a doctor's referral and a copy (front and back) of your valid Medicare and Supplemental and/or Secondary insurance cards in order to bill Medicare. Medicare does not guarantee payment.

Primary Medicare Insurance Company: ______________________________

Policy or ID #: ______________________________

Secondary and/or Supplemental Insurance Company: ______________________________

Policy or ID #: ____________________ Group # (if applicable) ____________________

I understand that payment in full is required on the day of service. I authorize payment of medical benefits to the UNCG Speech & Hearing Center for services rendered.

Signature: ______________________________ Date: ____________

[Client or Legal Guardian]

(See back re: e-mail)

UNCG Speech and Hearing Center
The University of North Carolina at Greensboro (UNCG)

Client – Provider E-mail Communication Form

http://provost.uncg.edu/documents/hipaa/hipaacommform.pdf

I request that workforce members of the **UNCG Speech and Hearing Center** (the Provider) at the University of North Carolina at Greensboro (UNCG) use electronic mail (e-mail) to communicate clinical information to me pertaining to health care services that I have received or may receive in the future. I acknowledge and understand that e-mail communication may contain my personal and private healthcare information including, but not limited to, my name, address, date of birth, types and dates of health care services received, Medicare coverage information, and messages regarding appointments. I understand that, although the Provider and UNCG may attempt to protect the privacy of the contents of email sent to me and will take reasonable measures to protect my privacy, ***the e-mail messages sent to me are not encrypted and travel over the Internet. As a result, there is a risk that the e-mail will be intercepted and read by unauthorized third parties.*** In requesting the Provider to send me e-mail, I assume this risk.

I also acknowledge and understand the following as it relates to these e-mail communications:

1. I will never use E-mail to contact the Provider about emergency medical or mental health matters.
2. I will do my best to not use e-mail for discussion of sensitive or highly confidential issues; for example, mental health, substance abuse, communicable disease, etc.
3. Employees of UNCG and the Provider such as faculty, students and health care staff members that are permitted access to my medical records may also have access to my e-mail address and the contents of emails between the Provider and me.
4. I, and not the Provider or UNCG, am responsible for the security of e-mail communications sent from or stored on my computer.
5. My decision to request that the Provider communicate with me by e-mail is voluntary, and treatment is not conditioned upon my election to do so.
6. The Provider or I may stop e-mail communication at any time for any reason. The Provider retains the discretion to deny this request and/or to communicate with me by other means.
7. I agree to notify the Provider when my e-mail address changes.
8. I will not hold the Provider, UNCG or their employees responsible for damages resulting from the use of e-mail or the failure of any information systems used to facilitate e-mail communication.

I request that the Provider send my clinical information to my e-mail address, which is (complete below):

E-mail Address (Print clearly): ______________________________

Client Name (Print): ______________________________ ***Date:*** ______________

Client or Legal Guardian Signature: ______________________________

☐ **I DO NOT WISH TO COMMUNICATE VIA E-MAIL.**

Keep in the Client's Record [some portions taken from University of Chicago Form]