



Better Speech & Swallow Corp.

BETTER SPEECH & SWALLOW CORPORATION'S PLEDGE REGARDING YOUR MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive through Better Speech and Swallow Corporation. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or received by the company, whether made by personnel or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. Your doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

1. Make sure that medical information that identifies you is kept private, and will be used or disclosed only as described by this Notice or applicable law;
2. Give you this Notice of our legal duties and privacy with respect to medical information about you; and
3. Follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose your medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

For Treatment

We will use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other therapy personnel who are involved in taking care of you.

For Healthcare Operations

We will use and disclose medical information about you for business Operations. These uses and disclosures are necessary to run the company and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.

Reminders

We may use and disclose medical information about you to contact you in an effort to provide appointment reminders for medical care.

As Required By Law

We will disclose medical information about you when required to do so by federal, state, or local law.

Individuals Involved in Your Care or Payment for Your Care

- We may release medical information about you to a friend or family member, who is involved in your medical care, has power of attorney or a similar document provided to us. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we will disclose medical information about you in response to a valid court or administrative order, or in the course of defending ourselves.

- For Law Enforcement Purposes when asked to do so by a law enforcement official when required,
- To Coroner, Medical Examiners, and Funeral Directors as necessary to assist them to carry out their duties.

WRITTEN AUTHORIZATION

Except as described above, we will disclose your medical information only with your prior written authorization. You may revoke that authorization, in writing, at any time, unless we have taken action relying on your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes and other mental health records under certain circumstances.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Company of Better Speech and Swallow. If you request a copy of the information, we may charge a fee for the cost of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy medical information in certain very limited circumstances, including requests by an inmate at a correctional institution, requests for information we obtained from someone else subject to certain confidentiality agreements, and some requests concerning ongoing research projects.

If you are denied access to medical information for any other reason, you may request that the denial be reviewed. Another licensed healthcare professional chosen by Better Speech and Swallow will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the company.

To request an amendment, your request must be made in writing and submitted to the company. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
2. Is not part of the medical information kept by or for Better Speech and Swallow;
3. Is not part of the information which you would be permitted to inspect and copy; or
4. Is accurate and complete.

If we deny your request, you may submit a written statement disagreeing with the denial. We will keep your statement on file and distribute it with all future disclosures of the information to which it relates.

Right to Request Restrictions

You also have the right to request a limit on the medical information we disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit of the medical information we disclose about you to someone who is involved in your care, or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Better Speech and Swallow Corp president. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Confidential Communications

You have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. All reasonable requests will be granted.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. Complaints about this Notice of Privacy Practices or how we handle your health information should be directed to:

Better Speech and Swallow Corporation:
c/o Karen J. Sowers
2814-B Wildwood Ct.
Walkersville, MD 21793



Better Speech & Swallow Corp.

A Statement to Our Patients

Better Speech and Swallow Corporation staff contribute to the health and well-being of our patients by providing quality healthcare as prescribed by those who are treating you. We want you and your family to know your rights, as well as your responsibilities, as a patient receiving services our company. We encourage you to talk openly with those caring for you.

Quality Healthcare

- We work together to coordinate your healthcare needs for prevention, diagnosis, treatment, rehabilitation, comfort, care and support.
- We do our best to provide clear, complete healthcare information and to answer your questions in a language you understand. Interpretation services are available.
- We will work with you to appropriately assess and manage pain you may experience. In addition, staff will seek to educate you about effective pain management practices.
- We provide equal access to needed healthcare, without regard to race, religion, color, creed, national origin, age, sex, handicap or source of payment.

Safe, Considerate and Respectful Care

- We tell you who we are and what we do. We call you by your name and take time to listen to you.
- We honor your privacy and protect the confidentiality of your healthcare information.
- We are committed to providing a medically safe, secure and healing environment.
- We respect your personal values, beliefs, and cultural heritage.

Care That Involves You and Your Family

- If you have a concern or suggestion, we encourage you to tell us in person, by phone or in writing. We will review your comments objectively and address them with you openly and without retribution.
- If you decide to refuse treatment or change your mind about a procedure for which you have given consent, we will respect your decision and inform you of the medical consequences and any options.
- If you choose, we will involve your family in your care as much as possible.

Please Help Us to Help You

- You know yourself best. We need to know about your symptoms, past treatments, medicines and other illnesses, and any pain you may experience.
- Please share these so that together we may plan the best care for you or your family.
- Please immediately report to our staff any situation that appears unsafe.
- We ask you to be responsible for doing the things you agree to do in your plan of care and to meet your financial obligations. If you cannot follow your healthcare plan for any reason, please tell us.
- Your long term health depends not only on care received by our company, but also on decisions you make in your daily life. Take time to recognize the effect of your lifestyle on your personal health.

A Statement to Infants, Children & Teens

Additionally, we want you to know:

- We provide care that respects your need to grow, play and learn. People who have experience with infants, children and teenagers will care for you.
- We will work with you and your parents to plan the care that is best for you. We want your parents to be as involved as they desire, and to feel free to ask any questions they may have regarding your treatment and care.
- For your comfort, a parent may stay with you during your treatment sessions.

If you have any questions or concerns related to the care received by our company "Better Speech and Swallow Corporation", please feel free to contact us in writing at:

Better Speech and Swallow Corporation
2814-B Wildwood Court
Walkersville, MD 21793



Better Speech & Swallow Corp.

Better Speech and Swallow Corporation

Patient: _____ DOB: _____

Current Residence: _____

Primary Care Physician Ordering Services: _____ Ph# _____

Consent and Financial Responsibility:

- 1. CONSENT FOR TREATMENT:** I hereby understand that I am under the care of my attending or treatment physician. I have been informed of the nature and purpose of medical treatment, procedures and services to be provided to me at my residence and of the risks involved. I have also been informed about alternative treatment, procedures and services. I have had the opportunity to ask questions of my physician and of the staff of Better Speech and Swallow Corporation. I voluntarily consent to receive home rehabilitative services as ordered by my physician.
- 2. STATEMENTS OF PATIENTS:** I acknowledge I have been provided and have had explained to me "A Statement to Patients" which describes my rights and responsibilities as a patient of Better Speech and Swallow Corporation.
- 3. DECISION ABOUT CARE:** I have received information and instructions concerning my rights to make decisions about my health care, including the right to refuse treatment.
- 4. AUTHORIZATION FOR RELEASE OF INFORMATION:** I understand that all information concerning my care is confidential. I authorize Better Speech and Swallow Corporation to release to my physician and other health care providers any information related to the provisions of services that may have an effect on the continuation of plan of care for services rendered.
- 5. FINANCIAL RESPONSIBILITY:** I will be responsible for payment of all speech services delivered to me by Better Speech and Swallow Corporation staff. All services will be paid for privately at the time services are rendered.

Checks payable to:
Better Speech and Swallow Corp.

EVALUATION CHARGE: _____

FOLLOW UP per VISIT CHARGE: _____

If a check is returned by the bank for any reason, an additional fee of \$40 to the patient will be charged. Future follow up visits will not be scheduled unless account is paid to date at the time services are rendered. An additional late fee of \$20 (per month) will be charged for any balance still owed following completion of services rendered.

Prepared by: _____ Date: _____

Patient Signature: _____ Date: _____

Responsible Party: _____ Date: _____

Relationship if other than patient: _____