Idaho State University

ISU Speech and Language Clinic
1311 E. Central Dr., Meridian, ID 83642
Phone: 208.373.1725 / Fax: 833.390.1293

Adult Patient Profile

Patient Name: _____ **DOB:** _____

Person Completing Form: _____ **Age:** _____

Emergency Contact: _____ **Phone No.:** _____

Address: _____ **City & Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Is it ok for us to leave a message regarding your treatment at the following #s?

Home: ☐ Yes ☐ No **Cell:** ☐ Yes ☐ No

Reasons for Rehabilitation

Diagnosis/Conditions/Reasons you are seeking rehabilitation services: _____

_____

_____

Your Primary goal for therapy is to be able to? _____

_____

_____

Things you would like to do at home that you cannot do right now (e.g., talking on the phone, daily activities, hobbies, etc.)

_____

_____

Activities you would like to do in the community that you cannot do right now (e.g., public speaking, going out to eat, ect.)

_____

_____

Health History

Do you have (or have you had) any of the following conditions? Please check all that apply.

Heart Disease	☐ Y ☐ N	Thyroid Disorder	☐ Y ☐ N	Bowel Issues	☐ Y ☐ N
Stroke	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N	Seizures	☐ Y ☐ N
High Blood Pressure	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Bleeding Disorder	☐ Y ☐ N
Lung Disease	☐ Y ☐ N	Arthritis	☐ Y ☐ N	Asthma/Hay Fever	☐ Y ☐ N
Cancer	☐ Y ☐ N	Headaches/Migraines	☐ Y ☐ N	Swallowing Issues	☐ Y ☐ N
Head Injury	☐ Y ☐ N	Concussion	☐ Y ☐ N	Other:_____	☐ Y ☐ N

Are you or could you be pregnant? ☐ Yes ☐ No

How would you describe your general health? ☐ Good ☐ Fair ☐ Poor If fair/poor, please explain:

_____

_____

Have you recently been or have you ever been hospitalized related to the condition for which you are seeking treatment? ☐ Yes ☐ No If yes, please provide the following information:

When: _____ **Where:** _____

How Long (Admit/Discharge Dates): _____

Have you experienced significant weight change (loss or gain) in the past 6 months?

☐ Loss ☐ Gain ☐ No Change If yes, how many pounds? _____

Was the change in weight intentional or expected? ☐ N/A ☐ Yes ☐ No

List any dietary restrictions (diabetic, food allergies, etc.): _____

_____

Are there any other health problems that you would like us to know about? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you use a wheelchair, walker, or other assistive device for mobility? ☐ Yes ☐ No

If yes, identify which type of device: _____

Do you have any balance problems? ☐ Yes ☐ No

Do you have left or right sided weakness? ☐ Yes ☐ No If yes, which side: _____

Have you had any previous surgeries? ☐ Yes ☐ No If yes, please explain below.

	Surgery/Procedure	Month/Year
1.		
2.		
3.		
4.		

Do you have any allergies? ☐ Yes ☐ No If yes, please list any allergies and the reaction you experience to each below (e.g., allergies to medications, latex, foods, products, etc.)

	Allergen	Reaction
1.		
2.		
3.		
4.		
5.		

Medications:

Are you currently taking any medication? ☐ Yes ☐ No If yes, please list below.

1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Previous Therapies:

Type of Therapy	Dates	Agency	Name of Therapist
Speech Therapy			
Physical Therapy			
Occupational Therapy			
Psychological/Counseling			
Other Rehab			

Special Needs: (Please check all that apply)

Vision: ☐ No Problems ☐ Glasses/Contact Lenses ☐ Visual Difficulties ☐ Glasses for Reading ☐ Require Enlarged Print

Communication: ☐ No Problems ☐ Difficulty Reading ☐ Difficulty Writing

☐ Communication Needs/Devices/Assist, please specify: _____

_____

Hearing: ☐ No Problems ☐ Hearing Aid(s) ☐ Difficulty Hearing

Living Situational/Level of Independence:

Home Type: ☐ Mobile/Trailer ☐ Single Level ☐ Split Level ☐ Multi Story ☐ Apt./Condo/Townhouse

☐ Other: _____ # of Steps to Main Living Space: _____

Live With: ☐ Spouse or Significant Other ☐ Grown Children ☐ Friend(s) ☐ Alone ☐ Caregiver

☐ Assisted Living ☐ Long-Term Care Facility ☐ Other: _____

Independence: Please rate your ability to perform the activities below, using the letters I = Independent A = Assistance

Bathing/Grooming _____ Dressing _____ Household Chores _____ Stairs _____ Driving _____

Education/Work History:

☐ _____ Grade ☐ High School Diploma ☐ Assoc. Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Post Graduate

I learn best by: ☐ Discussion ☐ Demonstration ☐ Written Language ☐ Videos ☐ Other: _____

Is there any information or education that you would like your therapist to provide to you? ☐ Yes ☐ No

If yes, please explain: _____

Work Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Medical Leave ☐ Retired

Occupation: _____ **Do you have any vocational concerns?** ☐ Yes ☐ No

Psychosocial History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children (how many): _____ **Ages:** _____

Is there anything in your home environment that causes concern(s) for your safety or for other family members?

☐ Yes ☐ No If yes, please explain: _____

Do you have any special cultural, religious, or spiritual practices that you would like us to recognize/address while here?

☐ Yes ☐ No If yes, please explain: _____

Are you experiencing any of the following: ☐ Loss of interest in previously enjoyed activities ☐ Feelings of Hopelessness

Below are words to describe your personality and behavior. Circle all that apply and underline all that you had before your accident/stroke/diagnosis.

Happy	Aggressive	Depressed	Enthusiastic	Friendly
Warm	Independent	Energetic	Distractible	Jealous
Tense	Prefers to be Alone	Dependent	Affectionate	Relaxed
Critical	Easily Fatigued/Tired	Directive	Can't Sleep	Impatient
Shy	Vigorous	Calm	Irritated	Angry

List description(s) not listed above: _____

Personal Interests/Activities:

What are your favorite leisure activities/hobbies? _____

What are your favorite TV shows? _____

What magazines/books/newspapers do you read? _____

Do you like to talk on the phone? ☐ Yes ☐ No

Do you use the internet/email? ☐ Yes ☐ No

Is there anything else you would like us to know that would help us to best serve your needs?

_____

_____

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Consent for Participation

I _____, give permission for the faculty and students of the Idaho State University Speech and Language Clinic to use information gathered from my participation in educational training. I understand that students, under the supervision of fully licensed and certified faculty clinicians, will be observing and conducting my treatment and/or evaluation as part of the student's education, and direct supervision may occur onsite or via secure remote access from a different location. In addition, I also understand that students in the educational process will be reviewing my evaluation and treatment results and records.

I understand that the treatment and/or evaluation will be observable by patient family members through the group observation area. I am aware that other parents, guardians, and family members will also be in the observation sessions and may be able to see or hear my child's and/or family member's therapy session.

I understand that as part of the treatment and/or evaluation process, aspects of the process will be videotaped for the educational process of the student, for analysis of patient communication, and for educational activities within the department. These videotapes will be used in the treatment and/or assessment process and will be destroyed when the information gathering process is complete or will be kept in a secure location within the department.

I understand that I can withdraw from my participation at any time during this experience and revoke my permission to use the information pertaining to my case. If I elect to withdraw and revoke my permission, I will inform the Clinic Director and the Department Chairperson of this action in writing. I further understand that a copy of this form will be given to me upon my request, and the original will be kept on file in the Department of Communication Sciences & Disorders.

The Idaho State University Speech and Language Clinic does not discriminate against any person on the basis of race, religion, color, creed, national origin, disability, age, gender, sexual orientation, gender identity, genetic information, veteran status or any other status protected by federal, state or local law in admission, treatment, or participation in its programs, services and activities.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative *Date*

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

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Telehealth Patient Consent Form

Purpose: The purpose of this form is to get consent for participation in a model of healthcare called telehealth. Telehealth involves the use of electronic communications to enable healthcare providers to share individual patient medical information for the purpose of improving patient care and providing care at a location separate from the provider. ISU will be using ZOOM remote technology to evaluate/re-evaluate virtually as well as provide speech-language therapy.

What is a Telehealth Consultation: Telehealth is a tool used to help people who cannot go to a healthcare provider's office to receive an examination or consultation. Telehealth uses electronic records including your health history and other information. Your consultation with the provider and these records will be used to address your health concerns or recommend further treatment.

What are the Risks, Benefits, and Alternatives?: The benefits of telehealth include having access to a healthcare provider without travelling to a provider's office or clinic. A potential risk of telehealth is that a face-to-face consultation with a healthcare provider may still be necessary after the telehealth appointment. At any time during the consultation, you may choose to end the session and seek care in our clinic based on availability.

Confidentiality: Current federal and Idaho laws about confidentiality apply to the information used or disclosed during your telehealth consultation. In rare cases, some of your records may unintentionally become available to people not connected with the consultation. You will be provided with a separate document, which describes how your private information will be handled. This is known as the "Notice of Privacy Practices."

Rights: You may choose not to participate in a telehealth therapy session at any time before and/or during the consultation. If you decide not to participate it will not affect your right to future care or treatment. You have the option to seek consultation or treatment in an office at any time before or after the telehealth consultation.

Fees associated with Telehealth: We have not changed our fee structure and will not be billing insurance for visits performed by Student Clinicians.

I have read and understand the information provided above regarding telehealth, have discussed it with my provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

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Photo, Interview and Media Consent Form

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Idaho State University Speech and Language Clinic and its affiliates and agents to take photographs or produce videotapes, audiotapes, electronic files, or other types of media production that capture my name, voice, and/or image, to be used for publicity purposes including:

- News media (online, print and or broadcast)
- Publications and/or promotional materials
- Closed circuit television programs
- Advertisements
- Websites and social media
- Medical and educational training and promotion
- Recruiting professional

The information to be disclosed includes (check all that apply):

- ❑ Photographic images of me
- ❑ Video or audio of me and/or my voice
- ❑ Information about my medical condition and/or prognosis
- ❑ Information about date(s), time(s), and type(s) of treatment received
- ❑ Other: _____

This authorization will be used by the Department of Communication Sciences & Disorders, Education of the Deaf at Idaho State University for a period not to exceed 10 years from the date of this authorization.

I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to ISU's Privacy Officer:

ISU HIPAA Compliance Officer:

Misty Olmsted
921 S. 8th Avenue, Stop 8410
Pocatello, ID 83209
(208) 282-4380
Email: HIPAA@health.isu.edu

I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative *Date*

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

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Notice of Disclosure

The purpose of the ISU Speech and Language Clinic is to provide training for graduate students. Graduate students observe, evaluate, and treat clients under the direct supervision of a licensed faculty clinician. While all services provided are supervised under program guidelines developed by the American Speech-Language-Hearing Association (ASHA), these services are often considered non-covered by insurance as defined below.

- **Medicare / Medicaid Participants**: We understand that you may have recently completed therapy under a certified plan of care with another speech therapist. We further understand that, even if your prior therapist has concluded that you have completed the course of therapy under that plan of care, you would like to continue working with our speech therapy students on the skills you have learned, to improve your general welfare, and to support the training mission of the Speech and Language student training program.

  Since the Medicare / Medicaid program does not cover services furnished under the policies and procedures of the student training program, you will be personally responsible for the fee established by ISU for the services provided by students in training. No Medicare / Medicaid payment may be made and, accordingly, no claims will be submitted to Medicare / Medicaid for these services.

- **Private Insurance:** Under our current insurance contracts, services furnished under the policies and procedures of the student training program are considered non-covered. Therefore, you will be personally responsible for the fee established by ISU for the services provided by students in training. No insurance payment may be made and, accordingly, no claims will be submitted to your insurance for these services.

While participating in the student training program, you will receive periodic evaluations by students under the supervision of their instructors as part of their training. If those evaluations reveal that your condition may warrant further evaluation by your physician and qualify as covered services under a new speech therapy plan of care, we would recommend that course of action to you and refer you to another clinic.

Regular attendance is critical to our student's learning experience. Patients with excessive cancellations and/or no shows will be discharged from our program.

The initial evaluation fee is $75.00 (charged annually) and the individual therapy session fees for the semester are combined into a flat fee of $350. The semester fee of $350 covers a minimum of 20 visits per semester. Opportunities for make-up sessions will be available for cancellations. The preschool group only fee is $150 per semester which meets twice a week.

As a client of the ISU Speech and Language Clinic, I understand that my insurance will not be billed for student services and that I will not submit a claim for these non-covered services. I also understand the attendance policy and will strive to attend regularly. I also understand that my account needs to be in good standing to participate in the program.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative *Date*

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Application for Fee Assistance

Contact Information:			
Patient Name:		**DOB:**	
Street Address:		**Phone:**	
City and State:		**Zip Code:**	

Household:			
Total Number in Household:			
Self			
Spouse or Partner			
Child		**Child**	
Child		**Child**	
Child		**Child**	

Income:	
Gross Monthly Income BEFORE Taxes *(Include both spouses if working)*	$
Other Income *(Unemployment, Social Security, Child Support, etc.)*:	$
TOTAL MONTHLY INCOME:	$
TOTAL ANNUAL INCOME:	$

Required Income Documentation: ***(must be received within 2 weeks of first visit)***

Employed: Most recent tax return or most recent pay stubs (2)
Unemployed: Public Assistance check stub/copy; Social Security check stub or Letter of Award; Certification Letter from Medical Assistance or Department of Social Services

I certify that the income and household composition information is true and correct to the best of my knowledge. I agree to notify Idaho State University of any income changes that may affect my eligibility in this program.

_____

Patient/Guardian Signature: **Date:**

Clinic Use Only: Cindy Rock (208) 373-1743

Sliding Scale Discount: %

_____

Approved By: **Date:**

Updated: 03/19/21

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Acknowledgement of Receipt of Notice of Privacy Practices

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices.

I acknowledge that I have received a copy of the ISU Speech and Language Clinic Notice of Privacy Practices.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative *Date*

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices.

1. Does the patient have a copy of the Notice of Private Practices? ☐ Yes ☐ No
2. If you answered "No" above, please explain why the patient did not sign acknowledgment form:

   ☐ Patient/individual refused to sign _____ (Date of Refusal).
   ☐ Communication barriers prohibited obtaining an acknowledgement.
   ☐ Legal representative not available.
   ☐ Patient bypassed registration.
   ☐ An emergency situation prevented ISU from obtaining an acknowledgement.
   ☐ Other: _____
   _____

Completed By: _____ _____
Signature Date

Idaho State University

ISU Speech and Language Clinic
Good Faith Estimate for Health Care Services

Patient			
Patient Name:		**DOB:**	
Address:		**Phone No.**	
		Diagnosis:	
	City *State* *Zip Code*		

Provider Information			
Provider Name:	ISU Speech and Language Clinic	**NPI:**	1952474777
Address:	1311 E. Central Dr.	**Tax ID:**	82-6000924
	Meridian, ID 83642		
Contact:	Cindy Rock	**Phone No:**	(208) 373-1743
Email:	rockcind@health.isu.edu		

Service Provided			
Service	**Quantity**	**Expected Cost**	
Initial Evaluation	1 x Annually	☐	$75.00
Individual Therapy Sessions (Appr. 20 sessions)	Semester	☐	$350.00
Preschool Group Therapy	Semester	☐	$150.00
Total Expected Charges from Idaho State University			
	TOTAL		

Additional Health Care Provider Notes:

This Good Faith Estimate does not include any discounts or sliding scale rates as these are our standard rates. Sliding scale rates apply to those who qualify based on family size and income.

☑ Check if Service is reoccurring. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

Idaho State University

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Notice of Privacy Practices

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.

Our Legal Responsibility

At Idaho State University, we are committed to protecting our patients' personal and health information. Under the Health Insurance Portability and Accountability Act (HIPAA) federal law gives individuals a fundamental right to be informed of the privacy practices of their health care providers, as well as to be informed of their privacy rights, with respect to their personal health information. We are legally required to protect the privacy of your health information, and to give you this Notice about or legal duties, privacy practices, and your rights with respect to your health information.

In this Notice, personal and health information is referred to as "health information" and includes your name, age, address, income or other financial information. We follow the privacy practices described in this Notice, while it is in effect. This Notice takes effect December 1st and will remain in effect until replaced.

If you have any questions about this Notice, if you want to exercise any of your rights listed in this Notice, or if you feel that your privacy rights have been violated, please contact ISU's HIPAA Compliance Officer, Misty Olmsted at (208) 282-4380 or by email at hipaa@health.isu.edu.

Protecting your Health Information

We protect your health information by:

- Maintaining the privacy and security of your health information as required by law.
- Letting you know if a breach occurs that may have compromised the privacy or security of your information.
- Following the privacy practices described in this notice and giving you a copy.

Uses and Disclosures of Your Health Information

We are allowed, by law, to use and disclose your health information with others without your authorization for many reasons. These examples describe different ways we may use or disclose your information. Please note that not each use or disclosure in each category is listed and these are general descriptions only.

- **Treatment**: We may provide another physician or subsequent healthcare provider who is treating you, with copies of various reports of your health information, that should assist them with your treatment.
    - Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
    - Example: We give information about you to your health insurance plan so it will pay for your services.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, training medical students, conducting training and educational programs, accreditation, certification, licensing or credentialing activities.
    - Example**:** We use health information about you to manage your treatment and services.
- **Appointment Reminders:** We may use health information about you to call, leave a voice message, text, email, or send a postcard or letter to you as a reminder about an appointment.
- **Public Health Disclosures:** We may disclose medical information about you for public health reporting purposes, such as preventing or controlling disease; reporting adverse events related to medications or medical products.
- **Law Enforcement:** We may release medical information, as authorized or required by law to identify suspects, fugitives, missing persons or material witnesses, to law enforcement.

- **Criminal Activity:** We may disclose your health information, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- **Abuse or Neglect:** We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law, including, but not limited to, court or administrative orders, subpoenas, discovery requests, other lawful process, or to defend ourselves against a lawsuit brought against us
- **Research:** Under certain limited circumstances, we may use and disclose health information about you for research purposes. All research projects are subject to a special approval process.
- **Organ, eye and tissue donation:** If you are an organ, eye or tissue donor, we may release medical information to organizations that handle organ, eye, or tissue procurement or transplantation; or to an eye, organ or tissue donation bank, as necessary to help with procurement, transplantation or donation.
- **Workers' compensation:** We may disclose medical information about you for Workers' compensation or similar programs as authorized or required by law.
- **Coroners, medical examiners and funeral directors:** We may disclose medical information to a coroner or medical examiner, and to funeral directors, as needed for them to carry out their duties.
- **Government Officials**: As authorized or required by law, we may disclose medical information about you to authorized federal officials so they may conduct special investigations or provide protection to the U.S. President, other authorized persons or foreign heads of state.
- **Business Associate:** We may share your medical information with third-parties referred to as "business associates" that provide various services on the behalf of ISU clinics, such as billing, transcription, software maintenance and legal services.
- **Parental Access:** Some state laws concerning minors permit or require disclosure of protected health information to patients, guardians or persons acting in a similar legal status. We will act consistently with the law of the state where the treatment is provided and will make disclosures following such laws.
- **Fundraising:** We may use or disclose your information in order to contact you for fundraising activities. You have the right to opt out of these fundraising communications.

Uses and Disclosures Made with Your Authorization

There are many uses and disclosures we will make only with your written authorization:

- **To Your Family and Friends:** We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
- **Persons Involved in Care:** We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member of your personal condition, or death. If you are present,

prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

- **Marketing Health-Related Services:** We will not use your health information for marketing without a written authorization from you.
- **Psychotherapy Notes:** Psychotherapy notes, made by your individual mental health provider during a counseling session, expect for certain limited purposes, related to treatment, payment and healthcare operations, or other limited exceptions, including government oversight and safety, will be disclosed with your authorization.
- **Sale of Medical Information:** We will not sell your health information to third parties without your authorization. Except certain purposes that are permitted under the regulations.
- If you give your authorization, you may change or revoke it at any time by giving us written notice. Your revocation will not be effective for uses and disclosures already made.

Your Rights Regarding your Health Information

You have the right to request all of the following:

- **Access to Your Health Information:** You have the right to request and receive a copy of your health information, including all billing information, in paper or electronic form. A reasonable fee may be charged for providing copies. However, this right does not include the following types of records: psychotherapy notes; records compiled in reasonable anticipation of a court action or administrative action or proceeding; and protected health information whose release is prohibited by federal or state laws. Access to your records may also be limited if it is determined that by providing the information it could possibly be harmful to you or another person. If access is limited for this reason, you have a right to request a review of that decision. If we maintain the medical information electronically and you request an electronic copy, we will give the information to you in the format you request, if it is readily available. If we cannot readily get the record in the form and format you request, we will give it in another readable electronic or paper format that we both agree to.
- **Amendment:** You have the right to request, in writing, an amendment to your health information. The request must identify which information is incorrect and an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make reasonable effort to include the amended information in future disclosures. (Amending a record does not mean that health information will be deleted.)
- **Accounting or Disclosures:** If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.
- **Restriction Requests:** You have the right to request that the clinic place additional restrictions on uses and disclosures of your health information. For example, when you have paid for your services out of pocket in full,

at your request, we will not share information about those services with your payer, as long as such disclosure is not required by law. For all other requests, we may not be able to accept your request, but if we do, we will uphold the restriction unless it is an emergency.

- **Confidential Communication:** You have the right to request that communication regarding your health information be done in an alternate way or be sent to an alternate location.
- **Electronic Notice:** If you received this notice by accessing a web site or by email, you are also entitled to have a paper copy which is available by request from the clinic or department.
- **Notification in the Case of a Breach:** We are required by law to notify you of a breach of your unsecured medical information. We will give such notification to you without unreasonable delay but no later than 60 days after we discover the breach.

Changes to this Notice

We reserve the right to change our privacy practices and terms of this Notice at any time, as permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make such changes, we will update this Notice and post the changes in the waiting room or lobby of the facility. You may also request a copy of the Notice at any time.

Questions and Complaints

To file a complaint if you feel your privacy rights have been violated, or if you would like to request a Restriction, request an Accounting of Disclosures or revoke an Authorization, please contact:

Misty Olmsted, HIPAA Compliance Officer
Office of General Counsel
921 S. 8th Ave, Stop 8410
Pocatello, ID 83209
(208) 282- 4380
hipaa@health.isu.edu

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:
US Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.,
Washington, D.C. 20201,
1-877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/
If you choose to make a complaint with us or the U.S. Department of Health and Human Services, we will not retaliate in any way.

Notice of Privacy Practices

Contacts

To Request your medical or billing information please contact the ISU Clinic directly.

ISU Student Health Center- Pocatello 990 Cesar Chavez Ave., Pocatello, ID 83209 Billing Address: 921 S 8th Ave., Stop 8311 Pocatello, ID 83209	ISU Bengal Pharmacy-Pocatello 990 Cesar Chavez Ave., Pocatello, ID 83209 Billing Address: 921 S 8th Ave., Stop 8158 Pocatello, ID 83209	Pocatello Family Dentistry 465 Memorial Drive Pocatello, ID 83209 Billing Address: 921 S 8th Ave., Stop 8088 Pocatello, ID 83209
ISU Speech and Hearing Clinic-Pocatello 650 Memorial Dr., Bldg. 68 Pocatello, ID 83209 Billing Address: 921 S 8th Ave., Stop 8116 Pocatello, ID 83209	ISU Dental Hygiene 999 Martin Luther King Jr. Way Pocatello, ID 83209 Billing Address: 921 S 8th Ave, Stop 8048 Pocatello, ID 83209	ISU PT/OT Clinic-Pocatello 1400 E Terry Dr., Bldg. 63 Pocatello, ID 83209 Billing Address: 921 S. 8th Ave., Stop 8045 Pocatello, ID 83642
ISU Integrated Mental Health 1311 E Central Drive Meridian, ID 83642 Billing Address: Same as Above	ISU Family Dentistry 1311 E Central Drive Meridian, ID 83642 Billing Address Same as Above	ISU Meridian Healthcare 1311 E Central Drive Meridian, ID 83642 Billing Address: Same as Above
ISU Speech & Language Clinic Meridian 1311 E Central Drive Meridian, ID 83642 Billing Address: Same as Above	ISU PT/OT Clinic-Meridian 1311 E Central Drive Meridian, ID 83642 Billing Address: 921 S 8th Ave., Stop 8045 Pocatello, ID 83209	ISU Speech & Hearing Clinic-Salmon 805 Main St. Salmon, ID 83467 Billing Address: 921 S 8th Ave., Stop 8116 Pocatello, ID 83209

ISU Nutrition
1311 E Central Drive
Meridian, ID 83642

Billing Address: Same as Above