Artz Communication Center
1625 19th Ave Seattle, WA 98122
Audiology: 206.323.5770
Speech: 206.388.1300
www.hsdc.org

POLICIES AGREEMENT AND ACKNOWLEDGEMENT OF RECEIPT

Client name:_____

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I received a copy of Hearing, Speech & Deaf Center's Notice of Privacy Practices effective as of September, 2013. The Notice provides information about how HSDC may use and disclose the medical information that we maintain about you. HSDC encourages you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

_____ _____
Printed name of client or personal representative Date

_____ _____
Signature of client or personal representative Date

CLIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

By signing below, I acknowledge that I have read and consent to the financial responsibility disclosure statement.

_____ _____
Signature of client or personal representative Date

GENERAL CLINIC POLICIES

By signing below, I acknowledge that I have read and understand the general clinic policies.

_____ _____
Signature of client or personal representative Date

ATTENDANCE POLICY

By signing below, I acknowledge that I have read and understand the attendance policy.

_____ _____
Signature of client or personal representative Date