Explanation of Services

To Whom This May Concern:

Thank you for your inquiry into our clinical audiology services. The University Hearing and Speech Clinic is a training facility for graduate students preparing for careers in speech-language pathology. As such, it operates on a semester system, with short breaks between semesters during which speech and hearing services are not provided. We make every effort to accept clients for evaluation as soon as possible after referrals are received. The number of clients seen, however, is determined in part by student enrollment and therefore availability and continuity of service cannot be guaranteed. If we are unable to accommodate you, a list of other agencies which provide speech-language and/or audiology services will be made available at your request. We are committed to the fair and equitable treatment of our clients. No individual shall be discriminated against on the basis of race, color, creed, religion, national origin, gender, sexual orientation, age, marital status, disability, or status as a disabled veteran or Vietnam era veteran.

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I have read this explanation of services and understand that enrollment in and continuation of therapy cannot be guaranteed.

Please sign, date and return this form to the clinic secretary.

_________________________  ________________________
Signature                           Date

☐Client  ☐Parent/Guardian  ☐Care Provider
NO SHOW AND CANCELLATION POLICY:
Please notify us 24 hours in advance if you must cancel. A $5 charge may be issued for cancellations with less than 24-hour notice. There will be no charge if 24-hour notice is received. Our policy also requires discontinuing treatment if you miss three (3) appointments without notice.

CHILD SUPERVISION POLICY:
Please supervise your children during your visit. We require that you remain in the clinic area during treatment, in case of an emergency. We cannot assume responsibility for your child's care or supervision before or after the therapy session or the care of siblings during the session. We appreciate your cooperation.

CLINICAL SERVICE AGREEMENT: (Revised 10-1-2010)

Client: ___________________________________________ Date of Birth: ____________________________

Contact Person: ______________________________________________

Current Address: _____________________________________________ City ___________________ State ______

Phone: (h) ___________________ (w) ___________________ Zip Code________________________

Please Indicate Your Method of Payment (✓):
The UPCD Clinic accepts the following insurance on a referral basis: *Please note: Our facility is not a Medicare Provider

- Aetna
- Asuris
- Community Health Plan of Washington (CHPW)
- Department of Social & Health Service - Medical Coupon (State of Washington) Open
- Group Health Options
- Premera Blue Cross
- Molina - Department of Social & Health Service - Medical Coupon (State of Washington)
- PHCO
- Premera Blue Cross/Blue Shield
- Self Pay
- TriWest
- Uniform Medical
- United Healthcare
- Other: ____________________________ (benefits will need to be verified)

Insurance ID #: ___________________________________ Subscriber: ____________________________

SSN of Responsible Party: ______________________________________

PAYMENT FOR SERVICES IS DUE ON THE DATE OF SERVICE. If we are a provider for your insurance company and you have been approved for services, we will, as a courtesy, bill for you; however, you are ultimately responsible for the total cost of services. You will also be responsible for any charges or fees associated with the collection of any unpaid accounts.

Client's Signature (or responsible party) ___________________________ Date ___________________
SLIDING FEE APPLICATION

The University Hearing and Speech Clinic offer a sliding fee schedule for persons with limited incomes. Health insurance coverage will be sought first. The fee adjustment is based on gross income and household size and is good for one university/academic year. Persons with extenuating financial circumstances may also be eligible for a temporary fee adjustment.

*Please complete this form only if you are interested in applying for the sliding fee.

*Please note that the sliding fee is not available for the purchase of a hearing aid or durable medical equipment.

To apply for a fee adjustment, the client or responsible party must provide the clinic with a copy of their most recent income tax return and a copy of their past two months pay stubs. The standard base fee will be in effect until the clinic has received the required financial documentation. As we are not a Medicare provider, Medicare patients are eligible for a specific fee adjustment. Please call the Patient Care Coordinator for details.

Name of Client: ___________________________ SS# ___________________________

Responsible Party: _______________________ Relationship: ____________________

Average income: $________________ per __________ # of persons in household ______

Verification Attached - Copies are satisfactory

____ Past 2 Months Pay stubs AND _____ Past Year's Tax Return _____ Other ______

Other financial information you would like to report or explain:
______________________________________________________________________________

To the best of my knowledge, the above information is correct.

_________________ ________________________________
Date of Application Signature of Applicant

************************************************************************************
FOR OFFICE USE ONLY ********************

Income/household size (SFS) □ Projected Annual Income:

Extenuating circumstance □ Wage Earner 1 $ ______________

Student Educational Training □ Wage Earner 2 $ ______________

TOTAL $________________

Effective date of adjustment_____________________

Academic Term __________ Year __________

____ (Initial) Evaluation fee $ ______________

Therapy fee per session / block $ ______________
(circle one)

____ (Initial) □ Per session: I agree to pay the above discounted rate for services and understand payment is due at the time of service.

____ (Initial) □ Per block: I agree to pay the above discounted rate for services and understand payment may be split between the date of first service and thirty days thereafter.

_________________ _________________________
Signature of client / representative Date

_________________ _________________________
Signature of Clinic Director Date
AUDIOLOGY CLINIC CASE HISTORY - ADULT

NAME: __________________________ AGE: ___ BIRTHDATE: ____________

ADDRESS: _______________________________________________________

CITY: _______________________ STATE: ____ ZIP CODE: ______

PHONE: HOME ( ) ___________ WORK ( ) ___________

SEASONAL ADDRESS (IF APPLICABLE) **

ADDRESS: _______________________________________________________

CITY: _______________________ STATE: ____ ZIP CODE: ______

REFERRED BY: NAME: ______________________________

ADDRESS: ______________________________

______________________________

DATE COMPLETED: ___________

REASON FOR VISIT: _____________________________________________

______________________________________________________________

______________________________________________________________
1. HAVE YOU EVER HAD A HEARING TEST BEFORE?
   YES___     NO___     WHEN___________

   IF YES, PLEASE BRING TEST RESULTS WITH YOU TO APPOINTMENT.

2. DO YOU HAVE ANY PROBLEMS HEARING
   YES___     NO___
   WHICH EAR?    RIGHT___  LEFT___  BOTH___
   BETTER EAR?   RIGHT___  LEFT___

3. WHEN DID YOU FIRST NOTICE YOUR HEARING PROBLEM?
   _______________________________________

4. IS YOUR HEARING WORSE SINCE YOU FIRST NOTICED IT, OR SINCE YOUR LAST HEARING TEST?
   YES___     NO___

5. WAS THE HEARING LOSS:
   GRADUAL___   SUDDEN___   FLUCTUATING___

6. WHAT DO YOU THINK CAUSED YOUR HEARING LOSS?
   _______________________________________

7. HAVE YOU EVER HAD EAR INFECTIONS?
   YES___     NO___
   WHICH EAR?    RIGHT___  LEFT___  BOTH___

8. HAVE YOU EVER HAD EAR SURGERY OR P-E TUBES IN YOUR EARS?
   YES___     NO___
   WHICH EAR?    RIGHT___  LEFT___  BOTH___

9. DOES ANYONE IN YOUR FAMILY HAVE A HEARING PROBLEM?
   YES___     NO___
   IF YES, LIST WHOM AND TYPE: ________________________________

10. DO YOU HEAR NOISES IN YOUR EARS OR HEAD?
    YES___     NO___
    WHICH EAR?    RIGHT___  LEFT___  BOTH___
11. CHECK THE FOLLOWING THAT BEST DESCRIBE THE NOISES THAT YOU HEAR:
   HIGH-PITCHED RINGING ___ BUZZING ___ ROARING ___
   PULSATED ___ CRICKETS ___ RUSHING WATER ___ OTHER ___

12. HOW OFTEN DO YOU HEAR THE NOISES?
    CONSTANTLY ____ FREQUENTLY ____ OCCASIONALLY ____

13. ARE YOU HAVING ANY DIZZINESS PROBLEMS?
    YES ____ NO ____
    IF YES, IS YOUR DIZZINESS ACCOMPANIED BY:
    NAUSEA? YES ____ NO ____
    VOMITTING YES ____ NO ____
    NOISE IN YOUR EARS? YES ____ NO ____

14. ARE YOU CURRENTLY UNDER A PHYSICIAN’S CARE FOR ANY MEDICAL PROBLEMS?
    DESCRIBE: ____________________________________________
    NAME OF PHYSICIAN: __________________________________
    ADDRESS: ____________________________________________

15. CHECK ANY ILLNESS THAT YOU HAVE HAD:
    MENINGITIS ____ MALARIA ____ MEASLES ____
    MUMPS ____ CHICKEN POX ____ DIABETES ____
    SCARLET FEVER ____ HIGH BLOOD PRESSURE ____
    HEAD INJURIES ____ HEART TROUBLE ____ EPILEPSY ____
    KIDNEY PROBLEMS ____ OTHER _____________

16. DO YOU TAKE ANY MEDICATIONS REGULARLY?
    YES ____ NO ____
    LIST TYPE, QUANTITY, AND DURATION: ____________________
                                ________________________________________
                                ________________________________________

17. HAVE YOU EVER BEEN TREATED WITH STREPTOMYCIN, NEOMYCIN, KANAMYCIN, QUININE, CISPLATIN, AND/OR CARBOPLATIN?
    YES ____ NO ____
    IF YES, EXPLAIN: __________________________________________
18. HAVE YOU BEEN EXPOSED TO LOUD NOISES FOR ANY LENGTH OF TIME:
   YES____ NO____
   PLEASE DESCRIBE: __________________________________________________________

19. WHAT IS, OR WAS, YOUR OCCUPATION? ____________________________
   __________________________________________________________
   __________________________________________________________

20. HAVE YOU EVER USED A HEARING AID?
   YES____ NO____
   WERE/ARE YOU SATISFIED WITH YOUR AID?
   YES ____ NO____
   IF NO, PLEASE DESCRIBE WHY: ________________________________________________
   MODEL AND MAKE OF HEARING AID: ____________________________________________
   WHERE AND WHEN PURCHASED: ________________________________________________

21. ARE YOU INTERESTED IN PURSUING HEARING AID USE?
   YES____ NO____

22. IN WHICH SITUATION ARE YOU HAVING DIFFICULTY HEARING?
   WORK _______ T.V./RADIO _______ SCHOOL _______
   SOCIAL ACTIVITIES ____ PERSONAL RELATIONSHIPS ____
   PHONE _____ DIRECTION OF SOUND _____
   THEATERS/MOVIES ____ OTHER ______________________

23. PEOPLE OFTEN HAVE DIFFICULTY COPING WITH HEARING LOSS. ARE YOU
    INTERESTED IN DISCUSSING THIS WITH OTHERS AND LEARNING SOME
    TECHNIQUES TO DEAL WITH THIS DIFFICULTY?
    YES____ NO____
Authorization for Mutual Exchange of Information

Client Name:___________________________________      Acct.#:___________

Last                    First

Date of Birth:___________________________________ Date reviewed:___________ (Initials)_____

Date:___________________________________________                 ___________ (Initials)_____

I do hereby authorize the mutual exchange of medical, psychiatric, social work, psychological, and educational information regarding the above client, for the next year, between the University Hearing and speech Clinic and:

(Please print clearly)

1. Name:_____________________________ 3. Name:_____________________________
   Address:______________________________ Address:______________________________
   City/State/Zip:________________________ City/State/Zip:________________________
   □ Receive information from        □ Receive information from
   □ Send information to            □ Send information to

2. Name:_____________________________ 4. Name:_____________________________
   Address:______________________________ Address:______________________________
   City/State/Zip:________________________ City/State/Zip:________________________
   □ Receive information from        □ Receive information from
   □ Send information to            □ Send information to

I understand that my consent for the release of this information is voluntary and I can withdraw my consent at any time in writing**. Should I withdraw my consent, I understand it would not apply to information that had already been provided under the prior consent.

Signed:_____________________________  Print Name:_________________________________
   Client, Parent or Legal Guardian
   Address: _________________________________

Telephone:_________________________     City/State/Zip: ______________________________

**Please complete a new form if changes or additions are made. Form valid for one year from completion date/last review date.
CASE HISTORY FORM SUPPLEMENT

Ethnic/Racial Information

Submitting ethnic or racial information is voluntary. Information obtained will be used by the University Programs in Communication Disorders Clinic to facilitate bias-free assessment and management of culturally and linguistically diverse individuals. This information will be kept confidential.

Please check the category(ies) which you identify as the primary ethnic or racial group(s) of the individual to be served by the U.P.C.D. Clinic.

☐ American Indian or Alaska Native -- Origins in any of the original people of North America who maintain cultural identification through tribal affiliation or community recognition.

☐ Asian or Pacific Islander -- Origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or Pacific Islands.

☐ Black, not Hispanic origin -- Origins in any black racial group.

☐ Hispanic -- Origins of Mexican, Puerto Rican, Cuba, Central or South American or other Spanish culture, regardless of race.

☐ White, not of Hispanic origin -- Origins in any of the original people in Europe, North Africa of the Middle East.

☐ Other -- Please specify._________________________________________.

Indicate name of individual to receive or received services through the U.P.C.D. Clinic.

____________________________________  ____________________________
 NAME                                     DATE
CONSENT TO AUDIO/VIDEO TAPE OR COLLECT DATA

The University Hearing & Speech Clinic is a student training and community service facility. As such, all persons are seen by student clinicians who are directed and observed by faculty and may be observed by fellow students. Students are required to videotape and audio tape for educational purposes as part of their training as Speech Language Pathologists. Clients, their family members, or guardians, however, may deny permission to video or audio tape.

☐ I do ☐ I do not give my permission for diagnostic and/or therapy sessions involving (patient’s name) ________________ to be audio/video taped.

☐ I do ☐ I do not give my permission for the data collected during my diagnosis and/or therapy sessions to be used for classroom instruction or research purposes. I understand that no unauthorized individual will view this data and that names will be kept confidential.

☐ I do ☐ I do not give my permission for these audio/video tapes to be used for classroom instruction or research purposes. I understand that no unauthorized individual will view/hear the tape/s and that names will be kept confidential.

☐ I do ☐ I do not give my permission for these audio/video tapes to be used for public relations purposes, understanding that only selected portions of tapes dealing with general information will be used. I understand that care will be used to insure that no confidential information is revealed.

☐ I do ☐ I do not give my permission for phone messages regarding appointments, cancellations, and other clinic related issues to be left on voice mail or answering machine at the following number(s):

   Home______________________ Work______________________ Cellular_______________________

CONSENT TO TREAT

I, as a client or representative thereof, give permission to student clinicians of University Hearing & Speech Clinic (UPCD) to provide necessary speech, language, and audiometric evaluations and to make instructional therapy plans in my best interest as a client, or for the client I represent. I understand that the results of testing or therapy will be kept confidential and will be made available only to the professional staff and other professional personnel concerned with this case for whom I have signed a separate release of information form. I understand that the student clinicians will be working under the supervision of an ASHA certified Speech-Language Pathologist or Audiologist. I also understand that pre-professionals (students) may be observing the evaluation and therapy sessions under the supervision of a UPCD based Speech-Language Pathologist or Audiologist.

Client or Representative Signature ___________________________ Date ___________________________
Research Consent Form

Purpose and Benefits
This consent seeks your permission to use your or your child’s/family member’s assessment and treatment information for educational and research purposes to further our understanding of the effectiveness of our treatment efforts. The primary purpose of the consent is for graduate students to have access and use of data from previously seen clients at our clinic to analyze and report in their master’s papers/projects. Very occasionally a student or faculty member may want to use the client file data for a retrospective study.

Procedures
We are requesting your permission to use assessment and treatment information from your or your child’s/family member’s clinic file from treatment received at the University Programs in Communication Disorders (UPCD) clinic under the supervision of certified Speech-Language Pathologists and/or Audiologists. Graduate students at UPCD are required to critically review assessment and/or treatment information about clients seen at the UPCD clinic. When students are making class presentations or writing papers, your or your child’s/family member’s name is not used. The file data are used to demonstrate the effectiveness of certain assessment or treatment methods. In this research, it is not necessary to reveal the identity of the person(s) being treated or assessed, so you or your child/family member will be treated anonymously in any reporting of the data.

Risk, Stress or Discomfort
No stress or discomfort is involved for you or your family member if you sign this permission. There is minimal risk of breach of confidentiality but we (the faculty and staff at UPCD) will ensure that no personal identifiers are shared in class or on written documents. This is standard procedure in our courses and all students have signed a confidentiality agreement.

Other Information
You are free to withdraw this permission at anytime without penalty or jeopardizing future care at UPCD or at any other facility. We appreciate your cooperation as we seek to improve our methods of assessment and treatment for communication and hearing disorders. Please feel free to discuss this consent with me, Doreen Nicholas, when you are at UPCD or call me at 509-828-1323.

Agreement for Voluntary Participation in the Study
The use of assessment and treatment information for research purposes has been explained to me and I voluntarily consent to allow my or my child’s/family member’s clinic file to be reviewed in the future. I have had the opportunity to ask questions about the purpose of this review. I am not waiving any of my legal rights by signing this form. I understand that if I decline participation, I will still be entitled to receive services at UPCD without penalty or prejudice. I understand that upon request, I will receive a signed copy of this consent form.

Name of Client (please print)                     Date

Signature of Client or Parent/Legal Guardian                  Date

Doreen Nicholas, MS, MHPA CCC-SLP, Clinic Director                  Date
ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE:
By signing this sheet you acknowledge that you have received a copy of EWU Notice of Privacy Practices. This acknowledgement will become part of your records.

Print Name: ______________________________

Date: __________________________

Signature (patient or person authorized to give consent)

If signed by person other than patient – provide reason and relationship to patient