Explanation of Services

To Whom This May Concern:

Thank you for your inquiry into our clinical 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 and/or treatment soon after referrals are received and, if a client is accepted for therapy, we attempt to maintain service until the treatment issues are resolved. The number of clients seen, however, is determined, in part, by student enrollment, 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.

***

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
CONFIDENTIAL CLIENT INFORMATION

Name of person for whom services are being sought: _______________________________

Birth Date ____________________________  Last  First

Address _____________________________  City/State _____________  Zip Code______

Phone Number_________________________  Patient’s Native language(s)____________________

If not English, at what age did the patient learn English? ____________________________

Patient’s ethno cultural background _____________________________________________

Patient’s birth place ___________________________________________________________

Patient’s highest level of education ______________________________________________

Patient’s current, or, if retired, previous, primary occupation________________________

List patient’s interests or favorite activities _________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Marital status: single _____  widowed_____  separated______

married_____  divorced______  remarried_______

List patient’s primary caregiver and/or immediate family members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
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Eastern Washington University and Washington State University are equal opportunity, affirmative action institutions  Revised Jan 2011
Medical History
Date of injury/onset of symptoms:____________________________________________

Patient’s handedness (before stroke or disease onset): Right_______  Left_______

Does the patient wear glasses?_______  See well enough to read?_______
Have any other visual problems, such as right/left visual field cut, cataracts, or macular
degeneration?___________________________________________________________

Does the patient have a hearing loss?_______  Wear a hearing aid?_______
If yes, in the right ear?_______, left ear?_______, or both?_______

Describe the patient’s general health__________________________________________
________________________________________________________________________
________________________________________________________________________

List the patient’s current medications and dosages:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Has the patient had or currently have any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
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<tr>
<td>Aphasia</td>
<td></td>
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<tr>
<td>Other Communication Disorder</td>
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<tr>
<td>Right or Left-sided weakness</td>
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<tr>
<td>Neglect</td>
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<tr>
<td>Dementia</td>
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<tr>
<td>Memory Impairment</td>
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<tr>
<td>Other Neurological disease</td>
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<tr>
<td>Head injury</td>
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<tr>
<td>Seizure disorder</td>
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<tr>
<td>Clinical depression</td>
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<tr>
<td>Other psychiatric problems</td>
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<tr>
<td>Alcohol abuse/problems</td>
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<tr>
<td>Other substance abuse</td>
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<tr>
<td>Other major illness</td>
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</tbody>
</table>
Communication and Cognitive Status and Needs
Patient’s current or suspected communication and/or cognitive problems
_______________________________________________________________________
_______________________________________________________________________

What communication and/or cognitive problems, if any, are of concern to the patient and
caregiver ______________________________________________________________
________________________________________________________________________
________________________________________________________________________

Cause of current or suspected communication and/or cognitive problems
Date of onset of communication and/or cognitive problems
How does the patient communicate? __________________________________________
How well does the patient understand? _______
What are the patient’s strengths/weaknesses in social
interactions? ______________________________________________________________
________________________________________________________________________

Current communication strategies used by:
Patient
Caregivers

Describe the patient’s cognitive status
Attention
Memory
Executive functioning (organization, decision making, reasoning)

Has the patient received previous treatment?
<table>
<thead>
<tr>
<th>Speech-language therapy</th>
<th>Dates</th>
<th>Agency</th>
<th>Address</th>
</tr>
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Audiology

Other? (e.g., neuropsychology evaluation)
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, Cuban, 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
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
   □ Send information to
   □ Receive information from
   □ Send information to

2. Name:_____________________________  4. Name:_____________________________
   Address:_____________________________       Address:_____________________________
   City/State/Zip:_______________________       City/State/Zip:_______________________
   □ Receive information from
   □ Send information to
   □ Receive information from
   □ 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.
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 audiomeric evaluations and to made 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
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 breech 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
HIPAA NOTICE OF PRIVACY PRACTICES
UNIVERSITY HEARING and SPEECH CLINIC
EFFECTIVE DATE: APRIL 14, 2003

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