Alabama A&M University

Communicative Sciences and Disorders

Carver Complex North, Rm 104

Dear Sir/Madam:

Thank you for your interest in choosing Alabama A&M University, *Communicative Sciences and Disorders Clinic* for speech-language services. We are conveniently located on Alabama A&M University's main campus in Carver Complex North, room 104. Attached is the *New Client Manual* which has a number of important forms that need to be filled out in preparation for the evaluation process. Please complete the forms and send to:

Alabama A&M University
Attn: Esther Phillips-Ross
Communicative Sciences and Disorders
PO BOX 357
Normal, AL 35762
esther.phillips@aamu.edu
256-372-4055 (fax)

These forms must be returned as soon as possible due to the current waiting list. You may also bring the forms with you to the appointed time for services. If you have further questions regarding this matter, please feel free to contact me via my direct line-372-4044.

Sincerely,

Esther Phillips-Ross

Esther Phillips-Ross MA,CCC/SLP/L
Director of Clinical Services
Communicative Sciences and Disorders Clinic
Alabama A&M University

ALABAMA A & M UNIVERSITY
Communicative Sciences & Disorders Clinic
(Carver Complex North 104)

NEW CLIENT HANDBOOK

2012-2013

We are proud to be an ASHA-Accredited Program!

We are accredited by the Council for Academic Accreditation (CAA) in Audiology and Speech-Language Pathology of the American Speech-Language-Hearing Association (ASHA).

To Contact ASHA:
2200 Research Boulevard
Rockville, MD 20850

***1-800-498-2071 or** http://www.asha.org*

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CLINICAL FACULTY/STAFF

Michele Brown, AAMU CSD Secretary
372-5541
Esther Phillips-Ross, Assistant Professor, **Director of Clinical Services**
M.A., CCC-SLP/L
372-4044
Cynthia Lewis, Assistant Professor, **Clinical Supervisor**
M.S., CCC-SLP/L
Jennifer Vinson, Professor, **Program Director**
Ed.D., CCC-SLP/L
372-4035
Hope Reed, Associate Professor, **Orofacial Myologist**
CCC-SLP-D
372-4036
Carol Deakin, Associate Professor, **Clinical Supervisor, TBI Specialist**
Ph.D, CCC-SLP/L
372-4043
Barbara Bush, Associate Professor, **Audiologist**
Au.D,CCC-A
372-4038

STATEMENT OF PURPOSE

Alabama A&M Communicative Sciences and Disorders Clinic is a training clinic. Our clinic provides hands-on training for our students as they progress through our program, learning to apply information gained in the classroom. All students are supervised by ASHA-certified faculty. As our student clinicians develop clinical skills, they are placed in a position to serve the speech-, language-, and hearing needs of individuals in our community and enhance the effectiveness and quality of communication.

SHARED COMMITMENTS

We will . . .

1. Prepare quality professionals who will be employed in both the public and private sectors (e.g., hospitals, schools, nursing homes) emphasizing transdisciplinary experiences with physicians, nurses, social workers, case managers, teachers, psychologists, and other specialists in health care fields,
2. Provide quality speech-, language-, and hearing clinical services to clients at Alabama A & M University and its surrounding communities,
3. Disseminate information regarding speech, language, and hearing behaviors through research and collaborative scholarly activities (e.g., presentations, consultations, and publications), and
4. Provide community service programs focusing on awareness, education, and prevention of speech-, language-, and hearing disorders.

CLINICAL SERVICES

Clinical services are provided by both undergraduate and graduate students in the Communicative Sciences and Disorders program while being supervised by nationally certified clinical faculty. (i.e., faculty who hold the Certificate of Clinical Competency from ASHA).

Specific services offered by the *Alabama A & M University Communicative Sciences and Disorders Clinic* include the diagnostic evaluation and remediation/treatment of speech-, language-, and hearing disorders. Prior to enrollment in any of the therapy programs, a current speech and language evaluation must be completed, as well as a hearing screening. Some voice clients may be required to present a physician's written referral. If a prior evaluation has been completed by another speech-language pathologist/audiologist, the client or guardian may request that the evaluation records be released to us. However, an evaluation will be administered to all new and returning clients. In addition, each client, (or guardian), must complete and sign the appropriate forms, which include:

1. Case history form,
2. Fee payment contract,
3. Authorization for video/audio taping, and student observations and chart review for educational purposes,
4. Authorization for release of information TO another agency or physician (if applicable), and
5. Authorization for release of information FROM another agency or physician (if applicable).

Therapy will not be initiated until these forms have been completed. These forms can be located on-line under "client forms and manuals", at http://www.aamu.edu/csd/csdclinic.aspx and in appendix A of this document.

EVALUATION

The evaluation of the client's communication skills addresses . . .

1. The ability to understand and produce language,
2. The ability to produce speech sounds,
3. Voice characteristics,
4. Speech fluency,
5. Oral-motor structures and functions, and
6. Auditory (hearing) skills.

Following the evaluation, recommendations may include enrollment for therapy, referral to another professional agency, or a re-evaluation at a later date.

SERVICE PROVISION POLICIES

Services are provided to clients of all ages. No client will be refused services on the basis of race, gender, ethnic origin, or religion. This policy is in compliance with Title VI of the Civil Rights Act of 1964 and other current regulations that safeguard against discrimination. The Alabama A & M University Communicative Sciences and Disorders Clinic reserves the right to refuse services to clients who may be considered inappropriate candidates in this clinical setting.

The Alabama A & M University Communicative Sciences and Disorders Clinic serves the educational and training needs of students. In order for the student clinicians to better understand the nature of a client's communication disorder, audiotapes and/or digital tapings may be made. These media are considered confidential and are solely for the purpose of education. They will be used only by student clinicians, clinical faculty, and clients. The client or guardian must sign an *Authorization for video/audio taping for educational purposes* form to allow these services to be performed. Occasionally, clients may be requested to participate in ongoing research. Such participation is formally requested, and proceeds only with the client's or guardian's consent.

CONFERENCES

Conferences with the family will be scheduled periodically. These conferences usually take place at the beginning and end of the semester. However, a client or family may request a conference at any time by contacting the client's faculty clinical supervisor.

PERIODIC RE-EVALUATIONS

Periodic re-evaluations will be performed throughout the therapy process to continually assess speech-, language-, and hearing skills. This allows for assessment of progress and the planning and development of future therapy goals.

OBSERVATION

Observation of diagnostic and therapy procedures is available to the client's family members in the AAMU CSD observation suites. To prevent client distraction, it is preferred that the family does not sit in the therapy room during a diagnostic or therapy session. In this educational/training environment, sessions may be observed by other students in training

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CONFIDENTIALITY OF RECORDS

A clinic/working folder is maintained for all clients seen at the Alabama A & M University Communicative Sciences and Disorders Clinic. Included in this folder are diagnostic findings/reports, therapy reports, case history information, consent forms, as well as other

pertinent information. This information is considered confidential. Access to the folder is granted to client's family members, faculty, and student clinicians.
When specifically requested in writing by the client or guardian using this clinic's forms (one form per request), the clinic will supply relevant information to specified entities such as physicians, schools, or other professionals.

A permanent record is kept for each client of activities in this clinic. No information which could potentially identify the client leaves the clinic. All such information is carefully guarded within the clinic. For more details, contact your faculty supervisor.

WAITING ROOM

The waiting room is for families of the clients enrolled in clinical services. Donations of books, magazines, and toys are greatly appreciated. Parents are asked to please keep the waiting area clean by returning items to their proper places when leaving. Children are to be supervised at all times. This is a "No smoking" area.

ATTENDANCE

Most clients are seen twice per week for 50-minute sessions. Therapy is most effective when attendance is regular. It is important that every effort be made to be present for ALL scheduled therapy sessions and to arrive on time. THREE absences in a semester or TWO consecutive absences could result in dismissal from therapy for the remainder of the semester. Extenuating circumstances may allow for exceptions at the discretion of the supervisor.

Upon dismissal from the program for absences, the client will be expected to call to request being placed back on the waiting list for the following semester. We begin taking clients for the upcoming semester approximately 1 month before the close of the current semester.

Fall semester – call in July
Spring semester – call in November
Summer semester – call in March

If you must be absent for any reason, please contact the clinical supervisor(s) -- Mrs. Phillips-Ross, 372-4044; Dr. Jennifer Vinson, 372-4035; or The clinic secretary Mrs. Michele Brown, 372-5541--as soon as you know that you will not be able to attend. If the supervisor is unavailable, please leave a voice mail message.

CLINIC FEES

Fees agreed upon at the beginning of the client's therapy program will remain in effect until the beginning of the next Fall semester. A new fee contract will be signed each Fall. Eligibility for reduced fees will be reviewed before the opening of the clinic each Fall. The amount designated as full fee for evaluation and therapy will not be changed by the Clinic Director except immediately prior to the beginning of the Fall clinic session. No change in

fee will be in effect without prior notice in writing or by phone call to the client or his/her caregiver.
Each client or client caregiver and the Clinic Director will sign a contract on the date of the client's first therapy session to verify the agreed-upon fees for service and the payment schedule. A copy of this contract will be kept on file in the Alabama A & M University Communicative Sciences and Disorders Clinic account files.

All fees for evaluation must be paid on the date of the evaluation or as previously arranged by the director of clinical services. For therapy/treatment sessions, payment is expected at the end of the period in question (e.g., the end of the week). If circumstances make payment on these terms challenging, the client or client's caregiver is responsible for notifying the Clinic Director so that payment may be negotiated.

GRIEVANCE PROCEDURE AND POLICY

The clinical faculty welcomes any comments or suggestions that may prove beneficial to the client during the diagnostic or therapy process. Complaints related to clinical services should be directed to the Clinic Director, Mrs. Phillips-Ross.

PARKING

All clients will be given a clinic parking pass during the first week of service.. All clients must display a parking pass in the windshield or rearview mirror of their vehicle. If for some reason you are not given a parking pass, please do not hesitate to request one. The parking pass will expire at the end of each semester, and a new one will need to be obtained for following semesters. Clients are permitted to park in the lots adjacent to either clinic (CCN, CCE, and CCS). You are permitted to park in spaces designated for CSD Patient Parking and in UN-NUMBERED faculty/staff parking spaces ONLY.

TRANSPORTATION

Clients needing transportation to the AAMU CSD Clinic may make arrangements through Handi Ride. There is an application process/fee and not all applicants will qualify. If you desire to inquire about the services Handi Ride provides, they may be contacted at 256-427-6857 (scheduling) or 256-532-RIDE

POLICY FOR COMMUNICABLE DISEASES

In the attempt to control the transmission of the communicable diseases listed below, the following policy will be adhered to in the Alabama A&M CSD Clinic:

DISEASE	**MINIMUM PERIOD OF ISOLATION OF THE CHILD**
Chicken Pox (varicella)	Individual must remain at home until all lesions are crusted and dry.

	Susceptible child exposed to chicken pox will be excluded from the 10th through the 21st day after exposure. Anyone who has received V12G will be excluded for 28 days.
Conjunctivitis (Pinkeye)	Individual must remain home until 24 hours after treatment (antibiotic eye drops) is initiated.
German Measles	Individual must remain at home for at least five (5) days after onset of rash. Susceptible child will be excluded from the 7th to the 21st day after exposure.
Impetigo	Individual must remain at home until 24 hours after treatment is initiated.
Influenza	Individual must remain home until no fever is detected for 24 hours.
Lice (Pediculosis)	Individual must remain at home until the morning after treatment.
Measles (Rubella)	Individual must remain at home for four (4) days after the appearance of rash. Susceptible child will be excluded from the 5th exposure.
Mumps	Individual must remain at home for nine (9) days after onset of swelling. Susceptible person will be excluded from the 12th to the 26th day after exposure.
Scabies	Individual must remain at home until treatment has been completed.
Streptococcus (strep)	Individual must remain home until 24 hours after the first dose of antibiotics is given and be free of fever.

REFERENCE: Isolation and Quarantine Regulations

Published by the Massachusetts Department of Public Health, Division of Communicable Disease, March, 1992. Report of the Committee on Infectious Diseases, American Academy of Pediatrics, 1991; Kidshealth, 2002; State of New york Department of Heath, 2008.

We wish you the best possible success here in the clinic. Together, we can make a difference!

Alabama A&M University
Communicative Sciences and Disorders
PROGRAM

CONFIDENTIALITY STATEMENT
Client Handbook

I understand that information regarding clients and or students in the CSD Program, (including anything observed in the clinic, and information heard re: other families, clients, faculty, staff or student clinicians) is to be held strictly confidential.

_____	_____	_____
Printed Name	Signature	Today's Date

****Please sign and submit this document to the Program Secretary, Mrs. Michele Brown during initial visit to the clinic.*

APPENDIX A

AAMU CSD CLIENT CLINIC FORMS

1. Child Case History Form
2. Adult Case History Form
3. Fee Payment Contract
4. Fee Sliding Scale
5. Authorization form Release of Information to Another Agency or Physician
6. Authorization form Release of information from Another Agency or Physician
7. Authorization form Video/Audio Taping for Educational Purposes

Alabama A & M University
Communicative Sciences and Disorders Clinic
P.O. Box 357
Normal, Alabama 35762
Phone: (256)372-5541 or (256)372-4044

CASE HISTORY FORM – CHILD

IDENTIFYING INFORMATION

Child's Name _____ Sex _____

Birthdate _____ Age _____ Today's Date _____

Name by which your child is called _____ Handedness Right Left
(circle)

Address: _____ Home Phone _____

City _____ State _____ Zip _____ Cell phone _____

Parents:	Name	Age	Occupation	Education	Work #
Father	_____	____	_____	_____	_____
Mother	_____	____	_____	_____	_____

If address of either parent is different from that of child, please indicate:

Is the child adopted? _____ yes _____ no If so, at what age? _____

List children, in order of birth:

Name	Sex	Age	Grade/School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do any siblings have any speech or language difficulties? _____ yes _____ no
Specify _____

Who referred you to the AAMU Speech and Hearing Clinic? _____

Address (if professional) _____

Child's Doctor: Name _____

Address of Dr. _____
Do you want a copy of our report(s) sent to your child's doctor? _____ yes _____ no

To what other professional person(s) or agency (ies) do you want a report sent? Please include names of professionals and addresses: _____

STATEMENT OF THE PROBLEM

Describe in your own words what problem(s) your child is/are having with speech, language, and/or hearing.
_____

Why did you want your child evaluated by the AAMU Speech and Hearing Clinic? _____

When was the problem first noticed? _____

Who first noticed the problem? _____

What reactions does the child, parent, siblings, relatives, and/or friends have towards the problem? _____

What have you done to help your child's speech? _____
_____

If your child's speech varies, under what circumstances does it become:

Better: _____

Worse: _____

Have you sought professional advice about your child's speech, language, and/or hearing problem before?
Evaluation _____ Therapy _____ When? _____

Whom did you see?_____

Length of therapy _____

Results _____

What recommendations were made? _____

What has been done since then? _____

How does your child feel about his/her speaking ability? _____

Has your child ever been diagnosed as a "poor reader"? _____ yes _____ no
By whom was the diagnosis made? _____

Check the items that your child seems to do more than other children the same age:

_____ 1. Avoids speaking at school.
_____ 2. Avoids speaking in play situations.
_____ 3. Avoids speaking at home.
_____ 4. Avoids speaking to children (male _____, female _____).
_____ 5. Avoids speaking to adults (male _____, female _____).
_____ 6. Avoids saying certain words. (List _____)
_____ 7. Cries when unable to communicate.
_____ 8. Becomes aggressive when unable to communicate.

GENERAL DEVELOPMENTAL HISTORY

Was this your first pregnancy? _____ yes _____ no
If not, how many pregnancies have you had? _____ Which pregnancy was this child? _____
Any medical problems prior to this pregnancy? _____ yes _____ no
If so, please describe: _____
Did you have an illness during pregnancy? _____ yes _____ no
If so, please explain: _____
Did you have to take medication during pregnancy? _____ yes _____ no
If so, what medications? _____
Did your baby come more than two weeks early? _____ yes _____ no
Did your baby come more than two weeks late? _____ yes _____ no
Was labor longer than 24 hours? _____ yes _____ no
Was the birth by Cesarean? _____ yes _____ no
Were forceps used during the birth? _____ yes _____ no
Birth weight _____ pounds, _____ ounces
Did your baby have trouble in the hospital? _____ yes _____ no
_____ blue spell _____ yellow jaundice _____ breathing problems
_____ required oxygen _____ infection diagnosed _____ required transfusion
Other: _____
How long were mother and child in the hospital? _____
Physician's Name _____ Hospital _____

Did you bottle feed your baby? _____ yes _____ no
Did your baby cry more than average? _____ yes _____ no
Did your baby spit a lot? _____ yes _____ no
Did your baby have any feeding problems? _____ yes _____ no
Did your baby have nasal stuffiness? _____ yes _____ no
Did your baby have rattling when breathing? _____ yes _____ no
Did your have any major concerns in the first three months of your baby's life? _____ yes _____ no

Give ages at which the following first occurred:
Held head up _____ Crawled _____ Reached for objects _____
Stood _____ Walked unaided _____ Ran _____
First tooth _____ Bladder trained _____ Bowel trained _____

SPEECH AND LANGUAGE DEVELOPMENT

Did your child make babbling or cooing sounds during the first 6 months? _____ yes _____ no

At what age did your child say his/her first word? _____

What were the child's first words? _____

Did your child keep adding words once he/she started talking? _____ yes _____ no

At what age did your child begin using 2- and 3-word sentences? _____
Examples _____

Does your child talk frequently? _____ occasionally? _____ never? _____
Does your child prefer to talk? _____ gesture? _____ both talk and gesture? _____
Does your child most frequently use sounds? _____ single words _____ 2-word sentences _____
3-word sentences _____ more than 3-word sentences _____

Does your child make sounds incorrectly? _____ yes _____ no
If so, which ones? _____

Does your child hesitate, "get stuck", or repeat or stutter on sounds or words? _____ yes _____ no
If so, describe. _____

Describe any recent changes in your child's speech: _____

Can your child say a nursery rhyme? _____ yes _____ no
Can your child tell a simple story? _____ yes _____ no
How well can your child be understand by his/her parents? _____
Siblings? _____ Friends? _____
Relatives? _____ Strangers? _____

Does your child understand what you say to him/her? _____ yes _____ no
Can he/she follow simple commands? _____ yes _____ no
Will he/she get common objects when asked to do so? _____ yes _____ no
Does your child have trouble remembering what you have told him/her? _____ yes _____ no
If so, when does this seem to happen? _____
Does your child use any books or games? _____ yes _____ no
How often do you read to your child? _____

BEHAVIORAL INFORMATION

Check these as they apply to your child:

	Yes	No	Explain: give ages, if possible
Eating problems			
Sleeping problems			
Ear infections			
Toilet training problems			
Difficulty concentrating			
Needed a lot of discipline			
Underactive			
Excitable			
Laughs easily			
Cried a lot			
Difficult to manage			
Overactive			
Sensitive			
Personality problem			
Gets along with children			
Gets along with adults			
Emotional			
Stays with an activity			
Makes friends easily			
Happy			
Irritable			
Prefers to play alone			

Describe any other type of behavior you consider to be a problem: _____
_____
_____
_____

EDUCATIONAL HISTORY

Does your child do average _____ below average _____ or above average _____ work in school?
What are your child's best subjects? _____
What are your child's poorest subjects? _____
Does your child receive any special assistance or help at school? _____ yes _____ no
If so, describe: _____
Has he/she repeated a grade? _____ yes _____ no
If so, which one(s)? _____
What is your impression of your child's learning abilities? _____

Describe any speech, language, hearing, psychological, and special education services that have been performed, including where this was done. Include how often your child was seen in this service. _____

OTHER

What games and toys does your child prefer? _____

How many hours each day does your child watch television? _____
Which programs does he/she watch? _____

Please list what you would consider your child's favorite food(s) and snack food(s). _____

What may we use for reinforcement for your child (i.e., candy, raisins, stickers, etc.)? _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to client _____

Address _____ Home phone _____

City _____ State _____ Zip _____ Cell phone _____

Alabama A & M University
Communicative Sciences and Disorders Clinic
P.O. Box 357
Normal, Alabama 35762
Phone: (256) 372-5541 or (256) 372-4044
Fax: (256) 372-4055

CASE HISTORY FORM – ADULT

IDENTIFYING INFORMATION

Name _____ Sex _____ Marital Status _____

Birthdate _____ Age ____ Today's Date _____ Handedness Right Left (circle)

Address: _____ Home Phone _____

City _____ State ____ Zip _____ Cell phone _____

Place of Employment or Previous Employment

Address: _____ Home Phone _____

City _____ State ____ Zip _____ Cell phone _____

Name of alternate contact person _____ Relationship _____

Address: _____ Home Phone _____

City _____ State ____ Zip _____ Cell phone _____

Who referred you to the AAMU Speech and Hearing Clinic? _____

Address (if professional) _____

Doctor _____

Address of Dr. _____
Do you want a copy of our report(s) sent to your doctor? Yes _ No ____

To what professional person(s) or agency(ies) do you want a report sent? Please include names of professionals and addresses: _____

_____

_____

List names and ages of person(s) in your home:

Name	Age	Relationship

EDUCATIONAL HISTORY

School	Location	Highest Grad or Degree Completed	Date

DESCRIBE YOUR PRESENT HEALTH

List periods of hospitalization or medical treatment:

Hospital/City/State	Dates	Reason

List all surgical procedures _____

List all prescription and nonprescription medication currently used

_____

_____

Have you had a neurological examination? If so, by whom, when, and where?

_____

_____

Is there a history of:

	Yes	No		Yes	No
Allergies	____	____	Heart trouble	____	____
Sinus infections	____	____	Numbness	____	____
Anemia	____	____	Paralysis//paresis	____	____
Asthma	____	____	Incoordination of face or tongue	____	____
Broken nose	____	____	Influenza	____	____
Bronchitis	____	____	Mouth-breathing	____	____
Chronic colds	____	____	Mumps	____	____
Chronic laryngitis	____	____	Pneumonia	____	____
Chronic ear infections	____	____	Physical defect	____	____
Cleft palate	____	____	Poliomyelitis	____	____
Diabetes	____	____	Psychological counseling	____	____
Diphtheria	____	____	Rheumatic fever	____	____
Ear disease	____	____	Scarlet fever	____	____
Glandular imbalance	____	____	Tremor/twitching	____	____
Hearing problem	____	____	Ulcers	____	____
Hearing aid	____	____	Visual problems	____	____
Hormone therapy	____	____	Glasses	____	____
Hyperthyroidism	____	____	Other	____	____
Emotional difficulty	____	____			
Smoking	____	____	Amount Per Day?	_____	
Drinking	____	____	Amount Per Day?	_____	

If the answer to any of the above items is “yes”, give the relevant details (e.g., how frequent are these episodes, how severe are these episodes, etc.)

_____

_____

_____

_____

If you speak a language other than English, please state the language _____

Please describe in your own words the nature of your communication problem(s).

_____

_____

What do you think caused the problem? _____

When did you first notice the problem? _____

What were the circumstances? _____

Have any members of your family had hearing or speech problems? _____

If so, whom and what was the problem? _____

_____

How do you feel your communication problem has affected your occupation?

_____

_____

How do you feel your communication problem has affected your social life?

_____

_____

If you didn't have a communication problem, how would your life be different?

_____

_____

Describe the reaction of people, including your immediate family, to your communication problem.

_____

_____

List any specific communication situations that present difficulty for you.

_____

_____

List any specific communication situations that you avoid.

_____

_____

List interests you have or activities you engage in (clubs, hobbies, organizations, etc.)

_____

_____

What, if anything, have you tried to do to correct your communication problem?

_____

_____

Are you coming to AAMU Speech and Hearing Clinic on your own? _____ Or by the advice of another person? _____

Have you ever received any prior speech, language, or hearing evaluations? Therapy? ___

If so where?

Agency _____ Agency _____

Address _____ Address _____

Dates _____ Dates _____

Results _____ Results _____

Did prior evaluation or therapy relate to the present problem? _

How effective has prior therapy been in helping with your problem (What helped the most? least?)

_____

_____

Why was therapy terminated? _____

Has the nature of the problem changed any time? _____

Explain _____

List any additional information that may be helpful to us in assisting you with our problem(s).

_____

_____

_____

_____

Alabama A&M University

Communicative Sciences and Disorders Clinic

Fee Payment Contract

Client's Name:_____

I,_____have read the *AAMU CSD Client Handbook* and I
(Name of guardian if client is a minor)
agree to pay $__50.00*__ for evaluation and $_30.00*_____ for each therapy session. I agree to pay the evaluation fee at the time that said services are provided. I will pay for therapy on the following schedule:

_____ at the time of the last weekly session

_____ on a bi-weekly basis

I am aware of and agree to abide by the rules and regulations developed by the Clinic regarding payment for services provided.

Date of Contract:_____ Client/Guardian Signature: _____
(signature of guardian required if client is under 18 years)

Clinical Director: _____
Esther J.Phillips- Ross MA,CCC/SLP/L

* Fees are subject to change if client is eligible for sliding scale fee reduction

Updated 8/30/2011

Alabama A&M University

Communicative Sciences and Disorders Clinic

FEE SCHEDULE

Note: Prices listed below are the maximum rate possible, and could be less depending on the information submitted on the Sliding Fee Scale.

Diagnostic (Evaluation) Fee Schedule

Speech and Language

Comprehensive Speech and Language Assessment $50.00
(Includes assessments of Voice, Fluency, Aural Rehabilitation, Aphasia, Augmentative Communication, Cognition, Articulation, Myofunctional (tongue thrust), Accent/Dialect Modification, Dysphagia)

Specialized Assessment (Reading) $50.00

Speech and/or Language Screening $35.00

School of Education Screenings..... $10.00

Audiology

Comprehensive Audiological Assessment $50.00

Hearing Screening $15.00

Intervention (Therapy) Fee Schedule

Individual Intervention Session $30.00

Group Intervention Session $22.50

Other

Consultations $25.00

Alabama A&M University

Communicative Sciences and Disorders Clinic

SLIDING FEE SCALE

Circle the NUMBER in your household and the LETTER corresponding to your income to obtain the percentage. Your charge will be that percentage of the regular fee listed on the first page for the service being provided. For example: A $40.00 hearing test for a client with an income of "J" and a household of "5+" would correspond at 50%, so the actual charge would be 50% of $40.00 or $20.00.

Income Category (Circle One)	**Annual Income Before Taxes** For Amounts Between:	**Number in Household** (Circle One)				
		1	**2**	**3**	**4**	**5+**
A	$0 - $4,999	G	G	G	G	G
B	$5,000 - $8,999	10%	10%	G	G	G
C	$9,000 - $10,999	30%	25%	10%	G	G
D	$11,000 - $12,999	35%	30%	25%	20%	15%
E	$13,000 - $14,999	40%	35%	30%	25%	20%
F	$15,000 - $19,999	50%	40%	35%	30%	25%
G	$20,000 - $24,999	60%	50%	40%	35%	30%
H	$25,000 - $29,999	70%	60%	50%	40%	35%
I	$30,000 - $34,999	80%	70%	60%	50%	40%
J	$35,000 - $39,999	90%	80%	70%	60%	50%
K	$40,000 - $44,999	100%	90%	80%	70%	60%
L	$45,000 - $49,999	100%	100%	90%	80%	70%
M	$50,000 - $54,999	100%	100%	100%	90%	80%
N	$55,000 - $59,999	100%	100%	100%	100%	90%
O	$60,000 - $64,999	100%	100%	100%	100%	100%

Alabama A&M University

Communicative Sciences and Disorders Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION

TO ANOTHER AGENCY OR PHYSICIAN

Client's Full Name: _____ Birthdate: _____

I ,_____hereby consent to the release of any and all hearing, speech,
(Name of guardian if client is a minor)
and language records concerning the above-named individual to:

Name/Agency: _____

Address: _____

_____

_____

Client/Guardian Signature: _____ Date: _____
(signature of guardian required if client is under 18 years)

Updated 8/30/2011

Alabama A&M University
Communicative Sciences and Disorders Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION FROM ANOTHER AGENCY OR PHYSICIAN

The person named below has requested services from our facility, *Alabama A & M University Communicative Sciences and Disorders (CSD) Clinic*. We understand that this individual has received professional services from you. Kindly forward any hearing, speech, language, medical, psychological, educational, or social records regarding this individual to aid us in better serving this client. Below is written authorization for the release of these records. Please send this information to the following:

Alabama A & M University CSD Clinic
Attention: Mrs. Esther Phillips-Ross, Director of Clinical Services
P O Box 357
Normal, AL 35762
esther.phillips@aamu.edu

Thank you for you cooperation.

This will certify that you have my permission to release information to *Alabama A & M Communicative Sciences and Disorders Clinic* concerning:

_____
(Client's full name)

Name of guardian authorizing release:_____
(Print full name)

Client/Guardian Signature: _____ Date: _____
(signature of guardian required if client is under 18 years)

Updated 8/30/2011

Alabama A&M University

Communicative Sciences and Disorders Clinic

AUTHORIZATION FOR OBSERVATION/VIDEO/AUDIOTAPING/PHOTOGRAPHS FOR EDUCATIONAL PURPOSES

Client's Full Name: _____ Birthdate: _____

I understand that the Alabama A & M University Communicative Sciences and Disorders Clinic is housed in an educational environment. I hereby consent to the following for teaching purposes only:

- ❑ Live Observation
- ❑ Video/Digital Recording
- ❑ Still photographs

I require the following exception(s): _____

Client/Guardian Signature: _____
(signature of guardian required if client is under 18 years)

Relationship to Client: _____

Witness: _____

Date: _____

Updated 8/30/2011

Alabama A&M University
Communicative Sciences and Disorders
PROGRAM

CONFIDENTIALITY STATEMENT
Client Handbook

I understand that information regarding clients and or students in the CSD Program, (including anything observed in the clinic, and information heard re: other families, clients, faculty, staff or student clinicians) is to be held strictly confidential.

_____ _____

Printed Name Signature

_____

Today's Date

****Please sign and submit this document to the Program Secretary, Mrs. Michele Brown during initial visit to the clinic.*

Alabama A & M University

Speech-Language-Hearing Clinic
REQUEST FOR CLINICAL SERVICES
FALL 2012

Client's Name: _____ **DOB:** _____ **Age:** _____

Spouse's/Parent's Name, if applicable: _____

Email address:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: home _____ work _____ other _____

Please circle/check the following information:

- Number of days per week you would prefer: 1 or 2
- Prefer: Individual Therapy or Group Therapy
- Preferred day(s) and time: Select BOTH preferred option and secondary option

Preferred Option

❒Monday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm
❒4:00-4:50 pm

❒Tuesday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒3:00-3:50pm

❒Wednesday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm
❒4:00-4:50 pm

❒Thursday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒3:00-3:50pm
❒4:00-4:50 pm

Secondary Option

❒Monday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm
❒4:00-4:50 pm

❒Tuesday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒3:00-3:50pm

❒Wednesday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm
❒4:00-4:50 pm

❒Thursday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒3:00-3:50pm
❒4:00-4:50 pm

____ I do not know my schedule for Fall '12 (for AAMU students only).

We will **attempt** to accommodate your preferred and secondary options. Please return these forms to your current student clinician as soon as possible, with a current email address as we be sending updates re: clinical service via this venue. **We MUST have these forms back to include you on the list for the coming semester by July 20th**.
The Clinic is scheduled to open September 10th thru December 7th . Make every effort to attend all therapy sessions to get the maximum benefit of therapy. Also be aware that attendance will be taken into consideration when scheduling for future semesters. A graduate clinician will be contacting you to confirm therapy times for Fall '12 during the last week in August, through September 5th. If you have any questions or concerns, please call or leave a voice mail message at 372-4044/5541. Feel free to write any more information that we may need in scheduling on the back of this form. Thank you for your continued support of our clinic. We look forward to working with you again.

Sincerely,

Mrs. Esther-Phillips-Ross

Mrs. Esther Phillips-Ross MA, CCC/SLP/L
Clinic Director
esther.phillips@aamu.edu
AAMU Communicative Sciences and Disorders Clinic

Alabama A & M University

Speech-Language-Hearing Clinic
REQUEST FOR CLINICAL SERVICES
SPRING 2013

Client's Name: _____ **DOB:** _____ **Age:** _____

Spouse's/Parent's Name, if applicable: _____

Email address:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: home _____ work _____ other _____

Please circle/check the following information:

- Number of days per week you would prefer: 1 or 2
- Prefer: Individual Therapy or Group Therapy
- Preferred day(s) and time: Select BOTH preferred option and secondary option

Preferred Option

❒Monday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm
❒4:00-4:50 pm

❒Tuesday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒3:00-3:50pm

❒Wednesday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm
❒4:00-4:50 pm

❒Thursday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒3:00-3:50pm
❒4:00-4:50 pm

Secondary Option

❒Monday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm
❒4:00-4:50 pm

❒Tuesday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒3:00-3:50pm

❒Wednesday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm
❒4:00-4:50 pm

❒Thursday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒3:00-3:50pm
❒4:00-4:50 pm

____ I do not know my schedule for Spring '13 (for AAMU students only).

We will **attempt** to accommodate your preferred and secondary options. Please return these forms to your current student clinician as soon as possible, with a current email address as we be sending updates re: clinical service via this venue. **We MUST have these forms back to include you on the list for the coming semester by January 13th**.
The Clinic is scheduled to open February 4th thru April 19th. Make every effort to attend all therapy sessions to get the maximum benefit of therapy. Also be aware that attendance will be taken into consideration when scheduling for future semesters.
A graduate clinician will be contacting you to confirm therapy times for Spring 2013 during the last week in January.
If you have any questions or concerns, please call or leave a voice mail message at 372-4044/5541. Feel free to write any more information that we may need in scheduling on the back of this form. Thank you for your continued support of our clinic. We look forward to working with you again.

Sincerely,

Mrs. Esther-Phillips-Ross

Mrs. Esther Phillips-Ross MA, CCC/SLP/L
Clinic Director
esther.phillips@aamu.edu
AAMU Communicative Sciences and Disorders Clinic

Alabama A & M University

Speech-Language-Hearing Clinic
REQUEST FOR CLINICAL SERVICES
*SUMMER 2013

Client's Name: _____ **DOB:** _____ **Age:** _____

Spouse's/Parent's Name, if applicable: _____

Email address:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: home _____ work _____ other _____

Please circle/check the following information:

- Number of days per week you would prefer: 1 or 2
- Prefer: Individual Therapy or Group Therapy
- Preferred day(s) and time: Select BOTH preferred option and secondary option

Preferred Option

❒Monday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm

❒Wednesday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm

Secondary Option

❒Monday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm

❒Wednesday

❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50am ❒1:00-1:50 pm
❒2:00-2:50 pm ❒3:00-3:50pm

____ I do not know my schedule for Summer '13 (ONLY for clients who are AAMU students).

We will **attempt** to accommodate your preferred and secondary options. Please return these forms to your current student clinician as soon as possible, with a current email address as we be sending updates re: clinical service via this venue. **We MUST have these forms back to include you on the list for the coming semester by May 3rd**.
The Clinic is scheduled to open June 6th thru July 19th . Make every effort to attend all therapy sessions to get the maximum benefit of therapy. Also be aware that attendance will be taken into consideration when scheduling for future semesters.
A graduate clinician will be contacting you to confirm therapy times for Summer '13 during the last week in May.
If you have any questions or concerns, please call or leave a voice mail message at 372-4044/5541. Feel free to write any more information that we may need in scheduling on the back of this form. Thank you for your continued support of our clinic. We look forward to working with you again.

Sincerely,
Mrs. Esther-Phillips-Ross

Mrs. Esther Phillips-Ross MA,
CCC/SLP/L
Clinic Director
esther.phillips@aamu.edu
AAMU Communicative Sciences and
Disorders Clinic