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

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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*** _____

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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) ☐
Extenuating circumstance ☐
Student Educational Training ☐

Projected Annual Income:
Wage Earner 1 $ _____
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

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CONFIDENTIAL CLIENT INFORMATION

Name of person for whom services are being sought:_____
Last First

Birth Date_____

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:

Name	Age	Relationship	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

310 North Riverpoint Blvd. • Box "V", Hearing & Speech • Spokane, Washington 99202-1675
E-mail: upcd@wsu.edu
Phone 509-358-7580 ◆ FAX 509-368-6890

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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:

			Onset Date and Current Status
Stroke	Yes	No	_____
Aphasia	Yes	No	_____
Other Communication Disorder	Yes	No	_____
Right or Left-sided weakness	Yes	No	_____
Neglect	Yes	No	_____
Dementia	Yes	No	_____
Memory Impairment	Yes	No	_____
Other Neurological disease	Yes	No	_____
Head injury	Yes	No	_____
Seizure disorder	Yes	No	_____
Clinical depression	Yes	No	_____
Other psychiatric problems	Yes	No	_____
Alcohol abuse/problems	Yes	No	_____
Other substance abuse	Yes	No	_____
Other major illness	Yes	No	_____

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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?

	Dates	Agency	Address
Speech-language therapy	_____	_____	_____
		_____	
Audiology	_____	_____	_____
		_____	

Other? (e.g., neuropsychology evaluation)_____

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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

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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:_____
   Address:_____
   _____
   City/State/Zip:_____
   □ Receive information from
   □ Send information to

2. Name:_____
   Address:_____
   _____
   City/State/Zip:_____
   □ Receive information from
   □ Send information to

3. Name:_____
   Address:_____
   _____
   City/State/Zip:_____
   □ Receive information from
   □ Send information to

4. Name:_____
   Address:_____
   _____
   City/State/Zip:_____
   □ 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.

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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 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

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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 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

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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

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