

Dear Prospective Client:

Thank you for your request for speech-language services in our clinic. Before we can schedule an appointment, we request that the enclosed case history questionnaire and consent-to-participate form be completed and returned to us. We would also appreciate it if you would sign the request for authorization for release of information, mail it to any speech-language pathologist or physician you may have seen within the last 6-12 months, and have them mail us the result of any diagnostic test. If you have a copy of a relevant report, enclose it with the completed forms.

Upon receiving this information, we will send you an acknowledgment letter. Please be aware that our clinic can provide appointments for diagnostic sessions in a relatively quick timeframe, but there is a significant waitlist for our therapy services. We look forward to providing speech-language services to you at the earliest possible date. If you have any questions, please feel free to contact the clinic at (301) 405-4218.

Sincerely,

Elizabeth Coon
Clinic Office Supervisor

EC:

I: spPacketADULT

Speech and Hearing Clinic
Department of Hearing and Speech Sciences
University of Maryland
College Park, Maryland 20742
(301) 405-4218

Adult Case History Form

Please answer the following questions as best you can and mail the form to the address at the top of this page. If there are some questions you can not answer, leave them blank. Your answers will help us provide you with the best and most efficient evaluation and/or treatment.

General Information

Name _____ Birthdate _____ Age _____

Address: _____ Sex _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Cele Phone _____

Email Address _____ May we contact you at work? Yes No

Are you affiliated with the University of Maryland Yes No ID # _____

Occupation _____ Employer _____

Name of person completing form _____ Relationship _____

Referred by _____ Marital Status _____ Spouse's name _____

Who lives in the home? _____

Race of Client* _____

0 = Not Reported

3 = Asian/Pacific Islander

1 = American Indian/Alaska Native

4 = Hispanic

2 = Black/African American

5 = White/Caucasian

* This information is requested because the University is a public teaching institution and will be used solely for the purpose of describing caseload diversity. Your response will not affect consideration of your application.

Educational History

Highest level of education achieved _____ Primary Language _____

Other languages spoken _____ Language spoken in the home _____

Do you have any reading and/or learning difficulties? Yes No

If yes, please describe _____

Present Speech, Language or Voice History

As complete as possible describe your speech and or language problem _____

How long have you had this problem? _____

What do you think caused this problem? _____

How has the problem changed since it was first noticed? _____

How does this problem affect you? _____

In your family? _____

Socially? _____

Vocationally? _____

Have you sought help for this problem elsewhere? Yes No

Please list the names of other clinics or agencies where you have been seen for evaluation or treatment of your communication problem.

Name	Location	Dates	Outcome
1.			
2.			
3.			

Medical History

Is there a medical reason for your present communication problem? Yes No

When did it occur? _____ Describe _____

If hospitalized, please give location and dates of hospitalization.

Hospital	Location	Date Admitted	Date Discharged
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Name of Physician treating this medical problem _____

Location _____ Phone _____

Do you have any other significant medical problems? Yes No

Describe _____

Do you have any eating or swallowing problems? Yes No

Describe _____

Please provide any additional information that might be helpful in our evaluation or treatment planning.



Consent Form

The Department of Hearing and Speech Sciences at the University of Maryland has three purposes: to train speech-language pathologists and audiologists, to render services to clients, and to conduct research in hearing, speech, and language. In order to meet these purposes, any of the following diagnostic, therapeutic, teaching, and/or research procedures may be used by authorized personnel within the department: direct observation, audio taping, video taping, photography, and review of client records. For research purposes, clients may be asked to participate in research projects conducted by authorized personnel. Client participation in any **research** project is strictly voluntary, and refusal to participate will in no way affect clinical services rendered to the client.

I consent to the participation of _____ in the clinical services of
Name of Client
the Department of Hearing and Speech Sciences at the University of Maryland.

In addition, I give permission for recordings (audio, video, photographic, transcripts, etc.) of clinical services to be permanently stored for review by authorized students and faculty of the Dept. of Hearing and Speech Sciences for the purposes of instruction/training for students and professionals in the discipline.

I grant this consent with the understanding that any use of privileged information, other than to meet the department's stated purposes, will not be undertaken without further written consent.

Signature: _____ Date: _____

Print Name: _____

Address: _____

Relationship to Patient: _____

The University of Maryland complies with all applicable federal, state, and local laws, including, but not limited to, the Americans with Disabilities Act of 1990, the Civil rights Act of 1964, the Equal Pay Act, the Age Discrimination in Employment Act, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 (to the Higher Education Act of 1965), the Rehabilitation Act of 1973, the Vietnam-era Veterans Readjustment Assistance Act 1974, and all amendments to the foregoing.



**Authorization for Release of Records
from the University of Maryland**

Patient Name: _____ DOB: _____

I hereby consent to the release of any and all hearing, language, and speech records for the individual named above to:

Name / Agency: _____

Address: _____

Name / Agency: _____

Address: _____

This information pertains to assessment and treatment by the Speech and Hearing Clinic, University of Maryland, College Park.

Signature: _____ Date: _____

Name: _____

Relationship To Patient _____

Witness: _____

FOR CLINIC USE ONLY – REPORTS TO BE MAILED

Report(s) Reports(s) Date Supv. Sig. Sent Sec



**Authorization for Release of Information
from Agency or Physician
to the University of Maryland**

Patient Name: _____ DOB: _____

Agency or Physician: _____

Address of Agency or Physician: _____

The above named person has requested the services of the University of Maryland Speech and Hearing Clinic. We understand that this individual was seen at your facility. Kindly forward any hearing, language, speech, medical, psychological, educational, or social information regarding the above named individual.

Please send your reply to the attention of Beth Coon, Office Manager, University of Maryland Speech and Hearing Clinic, College Park, MD 20742.

Thank you for your prompt cooperation.

Date: _____

This will certify that you have my permission to release information concerning the individual named above to the University of Maryland Speech and Hearing Clinic.

Signature: _____

Name: _____

Address: _____

Relationship

To Patient: _____

University of Maryland
Speech-Language Clinic

BILLING POLICY

Diagnostic evaluations are scheduled for three-hour time slots and billed at a flat rate (call for Fee Schedule). Full payment is due at the time service is rendered. Cancellations must be made more than 24 hours in advance of the scheduled testing date. Clients who cancel diagnostic appointments with less than 24 hours notice will be billed a \$75.00 fee.

Speech therapy fees are billed on a semester basis and are calculated based on the number of sessions per week multiplied by the weeks of service. Full payment is due on or before the first day of therapy unless specific alternate arrangements are made with the clinic office manager or clinic director.

Cancellations: Clients are responsible for paying for every scheduled session. Any sessions cancelled by clients (whether for vacation or illness) are not subtracted from the semester bill. Attempts will be made to arrange make-up sessions at times mutually convenient to both the client and clinician. However, if a make-up sessions cannot be scheduled, the client will be billed for the cancelled session.

If your clinician cancels a session for any reason or the University of Maryland in College Park closed for severe weather conditions, it is the clinician's responsibility to provide a make-up session. If a mutually convenient date is not available, then the clinic will cancel the charge for that therapy session.

Insurance: We encourage clients to investigate the possibility of insurance coverage for speech-language services. However, please note that clients are responsible for paying their bill in full on the first day of therapy and then requesting reimbursement from their insurance provider. The clinic cannot validate claim forms before semester bills have been settled. Clients should request that their insurance company reimburse them directly. If the insurance company sends a direct payment to the clinic, we will return it to the insurance company to be re-issued, to refund the client.

POLICY STATEMENT

The purposes of the University of Maryland Speech and Hearing Clinic are:

1. To provide a training facility for those students seeking to become certified speech pathologists and audiologists.
2. To provide an environment for research.
3. To provide speech and hearing services to the public.

Because the clinic is a training facility for students, services are provided to the public at a reduced cost. All students conducting clinical sessions are supervised by Speech-Language Pathologist and Audiologists licensed by the State of Maryland and certified by the American Speech and Hearing Association. The clinic operates by appointment only, and follows the academic calendar of the University of Maryland. Services of this clinic may occasionally be cancelled for professional meetings.

Since we have a commitment to provide varied experiences for students, acceptance into the clinical program is of a selective nature and cannot be guaranteed from semester to semester. In addition, we cannot assure you of immediate placement in our program following the initial examination. We make every effort to provide the needed rehabilitative services, but it is sometimes necessary for us to place prospective clients on a waiting list. If accepted into the program, clients are expected to maintain regular and punctual attendance. If frequent absence or tardiness occurs, we reserve the right to dismiss the client from our program. If a session is missed due to clinic emergencies, the session will be make up another time or the fee for that sessions refunded. Clients are responsible for payment of sessions they cancel.

We trust that the above policy statements will contribute toward a smooth running, pleasant experience for all those who participate in the program at the University of Maryland Speech and Hearing Clinic.