Explanation of Services

To Whom This May Concern:

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

***

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

310 North Riverpoint Blvd, Box V, Spokane Washington 99207-1675
E-mail: upcd@wsu.edu
Phone 509-828-1323 • FAX 509-368-6890

Eastern Washington University and Washington State University are equal opportunity, affirmative action institutions
CARE AGREEMENT

CONSENT TO AUDIO/VIDEO TAPE/OBSERVATION
The University Hearing & Speech Clinic is a student training and community service facility. As such, all patients are seen by graduate student clinicians who are directed and observed by licensed and certified faculty. These student clinicians may sometimes be required to videotape and/or audio tape part, or all, of the session for their training as Speech-Language Pathologists. These photographs, videotapes, and/or audio recordings of you also may be used to keep a record of your care and as an assessment and treatment tool during evaluation or treatment. In addition, some evaluation or treatment sessions may be observed by fellow student clinicians for educational purposes.

I understand that I am authorizing the University Hearing and Speech Clinic to take and use photographs, videotapes, and/or audio recordings from my sessions for the purpose of education and training. I also understand that sessions may be observed by fellow student clinicians for educational purposes.

This authorization will expire on 12/31/2099 OR when you revoke this consent by notifying the clinic in writing.

CONSENT TO TREAT
I, as a patient or representative thereof, give permission to graduate student clinicians of the University Hearing & Speech Clinic (UPCD) to provide necessary speech, language, and audiometric evaluations and to make instructional therapy plans in my best interest as a patient, or for the patient I represent. I understand that these graduate student clinicians will be working under the supervision of a state licensed and American Speech and Hearing Association (ASHA) certified Speech-Language Pathologist or Audiologist. 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.

SIGNATURE
If any part of this form is unclear or not fully understood please ask questions prior to signing.

By signing below I acknowledge that I have read (or had it read to you) and fully understand and accept the terms of this document and agree to receive healthcare from the University Hearing and Speech Clinic.

Patient or Authorized Representative Signature ___________________________ Date ____________

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Rev 8/2012
CLINICAL SERVICE AGREEMENT:  (Revised 8-1-2012)

Patient: ______________________________ Date of Birth: ______________________________

Current Address: ____________________________________________________________ City ___________________________ State ____________

Phone: (home) ___________________________ (work) ___________________________ Zip Code ______________________________

Contact Person (if different): ____________________________________________________

Please Indicate Your Method of Payment* (✓):

*Please note: Our facility is not a Medicare Provider

____ Self Pay

____ Insurance (Carrier)

Insurance ID #: ___________________________ Subscriber: ___________________________

Primary Care Physician: ___________________________ Office Phone#: ___________________________

No Show/Cancellation Policy:
Please notify us 24 hours in advance if you must cancel. Failure to attend three (3) sessions without at least 24 hours advance notice may result in forfeiture of scheduled appointment days and times and/or discharge from treatment.

Child Supervision Policy:
Parents/legal guardians are responsible for the supervision of their children during clinic visits. Parent/legal guardians are required to remain in the clinic area during treatment, in case of an emergency. The clinic does not assume responsibility for the care or supervision of children before or after sessions or the care of siblings during the session. Your cooperation is appreciated. Failure to provide adequate supervision may result in discharge from treatment.

Please Read Carefully:
If services are covered by your insurance company, the clinic will, as a courtesy, bill for you; however, you are ultimately responsible for the total cost of services. Medicare patients please note that services provided by the clinic are not covered. If your insurance company requires a referral, it is your responsibility to obtain the referral from your medical doctor. It is also your responsibility to fully understand your own insurance benefits and to keep track of both the number of visits allowed and number of visits used. Any benefit quotes provided to you by our office are solely based on information provided by your insurance carrier, and do not guarantee coverage for services. ___________ (Initials)

All co-pay and deductible amounts are expected to be paid on the date of service unless other arrangements have been made in advance. If you have a balance due after insurance has processed our bill, a statement will be sent to you. It will be your financial responsibility to pay this balance due and failure to do so may result in additional fees including late fees or collection fees. You will be held financially responsible to pay additional charges or fees associated with the collection of any unpaid accounts. ___________ (Initials)

I authorize the release of any medical records that might be necessary to facilitate payment for services and authorize my insurance company to make payments directly to us. I also understand that the Speech-Language Pathologists and Audiologists within the clinic have access to each other’s records without further authorization and that my records may be released to these other providers who are directly involved in my care. ___________ (Initials)

By signing below I acknowledge that I am over the age of 18, have read this document (or had it read to me), and fully understand and accept its terms and conditions.

Patient’s Signature (or responsible party) ___________________________ Date ___________________________

Revised August 2012
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.

_________________________________________ Signature of Applicant

Date of Application

******************************************************************************* 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
AUDIOLOGY CLINIC CASE HISTORY - ADULT

NAME: ____________________  AGE: ___  BIRTHDATE: __________

ADDRESS: ________________________________

CITY: ____________________  STATE: ___  ZIP CODE: ________

PHONE: HOME (   ) __________  WORK (   ) __________

SEASONAL ADDRESS (IF APPLICABLE) **

ADDRESS: ________________________________

CITY: ____________________  STATE: ___  ZIP CODE: ________

REFERRED BY: NAME: ____________________

ADDRESS: ________________________________

DATE COMPLETED: __________

REASON FOR VISIT: ____________________________________________

__________________________________________
1. **Have you ever had a hearing test before?**
   - YES ___  NO ___  WHEN___________

   If yes, please bring test results with you to appointment.

2. **Do you have any problems hearing?**
   - YES ___  NO ___
   - Which ear?  RIGHT ___  LEFT ___  BOTH ___
   - Better ear?  RIGHT ___  LEFT ___

3. **When did you first notice your hearing problem?**

4. **Is your hearing worse since you first noticed it, or since your last hearing test?**
   - YES ___  NO ___

5. **Was the hearing loss:**
   - GRADUAL ___  SUDDEN ___  FLUCTUATING ___

6. **What do you think caused your hearing loss?**

7. **Have you ever had ear infections?**
   - YES ___  NO ___
   - Which ear?  RIGHT ___  LEFT ___  BOTH ___

8. **Have you ever had ear surgery or P-E tubes in your ears?**
   - YES ___  NO ___
   - Which ear?  RIGHT ___  LEFT ___  BOTH ___

9. **Does anyone in your family have a hearing problem?**
   - YES ___  NO ___
   - If yes, list whom and type: ________________________________

10. **Do you hear noises in your ears or head?**
    - YES ___  NO ___
    - Which ear?  RIGHT ___  LEFT ___  BOTH ___
11. CHECK THE FOLLOWING THAT BEST DESCRIBE THE NOISES THAT YOU HEAR:
   HIGH-PITCHED RINGING ______ BUZZING ______ ROARING ______
   PULSATED ______ CRICKETS ______ RUSHING WATER ______ OTHER ______

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

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

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

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

16. DO YOU TAKE ANY MEDICATIONS REGULARLY?
   YES ______ NO ______
   LIST TYPE, QUANTITY, AND DURATION: ______________________________________

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

19. WHAT IS, OR WAS, YOUR OCCUPATION? __________________________
    ____________________________________________________________

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

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

22. IN WHICH SITUATION ARE YOU HAVING DIFFICULTY HEARING?
    WORK_____   T.V./RADIO_____   SCHOOL_____    
    SOCIAL ACTIVITIES_____ PERSONAL RELATIONSHIPS_____    
    PHONE_____   DIRECTION OF SOUND_____ 
    THEATERS/MOVIES_____ OTHER ________________________

23. PEOPLE OFTEN HAVE DIFFICULTY COPING WITH HEARING LOSS. ARE YOU
    INTERESTED IN DISCUSSING THIS WITH OTHERS AND LEARNING SOME
    TECHNIQUES TO DEAL WITH THIS DIFFICULTY?
    YES____   NO____
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 6  Rev Jan 2011
Request for Alternate Communications of Patient Information

I hereby request the following alternate communication method for communicating individually identifiable health information regarding me or another (if different, name of other patient: ______________________) from The University Hearing and Speech Clinic.

Alternate Communication Method Requested:

☐ I do 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 __________________

☐ I do give my permission for **email messages** regarding appointments, cancellations, and other clinic related issues to be sent to the following address(es):
________________________________________________________________________
________________________________________________________________________

Signature ___________________________ Date _________________________

Printed name __________________________

Relationship if not patient __________________________

Personal representative address __________________________
(if applicable)

The University Hearing and Speech Clinic must honor your request if the alternate communication method that you are requesting is reasonable. If The University Hearing and Speech Clinic finds the method that you have requested to be unreasonable, we will promptly notify you that it is unreasonable and why.

Signature of Designated Official or Designee __________________________ Date _________________________
Introduction

Eastern Washington University-Washington State University (University Hearing and Speech Clinic) provides patients the opportunity to communicate with their physicians, other health care providers, and administrative services by email. Transmitting confidential patient information by email, however, has a number of risks, both general and specific, that patients should consider before using email.

Risk Factors

- Among general email risks are the following:
  - Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
  - Recipients can forward email messages to other recipients without the original sender’s permission or knowledge.
  - Users can easily misaddress an email.
  - Email is easier to falsify than handwritten or signed documents.
  - Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.

- Among specific patient email risks are the following:
  - Email containing information pertaining to a patient’s diagnosis and/or treatment must be included in the patient’s medical records. Thus, all individuals who have access to the medical record will have access to the email messages.
  - Employees do not have an expectation of privacy in email that they send or receive at their place of employment. Thus, patients who send or receive email from their place of employment risk having their employer read their email.
  - If employers or others, such as insurance companies, read an employee’s email and learn of medical treatment, particularly mental health, sexually transmitted diseases, or alcohol and drug abuse information, they may discriminate against the employee/patient. For example, they may fire the employee, not promote the employee, deny insurance coverage, and the like. In addition, the employee could suffer social stigma from the disclosure of such information.
  - Patients have no way of anticipating how soon Eastern Washington University-Washington State University (University Hearing and Speech Clinic) and its employees and agent will respond to a particular email message. Although Eastern Washington University-Washington State University (University Hearing and Speech Clinic) and its employees and agents will endeavor to read and respond to email promptly, Eastern Washington University-Washington State University (University Hearing and Speech Clinic) cannot guarantee that any particular email message will be read and responded to within any particular period of time. Physicians, nurses, and other health care workers rarely have time during rounds, surgery, consultations, appointments, staff meetings, meetings away from the facility, and meetings with patients and their families to continually monitor whether they have received email. Thus, patients should not use email in a medical emergency.
Conditions for the Use of Email

- It is the policy of Eastern Washington University-Washington State University (University Hearing and Speech Clinic) that Eastern Washington University-Washington State University (University Hearing and Speech Clinic) will make all email messages sent or received that concern the diagnosis or treatment of a patient part of that patient’s medical record and will treat such email messages with the same degree of confidentiality as afforded other portions of the medical record. Eastern Washington University-Washington State University (University Hearing and Speech Clinic) will use reasonable means to protect the security and confidentiality of email information. Because of the risks outlined above, Eastern Washington University-Washington State University (University Hearing and Speech Clinic) cannot, however, guarantee the security and confidentiality of email communication.

- Thus, patients must consent to the use of email for confidential medical information after having been informed of the above risks. Consent to the use of email includes agreement with the following conditions:
  - All emails to or from the patient concerning diagnosis and/or treatment will be made a part of the patient’s medical record. As a part of the medical record, other individuals, such as other physicians, nurses, physical therapists, patient accounts personnel, and the like, and other entities, such as other health care providers and insurers, will have access to email messages contained in medical records.
  - Eastern Washington University-Washington State University (University Hearing and Speech Clinic) may forward email messages within the facility as necessary for diagnosis, treatment, and reimbursement. Eastern Washington University-Washington State University (University Hearing and Speech Clinic) will not, however, forward the email outside the facility without the consent of the patient or as required by law.
  - If the patient sends an email to [name of facility], one of its physicians, another health care provider, or an administrative department, Eastern Washington University-Washington State University (University Hearing and Speech Clinic) will endeavor to read the email promptly and to respond promptly, if warranted. However, Eastern Washington University-Washington State University (University Hearing and Speech Clinic) can provide no assurance that the recipient of a particular email will read the email message promptly. Because Eastern Washington University-Washington State University (University Hearing and Speech Clinic) cannot assure patients that recipients will read email messages promptly, patients must not use email in a medical emergency.
  - If a patient’s email requires or invites a response, and the recipient does not respond within a reasonable time, the patient is responsible for following up to determine whether the intended recipient received the email and when the recipient will respond.
  - Because some medical information is so sensitive that unauthorized disclosure can be very damaging, patients should not use email for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; mental health or developmental disability; or alcohol and drug abuse.
Because employees do not have a right of privacy in their employer’s email system, patients should not use their employer’s email system to transmit or receive confidential medical information.

Eastern Washington University-Washington State University (University Hearing and Speech Clinic) cannot guarantee that electronic communications will be private. Eastern Washington University-Washington State University (University Hearing and Speech Clinic) will take reasonable steps to protect the confidentiality of patient email, but Eastern Washington University-Washington State University (University Hearing and Speech Clinic) is not liable for improper disclosure of confidential information not caused by [name of facility]’s gross negligence or wanton misconduct.

If the patient consents to the use of email, the patient is responsible for informing Eastern Washington University-Washington State University (University Hearing and Speech Clinic) of any types of information that the patient does not want to be sent by email other than those set out above.

Patient is responsible for protecting patient’s password or other means of access to email sent or received from Eastern Washington University-Washington State University (University Hearing and Speech Clinic) to protect confidentiality. Eastern Washington University-Washington State University (University Hearing and Speech Clinic) is not liable for breaches of confidentiality caused by patient.

Any further use of email by the patient that discusses diagnosis or treatment by the patient constitutes informed consent to the foregoing. You may withdraw consent to the use of email at any time by email or written communication to [name of facility], attention: Director of Health Information.
Email Informed Consent Form

I have read the above risk factors and conditions for the use of email, and I hereby consent to the use of email for communications to and from Eastern Washington University-Washington State University (University Hearing and Speech Clinic) regarding my medical treatment.

Signature of Patient ___________________________ Date of Signature ___________________________

Printed Name of Patient ___________________________

Signature of Witness ___________________________ Date of Signature ___________________________

Printed Name of Witness ___________________________
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
University Hearing and Speech Clinic

University Programs in Communication Disorders
Eastern Washington University • Washington State University

Research Consent Form

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

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

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

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

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

Name of Client (please print) __________________________ Date ______________

Signature of Client or Parent/Legal Guardian __________________________ Date ______________

Doreen Nicholas, MS, MHPA CCC-SLP, Clinic Director __________________________ Date ______________

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Authorization 5

Rev 1/2011