

Dear Prospective Client:

Thank you for your request for speech-language services at the University of Maryland, Hearing and Speech Clinic. Before we can schedule an appointment, we request that the enclosed case history questionnaire, consent-to-participate form, and billing policy 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 or email us at hespclinic@umd.edu.

Sincerely,

Kay C. Lopez
Business Service Specialist
0110 Lefrak Hall
College Park, MD 20742
301-405-4218
301-314-2023 (Fax)
hespclinic@umd.edu
www.hesp.umd.edu

I: spPacket Rev 4/2019

SPEECH AND HEARING CLINIC
UNIVERSITY OF MARYLAND
0110 LEFRAK HALL
COLLEGE PARK, MARYLAND 20742
(301) 405-4218

CHILD CASE HISTORY FORM

Please answer the following questions as best you can and mail the form to the address given at the top of this page. If there are some questions which you cannot answer, leave them blank. Your answers will help us save time in understanding your child's problem.

I. ROUTINE INFORMATION

Name of your child: First name _____ MI: _____ Last name _____

Preferred Name: _____ DOB: _____ Age _____ Gender _____

Name(s) Parent #1 _____ Parent #2 _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work: Parent #1 _____ Parent #2 _____

Cellphone: Parent #1 _____ Parent #2 _____

Alt Contact Name & phone# _____

E-mail address: Parent #1 _____ Parent #2 _____

Name of person giving information _____

Relationship _____ Phone number if different from above _____

Who referred you to our clinic?: Name: _____ Phone #: _____

Insurance:

We do not participate with any insurer (including Medicaid and Medicare); therefore,

payment is due at the time of service. Because we are a non-participating provider, your insurance company will reimburse you directly. We cannot guarantee that you are eligible for coverage or reimbursement from them. Please contact your insurance company to verify benefits and reimbursement rates. We will provide you with information that you can submit to your insurance company.

Are you affiliated with the University of Maryland Yes : __ Student or __ Faculty/Staff UID # _____
No: _____

Race of the child* _____

- | | |
|------------------------------------|-----------------------------|
| 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 child's application.

Why has a speech evaluation been requested?

II. PRESENT SPEECH AND LANGUAGE STATUS

Does your child understand what you say to her/him? _____ If not describe her/his reactions: _____

Does your child have trouble understanding other people's speech? _____ Give examples: _____

Do you know why your child does not understand? _____ Please explain: _____

Does your child respond consistently to sounds in the home (doorbell, phone, etc.)? _____

Explain: _____

Do you suspect a hearing loss? _____ Why? _____

Does your child attempt to talk? _____ Is the child's speech understood by parents? _____

Siblings? _____ strangers? _____

What is your child's reactions when his/her speech is not understood? _____

What does your child do to express himself when his/her speech is not understood by others? _____

Does your child say as much as most children of the same age? _____ Give an example of a sentence your child might say: _____

Does your child pronounce words well? _____ List sounds or words that your child pronounces incorrectly: _____

Select one skill in each column that best describes your child:

responds to only loud sounds

makes no vocal sounds

responds only to sounds in the home

babbles only

understands single words

says single words

understands simple sentences

speaks in simple sentences

understands complex directions and sentences

uses complex sentences

uses only gestures

Does your child hesitate and/or repeat sounds or words? _____ How often does it happen? _____

When did you first notice this behavior? _____

Describe any struggle behaviors that accompany the hesitations/repetitions: _____

What, if anything, have you done about it? _____

Is your child's voice too high-pitched? _____ too low-pitched? _____ too weak or quiet? _____

Is your child's voice quality unusual? _____ If so, describe: _____

Is your child's speech too fast? _____ too slow? _____

Are there any physical causes for any of the above answers? _____ If yes. Please explain: _____

III. DEVELOPMENTAL HISTORY

A. Birth History

Mother's condition during pregnancy? _____

Full term? _____ If premature, how many weeks gestation? _____

Birth weight? _____ Any evidence of injury at birth? _____

If so, please describe: _____

Indications of weakness or poor health at birth? _____

Explain: _____

Any difficulty in initiating breathing? _____

B. Growth

During infancy, did your child demonstrate any feeding or swallowing problems? Please describe: _____

Has your child increased in height and weight normally? _____ If not, please describe: _____

C. Motor

Age of sitting up _____ Age of crawling _____ Age of walking _____

Does your child seem to have normal coordination for his/her age? _____ If not, please describe: _____

Which hand does your child use? _____

D. Speech Development

Did your child babble and coo during the first ten months? _____ At what age did your child use single words meaningfully? _____ Age for short phrases/sentences? _____

E. General Development

Does your child have opportunities to play with other children? _____ What ages? _____

How many? _____

Does your child like to play with other children or would your child prefer to play alone? _____

At what age did your child start feeding himself/herself? _____

Dressing himself/herself? _____ Become toilet-trained? _____

Does your child present any special behavior problems? _____ If so, please describe: _____

Check all of the following which describe your child:

- | | | |
|------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Friendly | <input type="checkbox"/> Unresponsive | <input type="checkbox"/> Temper Outbursts |
| <input type="checkbox"/> Happy | <input type="checkbox"/> Quiet | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Stubborn | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Tense |
| <input type="checkbox"/> Sensitive | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Talkative |

IV. MEDICAL HISTORY

A. List diseases/conditions and their effects and severity:

Disease/Condition	Age	Severity and Effects
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B. List significant injuries, ages and effects:

Injury	Age	Severity and Effects
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C. List operations and ages for each operation:

Operation	Age	Severity and Effects
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D. Name of child's current pediatrician _____

E. Address _____

F. Please list any conditions for which child is currently taking medication

Name and dosage of each medication _____

Does your child have any allergies or dietary restrictions? _____

V. SCHOOL HISTORY

A. Please complete all of the following that apply to your child:

	Name and Location	Age Entered	Dates Attended
Nursery School:	_____	_____	_____
Elementary School:	_____	_____	_____
Junior High:	_____	_____	_____
Senior High:	_____	_____	_____

B. Status

List subjects that are especially difficult for your child _____

Describe any serious behavior problems at school _____

Has your child ever repeated a grade? _____ Which one and why? _____

Has your child's school attendance been regular? _____

Describe your child's participation in after-school activities? _____

VI. SPEECH-LANGUAGE HISTORY

A. Describe any special work in speech and/or language in school _____

Dates _____ Group or individual sessions _____ Frequency _____

Name of therapist and school _____

B. Has your child received any speech/language services at any other clinic or agency? _____

Please list the names of other clinics or agencies where your child has been evaluated or treated for speech-language or hearing difficulties. Please attach copies of any reports to this form.

	Name	Location	Dates	Evaluated	Treatment
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

C. Describe any help given to your child by his family, friends, physicians, which has not been reported previously, in attempts to help your child correct his present speaking difficulties.

VII. FAMILY and SOCIAL HISTORY

A. Family
Parent #1's name _____ Age _____

Place of birth _____ Occupation _____

Education completed: _____ 8th grade _____ High school _____ College _____ Other _____

Parent #2's name _____ Age _____

Place of birth _____ Occupation _____

Education completed: _____ 8th grade _____ High school _____ College _____ Other _____

Names and age of brothers and sisters _____

Others in household _____

Describe any family history of speech/language or hearing difficulties (e.g. learning disabilities, stuttering, articulation impairment, deafness, etc.)

List any languages other than English that are spoken in your child's home or everyday environment _____

Please attach a recent photograph of your child. Since this photograph will not be returned to you, you need not send an expensive one. A snapshot will serve the purpose.



HEARING AND SPEECH CLINIC
Student Involvement, Collection of Video, and Research Contact Consent/Waiver Form

The Hearing and Speech Clinic is a student training facility. As such:

1. Services may be provided by students who are working towards their Master's degree in speech-language pathology or their Doctoral degree in audiology. These students are closely supervised by experienced speech-language pathologists and audiologists, who are faculty members of the Department of Hearing and Speech Sciences, certified by the American Speech-Language and Hearing Association (ASHA) and licensed by the Board of Examiners of the State of Maryland.
2. Your information may be used for educational or training purposes, but will be kept confidential.
3. Recordings of sessions may be taken for training purposes. These videos are not considered part of your medical record, and may be destroyed once no longer useful for training purposes.
4. Authorized students may have access to your medical files.

By signing below, I acknowledge that I have read, understand, and agree to the above.

Signature of patient or personal representative

Date

Printed name of patient or personal representative and his/her relationship to patient

In addition to being a training facility, the Hearing and Speech Clinic is also associated with the Department of Hearing and Speech Sciences, whose mission includes not only clinical training and clinical services, but also research. We would like for students and faculty to be able to review your records for potential study eligibility, and to contact you about research opportunities for which you might be eligible and interested. You may decline to participate in research at any time, and this will have no impact on your treatment in our clinic. Please sign here if you allow our faculty and students to review your files.

Signature

Date

UNIVERSITY OF MARYLAND HEARING AND SPEECH CLINIC

NOTICE OF PRIVACY PRACTICES (Short Version)

As Defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCUSSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

I. CLINIC'S COMMITMENT TO YOUR PRIVACY

The University of Maryland Hearing and Speech Clinic (Clinic) is dedicated to maintaining the privacy of your protected health information (PHI). PHI is individually identifiable health information about you that relates to your past, present or future physical or mental health or other condition, as well as any related health care services. This Notice of Privacy Practices (NOPP) provides you with the following important information: our obligations concerning your PHI; how the Clinic may use and disclose your PHI; and your rights with regard to your PHI. **A longer version of this NOPP is available on the Clinic's website and the Clinic will provide a hard copy upon request.**

II. UNIVERSITY STUDENTS

HIPAA requirements for PHI generally exclude student health information, but the confidentiality of such information is protected under the federal Family Education Rights and Privacy Act (FERPA), Maryland state law, and/or University Policy, as applicable. The Clinic recognizes the need for confidentiality and privacy with respect to student health information, and will use, disclose and otherwise treat your health information accordingly, following the requirements of applicable law and University policy (see Section IV below).

III. NON-STUDENTS

A. Clinic's Obligation. Federal and state laws require that the Clinic maintain the privacy of your PHI. By complying with these laws, the Clinic is required to provide you with this notice regarding its privacy practices, its legal duties, and your rights concerning your PHI. Except for student records and certain records the University creates or receives in its role as an employer, this NOPP applies to all records containing your PHI that are created or retained by the Clinic. A copy of the NOPP is posted in a visible location in the Clinic waiting room at all times, and you may request a copy of the NOPP at any time.

B. How The Clinic Uses And Discloses Your PHI. This paragraph describes, in general terms, the different ways the Clinic may use and disclose your PHI; it does not cover all possible uses and disclosures. The Clinic may use and disclose your PHI (1) to provide treatment and related health care services to you; (2) to bill and collect payment for the services and items you receive; (3) in connection the Clinic's health care operations, including administrative, financial, and legal activities; (4) to third-party business associates (e.g., billing services); (5) for health related services, such as recommending treatment alternatives; (5) to individuals involved in your care, unless you object; (6) under limited circumstances, for research purposes in accordance with applicable law and University policy; (7) when required or allowed by law; and (8) with your written authorization. For further information or if you have questions, please consult with the Clinic Directors (see below).

IV. YOUR RIGHTS REGARDING YOUR PHI

A. Non-Students. You have the following rights regarding the your PHI, and you may request any of the following:

(1) confidential communication of your PHI in the manner of your choosing; (2) restriction on communications with certain individuals otherwise permitted by law to inspect your PHI; (3) inspection of records containing your PHI; (4) copies of your records; (4) amendments to your PHI if you believe the information is incorrect or incomplete; (5) a list of disclosures we have made of your PHI; and (6) a copy of this NOPP.

B. University Students. University students have similar rights regarding their health information, including the rights to request confidential communications, restrictions on use or disclosure, inspection and copies, amendments, accounting of disclosures, and copies of this Notice. Those rights may, however, be implemented in different ways under FERPA, Maryland law, and/or University policy, as applicable. If you have questions about your rights regarding your health information, please contact the Clinic Directors (see below).

C. COPIES OF MATERIALS. You have a right to all of your medical records. Written authorization is required; the Clinic's records release form is available from the Clinic office. The Clinic can fax records or provide them in paper form; for the latter, the Clinic will charge \$0.25/page if the records are more than 5 pages.

V. IMPLEMENTATION, QUESTIONS, AND COMPLAINTS

A. Implementation. This NOPP provides a general overview of our privacy practices. This NOPP and our privacy practices are implemented in accordance with applicable University policies and procedures and the requirements of HIPAA and other federal and Maryland laws, as applicable.

B. Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Clinic. All complaints must be submitted in writing. We will not retaliate against you in any way if you file a complaint with us.

VI. CONTACT INFORMATION. If you have any questions regarding this Notice or our health information privacy practices, please contact:

Nicole Nguyen, Au.D., CCC-A
Director of Audiology Services
nknguyen@umd.edu
(301) 405 - 4221

Colleen Worthington, M.S., CCC-SLP
Director of Speech-Language Services, Clinic HIPAA Privacy Officer
ckworth@umd.edu
(301) 405 - 4238



**ACKNOWLEDGEMENT OF RECEIPT
HEARING AND SPEECH CLINIC NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of the University of Maryland Hearing and Speech Clinic's Notice of Privacy Practices.

Printed Name

Date

Signature

Relationship to Patient

.....
FOR INTERNAL USE ONLY

Client declined to provide signature for acknowledging receipt of privacy practices

Clinic Staff Signature and Date

Client was not able to provide signature for acknowledging receipt of privacy practices

Clinic Staff Signature and Date



HEARING AND SPEECH CLINIC

Patient Contact Preferences

Name of Patient: _____

I would prefer to be contacted for appointment reminders, etc. via the following mechanisms:

Email: _____
(please note that email is not a secure form of contact)

Phone: _____

You may leave a voicemail message at this number

You may leave a message with another individual at this number

Signature of patient or personal representative

Date

Printed name of patient or personal representative and his/her relationship to patient

BILLING POLICY (Required Form)

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 of the appointment.** 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. The weekdays and times identified for you are reserved for the entire semester. 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 session 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 refund the charge for that therapy session.

Insurance: Our clinic does not participate with any insurance plan (including Medicaid and Medicare). Payment is expected at the time that services are provided.

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 according to the terms of their payment agreement contract and then requesting reimbursement from their insurance provider. Clients should request that their insurance company reimburse them directly. We cannot guarantee that any of our services are eligible for coverage and reimbursement from your insurance plan. We will provide you with a receipt at the end of your visit (or the semester for Speech clients) with diagnosis codes and service codes for you to submit to your insurance company on your own. 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.

Financial hardship: If individual clients are experiencing financial hardship with payment of clinic fees, they may request consideration for a discount based on a sliding fee scale. Proof of income must be submitted to the clinic director, Colleen Worthington, in the form of the individuals'/family's most recent federal tax return (U.S. tax Form 1040).

Signature and Date

Yes, I read and understand the Clinic's billing policy

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.



HEARING AND SPEECH CLINIC AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA))

1. Authorization

I authorize the **University of Maryland Hearing & Speech Clinic** to use and disclose the protected health information described below to: Patient

(include address) _____

Additional Name/ Agency: _____

(include address): _____

2. Effective Period

This authorization for release of information covers the period of healthcare from (check one):

a. All periods until the present date

b. All past, present, and future periods

3. Extent of authorization

a. I authorize the release of my complete health record

b. I authorize the release of specific information: _____

4. This medical information may be used by the person I authorize to receive it (listed above) for medical treatment or consultation, billing or claims payments, or other purposes as I may direct.
5. This authorization shall be in force and effect until such time as it is revoked.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Date

Printed name of patient or personal representative and his/her relationship to patient



HEARING AND SPEECH CLINIC
AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA))

1. Authorization

I authorize the **University of Maryland Hearing & Speech Clinic** to obtain protected health information (described below) from:

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

2. Effective Period

This authorization for release of information covers the period of healthcare from (check one):

a. All periods until the present date

b. All past, present, and future periods

3. Extent of authorization

a. I authorize the release of my complete health record

b. I authorize the release of specific information: _____

4. This medical information may be used by the **University of Maryland Hearing & Speech Clinic** for medical treatment or consultation, billing or claims payments, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Date

Printed name of patient or personal representative and his/her relationship to patient

Notification of Use of Protected Health Information for Fundraising Purposes

We hope you appreciate the wonderful service you receive from our clinic! We would like to be able to reach out to you in the future both to evaluate your experiences here, and to be a supporter of the clinic. This would allow us to continue providing these valuable services to others in the community who need them.

With that in mind, this form is a courtesy notification to inform you that the administrative staff of the University of Maryland Hearing and Speech Clinic within the Department of Hearing and Speech Sciences and associated development officers of the College of Behavioral and Social Sciences may use your contact information (which constitutes protected health information) for fundraising purposes **in support of the University of Maryland Hearing and Speech Clinic ONLY.**

The health information that we may use for fundraising purposes includes:

- Patient demographic data (name, address, phone/email, date of birth, age, gender, etc)
- Dates of patient services
- General type of department from which the patient/client received services (Speech or Hearing)
- Information about the clinical faculty who supervised your services

This information will only be used to identify and contact you regarding opportunities to support the University of Maryland Hearing and Speech Clinic.

The health information that we will not use or disclose are as follows:

- Health insurance status
- Outcome information
- Diagnosis
- Nature of services
- Treatment

If you do not wish to receive any fundraising information from the University of Maryland Hearing and Speech Clinic, it is your right to opt out of any and all solicitations. If you wish to opt out, please check to box below and provide your name and date; otherwise thank you for your time and consideration.

I do NOT wish to receive fundraising information from the University of Maryland Hearing and Speech Clinic.

Printed Name: _____

Signature: _____ Date: _____