



University of Maryland Hearing & Speech Clinic

Adult Case History

To schedule an appointment, please submit these completed forms. Please attach any relevant reports or test results that you have. You can use the Authorization for Release of Information form to request that a speech-language pathologist or relevant physician send us any relevant test results.

Our clinic can often schedule evaluations relatively quickly, but there can be a significant waitlist for certain therapy services. We will schedule speech-language services as soon as possible.

Answer the questions as best you can. Leave any questions you cannot answer blank. This information will help us provide the best evaluation and/or treatment to meet your needs.

First name _____ Last name _____

Preferred Name _____ Gender _____ DOB _____ Age _____

Address: _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Cell Phone _____

Email Address _____ Preferred Method of Contact _____

Are you affiliated with the University of Maryland, College Park:

Student Faculty or Staff ID # _____
 Alumni No

Who referred you to our clinic? _____

Insurance Insurance Provider: _____

- **We cannot see anyone who has Medicare Part B.** We maintain a list of therapists that take Medicare and can refer you to a participating provider.
- **We do not participate with any insurer.** Payment is due at the time of service. Your insurance company *may* reimburse you for our services. Please contact your insurance company to verify benefits and reimbursement rates. We will provide you with information to submit to your insurance company.

Occupation (if applicable) _____ Employer (if applicable) _____

Name of person completing form _____ Relationship _____

Who lives in the home? _____

Race/Ethnicity of Client** _____

- | | | |
|----------------------------------|---------------------------|--------------------|
| 1. American Indian/Alaska Native | 3. Asian/Pacific Islander | 5. White/Caucasian |
| 2. Black/African American | 4. Hispanic | 6. Other _____ |

** This information is requested solely for the purpose of describing caseload diversity because the University is a public teaching institution. Your response will not affect consideration of your application. Leave blank if you prefer not to report.



Educational History

What is your educational background? _____ Primary Language _____

Other languages spoken _____ Language spoken in the home _____

Do you have any reading and/or learning difficulties? If yes, please describe _____

Present Speech, Language or Voice History

As complete as possible describe your speech/language/voice history _____

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

List other places where you have been seen for evaluation or treatment of this 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 |
|----------|----------|------|
| 1. _____ | | |
| 2. _____ | | |
| 3. _____ | | |

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.





University of Maryland Hearing & Speech Clinic Consent Form

The Department of Hearing and Speech Sciences at the University of Maryland has three purposes:

1. to train speech-language pathologists and audiologists,
2. to render services to clients, and
3. 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. Supervised students may be involved in both observation of sessions and conducting sessions. 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 programs of the
Name of Client

Department of Hearing and Speech Sciences at the University of Maryland and have been made aware of the direct involvement of students in the services rendered.

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.



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, Clinic HIPAA Privacy
nknguyen@umd.edu
(301) 405 - 4221

Kristin Kay Slawson, M.A., CCC-SLP
Director of Speech-Language Services
kslawson@umd.edu
(301) 405 - 8083



**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

Patient Contact Preferences

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

.....
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



University of Maryland Hearing & Speech Clinic

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. Your appointment days and times 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: We cannot see anyone who has Medicare Part B. We maintain a list of therapists that take Medicare and can refer you to a participating provider.

Our clinic does not participate with any insurance plan. We cannot bill your insurance. Payment is expected at the time that services are provided.

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

I read and understand the Clinic's billing policy

Signature and Date





University of Maryland Hearing & Speech Clinic POLICY STATEMENT

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

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

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. Clients who choose to decline services for a given semester (e.g., take summer break or sit out for fall) will no longer be considered as “active” and will be placed back on the therapy waitlist effective the date they inform us of their plans.

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.





Authorization for Release of Records from the University of Maryland

Use this form to request that records from the Hearing and
Speech Clinic be sent to another provider.

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

| <u>Report(s)</u> | <u>Reports(s) Date</u> | <u>Supv. Sig.</u> | <u>Sent</u> | <u>Sec</u> |
|------------------|------------------------|-------------------|-------------|------------|
|------------------|------------------------|-------------------|-------------|------------|





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

If you have any records relevant to speech and/or language that you would like sent to us from another medical provider, use this form. If you do not have any relevant records, you may leave this page blank.

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 the Clinic Coordinator, University of Maryland Speech and Hearing Clinic, College Park, Maryland 20742.

Thank you for your prompt consideration.

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 Hearing & Speech Clinic

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 the 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: _____

