STEPHEN F. AUSTIN STATE UNIVERSITY
Speech-Language Pathology Program
Stanley Center for Speech and Language Disorders
Nacogdoches, Texas 75962

Case History: Adult
The information on this form is <u>confidential</u> and will be used for professional use only.

CLIENT INFORMATION:

Client's last name: _____ First name: _____Middle initial: ____

Birth date: _____/_____/_____ Age: _____ Sex: ☐ M ☐ F

Name of person completing form: _____

Relationship to client: _____

Street address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) - _____-_____ Home Phone: (_____) - _____-_____

Email: _____

PERSONAL INFORMATION:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Spouses name: _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired

Job Title / Description: _____

Residential Living Status: ☐ Live Alone ☐ Live w/ Spouse/other adult ☐ Assisted Living Facility

Describe any family history of speech, language or learning disabilities of any kind? (i.e: stuttering, articulation impairment, lisp, language delay, etc.): _____

_____

_____

MEDICAL HISTORY:

List any diseases or conditions that may be impacting your speech/language abilities (i.e: autism, ADD, etc.): _____

Date of onset: _____

List any allergies or dietary restrictions: _____

_____

Are you currently taking medication(s) to manage any diseases/conditions? ☐Yes ☐ No

If yes, list medications: _____

_____

Is the condition for which you are seeking treatment a result of a stroke or Traumatic Brain Injury (TBI):
☐Yes ☐No

When did the incident occur? _____

What areas of the brain were impacted? _____

Do you have any paralysis? ☐ Yes ☐ No

Which side of your body is affected by the paralysis? ☐ Left ☐ Right ☐ Both sides

EDUCATIONAL:

Highest Level of Education Completed: _____

High School: _____

College: _____

Major: _____

FAMILY:

Mother: _____ Age: _____ Current Marital Status: _____

Educational Level: _____ Occupation: _____

Father: _____ Age: _____ Current Marital Status: _____

Educational Level: _____ Occupation: _____

Siblings Ages

Indicate whether each sibling lives with the patient or not, and whether each has any behavior, school, social or other problems.

_____

_____

_____

Do any other family members have a speech or hearing problem? Please state relationship to patient and describe problem. _____

_____

_____

Describe any factor in home which may relate to patient's problem. (Example of factors are: death, illness, conflict, etc.) _____

_____

SPEECH AND LANGUAGE HISTORY:

Have you ever received any speech and language services? ☐ Yes ☐ No

If yes, when and where did the speech services take place?

_____

Do you have any concerns about your hearing ability? ☐ Yes ☐ No

If yes, please explain your concerns:

_____

Have you had a hearing evaluation? ☐ Yes ☐ No

If yes, when and where was the hearing evaluation completed?

_____

What were the results of the hearing evaluation?

_____

CURRENT SPEECH AND LANGUAGE STATUS:

What are your areas of concern at this time? Please check all that apply.

☐ Receptive Language Skills (i.e., following directions, understanding concepts/questions, attention span)

☐ Expressive Language Skills (i.e., answering questions, limited vocabulary, forming grammatically correct sentences, word finding, stuttering, etc.)

☐ Articulation (i.e., difficulty producing specific sounds or sound combinations, intelligibility of conversational speech, lisp, etc.)

☐ Oral Motor Strength and Coordination (i.e., drooling, mouth/jaw/tongue strength and coordination, tongue protrusion)

☐ Vocal Quality (hoarseness, nasality, rate too fast/too slow, inappropriate pitch, etc.)

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____

Relationship to client: _____

Home phone no.: (___)_____

Work phone no.: (___)_____

* The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Speech Solutions or insurance company to release any information required to process my claims.

Signature: _____ Date: _____

CONSENT FOR COMMUNICATION

Clients frequently request that we communicate with them by phone, voicemail, email, or text. The Stanley Center for Speech and Language Disorders respects your right to confidential communication about your protected health information (PHI), as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide for us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. The Stanley Center for Speech and Language Disorders will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

Please indicate below what types of communication you give your consent for anyone at the Stanley Center for Speech and Language Disorders to use:

☐ I do not give my consent to use voicemail, email or texting communication

☐ I consent to receive communication using the following means (check all that you consent to):

☐ **Email**

☐ **Text**

☐ **Voicemail**

E-mail address you are consenting to communicate through: _____

Phone numbers you are consenting to communicate through (please list all):

_____

Client Name: _____

Client Signature or Authorized Representative/Guardian Signature:

_____

Date: _____

PERMISSION FOR TESTING AND TREATMENT

Approval is hereby given for our child to receive the appraisal services and treatment if warranted offered by the Stephen F. Austin State University's Stanley Center for Speech and Language Disorders. I understand that this evaluation and treatment will be done in the interest of the child's education development and will be supervised by a state licensed and ASHA certified Speech-Language Pathologist.

Signed: _____

_____
Relationship to Patient

PERMISSION TO RECORD/PHOTOGRAPH/OBSERVE

I hereby authorized the Stephen F. Austin Stanley Center for Speech and Language Disorders, exercising due discretions, for education and scientific/professional purposes, as in the public interest, to make customary and constructive use of information, photographs, and sounds recording, films and other records or materials pertaining to, and in consideration of, my enrollment, examination, instruction, and scientific participation, or that of my minor child(ren) _____ for whom I am legally responsible. The student clinician assigned may copy reports for the development of treatment plans.

Signed: _____

_____
Relationship to Patient

PAYMENT RESPONSIBILITY

We request that office visits be paid at the time service is rendered. Any unpaid balance is due within 30 days regardless of insurance claim status, unless otherwise specified.
I understand that I am responsible for all charges for the services rendered to me or my dependents regardless of insurance.

_____ _____
Client or Parent/Guardian *Date*

PROTECTED HEALTH INFORMATION

I have read the Notice of Health Information Practices provided by the Stephen F. Austin State University Stanley Center for Speech and Language Disorders. I understand how the clinic will utilize my or my child's protected health information (PHI) and my rights regarding my protected health information.

_____ _____
Client or Legal Guardian *Date*

Stephen F. Austin State University
Stanley Center for Speech and Language Disorders

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

_____ _____

CLIENT NAME DATE OF BIRTH

I undersigned, authorized the Stephen F. Austin State University Stanley Center for Speech and Language Disorders to acquire and/or release professional information to:

_____

Agency/Individual Name

_____

Address

_____

Phone Number

For the purpose of:

_____

_____

I authorize release of the following:

_____

_____

I understand that I may revoke this authorization by submitting a written request to the Stephen F. Austin State University Stanley Center for Speech and Language Disorders. Such a revocation does not apply to releases prior to the date of the request.

_____ _____

Client or Legal Guardian *Date*

Please Mail, Fax or E-mail Records to:

Speech-Language Pathology Program
Mail: P.O. Box 13019, SFA Station
Nacogdoches, TX 75962
Fax: (936) 468-7096
E-Mail: speechpath@sfasu.edu

BILLING NOTIFICATION

Fees will be calculated on a per-session basis using the following coding, unless prior payment arrangements have been made:

- ❖ Initial Evaluation - $75/evaluation
- ❖ Re-Evaluation (existing clients) - $30/evaluation (you will not be billed for more than one re-evaluation per year.)
- ❖ Treatment Session - $15/session

CANCELLATION/NO SHOW POLICY

1. **Cancellation/No Show Policy for Speech/Language Therapy Sessions**
    - We understand that there are times when you must miss an appointment due to emergencies or other obligations. However, when you do not call to cancel an appointment, you may be preventing your graduate clinician from getting required practicum hours.
        - If an appointment is not cancelled at least 24 hours in advance you will be charged for that session.
    - Therapy time will be automatically terminated with an accumulation of 3 absences without notification.

2. **Scheduled Appointments**
    - We know that delays can happen, however if you or the client are 15 minutes past their schedule therapy time without notification the appointment will be cancelled and viewed as “no show”.

3. **Account Balances and Payment Responsibility:**
    - We will require that patients pay their account balances monthly.
    - Patients who have questions about their bill or would like to discuss a payment plan arrangement may contact the front office at: (936) 468-7109.
    - Patients with prior balances must make arrangements to pay prior to the end of the semester.

I understand that I am responsible for all charges for the services rendered to me or my dependents regardless of insurance.

_____ _____

Client or Parent/Guardian *Date*