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

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
1= American Indian/ Alaska Native
2 = Black/ African American
3 = Asian/ Pacific Islander
4 = Hispanic
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
__responds only to sounds in the home
__understands single words
__understands simple sentences
__understands complex directions and sentences

__makes no vocal sounds
__babbles only
__says single words
__speaks in simple 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:

__Friendly	__Unresponsive	__Temper Outbursts
__Happy	__Quiet	__Shy
__Stubborn	__Aggressive	__Tense
__Sensitive	__Cooperative	__Talkative

IV. MEDICAL HISTORY

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

Disease/Condition	Age	Severity and Effects

B. List significant injuries, ages and effects:

Injury	Age	Severity and Effects

C. List operations and ages for each operation:

Operation	Age	Severity and Effects

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

Father's name_____Age_____

Place of birth_____Occupation_____

Education completed: _____8th grade _____High school _____College _____Other _____

Mother'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

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

Hearing and Speech Clinic
University of Maryland College Park
Consent to Unencrypted Email Communications for Clinical Progress Reports

The Hearing and Speech Clinic incorporates informational reports to clients/families about progress and homework assignments (together, "Progress Reports") designed to facilitate therapeutic progress. These reports do not contain Protected Health Information ("PHI") other than the client's name, a brief description of progress, and recommended activities to assist in making additional progress.

Email allows the Clinic to exchange information efficiently for the benefit of our patients and their families. As such, it is an important part of our programming. At the same time, we recognize that email is *not* an encrypted, completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

Thus, we view Progress Reports as an integral part of the treatment program. If you would allow us to send you Progress Reports via *unencrypted* and thus potentially *non-secure* email messages, please check the appropriate boxes and sign this consent form below. You are **not** required to authorize the use of email and a decision not to sign this authorization will not affect your care from the Clinic in any way (other than not receiving progress emails).

(Please note that if you authorize email use, HESP and the University are not responsible for disclosures that occur because (1) you have supplied the incorrect email address, and/or (2) the email address you supplied is shared or otherwise available to others.)

I consent to, and authorize the use of, unencrypted email when communicating Progress Reports with me and other authorized individuals as follows (check all that apply):

- ☐ Email address that we may use to send Progress Reports to you:

  _____

- ☐ Email address that we may use to send information to an individual (if any) whom you have authorized to receive Progress Reports: _____

I understand that I am responsible for notifying the Clinic if these email addresses change.

Printed Name of Patient: _____

Printed Name of Parent/Guardian: _____

_____ _____
Signature **Date**

YOU MAY REFUSE TO SIGN THIS FORM

---------- CLINIC USE ONLY ----------

☐ Yes, email addresses shown above have been verified using the NATO phonetic alphabet.
Verified on _____ (date)
Verified by: _____ (Clinic personnel)

University of Maryland
Speech-Language 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. 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).

_____ **Yes, I read and understand the Clinic's billing policy**
Signature and Date

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.

University of Maryland Speech and Hearing Clinic
0110 Lefrak Hall; College Park, Maryland 20742
(301) 405-4218

Authorization for Release of Records from the University of Maryland

Patient Name: _____ DOB: _____

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

Name / Agency: _____

Address: _____

_____

Name / Agency: _____

Address: _____

_____

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

Signature: _____ Date: _____

Name: _____

Relationship To Patient _____

Witness: _____

FOR CLINIC USE ONLY – REPORTS TO BE MAILED

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

spPacket

University of Maryland Speech and Hearing Clinic
0110 Lefrak Hall; College Park, Maryland 20742
(301) 405-4218

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

Patient Name: _____ DOB: _____

Agency or Physician: _____

Address of Agency or Physician: _____

_____

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

Please send your reply to the attention of Kay Lopez, Clinic Coordinator, University of Maryland Speech and Hearing Clinic, College Park, MD 20742.

Thank you for your prompt cooperation.

Date: _____

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

Signature: _____

Name: _____

Address: _____

_____

Relationship
To Patient: _____

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: _____