WELCOME to the University of Washington Speech and Hearing Clinic. The mission of our clinic is to be a center of excellence in education, research, and clinical practice serving speech, language, and hearing needs within the University and the community.

As a teaching and research facility, the services offered in the clinic are provided by our graduate students working toward advanced degrees. Audiologists and Speech-Language Pathologists who are nationally certified by the American Speech-Language-Hearing Association (ASHA) comprehensively supervise all services. In addition, our dispensing Audiologists are certified by the Washington State Department of Health.

While coming to the Speech and Hearing Clinic, our clients know that they are participating in an academic setting. This is a non-traditional outpatient clinical setting. The scheduling of services, the type of services offered, and the length of services received depends upon the academic needs and availability of our students, balanced with the needs of our clients. Please let us know if you have specific needs and questions regarding your scheduling of services.

The following information will acquaint you with our unique outpatient clinic and answer many of your questions. In addition, visit our web site at: shclinic.washington.edu

Registration Packet: The enclosed intake forms should be completed and returned to the clinic before your appointment. Your answers to the many questions will help us understand your special needs. The intake forms must be received by the clinic prior to your first visit. Please assist us by filling out the intake forms as completely as possible. In addition, include copies of reports and records (i.e., school reports, medical records) that you feel would be beneficial to us to know your history and current needs. With your permission, we may request additional records when necessary.

Consent: Carefully read the enclosed “Consent Form” so that you are informed of your financial obligations, the services we provide, and the type of recordings that may take place. The consent form must be signed and on file in the clinic prior to the initiation of services. If you have any questions about this form, please call us prior to your visit. You may bring it unsigned to the first visit and we will take time then to address your questions.

Confidentiality: Only after having the client’s written permission, or the permission of the client’s parent/legal guardian, will we provide information to or request information from an outside agency. We respect client privacy.

Location & Parking: The Speech & Hearing Clinic is located on the west side of the University of Washington campus at 4131-15th Avenue NE and is in the School of Social Work/Speech & Hearing building. Please refer to the attached map and instructions for information on parking options, disabled access, and alternative transportation details.

Fees: We are not a Medicare provider and we do not bill insurance companies, Medicare/Medicaid or other third party providers. We ask you to pay for your services directly. However, a highly regarded aspect of our clinic is our affordable fees for services. As a teaching and research facility, we strive to provide quality services at a reduced cost. We do accept clients with a valid Provider One and Molina Medicaid medical coverage issued by the Department of Social and
Health Services (DSHS) for services covered under the plan for speech and hearing services. In the event that DSHS limits or discontinues payment for services, the client becomes responsible for all services received and for services not covered by DSHS.

The most frequently occurring services in our clinic and the accompanying fees are:

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology Evaluation</td>
<td>$75-100</td>
</tr>
<tr>
<td>Speech-Language Evaluation</td>
<td>$200</td>
</tr>
<tr>
<td>Individual Speech Therapy</td>
<td>$35 per session</td>
</tr>
<tr>
<td>Group Speech Therapy</td>
<td>$15 per session</td>
</tr>
</tbody>
</table>

**We encourage our clients to pay at the time of each service and we welcome payment by cash, check or major credit card including Health Savings Account cards.** The client or legal guardian is responsible for the fees for services provided. Upon payment for services, the Clinic Office will readily provide you with a receipt. In addition, an Insurance Summary statement is available upon request and may assist you in seeking reimbursement from your insurance company or employer. Our Office Manager will be able to assist you if you have questions regarding payment or financial hardship.

**Academic Calendar:** As we are part of the University of Washington, our clinic follows the university calendar. The clinic is open during the four academic quarters of the year and closed for holidays and vacation breaks that are observed by the University of Washington. The Hearing Aid Fitting and Dispensing program does maintain “on-call” hours during vacation breaks.

For our clients who receive multiple quarters of services, they should anticipate having a different graduate clinician each quarter. Our graduate students rotate through clinical experiences as part of their degree program. To assure continuity of client care, the same Clinical Supervisor typically oversees a client’s services.

**Attendance:** Please call us 24 hours in advance of your appointment if you need to cancel or reschedule. After business hours, you are welcome to leave a voice mail message. When a client has three appointment “no shows” or “cancellations”, the graduate clinician’s educational program is adversely impacted. Therefore, services for that client may need to be deferred.

**Contacting Us:**
Mail address: U.W. Speech & Hearing Clinic  
4131 15th Avenue NE  
Seattle, WA 98105  
Phone: (206) 543-5440  
Fax: (206) 616-1185  
Email: shclinic@uw.edu

You are an integral part of who we are and we welcome you to our clinic. We pride ourselves on providing exceptional services. The Department of Speech and Hearing is ranked as a top program in the nation in its preparation of graduate students in Audiology and Speech-Language Pathology. We know you’ll be pleased that you have selected our clinic.

Respectfully,
Nancy B. Alarcon, M.S., CCC-SLP  
Clinic Director  
Joan W. Hanson  
Clinic Office Manager
APPLICATION FOR AUDIOLOGY SERVICES – CHILD

Please answer all items on this questionnaire the best you can. We are interested in learning about your child’s hearing problem from you. This information is confidential and will not be released without your permission. Wherever space is not sufficient, continue your answer on the back of the page. Mail your application back to us as soon as possible.

Today’s date: ___________ Child’s name: __________________________ Birth date: ___________ [Male] [Female]

Parent/Legal Guardian name: ________________________________________________________________

[Yes] [No] Lives with child? Relationship: __________________________________________________

Child’s Address: _______________________________________________________________________

(City, State, Zip) ______________________________________________________________________

Parent/Legal Guardian Address: ____________________________________________________________

(City, State, Zip) ______________________________________________________________________

Telephone numbers for parent/legal guardian:

Home: (_____) _____ - _______ Voice / TTY Who answers? ________________________________

Work: (_____) _____ - _______ Voice / TTY Who answers: ________________________________

Fax: (_____) _____ - _______ Home / Work

E-mail address: ____________________________

[Yes] [No] Has child been to our clinic before?

When? ____________________________________________________________________________

Who referred you to us? ______________________________________________________________

__________________________________________________________________________________

INSURANCE INFORMATION:

The Speech and Hearing Clinic Does Not Bill Insurance Companies. When services are paid in full by cash or check, the clinic will issue an Itemized Insurance Statement for you to submit to your Insurance Carrier for reimbursement to you. We DO accept Medical Coupons* from the State of Washington for payment.

*Medicaid Coupons (DSHS) YES:_____ NO:_______
(*We must have a current copy on file of a DSHS coupon per month for services rendered)

Other Insurance: ______________________________________________________

Address where reports and/or bills should be sent (if different from above address)

Bill to: ______________________________________________________________

Street Address _________________________________________________________

(City, State, Zip) ______________________________________________________

What would you like us to provide? Check all that apply.

☐ Hearing Evaluation (test child’s hearing and inform you of the findings)

☐ Hearing Aid Evaluation (discuss different kinds of hearing aids and determine if child would benefit

☐ Audiologic Rehabilitation (teach child speech-reading, listening and communication strategies)

Personal Background:

☐ Yes ☐ No Does child attend school/preschool?

Where? ________________________________________________________________

☐ Yes ☐ No Is child in special classes?

Describe? ______________________________________________________________

What does your child enjoy doing?

________________________________________________________________________

________________________________________________________________________

What other persons live with child? (List name and relationship of parent, brother/sister, friend, other)
General Medical Information

How is child’s general health?_______________________________________________________________

Major medical problems: ___________________________________________________________________________

Surgeries: _______________________________________________________________________________________

☐Yes ☐No  Ear infections. How many?__________Describe_____________________________________________

☐Yes ☐No  Tubes placed in ears? When?_________Describe____________________________________________

If child is taking any medications regularly, please write the medication and reason for taking it:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
<td>______</td>
</tr>
<tr>
<td>__________</td>
<td>______</td>
</tr>
<tr>
<td>__________</td>
<td>______</td>
</tr>
</tbody>
</table>

☐Yes ☐No  Was child’s birth normal? If no, describe_________________________________________________

☐Yes ☐No  Does child have physical handicaps? If so, describe________________________________________

Hearing Loss History:

What makes you concerned about child’s hearing?____________________________________________________

Do you think child’s hearing changes?_________________________________________________________________

When was child’s last hearing evaluation______________________________________________________________

Where was this evaluation done______________________________________________________________________

☐Right ear ☐Left ear  Which is child’s better ear?

At what age did child’s hearing loss begin?____________________________________________________________

How long has child had a hearing loss?_______________________________________________________________
What is the cause of child’s hearing loss:____________________________________________________

☐ Yes  ☐ No  Do child’s blood relatives have a significant hearing loss? Give the relationship (mother, aunt, etc.) and a bit about their hearing loss.

________________________________________________________________________________________

Add anything else you think might be important for us to know about child’s hearing loss.

________________________________________________________________________________________

________________________________________________________________________________________

Hearing Aid History:

When did child receive first hearing aids?  Right ear____________________  Left ear____________________

☐ Yes  ☐ No  Is child using hearing aids now?

Right ear                        Make and Model_____________________ Dispenser___________________ Year purchased____

Left ear                        Make and Model_____________________ Dispenser___________________ Year purchased____

☐ Yes  ☐ No  Are you satisfied with the help your child’s hearing aids provide?  If not, explain.

________________________________________________________________________________________

☐ Yes  ☐ No  Does your child likes to wear the hearing aids?  If not, explain:

________________________________________________________________________________________

If child is not wearing hearing aids now, how long has it been since they were worn?

________________________________________________________________________________________

Assistive Listening Devices History:

☐ Yes  ☐ No  Is child using any special devices to help with hearing? (FM, alerting devices, etc.)

If yes, describe them  ________________________________________________________________

☐ Yes  ☐ No  Is child using any special devices with the telephone? (amplified phone, cushions,etc.)

If yes, describe them.  ________________________________________________________________

Communication History:

☐ Yes  ☐ No  Do you have concerns about child’s speech/language?
Describe

[ ] Yes  [ ] No  Child has had speech/language evaluated?  Where

Results

[ ] Yes  [ ] No  Has your child taken classes in learning to communicate better?

Describe child’s most difficult communication problems.

____________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________

NOTE:  When visiting the clinic:

Please bring a copy of any hearing test results and any hearing aids child has to the first appointment.
Patient Authorization to Disclose, Release and/or Obtain Protected Health Information

Patient Name: __________________________ Date of Birth: __________ Telephone #: __________________________

Purpose of Disclosure:
☐ Attorney ☐ Insurance ☐ Provider ☐ Personal ☐ Other (specify) __________

INFORMATION TO BE RELEASED FROM:
☐ UW Speech & Hearing Clinic
☐ Harborview Medical Center & Clinics
☐ UW Medical Center & Clinics
☐ Northwest Hospital and Medical Center & Clinics
☐ Valley Medical Center & Clinics
☐ Hall Health Primary Care Center
☐ UW Neighborhood Clinics

OR:
_________________________ (Org/Person)
_________________________ (Address)
_________________________ (City, ST, Zip)
_________________________ (Phone/Fax)

INFORMATION TO BE RELEASED TO:
_________________________ (Org/Person)
_________________________ (Address)
_________________________ (City, ST, Zip)
_________________________ (Phone/Fax)

If requesting a copy of your own records, how would you like to receive the information? ☐ Paper ☐ CD

Type of Information (check appropriate box):
☐ Summary of Visit/Chart notes from date: __________ to date: __________
☐ All Medical Records from date: __________ to date: __________
☐ All Medical Records
☐ Images (specify type – radiology, endoscopy, e.g.) __________
☐ Other (specify type – discharge summary, operative reports, lab reports, billings, e.g.) __________
☐ I authorize VERBAL COMMUNICATION about my medical history and care.

OR:
☐ I authorize VERBAL COMMUNICATION ONLY about my medical history and care. (Checking this box means no physical records will be sent.)

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric condition.

I give my specific authorization for this information to be released: Yes____ No____

This authorization is valid until __________ (date) OR when the following event occurs:
(State when UW Medicine is no longer authorized to disclose my information based on this authorization. If no date or event is listed above, this authorization is valid for three years from the date on which it is signed.)

Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of one-year from the date signed by you.

By signing this page, I acknowledge that I have read and agreed to the terms on both sides of this form.

Signature (Patient Or Person Authorized To Give Authorization) __________________________

Date __________________________

If Signed by Person Other Than Patient, Provide Reason, Relationship to Patient, Description of Their Authority __________________________
AUTHORIZATION TO USE OR DISCLOSE PHOTOGRAPHY/VIDEO
& CONSENT for CARE AGREEMENT

PLEASE READ AND COMPLETE THE ENTIRE FORM IN ORDER FOR UW MEDICINE TO PROCESS THIS REQUEST

AUTHORIZATION TO USE OR DISCLOSE PHOTOGRAPHY/VIDEO

I, __________________________, authorize the following UW Medicine entity: UW Speech & Hearing Clinic

To take and or reproduce photos/video of my face or body for: EDUCATION & TRAINING (Purpose/disclosure of info)

Description of photos/video to be taken: SESSIONS OF MY EVALUATION AND/OR TREATMENT IN THIS CLINIC

Person / Organization to receive the information:

UW SPEECH & HEARING CLINIC & THE DEPT. OF SPEECH & HEARING SCIENCES

Information to be used or disclosed: Photographs, video and/or electronic media

This authorization expires on 01/01/2060 OR when the following event occurs: __________________________

(State when you want UW Medicine to stop disclosing information according to this authorization)

Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of 90 days from the date signed by you.

POTENTIAL FOR REDISCLOSURE: Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information.

Revocation: I understand I may revoke this authorization by submitting the revocation in writing to:

UW Speech & Hearing Clinic 4131 15th Ave NE Seattle, WA 98105, at any time.

Any revocation will not be effective to the extent that action has already been taken based on the original authorization or where UW Medicine requires the information in order to be paid for treatment provided to me.

I understand I have the following rights:

(a) To inspect or to receive a copy of my protected health information,
(b) To receive a copy of this signed authorization, and
(c) To refuse to sign this authorization.

I also understand: UW Medicine will not condition treatment or payment based on receipt of this signed authorization, except:

(1) UW Medicine may condition research-related treatment on provision of an authorization for the use or disclosure of my information for such research; or
(2) UW Medicine may condition health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party; for example, when a non-UW employer contracts with UW Medicine to conduct TB testing for purposes of employee health screening.

Continue on Page 2
**CONSENT for CARE AGREEMENT**

This form contains facts you should know about your health care at UW Medicine and from The UW Speech and Hearing Clinic. If there is any part of this form that is unclear you can ask questions about it. At the bottom of the form there is a place for you to sign your name so that we know you have read this form (or had it read to you) and agree to receive health care from us.

Your team consists of Graduate Student Clinicians, Speech Language Pathologist Supervisors, & Audiologists. By choosing to receive your speech and audiology services at the University of Washington Speech and Hearing Clinic, you will not only receive excellent care, but you are contributing to the education of future Audiologists and Speech Therapists. They will work together to diagnose and treat you.

*Photographs, videotapes, or other images of you may be used to keep a record of your care and treatment (including surgery). These images may become part of your medical record.

UW Medicine includes:
- UW Speech and Hearing Clinic
- Harborview Medical Center and Clinics
- UW Physicians Sports Medicine Clinic
- Hall Health Primary Care Center
- University of Washington Medical Center and Clinics
- UW Medicine Neighborhood Clinics
- UW Medicine Eastside Specialty Center
- UW Physicians

**PATIENT NAME (PRINTED)**

**DATE OF BIRTH**

**SIGNATURE** (PATIENT OR PERSON AUTHORIZED TO GIVE AUTHORIZATION)

**DATE**

**IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:**

- Guardian
- Durable Healthcare Power of Attorney
- Spouse/registered domestic partner
- Parent(s)
- Adult Brother(s)/sister(s)
- Adult Child(ren)

**FOR MINOR PATIENTS:**

- Guardian/legal custodian
- Court-authorized person for child in out-of-home placement Parent(s)
- Holder of signed authorization from parent(s)
- Adult representing self to be a relative responsible for the minor’s health

---

**FOR OFFICIAL USE ONLY**

**FOR OFFICE USE ONLY: REMARKS for UW Speech & Hearing Clinic**

AUTH TO USE/DISCLOSE PHOTOGRAPH AND CONSENT FOR CARE AGREEMENT:
(This section below is to be filled out by UW Medicine staff only)

<table>
<thead>
<tr>
<th>TYPE OF PHOTOGRAPH</th>
<th>SITE/DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PHOTOGRAPH</td>
<td>UW SPEECH AND HEARING CLINIC</td>
</tr>
<tr>
<td>2. VIDEO</td>
<td>UW SPEECH AND HEARING CLINIC</td>
</tr>
<tr>
<td>3. CLOSED CIRCUIT TELEVISION</td>
<td>UW SPEECH AND HEARING CLINIC</td>
</tr>
</tbody>
</table>

**COMPLETED BY:**

**DATE:**

UW Medicine Workforce Member

**Signature:**

**Date:**

---

UW Medicine - UW Medical Center - Harborview Medical Center - University of WA Physicians - Seattle, WA

AUTH TO USE/DISCLOSE PHOTOGRAPH AND CONSENT FOR CARE AGREEMENT *U0324/U0051*
Are you interested in being contacted and learning more about participating in research studies?

Filling out this form does not obligate you in any way. It merely allows a University of Washington researcher to contact you, explain their study, and answer any questions you may have. You may then decide whether or not you would like to participate. The information you give us, including your name, address and telephone number will be kept indefinitely. However, you may ask to be removed from the Participant Pool at any time. Your information will be stored securely and will only be shared with approved researchers. The information you give us will help us match you to the right study but you are free to leave out information that you do not wish to share.

### Contact Information

<table>
<thead>
<tr>
<th>Participant’s Name (Last, First):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent’s Name (if participant is a child):</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td></td>
</tr>
<tr>
<td>Primary Phone #:</td>
<td>Alternate Phone #:</td>
</tr>
<tr>
<td>Email Address:</td>
<td></td>
</tr>
</tbody>
</table>

Please remember that we can’t guarantee the confidentiality of information sent by email.

### Demographic Information

<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Male</th>
<th>Female</th>
<th>Right Handed</th>
<th>Left Handed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Language:</td>
<td>Other Fluent Language(s):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Racial Background &amp; Ethnicity (check all that apply):</td>
<td>American Indian/Alaska Native</td>
<td>Asian</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Black or African American</td>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>White</td>
<td></td>
</tr>
<tr>
<td>Other (specify):</td>
<td>Are you Hispanic or Latina/o?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

### Health Information

In order to help us match you to a study, please tell us if you have (had) any of the following:

YES (Check if yes, and describe if necessary.)

- Hearing Loss – Mild
- Moderate
- Severe/Profound – Age at onset:
- Hearing Aid(s) – Right Ear
- Left Ear
- Cochlear Implant – Date of Surgery: Type of Device:
- Difficulty understanding speech in the presence of background noise or in large rooms that echo
- Speech or Language Disorder – Describe:
- Reading or Learning Disability – Describe:
- Voice Disorder – Describe:
- Balance or Vestibular Disorder – Describe:
- Neurological Disorder – Describe:
- Stroke - When? On which side of the brain? Right
- Left
- Impaired Vision (Not able to be corrected with glasses/contacts.)
- Impaired Physical Mobility
- One or more of the above runs in my family – Describe:

In order to match you to a study, we may need to review your health records. We can only access your health records if you give us your signed permission. If you would like to give us this permission, please read and sign the attached form.

Department of Speech and Hearing Sciences 1417 N.E. 42nd St. Seattle, WA 98105 Ph: 206-616-9081
CSPP Clinic Enrollment rev. September 2013
HIPAA Authorization

For the Use of Patient Health Information for Research

Research Title: Human Subjects Recruitment Core
Lead researcher: Lynne A. Werner, PhD
Institution of lead researcher: University of Washington

A. Purpose of this form

The purpose of this form is to give your permission to the research team to obtain and use your patient health information. Your patient information will be used to do the research named above.

This document is also used for parents to provide permission to obtain the patient information of their minor children, and for legally-authorized representatives of subjects (such as an appropriate family member) to provide permission to obtain patient information of individuals who are not capable themselves of providing permission. In such cases, the terms “you” and “your patient information” refer to the subject rather than the person providing permission.

State and federal privacy laws protect your patient information. These laws say that, in most cases, your health care provider can release your identifiable patient information to the research team only if you give permission by signing this form.

You do not have to sign this permission form. If you do not, you will still be allowed to join the research study. Your decision to not sign this permission will not affect any other treatment, health care, enrollment in health plans or eligibility for benefits.

B. The patient information that will be obtained and used

“Patient information” means the health information in your medical or other healthcare records. It also includes information in your records that can identify you. For example, it can include your name, address, phone number, birthdate, and medical record number.

1. Location of patient information

By signing this form you are giving permission to the following organization(s) to disclose your patient information for this research.

- UW Medicine Department of Otolaryngology-HNS
- UW Speech and Hearing Clinic*
- CHDD Pediatric Audiology Clinic

2. Patient information that will be released for research use

This permission is for the health care provided to you during the following time period: from the time of your first visit to one of the organizations listed above until the end of this research study.

The specific information that will be released and used for this research is described below:

- Balance test records
- Hearing test records
- Health records related to your voice
- Speech or language test records
C. How your patient information will be used

The researcher will use your patient information only in the ways that are described in the research consent form that you sign and as described here.

The research consent form describes who will have access to your information. It also describes how your information will be protected. You can ask questions about what the research team will do with your information and how they will protect it.

The privacy laws do not always require the receiver of your information to keep your information confidential. After your information has been given to others, there is a risk that it could be shared without your permission.

D. Expiration

This permission for the researchers to obtain your patient information: ends when the research ends and any required monitoring of the study is finished.

E. Canceling your permission

You may change your mind at any time. To take back your permission, you must send your written request to:

Lynne A. Werner
Department of Speech and Hearing Sciences - Campus Box 354875
Seattle, WA 98195

If you take back your permission, the research team may still keep and use any patient information about you that they already have. But they can’t obtain more health information about you for this research unless it is required by a federal agency that is monitoring the research.

If you take back your permission, you will not need to leave the research study. Changing your mind will not affect any other treatment, payment, health care, enrollment in health plans or eligibility for benefits.

F. Giving permission

You give your permission to release your information by signing this form.

_____________________________________________________________________________________
Printed Name of Research Subject        Birthdate
_____________________________________________________________________________________
Signature of Research Subject       Date of signature
_____________________________________________________________________________________
Printed Name of Person Authorized to Give Permission
_____________________________________________________________________________________
Signature of Person Authorized to Give Permission                 Date of signature
_____________________________________________________________________________________
Relationship to Subject and Description of Authority
(Examples: parent of a young child; sister of an individual who is in a coma; researcher who signs for a subject who is unable to physically sign the authorization but was observed by the researcher to read and otherwise agree to the authorization.)

You will receive a copy of this signed form. Please keep it with your personal records.