

UNIVERSITY OF WASHINGTON
 SPEECH AND HEARING CLINIC
 4131 15th Avenue, NE
 Seattle, WA 98105-6299
 Telephone: (206) 543-5440 Fax: (206) 616-1185
<http://depts.washington.edu/sphsc>

<i>Clinic Use Only</i>
Date application received: _____
File # Assigned: _____
Entered into DB: _____
C:revised 6 02

APPLICATION FOR SPEECH AND LANGUAGE SERVICES - ADULT

Date the application was filled out: _____
 Have you been seen by our clinic before? Yes No
 If Yes, when? _____

Section I.

ø Identification Information

Name : _____ Birth Date : _____ Male Female
 Street Address : _____
 (City, State, Zip): _____
 Home Phone: _____
 Alternate Phone : _____
 Email Address: _____

Spouse, Parent(s) or Legal Guardian(s)	Relationship (e.g., mother, father, aunt, husband, wife)	“x” if lives with you

Services Desired (Please check those service you would like from this clinic)

Consultation/Screening/Voice Individual Treatment
 Evaluation Group Treatment
 Other _____

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

Bill to: _____
 Address: _____

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: _____

Other Family Members: Please list the members of the your family, including spouse, parents, and children. Include any other persons living in the home. Make an "X" in front of the name of family members living in the home.

"X" If lives w/ adult	Name	Age	Relation to Adult	Education Level	Present Employment or School Attending

Other Phone Numbers: _____

B. Referral Information

Who referred you to us?	From what institution/agency?

Section II. Communication:

ø **Current Communication Concerns/Needs/Questions:**

Please feel free to add information on other sheets if you wish

Section III. Medical History:

A. Medical Diagnosis: _____

When	
By Whom	

B. Communication Diagnosis (if known): _____

When	
By Whom	

C. Physician:

Name _____

Address _____

Phone _____

D. Other agencies or specialists who have provided *medical* services (i.e., surgery, neurology) to you:

1. Name of specialist _____ Specialty _____

Name of Agency _____

Address _____

Phone _____

What did they do? _____ When? _____

2. Name of specialist _____ Specialty _____

Name of Agency _____

Address _____

Phone _____

What did they do? _____ When? _____

E. Current Medications:

Type/Name	How much	How often	What is it for?

Please feel free to add information on other sheets if you wish

Section IV.

A. History of Speech, Language, Voice, Hearing, Cognition

Do you have a history of speech, language, voice, hearing, or cognitive difficulties from birth to present? YES _____ NO _____ Comments: _____

Please describe your previous speech-language evaluation and/or therapy (i.e. school, clinic, hospital, etc):

Services Received

When

Where

Services Received	When	Where

B. Concerns:

Are you currently or have you been seen by specialists (such as speech and language pathologists, psychologists or occupational therapist) for evaluations or therapy? Yes No

If yes, please indicate who saw you:

1. Name of specialist _____ Specialty _____
 Name of Agency _____
 Address _____
 What did they do? _____ When? _____

2. Name of specialist _____ Specialty _____
 Name of Agency _____
 Address _____
 What did they do? _____ When? _____

3. Name of specialist _____ Specialty _____
 Name of Agency _____
 Address _____
 What did they do? _____ When? _____

Please send copies, with this application, of any reports of evaluations or treatments that you have received in the past.

C. Hearing History:

Have you had a hearing test or hearing screening? Yes No
 If yes, *when* was the most recent? _____
 Who did it? Name _____
 Agency _____

What were the results? Normal Not Normal

If not normal please explain _____

Section V. Educational and Vocational History

Please indicate below the schools you have attended:

School Name	Location	When?	# of Years	Degree

Please briefly list your employment/work settings starting with most recent:

Job	Years Worked

If you have been employed, are you still working? Yes No
 If no, please explain:

If you have stopped working, do you have plans to return to work? Are you receiving assistance with vocational planning through an agency such as DVR?

Section VI. Other Information

A. Communication Partners

Who do you spend time with each week, or on a regular basis, communicating and interacting with? Please list their names and relationship to you:

Name	Relationship

B. Leisure Activities

Please tell us how you typically spend your day: including daily, weekly monthly recreational activities, hobbies, organizations you attend:

C. Any Additional Information

Additional Comments or Information you would like to share with us (e.g. scheduling difficulties, pending surgeries, etc.):

*Thank you for taking the time to fill this application.
It will help us provide the best services we can for you.*

Edited 11/18/2003

**Speech and Hearing Clinic
University of Washington
4131 – 15TH Avenue NE
Seattle, WA 98105**

Instructions: Please read this consent form carefully. If you are comfortable with the contents therein, please sign this form and return it with your application materials. If you have any questions or concerns about this form, please return the application without it. Then bring this form (unsigned) to the first appointment.

Consent Form

This Service Agreement and Consent (“Agreement”) is between you and the University of Washington Speech and Hearing Clinic (“the Clinic”). This Agreement concerns: (1) your financial obligations; and (2) your consent to have recordings made of the person receiving services (the “client”) and/or the person authorizing services (the “authorizing individual”).

1. Your Financial Obligations

You are responsible for the fees for service stated on the attached face sheet. The Clinic does not directly bill insurance companies or Medicare/Medicaid. You are responsible for payment of all fees to the Clinic regardless of any such coverage. The Clinic will furnish you an itemization of services received and paid for in cases where insurance companies will reimburse for services.

The exception to the above is if you have valid medical coupons issued by the Department of Social and Health Services (DSHS). In that case, you must show a current medical coupon to verify eligibility and your clinic fees will then be waived.

Fees are subject to change without notice

2. Your Consent for Services and Recording

The services offered to individuals seen in the Clinic and its affiliated laboratories are part of the University’s education program. University of Washington faculty, staff, and students receive educational benefits from observing diagnostic, treatment, and other services offered in the University of Washington facilities.

2a. Minimum Consent:

By accepting services from the Clinic and its affiliated laboratories, you consent to observation by University of Washington faculty, staff, and students, either live, via recording or via closed circuit television when you (or the client) receive services.

2b. Additional Consent:

In addition, the University of Washington may make audio and/or video recordings of you (or the client) during such service periods to be used for the University’s educational, research or technology transfer purposes provided the name of the client or other personal identification information is not revealed. The University may use, distribute, reproduce, and display these recordings, in whole or in part and in any media now known or later developed (including the World Wide Web, television and/or CD-Rom) or may permit others to do so. Such uses may include, but are not limited to, the following:

- Viewing/listening by registered students or participants in activities conducted, sponsored or licensed by University of Washington faculty or staff.
- Viewing/listening by the general public at activities or through media sponsored or licensed by the University of Washington or its faculty or staff. (e.g. Internet/World Wide Web, University of Washington TV)
- Viewing/listening by the general public through licensed commercial enterprises for

educational or research purposes, for example a CD-Rom enclosed in a textbook. Again, if you have any questions or concerns about these uses of recordings, please bring this form (unsigned) to the first appointment to discuss alternatives.

Name of client

Date

Signature of Authorizing Individual

Relationship of Authorizing Individual to the Client:

- Self
- Parent
- Legal guardian
- Other. Please explain relationship: _____

Printed Name of Authorizing Individual: _____

Address of Authorizing Individual: _____

Phone Number of Authorizing Individual: _____

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For Office Use Only:

Date Received: _____

Received by: _____

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Seattle, WA 98105

Phone: (206) -543-5440

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I hereby give permission for the mutual exchange of information regarding:

(Clients First Name Middle Name Last Name) (Date of Birth)

between the University of Washington Speech and Hearing Clinic and the following agency, professional or individual:

(Name)

(Address)

(City) (State) (Zip)

Attention: _____

This release is good for ninety (90) days from the date below and must be renewed for use beyond that time. I understand that I will be notified of any other requests for information that are received by this office, in order to give my permission to release this information of the above named individual. I understand this information will be shared for professional use only and that confidentiality will be maintained. I may revoke this release in writing at any time.

(Signature of Client or Guardian)

(Date)

(Signature of Client or Guardian)

(Date)

(Signature of Client or Guardian)

(Date)

(Signature of Client or Guardian)

(Date)