Idaho State University

ISU Speech and Language Clinic
1311 E. Central Dr., Meridian, ID 83642
Phone: 208.373.1725 / Fax: 833.390.1293

Pediatric Patient Profile

Patient Name: _____ **DOB:** _____

School: _____ **Grade:** _____ **Age:** _____

Parent/Guardian: _____

Emergency Contact: _____ **Phone No.:** _____

Address: _____ **City & Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Is it ok for us to leave a message regarding your child's treatment at the following #s?

Home: ☐ Yes ☐ No **Cell:** ☐ Yes ☐ No

Reasons for Rehabilitation

Diagnosis/Conditions/Reasons you are seeking rehabilitation services: _____

_____

Your Primary goal for therapy is to be able to? _____

_____

_____

Health History

Birth History: _____

_____

Developmental Milestones: (At what age did your child independently achieve)

Sitting Up: _____ Babbling: _____ Put Words Together: _____

Crawl: _____ Eat Solid Foods: _____ Understood by Strangers: _____

Walk: _____ 1st Word: _____ Toilet Trained: _____

Current No. of Words: _____

How much is your child understood by family? ☐ None ☐ Some ☐ Most ☐ Totally

How much is your child understood by strangers? ☐ None ☐ Some ☐ Most ☐ Totally

Medical Issues:

Does your child now have (or have you had) any of the following conditions? Please check all that apply.

Ear Infections	☐ Y ☐ N	Stress Disorders	☐ Y ☐ N	Stroke	☐ Y ☐ N
Tongue Thrust	☐ Y ☐ N	Developmental Delay	☐ Y ☐ N	Seizures	☐ Y ☐ N
Hoarseness	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Pneumonia	☐ Y ☐ N
Cleft Repair	☐ Y ☐ N	PE/Ear Tubes	☐ Y ☐ N	Asthma/Hay Fever	☐ Y ☐ N
Tonsillectomy	☐ Y ☐ N	Headaches/Migraines	☐ Y ☐ N	Swallowing/Feeding	☐ Y ☐ N
Head Injury	☐ Y ☐ N	Concussion	☐ Y ☐ N	Other: _____	☐ Y ☐ N

How would you describe your child's general health? ☐ Good ☐ Fair ☐ Poor

If fair/poor, please explain: _____

_____

_____

List any dietary restrictions (diabetic, food allergies, etc.): _____

_____

Are there any other health problems that you would like us to know about? ☐ Yes ☐ No

If yes, please explain: _____

_____

Does your child use a wheelchair, walker, or other assistive device for mobility? ☐ Yes ☐ No

If yes, identify which type of device: _____

Has your child had any previous surgeries? ☐ Yes ☐ No If yes, please explain below.

	Surgery/Procedure	Month/Year
1.		
2.		
3.		
4.		

Does your child have any allergies? ☐ Yes ☐ No If yes, please list any allergies and the reaction your child experiences to each below (e.g., allergies to medications, latex, foods, products, etc.)

	Allergen	Reaction
1.		
2.		
3.		
4.		
5.		

Medications:

Is your child currently taking any medication? ☐ Yes ☐ No If yes, please list below.

1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Previous Therapies:

Type of Therapy	Dates	Agency	Name of Therapist
Speech Therapy			
Physical Therapy			
Occupational Therapy			
Psychological/Counseling			
Other Rehab			

Special Needs: (Please check all that apply)

Vision: ☐ No Problems ☐ Glasses/Contact Lenses ☐ Visual Difficulties ☐ Glasses for Reading ☐ Require Enlarged Print

Communication: ☐ No Problems ☐ Difficulty Reading ☐ Difficulty Writing

☐ Communication Needs/Devices/Assist, please specify: _____

_____

Hearing: ☐ No Problems ☐ Hearing Aid(s) ☐ Difficulty Hearing

Areas of Concern:

Production of Speech Sounds	☐ Yes	☐ No	Voice	☐ Yes	☐ No
Understanding/Following Directions	☐ Yes	☐ No	Stuttering/Fluency	☐ Yes	☐ No
Understanding Questions	☐ Yes	☐ No	Understanding/Speaking English	☐ Yes	☐ No
Expressing Ideas/Wants/Needs	☐ Yes	☐ No	Pragmatics/Social Language	☐ Yes	☐ No

Below are words to describe your child's personality and behavior. Circle all that apply.

Happy	Aggressive	Depressed	Enthusiastic	Friendly
Warm	Independent	Energetic	Distractible	Jealous
Tense	Prefers to be Alone	Dependent	Affectionate	Relaxed
Critical	Easily Fatigued/Tired	Directive	Can't Sleep	Impatient
Shy	Vigorous	Calm	Irritated	Angry

List description(s) not listed above: _____

Interests/Activities:

How does your child feel about therapy? _____

How does your child feel about unfamiliar people/situations? _____

How does your child transition? _____

Tips that help you with transitions? _____

How does your child typically communicate with you? _____

What are your child's favorite things? _____

What are your child's favorite activities/hobbies? _____

What are your child's favorite motivators? _____

What are your child's least liked things? Avoidance? _____

How does your child react to them? _____

Is your child aware of his/her communication difference? _____

Is your child concerned about his/her communication difference? _____

Is there anything else you would like us to know that would help us to best serve your child's needs?

_____

_____

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Consent for Participation

I _____, give permission for the faculty and students of the Idaho State University Speech and Language Clinic to use information gathered from my participation in educational training. I understand that students, under the supervision of fully licensed and certified faculty clinicians, will be observing and conducting my treatment and/or evaluation as part of the student's education, and direct supervision may occur onsite or via secure remote access from a different location. In addition, I also understand that students in the educational process will be reviewing my evaluation and treatment results and records.

I understand that the treatment and/or evaluation will be observable by patient family members through the group observation area. I am aware that other parents, guardians, and family members will also be in the observation sessions and may be able to see or hear my child's and/or family member's therapy session.

I understand that as part of the treatment and/or evaluation process, aspects of the process will be videotaped for the educational process of the student, for analysis of patient communication, and for educational activities within the department. These videotapes will be used in the treatment and/or assessment process and will be destroyed when the information gathering process is complete or will be kept in a secure location within the department.

I understand that I can withdraw from my participation at any time during this experience and revoke my permission to use the information pertaining to my case. If I elect to withdraw and revoke my permission, I will inform the Clinic Director and the Department Chairperson of this action in writing. I further understand that a copy of this form will be given to me upon my request, and the original will be kept on file in the Department of Communication Sciences & Disorders.

The Idaho State University Speech and Language Clinic does not discriminate against any person on the basis of race, religion, color, creed, national origin, disability, age, gender, sexual orientation, gender identity, genetic information, veteran status or any other status protected by federal, state or local law in admission, treatment, or participation in its programs, services and activities.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative *Date*

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

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Telehealth Patient Consent Form

Purpose: The purpose of this form is to get consent for participation in a model of healthcare called telehealth. Telehealth involves the use of electronic communications to enable healthcare providers to share individual patient medical information for the purpose of improving patient care and providing care at a location separate from the provider. ISU will be using ZOOM remote technology to evaluate/re-evaluate virtually as well as provide speech-language therapy.

What is a Telehealth Consultation: Telehealth is a tool used to help people who cannot go to a healthcare provider's office to receive an examination or consultation. Telehealth uses electronic records including your health history and other information. Your consultation with the provider and these records will be used to address your health concerns or recommend further treatment.

What are the Risks, Benefits, and Alternatives?: The benefits of telehealth include having access to a healthcare provider without travelling to a provider's office or clinic. A potential risk of telehealth is that a face-to-face consultation with a healthcare provider may still be necessary after the telehealth appointment. At any time during the consultation, you may choose to end the session and seek care in our clinic based on availability.

Confidentiality: Current federal and Idaho laws about confidentiality apply to the information used or disclosed during your telehealth consultation. In rare cases, some of your records may unintentionally become available to people not connected with the consultation. You will be provided with a separate document, which describes how your private information will be handled. This is known as the "Notice of Privacy Practices."

Rights: You may choose not to participate in a telehealth therapy session at any time before and/or during the consultation. If you decide not to participate it will not affect your right to future care or treatment. You have the option to seek consultation or treatment in an office at any time before or after the telehealth consultation.

Fees associated with Telehealth: We have not changed our fee structure and will not be billing insurance for visits performed by Student Clinicians.

I have read and understand the information provided above regarding telehealth, have discussed it with my provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

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Photo, Interview and Media Consent Form

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Idaho State University Speech and Language Clinic and its affiliates and agents to take photographs or produce videotapes, audiotapes, electronic files, or other types of media production that capture my name, voice, and/or image, to be used for publicity purposes including:

- News media (online, print and or broadcast)
- Publications and/or promotional materials
- Closed circuit television programs
- Advertisements
- Websites and social media
- Medical and educational training and promotion
- Recruiting professional

The information to be disclosed includes (check all that apply):

- ❑ Photographic images of me
- ❑ Video or audio of me and/or my voice
- ❑ Information about my medical condition and/or prognosis
- ❑ Information about date(s), time(s), and type(s) of treatment received
- ❑ Other: _____

This authorization will be used by the Department of Communication Sciences & Disorders, Education of the Deaf at Idaho State University for a period not to exceed 10 years from the date of this authorization.

I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to ISU's Privacy Officer:

ISU HIPAA Compliance Officer:

Misty Olmsted
921 S. 8th Avenue, Stop 8410
Pocatello, ID 83209
(208) 282-4380
Email: HIPAA@health.isu.edu

I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative *Date*

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

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Notice of Disclosure

The purpose of the ISU Speech and Language Clinic is to provide training for graduate students. Graduate students observe, evaluate, and treat clients under the direct supervision of a licensed faculty clinician. While all services provided are supervised under program guidelines developed by the American Speech-Language-Hearing Association (ASHA), these services are often considered non-covered by insurance as defined below.

- **Medicare / Medicaid Participants**: We understand that you may have recently completed therapy under a certified plan of care with another speech therapist. We further understand that, even if your prior therapist has concluded that you have completed the course of therapy under that plan of care, you would like to continue working with our speech therapy students on the skills you have learned, to improve your general welfare, and to support the training mission of the Speech and Language student training program.

  Since the Medicare / Medicaid program does not cover services furnished under the policies and procedures of the student training program, you will be personally responsible for the fee established by ISU for the services provided by students in training. No Medicare / Medicaid payment may be made and, accordingly, no claims will be submitted to Medicare / Medicaid for these services.

- **Private Insurance:** Under our current insurance contracts, services furnished under the policies and procedures of the student training program are considered non-covered. Therefore, you will be personally responsible for the fee established by ISU for the services provided by students in training. No insurance payment may be made and, accordingly, no claims will be submitted to your insurance for these services.

While participating in the student training program, you will receive periodic evaluations by students under the supervision of their instructors as part of their training. If those evaluations reveal that your condition may warrant further evaluation by your physician and qualify as covered services under a new speech therapy plan of care, we would recommend that course of action to you and refer you to another clinic.

Regular attendance is critical to our student's learning experience. Patients with excessive cancellations and/or no shows will be discharged from our program.

The initial evaluation fee is $75.00 (charged annually) and the individual therapy session fees for the semester are combined into a flat fee of $300. The semester fee of $300 covers a minimum of 20 visits per semester. Opportunities for make-up sessions will be available for cancellations.

As a client of the ISU Speech and Language Clinic, I understand that my insurance will not be billed for student services and that I will not submit a claim for these non-covered services. I also understand the attendance policy and will strive to attend regularly. I also understand that my account needs to be in good standing to participate in the program.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative *Date*

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Scottish Rite Foundation of Idaho
Application for Funding Assistance

The Scottish Rite Foundation, a philanthropy of Scottish Rite Freemasonry in Idaho, was established in 1953 to help families pay for speech-language and learning intervention at Foundation approved programs. Thousands of children and their families have received this help. In 2018, Idaho State University was officially recognized as a Scottish RiteCare Facility. Scholarship funds are awarded to patients based on financial need.

I agree to the following:

1. Completion of ISUs Application for Fee Assistance every semester.
2. Patient co-payments must be paid monthly in order to receive SRF funds. Delinquent accounts will forfeit SRF funds.
3. Parent involvement and participation with the planning of intervention program with your child's clinician is expected.
4. Completing any home-based programs as recommended.
5. Attending sessions on a regular and consistent basis is required. Patients with chronic no-shows and cancellations will be dismissed.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative *Date*

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

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Application for Fee Assistance

Contact Information:			
Patient Name:		**DOB:**	
Street Address:		**Phone:**	
City and State:		**Zip Code:**	

Household:			
Total Number in Household:			
Self			
Spouse or Partner			
Child		**Child**	
Child		**Child**	
Child		**Child**	

Income:	
Gross Monthly Income BEFORE Taxes *(Include both spouses if working)*	$
Other Income *(Unemployment, Social Security, Child Support, etc.)*:	$
TOTAL MONTHLY INCOME:	$
TOTAL ANNUAL INCOME:	$

Required Income Documentation: ***(must be received within 2 weeks of first visit)***

Employed: Most recent tax return or most recent pay stubs (2)
Unemployed: Public Assistance check stub/copy; Social Security check stub or Letter of Award; Certification Letter from Medical Assistance or Department of Social Services

I certify that the income and household composition information is true and correct to the best of my knowledge. I agree to notify Idaho State University of any income changes that may affect my eligibility in this program.

_____

Patient/Guardian Signature: **Date:**

Clinic Use Only: Cindy Rock (208) 373-1743	
Sliding Scale Discount:	%

_____

Approved By: **Date:**

Updated: 03/19/21

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Acknowledgement of Receipt of Notice of Privacy Practices

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices.

I acknowledge that I have received a copy of the ISU Speech and Language Clinic Notice of Privacy Practices.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative *Date*

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices.

1. Does the patient have a copy of the Notice of Private Practices? ☐ Yes ☐ No
2. If you answered "No" above, please explain why the patient did not sign acknowledgment form:

   ☐ Patient/individual refused to sign _____ (Date of Refusal).
   ☐ Communication barriers prohibited obtaining an acknowledgement.
   ☐ Legal representative not available.
   ☐ Patient bypassed registration.
   ☐ An emergency situation prevented ISU from obtaining an acknowledgement.
   ☐ Other: _____
   _____

Completed By: _____ _____
Signature Date