### Adult Patient Profile

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Name:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DOB:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Person Completing Form:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Contact:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Phone No.:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>City &amp; Zip:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Home Phone:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Cell Phone:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Email:</strong></td>
<td></td>
</tr>
</tbody>
</table>

Is it ok for us to leave a message regarding your 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:**

______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________

**Things you would like to do at home that you cannot do right now (e.g., talking on the phone, daily activities, hobbies, etc.)**

______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________

**Activities you would like to do in the community that you cannot do right now (e.g., public speaking, going out to eat, ect.)**

______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________

### Health History

**Do you have (or have you had) any of the following conditions?** Please check all that apply.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches/Migraines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma/Hay Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swallowing Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: (____)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Are you or could you be pregnant?**
- [ ] Yes  [ ] No

Updated: 03/19/21
How would you describe your general health? □ Good □ Fair □ Poor If fair/poor, please explain:
______________________________________________________________________________________________________
______________________________________________________________________________________________________

Have you recently been or have you ever been hospitalized related to the condition for which you are seeking treatment? □ Yes □ No If yes, please provide the following information:
When: ______________________________ Where: ________________________________________________
How Long (Admit/Discharge Dates):
______________________________________________________________________________________________________

Have you experienced significant weight change (loss or gain) in the past 6 months?
□ Loss □ Gain □ No Change If yes, how many pounds? ____________
Was the change in weight intentional or expected? □ N/A □ Yes □ No
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:
______________________________________________________________________________________________________
______________________________________________________________________________________________________

Do you use a wheelchair, walker, or other assistive device for mobility? □ Yes □ No
If yes, identify which type of device: _____________________________________________________________

Do you have any balance problems? □ Yes □ No

Do you have left or right sided weakness? □ Yes □ No If yes, which side: _____________________________________________

Have you had any previous surgeries? □ Yes □ No If yes, please explain below.

<table>
<thead>
<tr>
<th>Surgery/Procedure</th>
<th>Month/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
</tbody>
</table>

Do you have any allergies? □ Yes □ No If yes, please list any allergies and the reaction you experience to each below (e.g., allergies to medications, latex, foods, products, etc.)

<table>
<thead>
<tr>
<th>Allergen</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
</tbody>
</table>
### Medications:

**Are you currently taking any medication?**
- [ ] Yes
- [ ] No

If yes, please list below.

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>7.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>8.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>9.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>10.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Previous Therapies:

<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th>Dates</th>
<th>Agency</th>
<th>Name of Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological/Counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Rehab</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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: ______________________________________________________

### Living Situational/Level of Independence:

- Home Type:  
  - [ ] Mobile/Trailer
  - [ ] Single Level
  - [ ] Split Level
  - [ ] Multi Story
  - [ ] Apt./Condo/Townhouse
  - [ ] Other: _______________________________________________  # of Steps to Main Living Space: _________________________
- Live With:  
  - [ ] Spouse or Significant Other
  - [ ] Grown Children
  - [ ] Friend(s)
  - [ ] Alone
  - [ ] Caregiver
  - [ ] Assisted Living
  - [ ] Long-Term Care Facility
  - [ ] Other: _______________________________________________

**Independence:** Please rate your ability to perform the activities below, using the letters
- I = Independent
- A = Assistance

<table>
<thead>
<tr>
<th>Activity</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing/Grooming</td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
</tr>
<tr>
<td>Household Chores</td>
<td></td>
</tr>
<tr>
<td>Stairs</td>
<td></td>
</tr>
<tr>
<td>Driving</td>
<td></td>
</tr>
</tbody>
</table>

### Education/Work History:

- [ ] _____ Grade
- [ ] High School Diploma
- [ ] Assoc. Degree
- [ ] Bachelor’s Degree
- [ ] Master’s Degree
- [ ] Post Graduate

**I learn best by:**  
- [ ] Discussion
- [ ] Demonstration
- [ ] Written Language
- [ ] Videos
- [ ] Other: ________________________________

**Is there any information or education that you would like your therapist to provide to you?**
- [ ] Yes
- [ ] No

If yes, please explain: ________________________________________________________________

### Work Status:

- [ ] Full Time
- [ ] Part Time
- [ ] Unemployed
- [ ] Medical Leave
- [ ] Retired

**Occupation:** ________________________________  
**Do you have any vocational concerns?**
- [ ] Yes
- [ ] No
Psychosocial History:

Marital Status:  □ Single  □ Married  □ Divorced  □ Widowed

Children (how many): ___________________  Ages: _____________________________________________________________

Is there anything in your home environment that causes concern(s) for your safety or for other family members?

□ Yes  □ No  If yes, please explain: ________________________________________________________________

Do you have any special cultural, religious, or spiritual practices that you would like us to recognize/address while here?

□ Yes  □ No  If yes, please explain: ______________________________________________________________________

Are you experiencing any of the following:  □ Loss of interest in previously enjoyed activities  □ Feelings of Hopelessness

Below are words to describe your personality and behavior. Circle all that apply and underline all that you had before your accident/stroke/diagnosis.

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:  ____________________________________________________________________________

Personal Interests/Activities:

What are your favorite leisure activities/hobbies?  ______________________________________________________________________________

What are your favorite TV shows?  __________________________________________________________________________________________

What magazines/books/newspapers do you read?  ______________________________________________________________________________

Do you like to talk on the phone?  □ Yes  □ No

Do you use the internet/email?  □ Yes  □ No

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

____________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________
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: _______________________________
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: ______________________________

Updated: 03/19/21
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 Privacy Officer:** Joanne Hirase-Stacey
921 S. 8th Avenue, Stop 8410
Pocatello, ID 83209
(208) 282-3234
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: __________________________________________________________________________
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.

**Evaluation and individual therapy session fees for our program are included in a flat registration fee of $300 per semester.** This fee 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
Application for Fee Assistance

<table>
<thead>
<tr>
<th>Contact Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
</tr>
<tr>
<td>Street Address:</td>
</tr>
<tr>
<td>City and State:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Household:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number in Household:</td>
</tr>
<tr>
<td>Self</td>
</tr>
<tr>
<td>Spouse or Partner</td>
</tr>
<tr>
<td>Child</td>
</tr>
<tr>
<td>Child</td>
</tr>
<tr>
<td>Child</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Monthly Income BEFORE Taxes (Include both spouses if working):</td>
</tr>
<tr>
<td>Other Income (Unemployment, Social Security, Child Support, etc.):</td>
</tr>
<tr>
<td>TOTAL MONTHLY INCOME:</td>
</tr>
<tr>
<td>TOTAL ANNUAL INCOME:</td>
</tr>
</tbody>
</table>

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
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