# Adult Patient Profile

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person Completing Form:</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact:</th>
<th>Phone No.:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>City &amp; Zip:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone:</th>
<th>Cell Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Phone:</th>
<th>Email:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Home:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cell:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

# Reasons for Rehabilitation

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

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

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

<p>| |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

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

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

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

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

# Health History

**Does 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>
</tbody>
</table>

**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>
</tbody>
</table>

**Are you or could you be pregnant?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
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>

Does 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.

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

**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: ______________________________________________________
  ______________________________________________________________________________________________________

**Hearing:**  
- [ ] No Problems  
- [ ] Hearing Aid(s)  
- [ ] Difficulty Hearing

**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

- Bathing/Grooming ________  
- Dressing ________  
- Household Chores ________  
- Stairs ________  
- Driving ________

**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
- Distractable
- 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 Hearing Clinic to use information gathered from my participation of educational training. I understand that students, under the supervision of fully licensed faculty clinicians, will be observing and conducting my treatment and/or evaluation as part of the student’s education. 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.

_________________________________________  __________________________
Print Name of Patient or Personal Representative   Date

______________________________
Signature of Patient or Personal Representative

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.

_______________________________________________  _______________________
Patient/Guardian Signature                              Date
Consent for Participation in Publicity Endeavors

I authorize that my protected health information in the form of photographs and video clips may be used by the Idaho State University Speech and Hearing Clinic for publicity purposes. The photographs and/or video clips may be on the ISU Speech and Hearing Clinic website, at job fairs, recruiting endeavors, and other events to recruit students to, or promote the professions of speech-language pathology, audiology, deaf education, and sign language studies for the Department of Communication Sciences & Disorders, and Education of the Deaf at Idaho State University.

The photographs and video clips may be used for the following purposes:

- To recruit professionals into the fields of speech-language pathology, audiology, deaf education, and sign language studies.
- To promote the Department of Communication Sciences & Disorders, and Education of the Deaf.
- To inform potential patients of the services offered at the ISU Speech and Hearing Clinic at Idaho State University.

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) 282-3022  
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: __________________________________________

Updated: 08/08/19
Authorization to Obtain
Emergency Medical Treatment

I authorize the Idaho State University Speech and Hearing Clinic to obtain emergency medical treatment at any hospital for the individual listed below. I agree to be fully responsible for any costs related to the said treatment, and to hold harmless Idaho State University of any such costs.

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: __________________________________________

Updated: 08/27/19
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 Hearing 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
Patient Authorization to Release Protected Health Information (PHI)

Patient Name: ___________________________ DOB: ___________________________
Address: ___________________________
Phone No.: ___________________________

I authorize ISU’s Speech and Hearing Clinic and any of their affiliated entities, employees, agents, or associated health care practitioners to use or disclose the patient’s protected health information (PHI) as described below:

1. I authorize the use and disclosure of my PHI to be RELEASED to the following entity:

   Name: ___________________________
   Address: ___________________________
   Phone: ___________________________ Fax: ___________________________
   □ Records from: ________________ to: ________________
   
   Records to be released:
   □ Evaluation Reports □ X-Ray Reports □ Laboratory Tests / Reports
   □ Progress Notes □ X-Ray Films □ Consultation Reports
   □ Discharge Summary □ Pathology Reports □ History and Physical Exam
   □ Other: ___________________________

2. I authorize the use and disclosure of my PHI to be OBTAINED from the following entity:

   Name: ___________________________
   Address: ___________________________
   Phone: ___________________________ Fax: ___________________________
   □ Records from: ________________ to: ________________
   
   Records to be released:
   □ Evaluation Reports □ X-Ray Reports □ Laboratory Tests / Reports
   □ Progress Notes □ X-Ray Films □ Consultation Reports
   □ Discharge Summary □ Pathology Reports □ History and Physical Exam
   □ Other: ___________________________

If the information includes records or information from another health care provider or entity, that information:
□ SHOULD or □ SHOULD NOT be released under this Authorization. This Authorization applies only to the information indicated above. Additional information shall require another Authorization.

3. The disclosure is for the following purpose (check one and complete as needed).

   □ Patient Request □ Continuity of Care □ Legal □ Other: ___________________________

Updated: 08/28/19
I acknowledge that the information to be released MAY INCLUDE information protected by federal and state laws.

The ISU Speech and Hearing Clinic will send information ONLY to the above address or fax number. Any disclosure of the patient’s PHI to another person or entity will require another authorization.

This Authorization is valid for one (1) year from the date set forth below. It may be revoked at any time in writing to ISU’s Privacy Officer below prior to the expiration of such 90-day period. Revocation of this authorization shall not affect releases to the revocation.

**ISU Privacy Officer:** James Francel, HIPAA & Privacy Officer  
921 S. 8th Avenue, Stop 8410  
Pocatello, ID 83209  
(208) 282-3022  
Email: franjam5@isu.edu

I may refuse to sign this authorization, which will not affect my treatment or payment for health care at the ISU Speech and Hearing Clinic.

After your PHI (medical records) are released by your authorization, the possibility exists that your PHI will no longer be subject to the protection of federal privacy regulations and may be re-disclosed by the recipient.

I certify that I have the authority to approve the requested release of information and sign this authorization.

______________________________________________  
Printed Patient Name

______________________________________________  
Patient or Personal Representative Signature

______________________________________________  
Date

Updated: 08/28/19
# ISU Speech and Language Clinic

**Sliding Fee Income Scale**

**FY 2022**

<table>
<thead>
<tr>
<th>Poverty Level*</th>
<th>0 - 100%</th>
<th>100% - 200%</th>
<th>200% - 300%</th>
<th>300% - 400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Size</td>
<td>80%</td>
<td>60%</td>
<td>40%</td>
<td>No Discount</td>
</tr>
<tr>
<td>1</td>
<td>$0-$12,880</td>
<td>$12,881 - $25,760</td>
<td>$25,761 - $38,640</td>
<td>$38,640</td>
</tr>
<tr>
<td>2</td>
<td>$0-$17,420</td>
<td>$17,421 - $34,840</td>
<td>$34,841 - $52,260</td>
<td>$52,260</td>
</tr>
<tr>
<td>3</td>
<td>$0-$21,960</td>
<td>$21,961 - $43,920</td>
<td>$43,921 - $65,880</td>
<td>$65,880</td>
</tr>
<tr>
<td>4</td>
<td>$0-$26,500</td>
<td>$26,501 - $53,000</td>
<td>$53,001 - $79,500</td>
<td>$79,500</td>
</tr>
<tr>
<td>5</td>
<td>$0-$31,040</td>
<td>$31,041 - $62,080</td>
<td>$62,081 - $93,120</td>
<td>$93,120</td>
</tr>
<tr>
<td>7</td>
<td>$0-$40,120</td>
<td>$40,121 - $80,240</td>
<td>$80,241 - $120,360</td>
<td>$120,360</td>
</tr>
<tr>
<td>8</td>
<td>$0-$44,660</td>
<td>$44,661 - $89,320</td>
<td>$89,321 - $133,980</td>
<td>$133,980</td>
</tr>
</tbody>
</table>

*Based on 2021 Federal Poverty Guidelines ([http://aspe.hhs.gov/poverty](http://aspe.hhs.gov/poverty))

*Gross Annual Income

**Evaluation** = $75 / 1 per year

**Therapy** = $25 / visit

<table>
<thead>
<tr>
<th>Poverty Level (At or Below)</th>
<th>Discount</th>
<th>Per Visit TX Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 100%</td>
<td>80%</td>
<td>$5</td>
</tr>
<tr>
<td>100% - 200%</td>
<td>60%</td>
<td>$10</td>
</tr>
<tr>
<td>200% - 300%</td>
<td>40%</td>
<td>$15</td>
</tr>
<tr>
<td>300% - 400%</td>
<td>0%</td>
<td>$25</td>
</tr>
</tbody>
</table>

- Evaluations will be charged one time per year and are also subject to the discount table with a minimum charge of $25 / $40 / $60 / $75.
- **Monthly payments are required** for continued participation in the discount program unless otherwise approved due to special circumstances.
- Accounts must be paid in full prior to participation in the following semester.
- Accounts over 90 days will be sent to collections and all discounts will be removed.
- Questions should be directed to Cindy Rock, 208-373-1743
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.

Current fees for services furnished in the student training program are as follows:

<table>
<thead>
<tr>
<th>Poverty Level (At or Below)</th>
<th>Discount</th>
<th>Per Visit TX Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 100%</td>
<td>80%</td>
<td>$5</td>
</tr>
<tr>
<td>100% - 200%</td>
<td>60%</td>
<td>$10</td>
</tr>
<tr>
<td>200% - 300%</td>
<td>40%</td>
<td>$15</td>
</tr>
<tr>
<td>300% - 400%</td>
<td>0%</td>
<td>$25</td>
</tr>
</tbody>
</table>

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 payments are required monthly to participate in the program.

**Print Name of Patient**

**Signature of Patient or Personal Representative**

**Date**

Updated: 07/30/20
# Application for Fee Assistance

## Contact Information:

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td></td>
</tr>
<tr>
<td>DOB:</td>
<td></td>
</tr>
<tr>
<td>Street Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>City and State:</td>
<td></td>
</tr>
<tr>
<td>Zip Code:</td>
<td></td>
</tr>
</tbody>
</table>

## Household:

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

## Income:

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Guardian Signature:</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
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</tbody>
</table>

## Clinic Use Only:

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sliding Scale Discount:</td>
<td>%</td>
</tr>
<tr>
<td>Approved By:</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Legal Responsibility

At Idaho State University, we are committed to protecting our patients’ personal and health information. Under the Health Insurance Portability and Accountability Act (HIPAA) federal law gives individuals a fundamental right to be informed of the privacy practices of their health care providers, as well as to be informed of their privacy rights, with respect to their personal health information. We are legally required to protect the privacy of your health information, and to give you this Notice about or legal duties, privacy practices, and your rights with respect to your health information.

In this Notice, personal and health information is referred to as “health information” and includes your name, age, address, income or other financial information. We follow the privacy practices described in this Notice, while it is in effect. This Notice takes effect December 1st and will remain in effect until replaced.

If you have any questions about this Notice, if you want to exercise any of your rights listed in this Notice, or if you feel that your privacy rights have been violated, please contact ISU’s HIPAA Compliance Officer, Misty Olmsted at (208) 282-4380 or by email at hipaa@health.isu.edu.

Protecting your Health Information

We protect your health information by:

- Maintaining the privacy and security of your health information as required by law.
- Letting you know if a breach occurs that may have compromised the privacy or security of your information.
- Following the privacy practices described in this notice and giving you a copy.

Uses and Disclosures of Your Health Information

We are allowed, by law, to use and disclose your health information with others without your authorization for many reasons. These examples describe different ways we may use or disclose your information. Please note that not each use or disclosure in each category is listed and these are general descriptions only.

- **Treatment**: We may provide another physician or subsequent healthcare provider who is treating you, with copies of various reports of your health information, that should assist them with your treatment.
  - Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- **Payment**: We may use and disclose your health information to obtain payment for services we provide to you.
  - Example: We give information about you to your health insurance plan so it will pay for your services.

- **Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, training medical students, conducting training and educational programs, accreditation, certification, licensing or credentialing activities.
  - Example: We use health information about you to manage your treatment and services.

- **Appointment Reminders**: We may use health information about you to call, leave a voice message, text, email, or send a postcard or letter to you as a reminder about an appointment.

- **Public Health Disclosures**: We may disclose medical information about you for public health reporting purposes, such as preventing or controlling disease; reporting adverse events related to medications or medical products.

- **Law Enforcement**: We may release medical information, as authorized or required by law to identify suspects, fugitives, missing persons or material witnesses, to law enforcement.
Notice of Privacy Practices

- **Criminal Activity:** We may disclose your health information, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **Abuse or Neglect:** We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

- **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

- **Required by Law:** We may use or disclose your health information when we are required to do so by law, including, but not limited to, court or administrative orders, subpoenas, discovery requests, other lawful process, or to defend ourselves against a lawsuit brought against us.

- **Research:** Under certain limited circumstances, we may use and disclose health information about you for research purposes. All research projects are subject to a special approval process.

- **Organ, eye and tissue donation:** If you are an organ, eye or tissue donor, we may release medical information to organizations that handle organ, eye, or tissue procurement or transplantation; or to an eye, organ or tissue donation bank, as necessary to help with procurement, transplantation or donation.

- **Workers’ compensation:** We may disclose medical information about you for Workers’ compensation or similar programs as authorized or required by law.

- **Coroners, medical examiners and funeral directors:** We may disclose medical information to a coroner or medical examiner, and to funeral directors, as needed for them to carry out their duties.

- **Government Officials:** As authorized or required by law, we may disclose medical information about you to authorized federal officials so they may conduct special investigations or provide protection to the U.S. President, other authorized persons or foreign heads of state.

- **Business Associate:** We may share your medical information with third-parties referred to as “business associates” that provide various services on the behalf of ISU clinics, such as billing, transcription, software maintenance and legal services.

- **Parental Access:** Some state laws concerning minors permit or require disclosure of protected health information to patients, guardians or persons acting in a similar legal status. We will act consistently with the law of the state where the treatment is provided and will make disclosures following such laws.

- **Fundraising:** We may use or disclose your information in order to contact you for fundraising activities. You have the right to opt out of these fundraising communications.

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**Uses and Disclosures Made with Your Authorization**

There are many uses and disclosures we will make only with your written authorization:

- **To Your Family and Friends:** We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

- **Persons Involved in Care:** We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member of your personal condition, or death. If you are present,
Notice of Privacy Practices

prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

- **Marketing Health-Related Services:** We will not use your health information for marketing without a written authorization from you.
- **Psychotherapy Notes:** Psychotherapy notes, made by your individual mental health provider during a counseling session, except for certain limited purposes, related to treatment, payment and healthcare operations, or other limited exceptions, including government oversight and safety, will be disclosed with your authorization.
- **Sale of Medical Information:** We will not sell your health information to third parties without your authorization. Except certain purposes that are permitted under the regulations.
- **If you give your authorization, you may change or revoke it at any time by giving us written notice. Your revocation will not be effective for uses and disclosures already made.**

Your Rights Regarding your Health Information

You have the right to request all of the following:

- **Access to Your Health Information:** You have the right to request and receive a copy of your health information, including all billing information, in paper or electronic form. A reasonable fee may be charged for providing copies. However, this right does not include the following types of records: psychotherapy notes; records compiled in reasonable anticipation of a court action or administrative action or proceeding; and protected health information whose release is prohibited by federal or state laws. Access to your records may also be limited if it is determined that by providing the information it could possibly be harmful to you or another person. If access is limited for this reason, you have a right to request a review of that decision. If we maintain the medical information electronically and you request an electronic copy, we will give the information to you in the format you request, if it is readily available. If we cannot readily get the record in the form and format you request, we will give it in another readable electronic or paper format that we both agree to.
- **Amendment:** You have the right to request, in writing, an amendment to your health information. The request must identify which information is incorrect and an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make reasonable effort to include the amended information in future disclosures. (Amending a record does not mean that health information will be deleted.)
- **Accounting or Disclosures:** If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.
- **Restriction Requests:** You have the right to request that the clinic place additional restrictions on uses and disclosures of your health information. For example, when you have paid for your services out of pocket in full,
Notice of Privacy Practices

at your request, we will not share information about those services with your payer, as long as such disclosure is not required by law. For all other requests, we may not be able to accept your request, but if we do, we will uphold the restriction unless it is an emergency.

- **Confidential Communication:** You have the right to request that communication regarding your health information be done in an alternate way or be sent to an alternate location.
- **Electronic Notice:** If you received this notice by accessing a web site or by email, you are also entitled to have a paper copy which is available by request from the clinic or department.
- **Notification in the Case of a Breach:** We are required by law to notify you of a breach of your unsecured medical information. We will give such notification to you without unreasonable delay but no later than 60 days after we discover the breach.

### Changes to this Notice

We reserve the right to change our privacy practices and terms of this Notice at any time, as permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make such changes, we will update this Notice and post the changes in the waiting room or lobby of the facility. You may also request a copy of the Notice at any time.

### Questions and Complaints

To file a complaint if you feel your privacy rights have been violated, or if you would like to request a Restriction, request an Accounting of Disclosures or revoke an Authorization, please contact:

**Misty Olmsted, HIPAA Compliance Officer**
**Office of General Counsel**
921 S. 8th Ave, Stop 8410
Pocatello, ID 83209
(208) 282-4380
hipaa@health.isu.edu

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:

US Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.,
Washington, D.C. 20201,
1-877-696-6775
[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)

If you choose to make a complaint with us or the U.S. Department of Health and Human Services, we will not retaliate in any way.
## Contacts

To Request your medical or billing information please contact the ISU Clinic directly.

<table>
<thead>
<tr>
<th>ISU Student Health Center- Pocatello</th>
<th>ISU Bengal Pharmacy-Pocatello</th>
<th>Pocatello Family Dentistry</th>
</tr>
</thead>
<tbody>
<tr>
<td>990 Cesar Chavez Ave., Pocatello, ID 83209</td>
<td>990 Cesar Chavez Ave., Pocatello, ID 83209</td>
<td>465 Memorial Drive, Pocatello, ID 83209</td>
</tr>
<tr>
<td>Billing Address: 921 S 8th Ave., Stop 8311</td>
<td>Billing Address: 921 S 8th Ave., Stop 8158</td>
<td>Billing Address: 921 S 8th Ave., Stop 8088</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ISU Speech and Hearing Clinic-Pocatello</th>
<th>ISU Dental Hygiene</th>
<th>ISU PT/OT Clinic-Pocatello</th>
</tr>
</thead>
<tbody>
<tr>
<td>650 Memorial Dr., Bldg. 68, Pocatello, ID 83209</td>
<td>999 Martin Luther King Jr. Way, Pocatello, ID 83209</td>
<td>1400 E Terry Dr., Bldg. 63, Pocatello, ID 83209</td>
</tr>
<tr>
<td>Billing Address: 921 S 8th Ave., Stop 8116</td>
<td>Billing Address: 921 S 8th Ave., Stop 8048</td>
<td>Billing Address: 921 S 8th Ave., Stop 8045</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ISU Integrated Mental Health</th>
<th>ISU Family Dentistry</th>
<th>ISU Meridian Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>1311 E Central Drive, Meridian, ID 83642</td>
<td>1311 E Central Drive, Meridian, ID 83642</td>
<td>1311 E Central Drive, Meridian, ID 83642</td>
</tr>
<tr>
<td>Billing Address: Same as Above</td>
<td>Billing Address Same as Above</td>
<td>Billing Address: Same as Above</td>
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</table>

<table>
<thead>
<tr>
<th>ISU Speech &amp; Language Clinic Meridian</th>
<th>ISU PT/OT Clinic-Meridian</th>
<th>ISU Speech &amp; Hearing Clinic-Salmon</th>
</tr>
</thead>
<tbody>
<tr>
<td>1311 E Central Drive, Meridian, ID 83642</td>
<td>1311 E Central Drive, Meridian, ID 83642</td>
<td>805 Main St., Salmon, ID 83467</td>
</tr>
<tr>
<td>Billing Address: Same as Above</td>
<td>Billing Address: 921 S 8th Ave., Stop 8045</td>
<td>Billing Address: 921 S 8th Ave., Stop 8116</td>
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<tr>
<td></td>
<td>Pocatello, ID 83209</td>
<td>Pocatello, ID 83209</td>
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</table>