



Adult Patient Profile

Patient Name: _____ DOB: _____
Person Completing Form: _____ Age: _____
Emergency Contact: _____ Phone No.: _____
Address: _____ City & Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____
Is it ok for us to leave a message regarding your treatment at the following #s?
Home: [] Yes [] No Cell: [] Yes [] No Work: [] 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

Does you have (or have you had) any of the following conditions? Please check all that apply.
Heart Disease [] Y [] N Thyroid Disorder [] Y [] N Bowel Issues [] Y [] N
Stroke [] Y [] N Kidney Disease [] Y [] N Seizures [] Y [] N
High Blood Pressure [] Y [] N Diabetes [] Y [] N Bleeding Disorder [] Y [] N
Lung Disease [] Y [] N Arthritis [] Y [] N Asthma/Hay Fever [] Y [] N
Cancer [] Y [] N Headaches/Migraines [] Y [] N Swallowing Issues [] Y [] N
Head Injury [] Y [] N Concussion [] Y [] N Other: _____ [] Y [] N
Are you or could you be pregnant? [] Yes [] No

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.

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

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.)

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

Medications:			
Are you currently taking any medication? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> No Problems <input type="checkbox"/> Glasses/Contact Lenses <input type="checkbox"/> Visual Difficulties <input type="checkbox"/> Glasses for Reading <input type="checkbox"/> Require Enlarged Print			
Communication: <input type="checkbox"/> No Problems <input type="checkbox"/> Difficulty Reading <input type="checkbox"/> Difficulty Writing			
<input type="checkbox"/> Communication Needs/Devices/Assist, please specify: _____			

Hearing: <input type="checkbox"/> No Problems <input type="checkbox"/> Hearing Aid(s) <input type="checkbox"/> Difficulty Hearing			
Living Situational/Level of Independence:			
Home Type: <input type="checkbox"/> Mobile/Trailer <input type="checkbox"/> Single Level <input type="checkbox"/> Split Level <input type="checkbox"/> Multi Story <input type="checkbox"/> Apt./Condo/Townhouse			
<input type="checkbox"/> Other: _____ # of Steps to Main Living Space: _____			
Live With: <input type="checkbox"/> Spouse or Significant Other <input type="checkbox"/> Grown Children <input type="checkbox"/> Friend(s) <input type="checkbox"/> Alone <input type="checkbox"/> Caregiver			
<input type="checkbox"/> Assisted Living <input type="checkbox"/> Long-Term Care Facility <input type="checkbox"/> 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:			
<input type="checkbox"/> ____ Grade <input type="checkbox"/> High School Diploma <input type="checkbox"/> Assoc. Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Post Graduate			
I learn best by: <input type="checkbox"/> Discussion <input type="checkbox"/> Demonstration <input type="checkbox"/> Written Language <input type="checkbox"/> Videos <input type="checkbox"/> Other: _____			
Is there any information or education that you would like your therapist to provide to you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain: _____			
Work Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Medical Leave <input type="checkbox"/> Retired			
Occupation: _____ Do you have any vocational concerns? <input type="checkbox"/> Yes <input type="checkbox"/> 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 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: Misty Olmstead
921 S. 8th Avenue, Stop 8410 Pocatello, ID 83209
(208) 282-4038
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.

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



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 <i>(Include both spouses if working)</i>	\$ _____
Other Income <i>(Unemployment, Social Security, Child Support, etc.):</i>	\$ _____
TOTAL MONTHLY INCOME:	\$ _____
TOTAL ANNUAL INCOME:	\$ _____

Required Income Documentation: <i>(must be received within 2 weeks of first visit)</i>	
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>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.</i>	
_____	_____
Patient/Guardian Signature:	Date:

Clinic Use Only:	
_____	Sliding Scale Discount: % _____
_____	_____
Approved By:	Date:



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



ISU Speech and Language Clinic
Good Faith Estimate for Health Care Services

Form containing Patient Information, Provider Information, Service Provided table, and Additional Health Care Provider Notes.

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.



If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.