Idaho State University

ISU Speech and Language Clinic
650 Memorial Dr., Bldg. 68, Pocatello, ID 83209
Phone: 208.282.3495 / Fax: 833.390.1293

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? ☐ Yes ☐ No If yes, please list below.

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

Previous Therapies:

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

Special Needs: (Please check all that apply)

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

Communication: ☐ No Problems ☐ Difficulty Reading ☐ Difficulty Writing

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

_____

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

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	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?

_____

_____

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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: _____

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Telehealth Patient Consent Form

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

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

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

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

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

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

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

_____ _____

Patient/Guardian Signature Date

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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: _____

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Notice of Disclosure

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

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

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

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

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

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

The initial evaluation fee is $75.00 (charged annually) and the individual therapy session fees for the semester are combined into a flat fee of $350. The semester fee of $350 covers a minimum of 20 visits per semester. Opportunities for make-up sessions will be available for cancellations.

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

_____

Print Name of Patient

_____ _____

Signature of Patient or Personal Representative *Date*

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Application for Fee Assistance

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

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

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

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

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

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

_____

Patient/Guardian Signature: **Date:**

Clinic Use Only:	
Sliding Scale Discount:	%

_____

Approved By: **Date:**

Updated: 08/27/19

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Acknowledgement of Receipt of Notice of Privacy Practices

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

I acknowledge that I have received a copy of the ISU Speech and 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

Idaho State University

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

Patient			
Patient Name:		**DOB:**	
Address:		**Phone No.**	
		Diagnosis:	
	City *State* *Zip Code*		

Provider Information			
Provider Name:	ISU Speech and Language Clinic	**NPI:**	1952474777
Address:	650 Memorial Dr., Bldg. 68	**Tax ID:**	82-6000924
	Pocatello, ID 93209		
Contact:	Cindy Rock	**Phone No:**	(208) 373-1743
Email:	rockcind@health.isu.edu		

Service Provided

Service	Quantity	Expected Cost
Initial Evaluation	1 x Annually	$75.00
Individual Therapy Sessions (Appr. 20 sessions)	Semester	$350.00
Total Expected Charges from Idaho State University		
	TOTAL	$425.00

Additional Health Care Provider Notes:

This Good Faith Estimate does not include any discounts or sliding scale rates as these are our standard rates. Sliding scale rates apply to those who qualify based on family size and income.

☑ Check if Service is reoccurring. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

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.

Idaho State University

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.