Date received at clinic:_____

WICHITA STATE UNIVERSITY
COLLEGE OF HEALTH PROFESSIONS
Evelyn Hendren Cassat Speech-Language-Hearing Clinic

Adult Client Case History Form

Are you a current Wichita State University Student YES NO

IDENTIFYING INFORMATION

Client's full name: _____ Preferred Name: _____

Date of birth: _____ Email:_____

Phone (h): _____ (c): _____ (w): _____

Address:_____

City: _____ State: _____ Zip: _____

Preferred method of communication: ☐ Email ☐ Cell phone/ Text ☐ Home Phone

Client primary language? _____ Race:_____

Is there a medical diagnosis that caused the problem? ☐ Yes ☐ No

Describe: _____

Please describe the difficulty that the client is having: _____

Please indicate the speech services the client wishes to receive: _____

If client is unable to fill out the form, please fill out the following information:

Person completing this form: _____ Relationship to client: _____ Date: _____

PRIMARY CARE PHYSICIAN

Primary Care Physician: _____Phone: _____

EMERGENCY CONTACT

Primary Emergency Contact

Name: _____Relationship to the client: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Secondary Emergency Contact

Name: _____Relationship to the client: _____

Home phone: _____ Cell phone: _____ Work phone: _____

PERMISSION FOR TEXT MESSAGES:

I give permission for the Evelyn Hendren Cassat Speech Language Hearing Clinic to send me text messages for appointment reminders. I understand that message and data rates may apply, and that I may opt out by calling the clinic at 316-978-3289.

Patient Name: _____

Cell phone number: _____Mobile phone carrier: _____

Signature: _____

Other Professionals providing care (e.g., PT, OT, SLP, Psychologist, etc):

Name: _____ Specialty: _____ Phone: _____ Frequency of therapy: _____

Name: _____ Specialty: _____ Phone: _____ Frequency of therapy: _____

Name: _____ Specialty: _____

Phone: _____ Frequency of therapy: _____ ***If needed, please attach additional sheet.*

MEDICAL HISTORY

Has the client ever had:	Yes	No	Date	If yes, please explain
Major injuries or illnesses?				
Head traumas (including concussions)?				
Seizures?				
Diabetes?				
Hearing loss?				If yes, hearing aids?
Vision loss?				If yes, glasses/contacts?
Trouble with ambulation?				If yes, wheelchair, cane, walker,etc.?

PERSONAL MEDICAL INFORMATION

Are you taking any medications? ☐ Yes ☐ No

Name of Medications	Why is it taken?
_____	_____
_____	_____
_____	_____

Please list allergies (drug, food, seasonal)

_____

_____

Please list major past medical history and surgeries:

_____

_____

_____

PREFERRED TREATMENT TIMES

Days and times ***PREFERRED*** (Check at least two):

Day:	Morning:	Afternoon:
Monday	8:00-12:00	1:00-5:00
Tuesday	8:00-12:00	1:00-5:00
Wednesday	8:00-12:00	1:00-5:00
Thursday	8:00-12:00	1:00-5:00
Friday	8:00-12:00	1:00-5:00

*If none of the above times work, please contact us or list your available times below:

Do you have a case manager? Yes No

If yes, name of agency: _____

Does the client have a Power of Attorney?

If yes, please provide a copy of the Power of Attorney.

If yes, name of the Power of Attorney: _____

ATTENDANCE AGREEMENT:

Our goal is to provide state of the art assessment and treatment services to you and your family. Part of good healthcare practice is to establish and communicate an attendance policy to our clients. Therefore, we must ask you to read and indicate your agreement with our clinic attendance and payment policy by signing this form. Exceptions to this policy can only be made with the approval of the Clinic Director.

ATTENDANCE: A critical factor in successful treatment is client attendance. While we expect clients to attend all scheduled sessions, we understand that emergencies/illnesses do occur and in those situations we ask that you call the clinic as early as possible to cancel your scheduled session. If the emergency/illness requires that you miss more than two consecutive sessions, we may temporarily dismiss you from treatment until such time when you can return to a regular schedule.

**If attendance falls below 80% for the semester, you will be dismissed from the clinic. Attendance will be monitored on a monthly basis. Those who are dismissed for low attendance may request reinstatement at a later date, however, there is no assurance of re-enrollment.

By signing this form, I acknowledge that I have received and understand the attendance policy.

Print Signature: _____

(Name of Client/ Parent/ Guardian)

Signature: _____ **Date:**: _____
(Signature of Client/ Parent/ Guardian)

WICHITA STATE UNIVERSITY
COLLEGE OF HEALTH PROFESSIONS
Evelyn Hendren Cassat Speech-Language-Hearing Clinic

WSU SPEECH LANGUAGE HEARING CLINIC FINANCIAL POLICY

PART 1: PATIENT INFORMATION – Fill out this form completely. Please print legibly.

Last Name:	First Name:	Middle Initial:
Date of Birth:		

***PART* 2: WSU SPEECH LANGUAGE HEARING CLINIC FINANCIAL POLICIES**

1. The cost of services provided by WSU Speech Language Hearing Clinic is your responsibility, whether you are covered by health insurance or not. Payment is expected at the time of service unless arrangements have been made prior to treatment. WSU Speech Language Hearing Clinic accepts cash, checks and credit cards. **Please note: checks must be imprinted with the bank name and the account holder's name.**
2. WSU Speech Language Hearing Clinic will process claims for any In Network Private Health Insurance Plans.
3. By giving WSU Speech Language Hearing Clinic your insurance information, you are authorizing WSU Speech Language Hearing Clinic to file a claim with (send a bill to) your insurance company for services rendered.
4. If you do not want WSU Speech Language Hearing Clinic to file a claim with your insurance company, you must notify WSU Speech Language Hearing Clinic at the time of your visit and pay in full any charges incurred at the time of the service.
5. Your insurance company may determine that some or all of the charges incurred at WSU Speech Language Hearing Clinic are not covered by your policy. It is your responsibility to know what your insurance covers and to ask questions prior to receiving services.
6. WSU Speech Language Hearing Clinic is not a contracting provider for and cannot bill KanCare, Medicaid, or Healthwave. If you have these types of government health benefits, you are responsible for paying all Speech Therapy and/or Audiology charges and it is your responsibility to seek reimbursement from these programs.
7. If you fail to pay any charges incurred within 6 months of services rendered, your outstanding charges will be sent to WSU Financial Services for collection. **Please note: if your account becomes past due, WSU Speech Language Hearing Clinic may discontinue providing services or goods until all past due amounts are paid**.
8. If you fail to pay any past due charges, WSU may refer your delinquent account to a third-party collection agency. You are responsible for paying the collection agency fee, together with all costs and expenses (including but not limited to reasonable attorney's fees and court costs) necessary for the collection of your delinquent account. You understand that your delinquent account may be reported to one or more of the national credit bureaus.9
9. WSU Speech Language Hearing Clinic may charge late cancel and no-show fees if I do not cancel an appointment within notification times outlined on the WSU Speech Language Hearing Clinic website and/or in appointment reminder messages.

By signing below, I am agreeing that I:

a. Have read any understand the SHS Financial Policies as set forth above, and which may be amended from time to time;
b. Am financially responsible to pay for all services that I receive, whether covered by insurance or not;
c. Authorize WSU Speech Language Hearing Clinic to submit a claim (send a bill) to my health insurance company for services rendered and for consideration of payment and to release any medical or other information necessary to process the claim;
d. Authorize payment of my insurance benefits directly to Wichita State University; and
e. Authorize WSU Speech Language Hearing Clinic to file any mandatory reporting to the State of Kansas as required by state law

PART 3: SIGNATURE

Patient Signature Date

Parent / Guardian Signature (if patient is under 18) Date

WICHITA STATE UNIVERSITY
PATIENT/CLIENT EMAIL CONSENT FORM

PLEASE READ CAREFULLY. THIS FORM DISCUSSES THE RISKS OF USING EMAIL TO SHARE PERSONAL HEALTH INFORMATION.

As a patient or client of a Wichita State University Clinic, you may request that we communicate with you via unencrypted electronic mail (email). This Fact Sheet will information of you the risks of communicating with your healthcare provider via email. Your health is important to us and we will make every effort to reasonably comply with your request to receive communications via email; however, we reserve the right to deny any request for email communications when it is determined that granting such a re quest would not be in your best interest.

WSU staff will make every effort to promptly respond to your requests for information via email; however, **IF YOU ARE EXPERIENCING AN EMERGENCY, YOU SHOULD NEVER RELY ON EMAIL COMMUNICATIONS AND SHOULD SEEK IMMEDIATE MEDICAL ATTENTION.**

Risks of using email to send protected health information include, but are not limited to:

- Email messages sent or received by WSU are generally not encrypted and may not be secure.
- Third parties may therefore be able to intercept, read, alter, forward or use personal health information transmitted by email, without authorization or detection by you or WSU.
- An unsecure email message may be accidentally or intentionally forwarded to unintended recipients.
- Employers and internet service providers generally have the right to inspect and review any email message transmitted, received, or stored using their systems.
- Information shared by email may be printed, copied, and stored by any recipient in multiple locations.
- Copies of email messages containing personal health information may be kept, for example on backup servers or hard drives, long after the “original” message is deleted by both the sender and the recipient.
- Documents may be forged, and identities may be stolen to take advantage of these vulnerabilities.
- Your personal health information in WSU’s records may include information relating to prescriptions and medications, communicable diseases, physical impairments, chronic conditions, genetics, behavioral and mental health services, alcohol and drug abuse or addiction, billing and payments, and other information related to your medical care and condition.
- WSU is not responsible for any unauthorized access to or use of your personal health information that results from any unencrypted transmission that you authorize.

PERMISSION TO ALLOW COMMUNICATIONS BY UNENCRYPTED EMAIL

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into your medical record at the provider’s discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means. By signing below, you agree to hold Wichita State University harmless for unauthorized use, disclosure, or access of your protection health information sent to the email address you provide.

Signature of Patient	Date
Printed Name of Patient	Email Address

WICHITA STATE UNIVERSITY

PATIENT PHOTO/VIDEO/AUDIO AUTHORIZATION AND RELEASE FORM

NOTE: This form is NOT required for photos or videos of patients used for the purposes of treatment or diagnosis, where the photo and/or video becomes part of the patient's medical record and is not used for any other purpose. The Wichita State University (WSU) (*insert name of clinic*) is a training facility for students enrolled at WSU. It is standard procedure for appointments and treatment to be videotaped or observed by others for supervision and educational purposes. In addition, students and faculty present clinical cases during their academic classes. You understand that, regardless of whether you sign this Authorization, your health information and Media may be shared internally at WSU in classrooms and other teaching and consultative environments.

SECTION A. INDIVIDUAL INFORMATION		
INDIVIDUAL'S NAME (LAST, FIRST, MIDDLE INITIAL):	DATE OF BIRTH (MM/DD/YYYY):	
STREET ADDRESS (INCLUDING CITY, STATE, AND ZIP):		
PHONE NUMBER:		

SECTION B. PHOTOGRAPHY/VIDEOGRAPHY/AUDIOGRAPHY RELEASE

I authorize the WSU (*insert name of clinic*) to take photographs and/or videos and/or audio recordings, or to allow third parties to take photographs and/or videos and/or audio recordings (collectively, "Media") of me for the following uses (check all that apply). You understand that by checking boxes below, the Media you have authorized for disclosure may be seen by members of the general public.

For Educational or Training Purposes Within WSU	
☐ In presentations by WSU faculty, staff, employees, and students to entities or individuals ***within*** WSU, for educational or training purposes	☐ In small group or one-on-one meetings with WSU faculty, staff, employees, or students for educational or training purposes
For Public Relations Purposes Outside of WSU	**For Medical or Educational Purposes Outside of WSU**
☐ On WSU internet and intranet sites	☐ In professional journals and other publications, including textbooks and electronic publications
☐ In WSU publications and brochures	☐ In presentations by WSU faculty, staff, employees, and students to entities or individuals ***outside of*** WSU, including at professional and educational conferences or seminars
☐ In the public media, such as newspapers, magazines, on the internet and on television	
☐ In presentations, publications, brochures, advertisements, or articles by non-WSU agencies or companies, such as other non- profit organizations or for-profit companies who provide support to WSU	

SECTION C. USE OF NAME

_____ **I consent to the use of my name**. I understand that I may be identified by name in printed, internet, or broadcast information that might initial accompany the media of me.

-OR-

_____ **I do not consent to the use of my name**. I understand that, even though my name will not be used, it is possible that someone may initial recognize me based on the media alone.

SECTION D. SIGNATURE/DATE

By signing below, I understand that:

- I do not have to sign this Authorization
- My refusal to sign this Authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- Information shared under this Authorization may be subject to redisclosure, and such redisclosures may be made to anyone, including but not limited to media outlets and the general public, and may no longer be protected by federal or state law.

- I may change my mind and revoke (take back) this authorization at any time. To revoke this authorization, I must provide a written revocation to the WSU clinic for whom I signed this Authorization.
- Information that has already been shared based on this authorization cannot be taken back.
- I may request a copy of this Authorization.
- Any facsimile or copy of this Authorization authorizes the release of the records requested herein.
- I acknowledge that I have received a copy of this Authorization.
- Unless otherwise revoked, this authorization will expire ten (10) years from the date it is signed.

Signature of Individual (if 18 years of age or older): _____ Date _____

Signature of Parent or Legal Representative (if applicable): _____ Date _____

Relationship to Individual, if not signed by Individual: _____

PRI-09 HIPAA PATIENT PHOTO/VIDEO/AUDIO AUTHORIZATION AND RELEASE FORM (rev. 11/2023)