Wichita State University
College of Health Professions
Evelyn Hendren Cassat Speech-Language-Hearing Clinic

Date received at clinic:_____

SLP Child Case History

DEMOGRAPHICS

Client's Name: _____Date of Birth: _____

Parent(s) or Guardian(s): _____

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

Address: _____

City: _____ State: _____ Zip: _____ County:_____

E-mail(s): _____

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

EMERGENCY CONTACT LIST

Primary Emergency Contact

Name: _____Relationship to the client: _____

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

Address: _____

City: _____ State: _____ Zip: _____ County:_____

E-mail(s): _____

Secondary Emergency Contact

Name: _____Relationship to the client: _____

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

Address: _____

City: _____ State: _____ Zip: _____ County:_____

E-mail(s): _____

MEDICAL

Allergies: _____

Special Concerns: _____

Physician: _____ Hospital: _____

***I authorize those persons listed below to be contacted in case of an emergency. I understand that I am responsible for notifying the Clinic in writing if any person on this list no longer has permission to be contacted in case of an emergency.**

_____ _____
Signature Date

Financial Agreement:

The Wichita State University Evelyn Hendren Cassat Speech-Language-Hearing Clinic serves the community needs and University academic programs by providing a laboratory learning experience for graduate students. Services are provided by graduate students under the supervision of University faculty. As such, you will receive quality services while helping to facilitate the education of University students.

Payment in full is due at the time of service, unless prior arrangements have been made. All group services being provided at Wichita State University Evelyn Hendren Cassat Speech-Language-Hearing Clinic are considered private pay**.**

Estimate of Payment: We provide a close estimate of patient out-of-pocket expenses. For any major expense, we highly recommend a pre-determination be submitted to your insurance company.

Group Fall/ Spring Session charges:

- $160.00 Social Group
- $185.00 Supper Club
- $250.00 Feeding Group

Group Summer Session charges:

- $75.00 Social Group
- $100.00 Supper Club

Delinquent Accounts: If a patient elects not to pay a debt in full or set up payment plan, the account will be turned over to collection agency, which will report your name to the credit bureau and supplementary communications may use pre-recorded voice or texting to cellular or wireless devices. Collection fees may be charged to your account, up to 33%. **Please note: as an institution of the State of Kansas, your name may be submitted to the Kansas Setoff Program, resulting in any debt owed to be collected from state income tax returns/refunds.**

By my signature below, I am indicating that I have read and fully understand and accept the Finanial Agreement at WSU Evelyn Hendran Cassat Speech Language Hearing Clinic and the guidelines presented above. I confirm that insurance will not be billed for group services received at the WSU Evelyn Hendren Cassat Speech-Language-Hearing Clinic, I have provided accurate information WSU Evelyn Hendran Cassat Speech Language Hearing Clinic. I understand that this agreement will be reviewed every semester and that I may be denied services for the following semester if my account is delinquent at the close of a semester, and could be sent to collections for any delinquent amounts.

Signature of Client: _____ **Date:** _____

(responsible party or guardian)

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)

NOTICE OF PRIVACY ACKNOWLEDGEMENT

Patient's Acknowledgement

I acknowledge that the **WSU Speech Language Hearing Clinic** has provided me with a copy of the Wichita State University Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act. I also acknowledge that I have been specifically advised that on subsequent visits to the WSU Speech Language Hearing Clinic, I will not be given additional copies of the Notice of Privacy Practices unless I request one. I acknowledge that patient records are stored in an electronic healthcare record.

NOTE: Information regarding my records at WSU can be shared with the following:

Name	Relationship

_____ _____

Signature Print Name

_____ _____

Patient's name if different than above Date

WSU Staff Acknowledgement of Signature Refusal

I acknowledge that (patient's name)_____was given a copy of the Wichita State University Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act. I also note that this individual was asked to sign this Acknowledgment of Receipt of Notice of Privacy Practices, but refused to sign.

_____ _____

Signature Print Name

Title: _____ Date:_____