UNIVERSITY OF THE
PACIFIC
Thomas J. Long School of
Pharmacy & Health Sciences

Dear Potential Client:

The Pacific Speech and Hearing Center provides a teaching facility for the students in the Department of Speech-Language Pathology. The therapy sessions are conducted by student therapists and supervised by certified and licensed speech pathologists and audiologists.

Enclosed are the forms that we need to have you complete and return to us in order for us to place your name on our waiting list.

Also enclosed is a medical information release form, which will enable us to obtain pertinent medical and professional information that may assist us in preparation for your therapy. Please sign all forms where requested. Your signature on the enclosed, Release Form for Media Recording, allows our supervisors to observe, guide and critique the diagnostic examination and therapy sessions, which are conducted by student therapists. If you have any questions, please check with us in advance.

While we do not currently have mandatory fee for services, it is suggested that clients and/or their families make a voluntary donation of $200 each semester to the University of the Pacific's Speech and Hearing Center to furnish student clinicians with the necessary materials and supplies to conduct their therapy sessions.

Thank you for your interest in our clinic.

Sincerely,

Kristen Hernandez

Kristen Hernandez
Office Manager
209/946-2381

Enclosures

University of the Pacific
Speech, Hearing and Language Center
ADULT CASE HISTORY

Today's Date: _____

Please complete the following form. All information is confidential. Some information may not pertain to you, but please fill-out the form as completely as possible. Return the completed form as soon as possible.

Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____ Phone: _____

Alternate Phone: _____ Email: _____

Referred By: _____ Phone: _____

BACKGROUND INFORMATION:

What are your current concerns regarding your speech, hearing and/or language skills?

_____

_____

_____

_____

_____

What do you think caused the above problem? _____

_____

_____

When was the problem first noticed and by whom? _____

_____

_____

Has the problem changed since it was first noticed? Please describe the change(s).

_____

_____

_____

Does your family have a history of speech, hearing or language problems? ☐ Yes ☐ No

If yes, please describe. _____

_____

_____

_____

MEDICAL HISTORY:

Please list and describe any current health issues/diagnoses. _____

_____

_____

_____

Please list any current medications (please attach another page if more space is needed):

Medication	Amount Taken	Frequency

Have you ever had surgery or been hospitalized (please attach another page if more space is needed)?

	Age	Severity	Duration	Amount of Recovery
Accident				
Surgery				
Hospitalization				

Do you/have you ever suffered from any of the following illnesses/medical conditions (check all that apply):

☐ Adenoidectomy	☐ Asthma	☐ Chicken Pox
☐ Colds	☐ Croup	☐ Dizziness
☐ Ear Drainage	☐ Ear Infections	☐ Encephalitis
☐ German Measles	☐ Headaches	☐ Hearing Loss
☐ High Fever	☐ Influenza	☐ Mastoditis
☐ Measles	☐ Meningitis	☐ Mumps
☐ Noise Exposure	☐ Otosclerosis	☐ Pneumonia
☐ Seizures	☐ Sinusitis	☐ Tinnitus
☐ Tonsillectomy	☐ Tonsillitis	☐ Other _____

Do you have any known allergies (e.g. medications, food, latex, seasonal, etc.)? Please list.

_____

_____

Has your hearing been evaluated? If so, indicate where, when and the results of the evaluation?

_____

_____

What language(s) do you speak? If more than one, which is your dominant language?

_____

_____

Although an accent is not a disorder, do you find that an accent is affecting your ability to effectively communicate with others? ☐ Yes ☐ No

FAMILY/SOCIAL HISTORY:

Indicate your current marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's name, if applicable: _____

List any children:

Name	Gender	Age

Current or past occupation/employer: _____

Highest grade, diploma or degree earned: _____

Please list any hobbies or interests: _____

THERAPY HISTORY:

Have you ever received any type of therapy (speech/language, occupational, physical)? ☐ Yes ☐ No

Condition Treated	Type of Therapy	Duration

SPEECH AND LANGUAGE SKILLS:

Do you have difficulty expressing your wants and needs? If yes, please explain. _____

Do others find you difficult to understand? If yes, please explain. _____

Do you find it hard to understand others? If yes, please explain. _____

Do you have short-term and/or long term memory difficulties? If yes, please explain. _____

Do you have difficulty with word-finding (i.e. remembering the names of objects/people)? If yes, explain.

Do you have difficulty with reading or writing? If yes, please explain. _____

Have there been any changes to your voice (i.e. hoarse, breathy, loss of volume)? If yes, please explain.

SWALLOWING SKILLS:

Please indicate (check mark) if you have difficulty with any of the following:

- ☐ Chewing Food
- ☐ Drooling
- ☐ Moving food to the back of the mouth
- ☐ Managing Liquids
- ☐ Increased meal times
- ☐ Watery eyes when eating/drinking
- ☐ Coughing
- ☐ Holding cup/utensils
- ☐ Clearing food/ liquid from the mouth
- ☐ Choking
- ☐ Other _____

Are you currently on a modified food and/or liquid diet? If yes, please explain. _____

Are there food/liquid textures that you avoid? _____

Do you currently wear dentures? Indicate full or partial. _____

ACTIVITIES OF DAILY LIVING:

Do you require assistance with any of the following?

- ☐ Dressing
- ☐ Toileting
- ☐ Money Management/ Bill Payments
- ☐ Cooking
- ☐ Transportation/ Driving
- ☐ Keeping track of appointments
- ☐ Eating
- ☐ Showering/ Personal Hygiene
- ☐ Moving/ walking from place to place
- ☐ Telling Time
- ☐ Making phone calls
- ☐ Grocery Shopping
- ☐ Housekeeping
- ☐ Other _____

Do you have any difficulties with fine motor skills to be able to manipulate clothing fasteners, utensils, opening jars, keyboarding, etc.? If yes, please explain. _____

THERAPY GOALS:

What are your current speech, hearing and/or language therapy goals/expectations? _____

Please provide any additional information that may be helpful to the evaluation/treatment process:

Completed by: _____ Date: _____

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we reserve the right to charge you $0.10 for each page copied, as well as postage charges if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

Contact Information:
University of the Pacific
Speech, Hearing and Language Center
3601 Pacific Avenue
Stockton, CA 95211

Phone: 209-946-2381
Fax: 209-946-2647

Pacific Speech, Hearing and Language Center

Physical Address:
757 Brookside Road
Stockton, CA 95207

UNIVERSITY OF THE PACIFIC

NOTICE OF PRIVACY PRACTICES

University of the Pacific
Speech, Hearing and Language Center

Notice of Privacy Practices

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time provided such changes are permitted by applicable law. We reserve the right to make the 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 a significant change in our privacy practices, we will change this notice and make the new notice available to you.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this notice

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

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, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. As an educational institution your health information may be accessed by student, faculty and staff of the University of the Pacific's Speech, Hearing and Language Center during the course of clinical operations.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to sue your health information or to disclose it to anyone for any purpose. If you give us an authorization , you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient writes section of this Notice. 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 health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then 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 various forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. 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 to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

UNIVERSITY OF THE PACIFIC
Speech & Hearing Center

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

** You May Refuse to Sign This Acknowledgement **

I, _____, have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides, in detail, the uses and disclosures of my protected health information that may be made in this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

_____ _____
(Signature) (Date)

_____
(Relationship to Patient)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify): _____

_____

_____

UNIVERSITY OF THE PACIFIC
Speech & Hearing Center

PHOTOGRAPHY AND AUDIO/VIDEO RECORDING CONSENT FORM

I, _____, grant the Pacific Speech and Hearing Center and its employees/ students, my permission to take photographs of me, to interview me, to publish, print and broadcast my voice and image to be used for educational purposes in student training.

I understand that I have the right to withdraw my consent at any time, with a reasonable amount time before the photograph or videotape is used. Please contact the Pacific Speech and Hearing Center at pacificslp@pacific.edu to withdraw your consent. A written request for withdrawal of consent can also be mailed to: University of the Pacific, ATTN: Speech and Hearing Center, 3601 Pacific Avenue, Stockton, CA 95211.

The photographs and videos will be stored by the University of the Pacific's Speech-Language Pathology Department and will be destroyed when no longer needed. Photographs and videos include any electronic or audio recordings.

I release the Pacific Speech and Hearing Center and its employees/students, from any and all liability.

I voluntarily release and hold harmless Pacific's Speech and Hearing Center and its employees from any and all liability which may or could arise from the taking, recording, publication, distribution or other use of photography and audio/video media.

MUST CHECK ONE

☐ I give **UNLIMITED** permission to the Pacific Speech and Hearing Center to use my image and voice in photographs and audio/video media for use in departmental, educational and promotional materials, print, internet/web and displays to be used internally and publicly (i.e. in the Pacific Speech and Hearing Center, Department of Speech-Language Pathology, clinic and department publications, etc.).

☐ I give **LIMITED** permission to the Pacific Speech and Hearing Center to use my image and voice in photographs and audio/video media for use in departmental, educational and promotional materials for INTERNAL USE ONLY (i.e. in the Pacific Speech and Hearing Center and in the Department of Speech-Language Pathology classroom).

☐ I **DENY** permission to use my image at all. **NOTE:** by marking this selection you will be considered ineligible for our therapy services, as our clinic's purpose is to serve as a learning environment/tool for our students).

IN ALL CASES

I waive any right to compensation. I hold the Pacific Speech and Hearing Center and its employees/students harmless from and against any claim for injury and or compensation resulting from the activities authorized by this agreement.

Today's Date _____

Print Name _____ Signature _____

If client is under the age of 18, a parent or legal guardian authorization is required below

Print Name _____ Signature _____

Address _____

City/State/Zip _____ Phone _____

Witness (if unable to sign):

Print Name _____ Signature _____

UNIVERSITY OF THE
PACIFIC
Speech and Hearing Center

University of the Pacific
Speech and Hearing Center
3601 Pacific Avenue
Stockton, CA 95211
(209) 946-2381

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Explanation

This authorization for use or disclosure of my health information is required by state and federal law. Failure to provide all information requested may invalidate this authorization.

Patient Name: _____ **DOB:** _____

I authorize _____
Name of hospital, physician, health care provider

_____
Street Address City State ZIP

to use and/or disclose my health information to:

University of the Pacific – Speech and Hearing Center
Name of hospital, physician, health care provider

3601 Pacific Avenue	Stockton	CA	95211
Street Address	City	State	ZIP

Type of records to be released:

- ☐ Speech Therapy Records Only
- ☐ Audiology Records Only
- ☐ Speech therapy and Audiology Records
- ☐ Complete Medical Records

Purpose for disclosing information: speech therapy/speech treatment

Expiration

This authorization will expire on _____ (not to exceed 2 years from the original date of signature) or one year from the date of this authorization.

Restrictions

California law prohibits the recipient of this form from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

Your Rights:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment or health plan enrollment or eligibility for benefits.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to:

University of the Pacific
Speech and Hearing Center
3601 Pacific Avenue
Stockton, CA 95211

- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure of my health information.
- I have a right to receive a copy of this authorization.

If this box ☐ is checked, a copy of this authorization was requested and received.

Signature: _____ Date: _____
Patient or Legal Representative

If signed by other than patient, print name and relationship to the patient:

Name: _____ Relationship: _____

Witness Signature: _____ Date: _____
Only needed if patient was unable to sign

☐ Check if you have Power of Attorney (POA) for the above patient. Please attach a copy of your POA form.