UT Health San Antonio
Department of Communication Sciences and Disorders
School of Health Professions – Speech-Language Pathology
7703 Floyd Curl Drive, San Antonio, TX 78229
Phone: (210) 450-8353 Fax: (210) 567-4828

CLIENT IDENTIFICATION INFORMATION

Child's Name: _____ DOB: ____/____/_____ Age: ____ Sex: _____
(month) (day) (year)

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

For Diagnostic Evaluation:

Preferred Appointment Date: ____ Monday AM / PM ____ Tuesday AM / PM ____ Wednesday AM / PM

____ Thursday AM / PM ____ Friday AM / PM

For a child to receive services at the UT Health San Antonio SLP Summer Clinic, a parent or Legal Guardian must complete the information below:

Parent's Name: _____ DOB: _____

Home Address: _____ City/State/Zip: _____

Occupation: _____ Education: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Parent's Name: _____ DOB: _____

Home Address: _____ City/State/Zip: _____

Occupation: _____ Education: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Legal Guardian (if other than parent): _____ DOB: _____

Home Address: _____ City/State/Zip: _____

Occupation: _____ Education: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact #1:

Name: _____ **Relationship:** _____ **Phone Number:** _____

Emergency Contact #2:

Name: _____ **Relationship:** _____ **Phone Number:** _____

Emergency Contact #3:

Name: _____ **Relationship:** _____ **Phone Number:** _____

Other children in family:

Name: _____ _____ _____ _____

DOB: _____ _____ _____ _____

Sex: _____ _____ _____ _____

Grade Level: _____ _____ _____ _____

Speech/language difficulties? _____ _____ _____ _____

Other special school services? _____ _____ _____ _____

Describe your child's speech and/or language difficulties.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What do you hope to learn from this evaluation or participation in this clinic?

_____

_____

When did you first become concerned that your child had a speech and/or language problem?

_____

PRENATAL AND BIRTH HISTORY

Is your child adopted? _____ At what age? _____

Length of pregnancy: _____ Child's birth weight: _____

Were there any complications during the pregnancy? _____

_____

Were there any complications during the labor and/or delivery? _____

_____

How long did your child remain in the hospital after his/her birth? _____

Did your child require any special treatment during this time? _____

DEVELOPMENTAL HISTORY

Skill	Age Acquired	Problems or Concerns
Sat alone without support		
Walked unaided		
Toilet trained		

Do you have any concerns about your child's fine or gross motor coordination or skills? _____

_____

HEALTH AND MEDICAL HISTORY

Describe your child's current health: _____

Does your child have a history of ear infections/aches? _____ Frequency? _____

Please indicate any known allergies:

Foods: _____

Environmental: _____

Latex: Yes / No

Please list your child's current medications: _____

_____

Describe if any problems with vision or hearing: _____

Describe any dental/orthodontic concerns: _____

Describe significant illnesses: (example: sustained high fever, viral infection, respiratory conditions, etc.) _____

_____

Has your child ever been hospitalized? _____

_____

Do you have any concerns about your child's sleep patterns? _____

_____

Do you have any concerns about your child's eating? _____

_____

Immunization History:

****Please provide or attach copy of Immunization Record***

	Vaccine		MO (XX)	DAY (XX)	YR (XXXX)
Diphtheria, Tetanus, Pertussis (DTP) • 3 doses during 1st year • 4th dose at 12-19 months • 5th dose at 4-6 years		1			
		2			
		3			
		4			
		5			
Hepatitis B (Hep B) • 3 doses between birth and 18 months		1			
		2			
		3			

Rotavirus					
Haemophilus Influenzae Type B (Hib) • 3-4 doses for children 2-15 months		1			
		2			
		3			
		4			
Pneumococcal Conjugate Vaccine (PCV) • 2-4 doses for all children 2-24 months		1			
		2			
		3			
		4			
Inactivated Poliovirus (IPV) • 3 doses at 2-18 months • 4th dose at 4-6 years					
Influenza (Flu)					

SPEECH AND LANGUAGE HISTORY

Please state the age at which your child

spoke his/her first word: _____ spoke in two-word utterances: _____ spoke in sentences: _____

Did speech/language development ever seem to stop for a period of time? _____ If so, describe: _____

_____

Are there any concerns about your child's ability to understand spoken language? _____

_____

Are there any concerns about your child's ability verbally express ideas? _____

_____

If your child stutters, please indicate when it began and describe the stuttering behaviors: _____

_____

Are there any sounds your child has difficulty producing? (please list) _____

Using percentages, please rate the intelligibility of your child's speech to the following listeners:

Listener	Topic Known	Topic Unknown
You		
Spouse		
Unfamiliar listeners		

Is your child aware of his/her speech difficulties? _____

What efforts does your child make to communicate when not understood? _____

_____

EDUCATIONAL HISTORY

Did your child attend preschool? Yes / No If yes, at what age did he/she start attending? _____

At what age did your child start first grade school? _____

Has your child received any special services at school? Yes / No (If yes, please describe) _____

_____

Current grade: _____ School name: _____

School address: _____

Are there any concerns about your child's school performance? _____

_____

Is a speech-language pathologist available to your child within his/her school or the school district? _____

GENERAL BEHAVIOR AND ENVIRONMENTAL HISTORY

How would you best describe your child's personality? Outgoing _____ Shy _____ Anxious _____ Easygoing _____

Aggressive _____ Stubborn _____ Independent _____ Dependent _____ Other _____

How would you best describe your child's behavior? Easy to manage _____ Difficulty to manage _____ Noisy _____

Very active _____ Talkative _____ Quiet _____ Imaginative _____ Cooperative _____ Destructive _____

Other _____

Do you feel that your child needs much or little discipline? (*circle one*)

Does your child become easily frustrated? Yes / No

How does he/she respond to frustration? _____

_____

In what organizations or extracurricular activities does your child participate? _____

_____

What opportunities does he/she have to play with other children his/her own age? _____

_____

How does your child utilize free time? _____

Are there concerns about your child's ability to get along with others? Yes / No

OTHER EVALUATIONS/TREATMENT Please indicate any prior evaluation(s) and/or treatment(s) your child has had.

	Prior Evaluation (date/site)	Prior Treatment (date/site)	Current Treatment (date/site)
Speech/Language			
LD/Educational			
Audiological/Hearing			
Psychological/Counseling			
Other:			

UT Health San Antonio SLP Summer Clinic

General Consent Form

I. GENERAL CONSENTS AND ACKNOWLEDGEMENTS

A. CONSENT FOR DIAGNOSIS, CARE AND TREATMENT

I, _____, the legal parent/guardian or legal representative of_____, hereby give my consent and permission for UT Health San Antonio to administer a speech- language assessment, treatment, and therapeutic services that may be deemed necessary for my child. I acknowledge that no guarantees have been made to me about the results of my child's assessment or treatment by any UT Health San Antonio clinician. I acknowledge that the assessment, treatment, and therapeutic services will be provided by master's level speech-language pathology graduate students under the direct supervision of licensed and certified speech-language pathologists. All services provided are free of charge and voluntary.

I acknowledge that the practice of Speech and Language Therapy is not an exact science and that treatment may involve risk of adverse results and injury. I acknowledge that no guarantees have been made as to the results of therapeutic treatment that may be undertaken at UT Health San Antonio. While routinely performed without incident, there may be material risks associated with certain treatments.

I hereby waive and release UT Health San Antonio from all liability and expressly assume all such risk and responsibility for any adverse results, injury, damages, liabilities, losses or expenses which may occur as a result of my child's participation in therapy or treatment.

B. CONSENT FOR MEDICAL TREATMENT

I, _____, the legal parent/guardian or legal representative of _____ give permission for my child to receive medical treatment in the event of a medical emergency, accident, injury or significant sickness. I give authorization for treatment to all medical personnel, including licensed physicians, nurses, technicians, emergency responders, and other medical personnel. I also assume responsibility for the cost associated for the emergent treatment.

C. ACKNOWLEDGEMENT OF EDUCATIONAL AND RESEARCH MISSIONS

The mission of UT Health San Antonio is to make lives better through excellence in education, research, health care and community engagement. Strategies for achieving this mission are: Educating a diverse student body to become excellent health care providers and scientists. Engaging in research to understand health and disease. Commercializing discoveries, as appropriate, to benefit the public. Providing compassionate and culturally proficient health care. Engaging our community to improve health. Influencing thoughtful advances in health policy. I acknowledge that confidential information may be used for educational purposes.

D. RECORDING

I am aware that audio and or video recordings are used routinely during the assessment (testing and interviewing) and during treatment sessions. I authorize for audio and video recordings of my child to be made for assessment, treatment and utilized for educational purposes within UT Health San Antonio. I will make no monetary or other claims against the University for their use. I understand that this permission extends to any and all sessions that my minor child, may have at the UT Health San Antonio SLP Summer Clinic.

II. HEALTH INFORMATION

I understand that UT Health San Antonio records medical and other information related to my child's assessment, care, and treatment in electronic, video, audio, and other forms. I certify that any information regarding my child's history or medical condition communicated to UT Health San Antonio is true and complete to the best of my knowledge. I understand that my medical information is confidential and will only be used by UT Health San Antonio staff for purposes related to my medical care and will only be released to others with my consent. I also give permission to UT Health San Antonio to provide medical information necessary to provide continuity of care recommended by UT Health San Antonio staff to non-UT Health San Antonio providers of healthcare or related diagnostic or therapeutic services.

III. RECEIPT OF WRITTEN MATERIALS

_____ I acknowledge receipt of UT Health San Antonio's Notice of Privacy Practices.

Initial Here

IV. SIGNATURE

My written signature indicates my consent, agreement with and acknowledgment of the above.

_____

Signature of Legal Parent, Guardian, or Legal Authorized Representative

Date of Signature

_____

Relationship of Legally Authorized Presentative to Patient

_____

Printed Name of Patient/Child

UT Health San Antonio

Consent for Photography

Patient Name: _____ **DOB:** _____

Parent or Legal Guardian: _____

I consent to have my (or child or an individual to whom I provide guardianship) image to be taken by the staff at UT Health San Antonio Speech Language Pathology Summer Clinic as described below.

I understand that my (or child or an individual to whom I provide guardianship) photographs, videotapes, digital, and other images may be recorded to document and assist with my care (or child or an individual to whom I provide guardianship). These images may be used to assist in the education of students and residents within the institution. I understand that the UT Health San Antonio will own these images, but that I will be allowed access to view them or to obtain copies of them at a reasonable cost. Other than for treatment and education, images that identify me (or child or an individual to whom I provide guardianship) will be released and/or used outside the organization only upon written authorization from me or the patient representative.

If the images are to be taken for any purpose other than for treatment, education, or payment purposes, the purpose(s) must be stated:_____

_____

I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

I release and hold harmless the UT Health San Antonio, the Department of Communication Sciences and Disorders, its staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the photograph or other image.

By signing below, I am indicating that I have read and understand the "Consent for Photography" form. I am either the patient or have the authority to give consent for the patient. My questions regarding this consent have been answered.

_____ _____

Patient or Patient Representative Signature Date

_____ _____

If Patient Representative, Relationship to Patient Printed Name

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Purpose: The University of Texas Health Science Center at San Antonio (UT Health San Antonio) is committed to protecting Health Information about you. UT Health San Antonio and its faculty, students, residents, employees, non-employees, and all of their affiliated entities follow the privacy practices described in this Notice. UT Health San Antonio maintains your health information in records that are kept in a confidential manner, as required by law. UT Health San Antonio must use and disclose or share your health information as necessary for treatment, payment, and health care operations to provide you with quality health care.

Use and Release of Your Health Information for Treatment, Payment, and Health Care Operations: UT Health San Antonio has to use and release some of your health information to conduct its business. We are permitted to use and release health information without authorization from you. Treatment includes sharing information among health care providers involved in your care. For example, your health care provider may share information about your condition with radiologists or other consultants to make a diagnosis. UT Health San Antonio may use your health information as required by your insurer to determine eligibility or to obtain payment for your treatment. In addition, UT Health San Antonio may use and disclose your health information to improve the quality of care, and for education and training purposes of UT Health San Antonio students, residents, and faculty.

How Will the UT Health San Antonio Use and Disclose My Health Information? Your health information may be used for the following purposes unless you ask for restrictions on a specific use or disclosure:

Note: You will have the opportunity to refuse some of these communications about your health information, indicated by (*).

- UT Health San Antonio directories, which may include your name, and your location in the UT Health San Antonio (*).
- Family members or close friends involved in your care or payment for treatment. (*)
- Disaster relief agency if you are involved in a disaster relief effort. (*)
- Fundraising activities by UT Health San Antonio. Such information will be limited to your name, address, phone number, and dates of treatment. If you do not want us to contact you

for fundraising efforts, please contact the Office of Institutional Advancement at (210) 567-9219. (*)

- Health Information Exchange. HIE is a secure computer system for health care providers to share your health information to support treatment, healthcare operations and continuity of care. Your record in the HIE includes medicines (prescriptions), lab and test results, imaging reports, conditions, diagnoses or health problems. To ensure your health information is entered into the correct record, also included are your full name, birth date and social security number. All information contained in the HIE is kept private and used in accordance with applicable state and federal laws and regulations.
- Appointment reminders.
- To contact you regarding treatment alternatives.
- Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect, or domestic violence.
- Health oversight activities, such as audits, inspections, investigations, and licensure.
- Law enforcement, as required by federal, state or local law.
- Lawsuit and disputes, in response to a court or administrative order, subpoena, discovery request or other lawful request.
- Coroners, medical examiners, and funeral directors.
- Organ and tissue donation.
- Certain research projects, which requires a special approval process by the University.
- To prevent a serious threat to health or safety.
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
- National security and intelligence activities to authorized persons to conduct special investigations.
- Workers' Compensation. Your medical information regarding benefits for work-related injuries and illnesses may be released as appropriate.
- To carry out health care treatment, payment, and operations functions through business associates, such as to install a new computer system.

Your Authorization Is Required for Other Disclosures. Your authorization will be required for most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and disclosures that constitute a sale of protected health information. Except as described above, we will not use or disclose your medical information, unless you allow UT Health San Antonio in writing to do so. For example, we will not use your photographs for presentations outside UT Health San Antonio without your written permission. You may withdraw or revoke your permission, which will be effective only after the date of your written withdrawal.

Alcohol and drug abuse information has special privacy protections. UT Health San Antonio will not disclose any information identifying an individual as being a patient or provide any health information relating to the patient's substance abuse treatment unless the patient authorizes in writing; to carry out treatment, payment, and operations; or as required by law.

You Have Rights Regarding Your Health Information. You have the following rights regarding your medical information, if requested on the form(s) provided by UT Health San Antonio:

- **Right to request restriction.** You may request limitations on your health information that we use or disclose for health care treatment, payment, or operations, although we are not required to comply with your request. For example, you may ask us not to disclose that you have had a particular procedure. We will release the information if necessary for emergency treatment. We will notify you in writing whether we honor your request or not.
- **Right to confidential communications.** You may request communications of your health information in a certain way or at a certain location, but you must tell us how or where you wish to be contacted.
- **Right to inspect and copy.** You have the right to review and obtain a copy of your medical or health record. Psychotherapy notes may not be inspected or copied. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by UT Health San Antonio. UT Health San Antonio will comply with the outcome of the review.
- **Right to request amendment.** If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment on the form provided by UT Health San Antonio. UT Health San Antonio is not required to accept the amendment.
- **Right to accounting of disclosures.** You may request a list of the disclosures of your health information that have been made to persons or entities during the past six (6) years prior to the request, except for disclosures for health care treatment, payment and operations, and disclosures based on patient authorization, or as required by law. After the first request, there may be a charge.
- **Right to restrict certain disclosures to a Health Plan.** You may request a restriction of certain disclosures of your protected health information to a health plan if you have paid out of pocket in full for the health care item or service.
- **Right to a copy of this Notice.** You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice at our website, http://www.uthscsa.edu/hipaa/patientrights.asp. A more detailed Notice is also available at this website if you would like more information about these practices.

Requirements Regarding This Notice. UT Health San Antonio is required by law to provide you with this Notice. We will comply with this Notice for as long as it is in effect. UT Health San Antonio may change this Notice, and these changes will be effective for health information we

have about you, as well as any information we receive in the future. Each time you register at UT Health San Antonio for health services, you may receive a copy of the Notice in effect at the time.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with:

UT Health San Antonio Privacy Officer
Office of Regulatory Affairs & Compliance
7703 Floyd Curl Drive, Mail Code 7861
San Antonio, TX 78229-3900
(210) 567-2014

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509 F, HHH Building
Washington, D.C. 20201

We will not penalize or retaliate against you in any way for making a complaint to UT Health San Antonio or to the Department of Health and Human Services. We will notify you in the unlikely event of a breach of your unsecured protected health information.

Contact UT Health San Antonio's Privacy Officer at (210) 567-2014 if:

- You have any questions about this Notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- You wish to obtain a form to exercise your individual rights.