UNIVERSITY OF SOUTH FLORIDA
DEPARTMENT OF COMMUNICATION SCIENCES AND DISORDERS
SPEECH, LANGUAGE, HEARING CENTER - PCD 1017
TAMPA, FLORIDA 33620-8150
Speech-Language: (813) 974-9844 **Audiology: (813) 974-8804**
Fax: (813) 905-8928

PRE-EVALUATION CASE HISTORY FORM FOR ADULTS - SPEECH/LANGUAGE PATHOLOGY

PLEASE READ CAREFULLY

Enclosed are several forms which **MUST** be completed and returned to this Center before an appointment can be scheduled. Please take the time to complete the case history form accurately and thoroughly. This information is for the Center records and will be treated as confidential. We cannot schedule an appointment until this completed form has been returned, **all release forms have been signed**, and all essential reports from other professionals and agencies have been received. You will then be contacted when an opening is available.

Please describe in your own words, your speech, language or hearing difficulty:

_____

_____

_____

Date form completed:_____ File #:_____

IDENTIFICATION

Name of Client:_____ Miss Ms. Mrs. Mr. Dr.
Last First Middle

Ethnicity (optional): African Amer. Asian/Pacific Islander Caucasian Hispanic Native Amer. Other _____

Date of Birth:_____ Age:_____ Gender (optional): Male Female

Address:_____
Street City State Zip

Home Phone:_____ Cell Phone:_____ Email:_____

Educational level attained: Elementary High School College Other

Occupation:_____ Place of Employment:_____ Phone:_____

Language(s) spoken by client:_____ Primary language spoken in home:_____

Primary Care Physician:_____

Address:_____ Phone:_____
Street City State Zip

Referred by:_____
Name Address Zip

Person to contact in case of emergency:_____ Relationship:_____

Phone:_____

Where did you learn about our services? _____

Person Completing Questionnaire:_____ Relationship to Client:_____

COMMUNICATION HISTORY

Does your communication difficulty interfere with your job performance? Yes No If yes, how? _____

_____

Do any family members have communication problems? Yes No If yes, describe:_____

Is the problem consistent? Yes No

Have you consulted with anyone about your communication problem? Yes No If yes, when? _____

Where and with whom? _____

Results and recommendations: _____

Are you presently enrolled in therapy? Yes No How often? _____

Where and with whom? _____

MEDICAL HISTORY

Please indicate any of the following you have experienced:

Stroke	Ears Ringing	Dizziness	Vision Problems
Cancer	Heart Attacks	Headaches	Ear Infections
Paralysis	Earaches	Seizures	Mumps
Ear Drainage	Meningitis	Measles	Air Bag Deployment
Head Trauma	Kidney Problems	Diabetes	Other: _____

For any conditions checked above, describe in detail (include date of occurrence, seriousness, hospitalization, treatment, etc.):

_____

_____

List accidents, injuries, or surgeries (include date of occurrence, seriousness, hospitalization, treatment, etc.):

_____

_____

Are you under any medical treatment now? Yes No If yes, for what? _____

_____

Are you under the care of a specialist? Yes No

If yes, state name (first and last) and specialty: _____

Are you taking any prescribed medications? Yes No Are you taking over-the-counter medications? Yes No

If yes, please list (include dosage and reason): _____

_____

Please check all of the following which you have ever taken:

Alcohol	Cocaine	Marijuana	Nicotine
Aspirin	Anti-seizure medication	Anti-anxiety medication	Anti-depressant medication

For any drugs checked above, describe in detail (include dates, dosage and reason): _____

_____

_____

Please include any other information that might help us: _____

_____

UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

Speech and Language Clinic
(813) 974-9844
(813) 905-8928 – FAX

Client/Patient Authorization regarding Research Studies, Mode of Communication and Educational Use of Recorded Sessions

*Client/Patient's Name:*_____

Participation in research projects:
Clients/patients may be asked by researchers in the Department if they would be interested in participating in a research study pertaining to their condition. When contacted, clients will be given an opportunity to review information about the study in order to decide whether or not they wish to participate. **Participation in any research study is always optional and will not affect the clinical care delivered to the client. Clients/patients who do not wish to be contacted regarding opportunities to participate in research may opt out at any time by contacting the clinic or by checking the statement below.**

Initials_____

____ Please do NOT contact me with opportunities to participate in research

Electronic communication and transmission of service related information:
Authorization is given to the Speech, Language, Hearing Center of the Department of Communication Sciences and Disorders, University of South Florida, 4202 E. Fowler Ave., Tampa, Florida 33620-8150, to communicate with me via **email, telephone (voice/text) and/or fax,** regarding therapy and/or assessment for the above named client. I acknowledge that the Speech, Language, Hearing Center of the Department of Communication Sciences and Disorders cannot be responsible for non-secured communication.

Initials_____

Acknowledgement of the recording of sessions (audio and video):
The University of South Florida Department of Communication Sciences and Disorders operates a clinical facility primarily for the training of future professionals in Speech-Language Pathology, Audiology, and Aural (Re)Habilitation. All clients/patients seen in the clinic for diagnostic and therapeutic services must agree to the recording of sessions. Recordings may be reviewed and used by faculty, staff and students as part of a client/patient's plan of care, as part of a research project and/or to facilitate instructional objectives for students enrolled in the program. Appropriate safeguards related to privacy and confidentiality will be utilized for the use and storage of such recordings and this specific authorization regarding the recordings is attached below and must be signed by each patient.

"I understand the above and hereby release to the University of South Florida Department of Communication Sciences and Disorders, the right to make audio and video recordings or to photograph said person in any and all phases of the educational or remedial process and to put the audio and video recordings or photographs to any legitimate educational or training uses. All recordings, photographs and their reproductions shall remain the property of the Department of Communication Sciences and Disorders of the University of South Florida. It is further agreed that in the event the Department of Communication Sciences and Disorders of the University of South Florida or its assigns shall become a party defendant to litigation by said persons as a result of the legitimate use of said audio and video recordings, photographs, and/or descriptive literature or sound tracks, (I/We) shall hold harmless and indemnify it or its assigns from any judgment which may be entered against it or its assigns."

Signature:_____ Date:_____
Client/Parent/Guardian

Signature:_____ Date:_____
Client/Parent/Guardian

USF HEALTH

Guide to Understanding your Health Insurance Coverage and Payment Practices

USF Health contracts with many insurance companies. If you have insurance with one of these companies, our billing offices will submit a claim for payment of services rendered for you unless you instruct us not to. All needed insurance information including special forms, must be completed by you before you leave your appointment. Please be advised that we will work diligently with your insurance company to ensure that they have all the information they need to process your claim(s). If you have a change in insurance or benefits, please notify us immediately by calling 813-974-0509.

It is important for you to know which medical treatments your insurance plan covers. Your Health Insurance Policy is a contract between you and your health insurance company and outlines services your insurance will and will not cover. Your insurance plan also may require you to pay for certain out-of-pocket expenses such as co-pays, coinsurance and/or deductible.

1. **Will USF Health determine ahead of time what my insurance covers?**
   - USF Health performs a "verification of eligibility" prior to your visit.
   - Your insurance company will verify that the policy is current and the amount of your co-pay, co-insurance or deductible
   - You are responsible for paying all amounts which your health insurance plan has assigned as your financial responsibility.

2. **What if my health insurance company does not pay, or pays only a portion of my bill?**
   - You are responsible for paying the amount your health insurance plan does not cover.
   - You should receive an explanation of benefits (EOB) from your insurance company telling you how much they paid your provider and the amount you owe.
   - You may be required to call your insurer or employer to update them with information such as other insurance coverage, dependent information or your choice of physician.

3. **What are some reasons a health insurance company may not pay for treatment?**
   - In the course of a physical/well/preventive visit, you may be treated for a separate problem. Depending on your benefits, your insurance may require that you pay an additional copay for the added service.
   - You did not provide the health insurance company with information or forms required.
   - A spouse or child is not covered under the plan or was not added to the policy.
   - The doctor is out of network.

Please note that Insurance plans may change from one year to the next, so be sure to review your benefit coverage as well as changes in co-pays, coinsurance, or deductibles at the start of a new contract period.

Billing Inquiries:
813-974-0509 or toll free 800-933-8672

Appointment or General Information Inquiries.
813 974-2201 or toll free 888-873-3627

USF HIPAA COVERED COMPONENT
ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES AND NOTICE OF HEALTH CARE ARRANGEMENT

Effective August 1, 2015

By signing below, I acknowledge that I have been provided a copy of this Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement and have thereby been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

_____ _____

Signature of Patient (or Authorized Personal Representative) Date

_____ _____

Print Name of Patient (or Authorized Personal Representative) Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate)

DOCUMENTATION OF GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES AND NOTICE OF HEALTH CARE ARRANGEMENT

The patient presented for his/her service on this date and was provided a copy of the Joint Notice of Privacy Practices and Notice of Health Care Arrangement. A good faith effort was made to obtain a written acknowledgment of receipt of the Notice. However, an acknowledgment of receipt was not obtained because of the following reason(s):

- ☐ Patient refused to sign the Acknowledgement of Receipt.
- ☐ Patient was unable to sign or initial the Acknowledgement of Receipt.

_____ _____

Signature of employee completing this form Date

_____

Print name of employee

Medical Record Number: _____

Or Affix Patient Label:

Scan/File Original in the Medical Record

USF HEALTH

CONDITIONS OF TREATMENT BY UNIVERSITY OF SOUTH FLORIDA (USF) COLLEGE OF MEDICINE

Permission for Treatment: Permission is hereby granted for physicians, residents, employees or agents of the USF College of Medicine ("USF Physicians Group") (collectively, the "Provider") to render the patient named below such medical and surgical treatment as is deemed necessary.

Authorization for Release of Information: The Provider (through its employees or contracted copying services) may disclose the patient's medical record and account to:

1. Any person or corporation which is or may be liable for all or any portion of the patient's charges, including but not limited to insurance companies, health care service plans, and worker's compensation carriers to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement.
2. Any referring physician to ensure continuity of medical care.
3. Other treatment providers within the USF College of Medicine/USF Physicians Group. (The USF Medical Clinics combine all records pertaining to each individual patient in one file. Therefore, in the event a patient is seeing more than one Provider within the USF College of Medicine/USF Physicians Group, each Provider will have access to the records created by every other Provider for that patient.)

Financial Agreement: (Please initial as applicable)

_____ **Assignment of Insurance Benefits:** I request my insurance carrier to pay to University Medical Service Association, Inc. all benefits due me related to my pending claim for medical and surgical services. I agree to pay all applicable deductible and coinsurance amounts due and other fees for services rendered for which my insurance plan/HMO is not liable for payment to the Provider, and agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect such amounts.

_____ **Medicare B Authorization:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related Medical Claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

_____ **Self-Paying Patient.** I have been informed that the USF College of Medicine/USF Physicians Group does not have a contract to participate with my insurance plan or HMO, and the requested services have not been authorized by my insurance plan/HMO, as applicable. I am requesting medical services as a fee-for-service, self-paying patient. I agree that I am responsible for all charges incurred as a result of this visit, including but not limited to all medical/surgical professional services, laboratory, radiological, and any other ancillary services. I agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect this account.

_____
Print Patient's Name

_____ _____
Signature (Patient, Patient Representative) Date

_____ _____
Signature (Witness) Date

_____ _____
Signature (Financially Responsible Party) Date

_____ _____
Signature (Witness) Date

Authorization to Records Custodian for the Release of Medical Records

USF HEALTH

13330 USF Laurel Drive, MDC 33
Tampa, FL 33612
Phone (813) 974-9818
Fax (813) 974-4280

Patient's Name _____ Date of birth _____

Patient's last 4 Number of Social Security No. _____ Medical Record No. _____

Representative Name _____ Relationship to Patient _____

Representative Address _____ Legal Authority _____

Verification of Identity _____ Verfication of Authority _____

By signing this form I understand that I am authorizing the designated medical records custodians or database custodian to use and/or disclose my protected health information (PHI) as defined under 45 CFR 164.501, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as described below to the following person(s) or organization(s)

Release to: _____ Obtain from: _____

_____ _____

Name Name

_____ _____

Street Address Street Address

_____ _____

City, State, Zip Code City, State, Zip Code

Purpose of requesting records: _____

I specifically authorize the use and disclosure of the following PHI: (Please provide a detailed description of the particular data and period of time you are requesting) **Initial next to A, B, or C and circle specifics**

A. _____ ALL medical records in the custody of USF Health _____

_____ Records of the treating physician _____

_____ Last office visit Note, or Medication list _____

_____ Labs or Pathology _____

_____ Radiology report or Images _____

B. _____ Other Information Requested _____

C. _____ **I further authorize the release of records regarding**

A. _____ Mental/Emotional Health B. _____ Substance Abuse C. _____ HIV/AIDS

D. _____ Genetic Information E _____ Records created by non USF health providers

I understand that I may be charged for the copying of these patient records and payment is expected at the time the copies are received from USF Health.

If requesting information relating to: (1) Acquired immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; (3) mental or emotional health or psychiatric care, excluding psychotherapy notes or (4) genetic testing, specific authorization on this form or a court order is required since this information is privileged. A separate authorization is required for psychotherapy session notes. Psychotherapy session notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date. 45 CFR 164.501.

I may revoke this authorization form at any time by notifying the above-referenced records custodian at the location listed above, of my intent to revoke this authorization. Returning [a copy] of this form, signed and dated with the words "authorization revoked" is sufficient notice. However, I understand that such revocation will not have any effect on any information already used or disclosed by the University of South Florida prior to the University receiving my written notice of revocation. This authorization form expires one year from signature or on _____ or on the occurence of _____. I understand that protected health information released to a third party pursuant to this form may be re-disclosed and may no longer be protected by state and federal law.

I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form.
I understand that I am not required to sign this Authorization form in exchange for the patient receiving treatment from the University of South Florida.
I also understand that payment, enrollment in a health plan and/or eligibility for benefits will not be conditioned upon my signing this form.
I understand that I may refuse to sign this form.

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed name of **patient** or **personal representative** (circle one) Relationship to patient giving representative authority to act for patient

PRIOR EXPRESS CONSENT

FOR COMMUNICATIONS FOR DEBT COLLECTION AND PAYMENT PURPOSES

I expressly agree and consent that, in order for University Medical Service Association, Inc. ("UMSA"), and its agents and affiliates, to service my account including debt collection and payment purposes, UMSA, or any of its agents or affiliates, may contact me by telephone at any telephone number associated with my account, including any wireless/cellular telephone numbers, which could result in charges to me. UMSA, or any of its agents or affiliates, may also contact me for debt collection and payment purposes by sending text messages or e-mails, using any e-mail address I provide to UMSA. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

I have read this Consent and agree that UMSA may contact me as described above. I hereby affirm that either (i) I am the patient and sign this Consent of my own behalf, or (ii) if I am signing this Consent on behalf of the patient, I have reviewed this Consent with the patient and he/she has expressly authorized me to sign this Consent on his/her behalf.

_____ _____

Patientor Patient's Authorized Representative Date

_____

(Relationship to Patient)

Patient Refused to Sign

_____ _____

(Signature of USF Health Rep) Date

USF HEALTH

Patient Name:_____ MRN Number:_____

As a result of the American Recovery and Reinvestment Act, the USF Physicians Group is required to collect patient data regarding race, ethnicity and language as part of information provided to the Centers for Medicare & Medicaid Services (CMS) under the Meaningful Use requirements. This information is required for all patients.

Accordingly, we are required to request that you indicate your racial background, ethnicity and primary language by indicating one of the following:

Race

___ American Indian/Alaska Native

___ Asian

___ Black

___ Native Hawaiian/Other Pacific Islander

___ White

___ Declined

___ Unknown

Ethnicity

___ Hispanic or Latino or Spanish Origin

___ Not Hispanic or Latino or Spanish Origin

___ Declined

___ Unknown

Please note that you have the option of indicating "declined" above.

Language_____

Other required data to offer better service to you:

Preferred Method to Notify You of Upcoming Appointment (*if you currently subscribe to the FollowMyHealth patient portal, you will receive appointment reminders through this method*)

_____Cell Phone Number _____

_____Home Phone Number_____

_____E-Mail – E-Mail Address_____

_____Text Message – Phone Number to Text_____

_____Do Not Call Me

_____No Response

*DATE ENTERED:*_____ *BY:*_____ *(Initials)*

USF SLHC Patient and Caregiver Policies

Client Name: _____ DOB: _____

Parking:

1. Your parking permit should be visible and you should only park in designated areas.

Caregivers/Parents/Guardians present during sessions:

2. Per USF (legal counsel) policies, for parents/guardians of minors, parents/guardians must be on-site while the patient is in our facilities.
3. For caregivers of adults with no ability to communicate immediate wants and needs, caregivers must be on-site while the adult patient is in our facilities OR the adult patient must have in his/her possession the contact information for us to reach the caregiver.

Tardiness, Attendance and Sick Policy:

4. Attendance at your sessions is important and most Medicare, Medicaid and private insurance plans are careful to monitor attendance. As a training facility, our students depend on your attendance to complete the hours required as part of their practicum. We ask you to:
    a. Notify us two hours in advanced if you are going to be absent. Please call the clinic at (813) 974-9844.
    b. Be on time for your session, but please notify us if you are going to be late for your session. We cannot extend the sessions if you are late. If you arrive 15 minutes or more after your scheduled appointment time and you have not called to provide advanced notice of the tardy, the session will be cancelled and/or rescheduled.
5. If the client receiving therapy has had a fever, vomiting, diarrhea, a positive flu test, pink eye, or another contagious illness in the last 24 hours, please notify us and do not attend therapy.
6. Three consecutive absences from scheduled therapy sessions without prior notification may result in discharge from therapy.
7. Please be sure to coordinate make up sessions with your clinician. If you inform him/her ahead of time, he/she might be able to reschedule the session within the same week.
8. If you discontinue services during the semester, without a reasonable excuse, it will be at our discretion whether or not to keep you on the waiting list. Remember, our therapy recommendations are based on client needs and poor attendance impacts performance. Additionally, students need to complete a specific number of hours per semester and your cancellation can impact completion of these hours.

Observations and personal video recording and photography Policy:

9. As a teaching facility, we allow for observation of the sessions from our Speech Clinic observation rooms. Parents/caregivers, students, and on occasion, supervisors utilize the observation rooms. Please remember we cannot accommodate more than 2 observers per session. If you are watching from an observation room, please be quiet, do not eat, and do not speak on your cell phone. Noise may disrupt the treatment session. Please do not move furniture from the rooms. Please do not turn the lights on in the observation room because it can be disruptive to the patient and could lead to visibility from the therapy room into the observation room.
10. Video recording or photography of the sessions using personal devices is not allowed without written consent from the Supervisor and Graduate student clinician. If other clients are present in the session, recording of the session is never allowed.

Speech therapy sessions:

11. Within the time allotted for your session, we include the following: warm up/rapport building, therapy, and brief consultation with parents and/or caregivers. We cannot extend our sessions for consultations without prior notice. If you need to talk for an extended amount of time to your clinician or supervisor, please notify us before the session begins so we can allow time for it.

Billing and Insurance:

12. Within the list of USF-Health accepted insurances, USF SLHC has the ability to bill insurance for certain Audiology and Speech-Language sessions. Our providers might be in-network or out-of-network providers within the list of accepted insurances. Insurance copayments, fees for all evaluations and treatments for insurance plans not accepted, and/or fees for services provided to individuals without insurance are due and payable at the time services are rendered. The Client Services Associate will identify if your insurance is accepted by USF-Health, provide copayment amounts, and/or provide a price for the service scheduled.

I have read the above information and agree to the USF-SLHC rules.

Signature _____ Date _____

Print name _____

Relation to client _____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

USF Speech and Language Clinic

Treatment Scheduling, Wait List, and Provider Assignment Policies

Evaluation does not guarantee treatment

A completed Speech and Language evaluation is not guarantee of future treatment in the USF Speech and Language Clinic.

Wait List for Treatment

Following Speech and Language evaluation, you or your child might be placed on a wait list for treatment. An estimate of the wait time cannot be provided as it depends on provider and clinical instructor availability. If you are interested in receiving treatment at another facility, please notify us.

Providers, Clinical Instructors, and Students

Since this is a training facility, providers, clinical instructors and students work in our clinic. At any point in during your care in our clinic, you could be assigned to any of these individuals for evaluation and/or treatment. To meet training needs for our students, you or your child might be reassigned to a therapist or clinical instructor at any time.

I acknowledge that I have read and reviewed and agree to the policies documented above.

_____ _____

Patient Name **Patient DOB**

_____ _____

Patient/Caregiver (if patient is under 18) Signature **Date**

Patient MRN _____