**TEXAS STATE UNIVERSITY-SAN MARCOS**

**SPEECH-LANGUAGE-HEARING CLINIC**

**PATIENT INFORMATION SHEET**

**Please complete the following information.**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

DOB:\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Permanent Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Home Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent(s) or Guardian(s) if patient is under the age of 18: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has Patient previously been seen here? Y N Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by (Name, Address, Telephone #): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Audiology – Insurance Only**

Name of insurance company or payer of services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/client ID verified: Yes No

Initials:

I understand that I am responsible for all charges incurred as a result of this visit. I hereby authorize the above provider to release information to my insurance carrier. I hereby authorize payment directly to the above provider of benefits and understand that this authorization does not release me from my personal responsibility for payment of all charges.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**TEXAS STATE UNIVERSITY-SAN MARCOS**

**SPEECH-LANGUAGE-HEARING CLINIC**

**CONSENT FOR TREATMENT**

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the above named patient, I give my permission to allow student clinicians under direct supervision of TEXAS STATE UNIVERSITY-SAN MARCOS Speech–Language-Hearing Clinic faculty to: **(Please initial)**

\_\_\_\_\_\_\_\_\_\_ Interview, evaluate, and treat communication skills as indicated.

\_\_\_\_\_\_\_\_\_\_\_Video tape and/or photograph the interview, evaluation and/or therapy. These exhibits remain part of the client medical record and may be used in the clinical education of students in the Communication Disorders program.

\_\_\_\_\_\_\_\_\_\_\_ Allow photographs obtained by CDIS personnel to be used in departmental marketing material(s) such as brochures, and/or on the Texas State University CDIS website for an unlimited period of time.

\_\_\_\_\_\_\_\_\_\_\_Give food and/or beverage during evaluation or therapy

**Please list dietary restrictions**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_ Allow live observation of session(s) by Texas State Faculty and students for educational and clinical training purposes.

I further release the student clinicians, faculty, and TEXAS STATE UNIVERSITY-SAN MARCOS from any liability if injury is incurred during therapy activities, and give TEXAS STATE UNIVERSITY-SAN MARCOS permission to seek emergency medical treatment, if necessary.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date Relationship if Not Client

**AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

**FROM**

**TEXAS STATE UNIVERSITY-SAN MARCOS**

**SPEECH-LANGUAGE-HEARING CLINIC**

I hereby give my permission for the release of confidential reports containing protected health information belonging to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name DOB

**This information may be submitted via: fax, e-mail, or US mail (circle all approved media) to the following person(s) or agency(ies): Specific names and contact information MUST be provided by the parent or legal guardian prior to transmission. The speech-language-hearing clinic will not release information if this section is incomplete.**

1 2 3

|  |  |  |
| --- | --- | --- |
| Name: |  |  |
| Address: |  |  |
|  |  |  |
| Phone: |  |  |
| e-mail: |  |  |
|  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Date Relationship if not Client