SAN JOSÉ STATE UNIVERSITY

Connie L. Lurie College of Education

Communicative Disorders and Sciences

Department Chair
Michael L. Kimbarow, Ph.D.

Faculty
Henriette W. Langdon, Ed.D.
June McCullough, Ph.D.
Jean M. Novak, Ph.D.
Wendy Quach, Ph.D

Administrative Support Coordinator II
Nikole M. Abrego
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Kay Armstead Center for
Communicative Disorders

Clinic Coordinator
(408) 924-3679

www.sjsu.edu/cds/clinic

One Washington Square
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COUNCIL ON ACADEMIC ACCREDITATION
ACCREDITED SPEECH-LANGUAGE PATHOLOGY

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Chancellor's Office
Bakersfield, Channel Islands, Chico, Dominguez Hills, East Bay, Fresno, Fullerton, Humboldt, Long Beach, Los Angeles, Maritime Academy, Monterey Bay, Northridge, Pomona, Sacramento, San Bernardino, San Diego, San Francisco, San José, San Luis Obispo, San Marcos, Sonoma, Stanislaus

NEW CLIENT PACKET

Dear Client/Caregiver,

Welcome to the Kay Armstead Center for Communication Disorders. We are happy to have you attend the clinic and we and look forward to serving you this semester.

As you may know, our center is a training facility for the Communicative Sciences and Disorders program, and our mission is twofold:

1: Our clients will be served to the best of our ability.

2: We will train excellent speech-language-pathologists.

It is our goal to establish a mutually valuable relationship that benefits both our clients and students. The following information will assist you in maximizing your clinical experience.

- **WAIT LIST** Our waiting list functions as an applicant pool, and selections are based on many criteria, including, but not limited to: current clients and groupings, age and skills of the client, the extent to which the center can adequately serve the client's needs, availability of the client, expertise of the supervisor, and the educational needs of our student clinicians.

- **EVALUATIONS** Potential clients without recent and/or adequate evaluative information are referred to our diagnostic clinic. Potential clients with recent and adequate evaluative information can request to automatically be put on our treatment waiting list. It is the responsibility of the individual or caregiver to keep files up to date on current evaluative information.

- **REASSESMENTS** Once a client has received therapy for four semesters, he or she is reassessed through our diagnostic clinic to determine if they should continue at the center or not. There is no charge for this reassessment. Unfortunately, failure to schedule an appointment for reassessment will result in automatic discharge from the clinic.

- **FEE AGREEMENT/ABSENCE POLICY** Clients/Caregivers must adhere to the fee agreement and absence policy (Please see attached Fee Agreement & Absence policy on page 4).

- **ACCOUNT STATUS** Clients/Caregivers are required to keep their clinic accounts current, adhering to their designated plan of payment. (Please see attached Fee Schedule on page 5).

- **SESSIONS** Regular sessions last 50 minutes. Clinicians only have 2-3 minutes available for caregiver consultation after the clinical hour. Thereafter, they must use the remainder of the hour to make notes and prepare for their next client, or clean the room for the next clinician. Detailed consultation may cut into another client's therapy time. Our basic clinical model for bi-weekly therapy sessions includes one individual and one group session. Clients who are seen only one time per week are seen on an individual basis.

- **ADULT AUTISM GROUP** Our Communication Skills Group for adults, teaches communication in all modalities, including use of the phone and email. Therefore, we ask our clients to share their contact information with the clinicians and other group members who are participating in that respective semester. Communication skills projects are designed around contacting each other outside of group time to practice independence and social language. Our clients have shown to benefit greatly from this model. Please note that there is an "opt out" form available if caregivers or clients do not wish to disclose their personal contact information to others in the group. Please be advised that opting out will limit the client's participation in group activities.

- **CAREGIVER OBSERVATION** We are not yet equipped to provide the opportunity for caregivers to observe sessions. Caregivers may be invited into the sessions for a few minutes to review skill work and so that your clinician can give you suggestions for home. Your student clinician will keep you informed of progress in therapy as well as any behavioral concerns that arise. Recordings of sessions are not available.

- **CERTIFIED SUPERVISORS** We have assembled a wonderful team of master's and doctoral level licensed and certified clinicians to supervise the students who are working in our clinic with our clients. Our supervisors have varied expertise and many years of clinical experience as well as supervision experience. The supervisors are evaluated each semester by their students, the clinic director, and the department chair. Clinical decisions ultimately rest with the clinical supervisor. We value caregivers as part of our team and welcome input. However, as a student training clinic, we cannot be expected to provide specific therapies upon request (i.e. ABA, Lindamood-Bell, TEAACH, etc.). We will always strive to provide the most appropriate and effective therapeutic interventions for you and your loved ones, by abiding by our professional scope of practice and code of ethics.

- **WAITING AREA POLICY** It is MANDATORY for parents and caregivers of our clients to wait in or around the outside of the waiting room, or a predetermined area nearby. A student clinician should always be able to locate their client's parent or caregiver. If you will be leaving the waiting area momentarily (to move your car or get a cup of coffee at JustBelow), please let your student clinician know before the session begins, remembering to provide him or her with your cell phone number.

🗁 **FORMS** The following forms will be provided by the center and are required to obtain services:

- Consent for Evaluation and Treatment
- Contact Form
- Video Consent and Release Form
- Documentation Checklist

The following forms will be provided by the center and are optional:

- Release of Information
- Request for Information
- Media Release Form
- Contact Information Opt Out Form (for Communication Skills Class)

It is our sincere hope that our clients receive the best possible services and that our student clinicians have the best possible clinical education while serving our clients. We are happy that you've joined us and we look forward to a mutually beneficial relationship!

Please direct any questions first to your student clinician, then to their direct supervisor, and then to the clinic director.

Thank you,

Michael L. Kimbarow, Ph.D.
Associate Professor and Department Chair
Communicative Disorders and Sciences
San Jose State University
One Washington Square
San Jose, CA 95192-0079

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FEE AGREEMENT & ABSENCE POLICY

FEE AGREEMENT:

Adult Autism Communication Group: **$125/semester***
AAC Conversation Group: **$125/semester***

Speech/Language Evaluation: **$300***
AAC Evaluation: **$500***

2x/Week Therapy: **$520/semester****
1x/Week Therapy: **$260/semester****

***Clients attending the AUSTISM, AAC, or ASSESSMENT clinics must be pay their semester fees in full on the first day of therapy**.

**The clinic prefers 2x/week and 1x/week therapy accounts be paid in full on the first day of therapy. However, if you are unable to pay the full amount on the first day, please see page 5 for payment options.

ABSENCE POLICY:

- Fees are based on semester enrollment, not individual sessions. Because of this, refunds will not be issued for missed therapy sessions due to illness or otherwise.
- Partial payments for arriving late or leaving early are not permitted.
- **24-hour cancellation policy**: Parents and caregivers are required to give 24-hour notice to their student clinician if the client will be absent. Please always have your clinician's contact information ready.
- The client is limited to two excused absences per semester. Three or more absences may result in automatic dismissal from therapy and/or denial of future services, at the discretion of the clinic director.
- Clients will be offered a make-up session if their student clinician cancels a session.
- Student clinicians are not obligated to make up a session if the client or caregiver cancels; however, they often will, according to their availability and availability of supervision.
- Clients are not to attend therapy if they have had a fever, have vomited, have had diarrhea, or if they have had green mucus within the last 24 hours.

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SPRING 2011 · FEE SCHEDULE

KAY ARMSTEAD CENTER FOR COMMUNICATIVE DISORDERS

Should a client need more time to pay their fees, we offer several payment plans that allow them to divide the semester fee into 2, 3, or 5 payments. Please contact the clinic director to arrange a personalized payment plan. Payments can be made via cash, check or by PayPal, which is our preferred method of payment. PayPal allows you to use your debit card, credit card or bank account to pay your fees in a secure, fast, and easy way. If you do not have a PayPal account, you will not be required to create one if you are paying with a debit or credit card. Please visit www.sjsu.edu/cds/clinic to make an online PayPal payment.

Fees listed below do not include the $10.00 fee for a clinic parking pass that is REQUIRED each semester.

1 payment: *PREFERRED*

Payment Number	AAC/Aut.	1x/Week	2x/Week	Due Date
1	$125	$260	$520	Jan. 31st- Feb. 4th

2 payments:

Payment Number	1x/Week	2x/Week	Due Date
1	$130	$260	Jan. 31st- Feb. 4th
2	$130	$260	March 14th - 18th

3 payments:

Payment Number	1x/Week	2x/Week	Due Date
1	$87	$174	Jan. 31st- Feb. 4th
2	$87	$173	Feb. 28th - March 4th
3	$86	$173	April 4th - 8th

5 payments:

Payment Number	1x/Week	2x/Week	Due Date
1	$52	$104	Jan. 31st- Feb. 4th
2	$52	$104	Feb. 21st – 25th
3	$52	$104	March 7th – 11th
4	$52	$104	April 4th – 8th
5	$52	$104	May 2nd – 6th

* It is the sole responsibility of the client and/or caregiver to pay their fees by the above dates in accordance with their individualized payment plan. Failure to pay will result in immediate dismissal from the KACCD.
NOTE: Failure to purchase a new parking pass each semester will result in an irreversible parking ticket.

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Documentation Checklist

In-Office Record

Client's Name: _____ Date of Birth: _____

Caregivers Name: _____

I have read and agree to the policies and procedures outlined in the: 1) welcome letter from the clinic; 2) the absence policy; and, 3) the fee schedule.

Signed: _____ Date: _____

I have provided the clinic with the following *REQUIRED* documentation for my file:

- ☐ Consent for Evaluation and Treatment
- ☐ Contact Form
- ☐ Video Consent and Release Form

I have provided the clinic with the following *OPTIONAL* documentation for my file:

- ☐ Release of Information
- ☐ Request for information
- ☐ Media Release Form
- ☐ Opt Out Form for Sharing Contact Info (Communication Skills Class Only)

In the space provided below, please list any additional documents or informational materials that you have provided or will provide to your student clinician.

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Consent for Evaluation and Treatment

The Kay Armstead Center for Communicative Disorders was established primarily for the purpose of teaching and training students. By utilizing the services of the clinic, the client should understand that in order to accomplish teaching and training goals, it is frequently necessary that observation, audio and video recording, and/or other media be used. However, it should be clearly understood that the information obtained from or divulged by the client is protected and treated with the strictest confidence.

I understand that any written information exchanges with other parties will require my written permission.

I hereby consent to:

- ☐ Diagnostic testing
- ☐ Therapy

Furthermore, I consent to the:

- ☐ Observation of interviews, therapy, or diagnostics
- ☐ Listening of interviews, therapy, or diagnostics
- ☐ Video & Audio Recording of interviews, therapy, or diagnostics

I consent to all of the above with the understanding such observation, listening, recording, and/or taping is strictly for instructional purposes.

Lastly, I consent to the discussion of relevant confidential material with qualified professional personnel in furtherance of clinical service on behalf of me, or any other person named below. I also authorize any professional individual or agency to discuss such information upon request from The Kay Armstead Center for Communicative Disorders at San José State University.

Name of Client (please print)	Client Signature
Name of Parent/Guardian (please print)	Relationship
Signature of Parent/Guardian	Date

SAN JOSÉ STATE
UNIVERSITY

CLIENT CONTACT FORM

Kay Armstead Center for Communicative Disorders

PLEASE PRINT LEGIBLY

Client Name: _____ Date:_____

Date of Birth: _____ Chron. Age_____ ☐Male ☐Female

Caregiver (if applicable) _____

Relationship of Caregiver to Client: _____

Email: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Other Phone: (_____) _____ - _____

Address: _____ _____
Street Number & Name Apt. #

_____ _____ _____
City State Zip

Other Contact Information: _____

Emergency Contact Name: _____

Emergency Phone (s): (_____) _____ - _____ or (_____) _____ - _____

Current Status:

☐ Diagnostic Client ☐ Speech-Language Therapy Client

☐ Aural Rehab Client ☐ Waiting List for Speech-Language Therapy

Schedule/Availability:

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VIDEO CONSENT AND RELEASE FORM

Consent is hereby granted to the Kay Armstead Center for Communicative Disorders at San José State University to record individual or group treatment videos via computer, television, and sound and/or to take individual or group pictures of _____, for purposes set forth hereafter.
Client Name

It is understood that said video(s) or pictures are to be taken for the purpose of instructional telecasting, both on open or closed circuit, and for the publication of educational materials by San José State University.

It is agreed that I shall not have any right, title, or interest in the video(s) or pictures. Furthermore, nor shall there arise or vest in me any cause of action for damages for injuries other than physical injury which may be caused by negligence, and without contributory negligence on my and/or my child's part, by virtue of the making of said videotape or photograph in the manner and for the purposes herein described.

All parties hereby agree to comply with the forgoing terms.

Parent/Caregiver Name (print please)	Relationship to Client
Parent/Caregiver Signature (if applicable)	Date
Client Signature	Date

San José State University

Name of Witness (print please) **[witness cannot be student clinician]**	
Signature of Witness	Date

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Release of Information Form

Client Name: _____ DOB: _____

Address: _____ _____
Street Number & Name Apt. #

_____ _____ _____
City State Zip

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____
Cell Phone: (_____) _____ - _____ Other Phone: (_____) _____ - _____
Email: _____

I hereby authorize the Kay Armstead Center for Communicative Disorders to release any and all speech, language and hearing diagnostic/therapy information on the above named individual to the person or agencies listed below.

Name: _____ Title: _____

Facility: _____

Address: _____ _____ _____ _____
Street Number & Name City State Zip

Phone(s): (_____) _____ - _____ (_____) _____ - _____

Email: _____

Name: _____ Title: _____

Facility: _____

Address: _____ _____ _____ _____
Street Number & Name City State Zip

Phone(s): (_____) _____ - _____ (_____) _____ - _____

Email: _____

_____ _____
Parent/Caregiver Name (please print) Relationship

_____ _____
Parent/Caregiver Signature Date

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Request for Information Form

Client Name: _____ DOB: _____

Address: _____ _____
Street Number & Name Apt. #

_____ _____ _____
City State Zip

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____
Cell Phone: (_____) _____ - _____ Other Phone: (_____) _____ - _____
Email: _____

I hereby authorize the Kay Armstead Center for Communicative Disorders to obtain any and all speech, language and hearing diagnostic/therapy information on the above named individual from the person or agencies listed below.

Name: _____ Title: _____

Facility: _____

Address: _____ _____ _____ _____
Street Number & Name City State Zip

Phone(s): (_____) _____ - _____ (_____) _____ - _____

Email: _____

Name: _____ Title: _____

Facility: _____

Address: _____ _____ _____ _____
Street Number & Name City State Zip

Phone(s): (_____) _____ - _____ (_____) _____ - _____

Email: _____

_____ _____
Parent/Caregiver Name (please print) Relationship

_____ _____
Parent/Caregiver Signature Date

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MEDIA CONSENT FORM

From time to time photographs, videos, and/or audio clips may be taken of clients, students and faculty engaging in CD&S programs and activities. The Kay Armstead Center for Communicative Disorders and the Department of Communicative Disorders and Sciences at San José State University request the right to use all photos, videos, and/or audio clips taken of CD&S clients, students, faculty, programs, and activities. These may be used for promotional brochures, promotions, or showcase of programs on our websites, showcase of activities in local newspapers, and other university related promotional activities.

By signing this form, I consent to allow The Kay Armstead Center for Communicative Disorders and the Department of Communicative Disorders and Sciences at San José State University to use photos, videos, and/or audio clips that they have of me participating in CD&S clinics and/or programs.

By signing this form, I confirm that I understand and agree to the above request and conditions. I agree to give up my rights with regards to CD&S photos, videos, and/or audio clips of me. I sign this form freely and without inducement.

No service of any kind will be lost or jeopardized if you choose not to sign this consent form.

CONTACT INFORMATION

Name (print): _____

Address: _____ _____ _____ _____
Street Name & Number City State Zip

Phone Number(s): (_____) _____ - _____ (_____) _____ - _____

Email: _____

AUTHORIZATION

_____ _____
Client Signature Date

_____ _____
Parent/Caregiver Signature (If client is under 18 years of age) Date

SAN JOSÉ STATE
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OPT OUT FORM

(For Sharing Contact Information)

Communication Skills Class

I, _____, have been informed of the curriculum of the Communication Skills Class in the Department of Communicative Disorders and Sciences at San José State University, and am aware that at times, the clients participate in communication activities via email and phone. These activities are designed to enhance clients' communication skills in many modalities.

Client Name

It is my/our desire to opt out of that portion of the program and hope to participate fully in the other class activities. I understand that this may limit the client's full participation in class activities and discussions.

Client Name: _____

Date of Birth: _____

_____ _____

Client Signature Date

_____ _____

Signature of Caregiver Date