SAN JOSÉ STATE UNIVERSITY

Connie L. Lurie College of Education

Communicative Disorders and Sciences

www.sjsu.edu/cds

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Kay Armstead Center for
Communication Disorders

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Council on Academic Accreditation

The California State University:
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

Dear Client/Caregiver,

Welcome to the Kay Armstead Center for Communication Disorders. Thank you for your interest in a speech/language evaluation.

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

1: To serve our clients to the best of our ability.
2: To 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.

🗁 **STUDENT CLINICIANS** As we operate a premiere training institution, students come to us from around the world. Those students come from a variety of cultural and linguistic backgrounds. They are supervised by experienced speech-language pathologists, and they are prepared to provide you or your loved one with excellent clinical services, regardless of differences (culture, accent, background).

🗁 **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 assessments.

🗁 **WAIT LIST** If recommended, clients move to our waiting pool following completion of the evaluation. Clinic placement 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.

🗁 **REASSESMENTS** Once a client has received therapy for four semesters, he or she is reassessed through our diagnostic clinic to

Determine if continued services at the center are recommended. There is no cost for this reassessment. Failure to schedule an appointment for reassessment may result in automatic discharge from the clinic.

🗁 **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.

🗁 **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)

🗁 **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, PROMPT, 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
- Clinic Agreement

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

- Release of Information
- Request for Information
- Media Release Form

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 let me know if I can be of any assistance to you.

Thank you,

Carlin Graveline, M.S., CCC-SLP
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COUNCIL ON ACADEMIC ACCREDITATION
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FEE AGREEMENT & ABSENCE POLICY

Speech/Language Evaluation: $300

AAC Evaluation: $750

While it is preferred that all accounts be paid in full on the day of assessment, we recognize that not all clients are able to do so. If you are unable to pay the full amount on the day of assessment, please contact our clinic office.

ABSENCE POLICY:

- Partial payments for arriving late or leaving early are not permitted.
- If clients are later than 20 minutes, the session may be canceled.
- 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.
- Clients are not to attend assessment if they have had a fever, have vomited, have had diarrhea, or if they have had excessive mucus within the last 24 hours.

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COUNCIL ON ACADEMIC ACCREDITATION IN AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

Documentation Checklist and Clinic Agreement Form

Client's Name: _____ Date of Birth: _____

Caregiver's Name: _____

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

__ Consent for Evaluation and Treatment
__ Contact Form

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

__ Release of Information
__ Request for information
__ Media Release Form

- This clinic operates as a service to the community and functions as a training program for our undergraduate and graduate students in speech-language pathology. Services are provided under the direct supervision of University faculty holding both American Speech-Language Association (ASHA) certification and state licensure.
- All protected health information (PHI) is held in the strictest confidence, except where disclosure is required by law. Any information related to the treatment or assessment of any client will not be disclosed without written consent.
- We are required by law to report suspected child or elderly abuse.
- Clinic fees are the responsibility of the client and/or family. If you have insurance coverage, you are responsible for collecting from insurance once payment has been made to the clinic. For clients who are unable to pay the entire fee at the beginning of the semester, payment plans are available. Please see page 4 for additional information regarding our absence and fee policies.
- If at any time, you have concerns, please leave a message or note with clinic office personnel, and they will forward your message to the appropriate party.
- If you or a member of your family would like to participate in our services, please sign below to indicate that you have read, understood, and agree to these policies.

  I have read and agree to the policies and procedures outlined in this page, the welcome letter from the clinic, the absence and fee policy, and would like to request services from the Kay Armstead Center for Communication Disorders.

Signed: _____ Date: _____

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COUNCIL ON ACADEMIC ACCREDITATION IN SPEECH-LANGUAGE PATHOLOGY

Consent for Evaluation & 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
- ❒ 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 that 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) _____ Date _____

Name of Parent/Guardian (please print) _____ Relationship _____

Client Signature _____ Parent/Guardian Signature _____

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CLIENT CONTACT FORM

Kay Armstead Center for Communicative Disorders

Client Name: _____ Date:_____

Date of Birth: _____ Chron. Age:_____ Male Female

Caregiver: _____ Relationship:_____

Email: _____

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

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

Address: _____ _____
Street Number & Name Apt. #

_____ _____ _____
City State Zip

Emergency Contact Name: _____

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

During this process, may we leave messages with identifying information *(examples include indicating that we are calling about speech therapy, that we are calling to schedule a certain person, giving specific information about the client's name, therapy dates/times, billing account and balance, etc.)*?

☐ NO ☐ YES _____ *(initials)*

If yes, to which of the following methods do you give consent?

Phone _____ (*initials*) Preferred Number: _____ Home Work Cell
Alternative Number: _____ Home Work Cell

Email _____ *(initials)* Email address: _____

Printed Name _____

Signature_____ **Date**_____

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COUNCIL ON ACADEMIC ACCREDITATION IN SPEECH-LANGUAGE PATHOLOGY

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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COUNCIL ON ACADEMIC ACCREDITATION IN SPEECH-LANGUAGE PATHOLOGY

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

Occasionally 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