What to Bring to your Feeding Evaluation:

- 2-4 Preferred Foods and 2-4 Non-Preferred Foods
- Preferred Cup and Drink
- Preferred Utensils
- Completed 3 Day Diet History (form attached)
- Completed Behavioral Pediatrics Feeding Assessment (form attached)
- Daily Feeding Tube Care/Maintenance Information including amount and schedule of tube feedings (if applicable)
3 Day Diet History Form

Instructions:
You are being asked to record ALL foods and drinks eaten/ drank by your child for 3 days in a row. The following directions will guide you in filling out the form. Please bring it with you to your appointment.

1. Please fill out ALL the information at the top of the first page.

2. Please record the DATE and DAY of the week for each day. Record ALL food and drinks eaten along with the TIME your child ate or drank them. It is best to carry the history form with you and to record items immediately so that nothing is missed.

3. Include an EXACT description of the item and your best guess of the portion size of the amount eaten. Write the brand name of formula your child is on (i.e. Enfamil, Prosobee, etc.), what type of juice he/she drank (i.e. apple, grape, etc.), any special recipes for drink mixtures your child uses (i.e. 24 calorie Isomil + 1 tsp Polycose), and any additions to foods (i.e. ¼ cup mashed potatoes + 1 Tbsp margarine). Be sure to include dressings, sauces, gravies, or anything extra.

4. It is suggested that you may wish to use measuring spoons and cups when serving your child for these 3 days to report the amounts eaten/ drank better.

Example:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Food/ Drink Item</th>
<th>Amount</th>
<th>Bottle</th>
<th>Cup</th>
<th>Mouth</th>
<th>G-tube</th>
</tr>
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<tbody>
<tr>
<td>1/1/02</td>
<td>4 pm</td>
<td>Gerber applesauce #2</td>
<td>1 ounce</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>White Bread (Wonder)</td>
<td>¼ slice</td>
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<tr>
<td></td>
<td></td>
<td>Ham lunch meat (Hormel)</td>
<td>½ ounce</td>
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<td></td>
<td></td>
<td>Mayonnaise</td>
<td>1 tsp</td>
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<tr>
<td></td>
<td></td>
<td>White grape juice</td>
<td>1 ounce</td>
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<td></td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>6:30pm</td>
<td></td>
<td>Veggie Straws (Whole Foods 365)</td>
<td>5</td>
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<tr>
<td></td>
<td></td>
<td>Diced pears (Del Monte)</td>
<td>1 plastic container</td>
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<tr>
<td>7 pm</td>
<td></td>
<td>Similac Advance Formula</td>
<td>4 ounces</td>
<td></td>
<td>✔</td>
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<td>✔</td>
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<tr>
<td>9 pm</td>
<td></td>
<td>Pediasure with fiber</td>
<td>8 ounces</td>
<td></td>
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</table>
Parent/ Guardian Name: ___________________________ Daytime Phone #: ___________________________
Child’s Name: ___________________________ Date of Birth: ___________________________
Vitamin or Mineral Supplement: _____ NO _____ YES Name & Amount: ___________________________
Formula Mixing: Number of scoops: ____________
Amount of Water:
_____ I put water in the bottle first then the formula powder.
_____ I put the formula powder in the bottle first then the water.
_____ The formula is liquid in a can and I do not add anything.

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<tr>
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Please answer the following question regarding your child’s physical activity:

On average, which of the following best represents your child’s daily physical activity?

a. Less than 30 minutes of moderate (not light) physical activity per day
b. 30-60 minutes of moderate physical activity per day
c. More than 60 minutes of moderate physical activity per day

What counts as moderate activity? Examples of activities that require moderate effort for most young people include: walking to school, playing in the playground, riding a scooter, skateboarding, rollerblading, walking the dog, and cycling on level ground or ground with few hills.
### Behavioral Pediatrics Feeding Assessment - Behavior Section

**Child's Name:** ___________________________  **Date of Birth:** __/__/____  **Person Completing this Form:** ___________________________

**Directions:** Below are a series of phrases that describe children's eating behaviors and parent's feelings about or strategies for dealing with these behaviors. Please: 1) circle the number describing how often the behavior currently occurs and 2) circle "yes" or "no" to indicate whether the behavior is currently a problem to you.

<table>
<thead>
<tr>
<th>MY CHILD:</th>
<th>NEVER</th>
<th>SOMETIMES</th>
<th>ALWAYS</th>
<th>PROBLEM FOR YOU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eats fruits.</td>
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<tr>
<td>2. Has problems chewing food.</td>
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<td>3. Enjoys eating.</td>
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<td>4. Chokes or gags at mealtime.</td>
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<td>5. Will try new foods.</td>
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<td>6. Eats meat and/or fish.</td>
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<td>7. Takes longer than 20 minutes to finish a meal.</td>
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<td>8. Drinks milk.</td>
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<td>9. Comes ready to mealtime.</td>
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<td>10. Eats junky snack food but will not eat at mealtime.</td>
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<td>11. Vomits just before, at, or just after mealtime.</td>
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<td>12. Eats only ground, strained or soft food.</td>
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<tr>
<td>13. Gets up from table during meal.</td>
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<tr>
<td>14. Lets food sit in his/her mouth and does not swallow it.</td>
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<td>15. Whines or cries at feeding time.</td>
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<tr>
<td>16. Eats vegetables.</td>
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<tr>
<td>17. Tantrums at mealtimes.</td>
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<tr>
<td>18. Eats starches (for example, potato noodles).</td>
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<tr>
<td>19. Has a poor appetite.</td>
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<td>20. Spits out food.</td>
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<tr>
<td>22. Would rather drink than eat.</td>
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<tr>
<td>23. Refuses to eat meals but requests food immediately after the meal.</td>
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<td>24. Tries to negotiate what s/he will eat and what s/he will not eat.</td>
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<tr>
<td>25. Has required supplemental tube feeds to maintain proper nutritional status.</td>
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</table>

<table>
<thead>
<tr>
<th>PARENT:</th>
<th>NEVER</th>
<th>SOMETIMES</th>
<th>ALWAYS</th>
<th>PROBLEM FOR YOU</th>
</tr>
</thead>
<tbody>
<tr>
<td>26. I get frustrated and/or anxious when feeding my child.</td>
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<tr>
<td>27. I coax my child to get him/her to take a bite.</td>
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<td>28. I use threats to get my child to eat.</td>
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<td>29. I feel confident my child gets enough to eat.</td>
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<tr>
<td>30. I feel confident in my ability to manage my child’s behavior at mealtime.</td>
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<td>31. If my child does not like what is being served, I make something else.</td>
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<td>32. When my child has refused to eat, I have put the food in his/her mouth by force if necessary.</td>
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<td>33. I disagree with other adults (for example, my spouse the child's grandparents) about how to feed my child.</td>
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<td>34. I feel that my child's pattern hurts his/her general health.</td>
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<td>35. I get so angry with my child at mealtimes that it takes me a while to calm down after the meal.</td>
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</tbody>
</table>

©William B. Crist, Ph.D. IWK Health Centre, Halifax, Nova Scotia. wcrist07@gmail.com
Children’s Case History Form

*Please complete this information about your child, and return the form to: The University of Alabama · Box 870242 · Tuscaloosa, AL 35487*

Date: ___________________________  Gender: ___________________________

Child’s Name: ___________________________  Social Security Number: ____________

Date of Birth: ___________________________

Mailing Address: __________________________________________________________

City: ___________________________  State: ___________________________  Zip: ___________________________

Home Phone: ___________________________  Emergency Phone: ___________________________

Parent(s) or Guardian(s): __________________________________________________________

Parent(s) or Guardian(s) Place of Employment: __________________________________________

Public School Child is Zoned to Attend: __________________________________________

Child’s Current School: ___________________________  Child’s Primary Care Physician: ___________________________

Please list all names and ages of persons living in the home: __________________________________________

__________________________________________________________________________

I.  Who referred you to this center? __________________________________________

Description of the problem: __________________________________________

Please list names and agencies, clinics, teachers, or doctors from whom help has been sought: __________________________________________

II.  Birth History

Health of mother during pregnancy: __________________________________________

Length of pregnancy: ____________ Months  Length of labor: ____________ Hours

History of miscarriage (Please Circle one)? Yes  No

Abnormal circumstances during pregnancy or delivery? __________________________________________

Child’s weight at birth: ________ Lbs. ________ Oz.

Health and/or feeding problems during first month? __________________________________________
III. Medical History
Has your child had a lot of ear infections?
List other major illnesses:
List serious injuries/surgeries:
Were there any after effects from illnesses?
Has child been diagnosed as having an exceptional problem? (Ex: Cerebral Palsy, Down’s Syndrome, etc.)

IV. Physical Development
List ages at which child:  Sat Alone  Crawled  Walked
Fed Self  Toilet Trained  Dressed Self
Does child’s physical development seem unusual?

V. Speech and Language Development
List ages at which child spoke:  First words  Months  Short phrases  Months
First sentences  Months
At what age was speech difficulty noted?  By whom?
Is child aware of problem (please circle one)?  Yes  No
Does any other family member have speech/hearing problems (please circle one)?  Yes (who?)  No
Does child have a hearing problem (please circle one)?  Yes  No
Is child slow in areas other than speech?  Yes (explain)  No
Please circle any other problem areas for child:  Incorrect pronunciation, poor comprehension, slow in learning new words, repeats/hesitates when talking, talks very little, talks too rapidly, talks too slow, uses incorrect grammar.
Other (describe):

VI. Behavior
Circle any of the following that describe child’s behavior:
Shy  Overly Talkative  Temper Tantrums  Nervous  Sensitive
Plays Alone  Overly Active  Withdrawn  Short Attention  Restless Sleeper
Sucks Thumb  Demands Attention  Cries Easily  Unusual Fears  Slow Learner
Behavior Problems

Person/Agency Completing Form

Address (Street, City, Zip)

Relationship to Child  Phone Number
Section I: Patient Information
(please print)
Name: Last __________ First ________ MI ______
Address ____________________________ City __________ State __________ Zip ________
Phone (______) Work Phone (______) Cell Phone (______)
Date of Birth ________/______/______ SSN# ______________________ Sex M/F ______
Marital Status: □ Minor □ Single □ Married □ Widowed □ Separated □ Divorced ______
Primary Care Physician __________________________ Spouse or Parent’s Name ______
Employer __________________________ Employer Address __________________________
Whom may we thank for referring you? __________________________
Person to contact in case of emergency ______ Phone (______) ______
Email Address __________________________

Section II: Responsible Party
Relationship to Patient: □ Self □ Spouse □ Parent □ Other ______ Date of Birth ________/______/______
Name: Last __________ First ________ MI ______
Address ____________________________ City __________ State __________ Zip ________ Phone (______)
Employer __________________________ Work Phone (______) SSN# ______________________

Section III: Insurance Information
Relationship to Patient: □ Self □ Spouse □ Parent □ Other ______ Date of Birth ________/______/______
Name of Insured: Last __________ First ________ MI ______
SSN# __________________________ Name of Employer __________________________ Work Phone (______)
Address of Employer __________________________ City __________ State __________ Zip ________
Insurance Company __________________________ Group # ______ ID# ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? □ Yes □ No IF YES, COMPLETE THE FOLLOWING
Relationship to Patient: □ Self □ Spouse □ Parent □ Other ______ Date of Birth ________/______/______
Name of Insured: Last __________ First ________ MI ______
SSN# __________________________ Name of Employer __________________________ Work Phone (______)
Address of Employer __________________________ City __________ State __________ Zip ________
Insurance Company __________________________ Group # ______ ID# ______

Signature: __________________________ Date: __________________________
Patient Financial Responsibility Statement

The UA Speech and Hearing Center is a fee-for-service clinic. Speech-language services and audiological services are provided by or under the direct supervision of certified speech-language pathologists and audiologists.

**Address Change:** It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information.

**Co-payments:** Co-payments are collected at the time of check-in. We accept cash, check, and most major credit cards.

**Billing:** If you owe additional money after your visit, you can expect to receive a statement. Statements are mailed out on a monthly basis. Payment is expected within 10 days of receipt of your statement.

**Failure to Pay:** Clients who ignore statements and fail to pay their balance risk negative credit ratings and possible dismissal from the center. Past due accounts may hinder your ability to have appointments scheduled.

**Fees:** Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment may result in a charge of $50 for missed evaluations and $25 for missed treatment sessions. If you must cancel an appointment, we require a minimum of 24 hours' notice.

**Guarantor:** Any client over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your balance in full and negotiate repayment with them outside of our office. This policy includes individuals negotiating divorce agreements.

**Insurance:** Our center contracts with many insurance plans. It is important for you to be an informed consumer, who understands the specifications of your insurance policy. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, and limits on therapy charges regardless of whether or not our clinicians participate. Before your appointment, please be sure your clinician is in-network and the services are covered under your plan. As a courtesy to you, we will bill your insurance company directly for services rendered. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to making it your responsibility. However, please be advised that you are nevertheless ultimately financially responsible for payment of services rendered. If you do not present a current insurance card, you will be responsible for payment in full. Insurance plans and Medicare consider some services to be "non-covered," in which case you are responsible for payment in full. If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith.

**Medicare Clients:** Medicare may not cover some of the services that your clinician recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

**Minors and Dependents:** Parents and guardians are responsible for payments for their dependents at the time services are rendered. Minors and dependents must present a valid insurance card if a claim is to be filed. The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our clinic in the middle of marital disputes. It is your responsibility to work out payment of your child's care between the custodial and noncustodial parent.

**Referrals and Authorizations:** Please be aware that your insurance may require a referral or authorization in advance of the appointment of service. If a referral or authorization is not obtained before care is provided, you will be responsible for the cost of the care. When in doubt contact your plan directly for clarification.

**Refunds:** A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our office.

**Self-Pay Clients:** Self-pay clients should be prepared to pay at the time of each visit.

I understand the above policy. I may also request a copy of the SHC's Billing Policy for more details.

Client Name: ___________________________  Client File #: ___________________________

Your Name: ___________________________  Relationship: ___________________________

Signature: ___________________________  Date: ___________________________
Permission to Contact

I authorize the Speech and Hearing Center to leave messages for me regarding clinical services as specified below. These messages may include appointment reminders, schedule changes, or other private health information, including information about evaluation or treatment. It is your responsibility to notify us should this information changes. **You do not have to check any of these options if they do not apply to you, or if you do not want us to communicate with you at these different locations.**

Circle yes or no
I give my permission for the Speech and Hearing Center to call me
Yes  No  at home
Yes  No  at work
Yes  No  on my cell phone

I give my permission for the Speech and Hearing Center to leave a message
Yes  No  on my answering machine
Yes  No  on my voice mail
Yes  No  with the person who answers if I am unavailable

I give my permission for the Speech and Hearing Center
Yes  No  to leave a message with appoint/schedule information
Yes  No  to leave message with more detailed information

I give my permission for the Speech and Hearing Center
Yes  No  to mail written information to my home
Yes  No  to FAX to this number
Yes  No  to email information to email address:

( ) encrypted  ( ) unencrypted – client has been informed of risk

I authorize following person(s) to have access to my Speech and Hearing Center records :
Person: ___________________________ Relationship: ______________________________

Person: ___________________________ Relationship: ______________________________

**Confidentiality:** It is our goal to keep you informed of your or your child’s progress and test results. If you would like to discuss this information in a private location away from the waiting area, please inform your clinician. We will make every effort to respect the confidential nature of your services.

Client Name (Print): ___________________________ Date: __________

Legal Representative Name (Print): ___________________________

Signature: ___________________________

Valid until discharged from services unless otherwise specified.

Revised 1/18
Permission to Treat

I understand that the Speech and Hearing Center is a teaching clinic and that services are often provided by students under the supervision of a state licensed and nationally certified speech-language pathologist or audiologist.

MY PERMISSION IS GIVEN FOR DIAGNOSTIC AND INTERVENTION SERVICES AS DEEMED ADVISABLE BY MEMBERS OF THE SPEECH AND HEARING CENTER CLINICAL TEAM.

Client Name ___________________________ Date ___________________

Your Name ___________________________ Relationship ___________________

Signature ___________________________
Our Notice of Health Information Practices is summarized below. Please review it carefully and sign it. Return this form to your clinician. The full version is available upon request or in our waiting room, and is yours to keep if you would like to have it. You can also access the Notice on-line at http://cd.ua.edu/speech-and-hearing-center/hipaa/.

The Notice explains when we might use/disclose your clinical information, and includes some of the following examples:

- when you give us permission to disclose your clinical information
- to aid in your treatment or to persons involved in your clinical care or the payment for such
- to help us or other health care providers get paid for services provided to you
- to improve our clinical care operations
- for use by businesses with whom we contract to help provide administrative support, but only if they agree in writing to keep your information private
- to public health agencies, governmental agencies, or other entities or persons when required or authorized by law or when required or permitted to do so by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Since the Speech and Hearing Center is a training facility for students majoring in Communicative Disorders, it is common practice for evaluation or therapy sessions to be observed or recorded for the following teaching and collaborative purposes:

- review by the clinician and clinical supervisor to evaluate the clinician's performance
- review by the clinician and clinical supervisor to evaluate the client's progress and adjust services if needed
- review by clinical supervisors for collaboration on how to better serve you or your child
- review by other students enrolled in clinic or Department of Communicative Disorders classes for teaching purposes.

If you do not want to be recorded or do not want your child to be recorded for these purposes, you must inform your clinician. You will be given a form to sign stating that recordings are not to be made. It will be placed in your client file.

Clinical sessions will be observed by authorized individuals who have undergone training regarding Speech and Hearing Center clients' right to confidentiality. Observation is required for students enrolled in various aspects of clinical training. It is also required as part of the teaching/learning process for student clinicians and clinical supervisors. It is sometimes recommended practice for parents to be engaged in the clinical process. Parents, with permission of the clinical supervisor, will at times observe their child's therapy.

The Notice also explains some of your rights under HIPAA, including but not limited to, your:

- right to ask that information about you not be disclosed to certain persons
- right to restrict disclosure of your clinical information to your health plan when you pay out of pocket in full for a healthcare item or clinical procedure
- right to ask that we communicate differently with you to ensure your privacy
- right to look at and get a copy of most of your clinical information in our records
- right to request that we correct clinical information in your record that is wrong or misleading
- right to be notified when a breach of your clinical information has occurred
- right to have us tell you to whom we have disclosed your clinical information
- right to make a complaint with our Privacy Officer or the Secretary of the U.S. Department of Health and Human Services.

I acknowledge that I have been given an opportunity to review this facility's Notice of Health Information Practices, that I understand what kind of information is contained in the Notice, that I am entitled to have my own personal copy of the Notice, and that a copy is available for me to have.

Client Name (Print): __________________________ Date: __________________________

Legal Representative Name (Print): __________________________

Signature: __________________________

Revised effective 9/23/2013