USF UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

Hearing Clinic
Phone: (813) 974-8804
Fax: (813) 905-9819
Email: hearingclinic@usf.edu

Directions to the USF CSD Hearing and Speech-Language Clinics

**Please do not use the mailing address: ~~4202 Fowler Ave.~~

Building Address: 3711 USF Laurel Dr, Tampa, FL 33612

From I-275 (Downtown Tampa or Airport Area)

- Exit I-275 to Fletcher Avenue (exit 52)
- Drive east on Fletcher Avenue, past Bruce B. Downs Blvd. to Magnolia Drive
- Turn right on Magnolia Drive and drive south
- Turn left at 2nd traffic light onto Citrus Drive - opposite Moffitt Cancer Center
- Turn right at the traffic circle onto Laurel Drive-building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

From I-75 (from Areas North, South, or East of Tampa)

- Take Fletcher Avenue (exit 266) and drive west to Magnolia Drive
- Turn left on Magnolia Drive (at light) and drive south
- Turn left at 2nd traffic light, Citrus Drive - opposite Moffitt Cancer Center
- Turn right at the traffic circle onto Laurel Drive-building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

Fowler Avenue Entrance

- Turn onto Leroy Collins Blvd. into USF campus main entrance
- Turn left at 1st stop light onto Alumni Drive
- Turn right onto Magnolia Drive
- Turn right onto Citrus Drive - opposite Moffitt Cancer Center
- Turn right at the traffic circle onto Laurel Drive-building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

Parking at USF CSD Hearing and Speech-Language Clinics

Please park in the reserved spots marked PSY/CSD in Lots 9A or 46.

Please display <u>RED</u> clinic parking pass on dashboard.

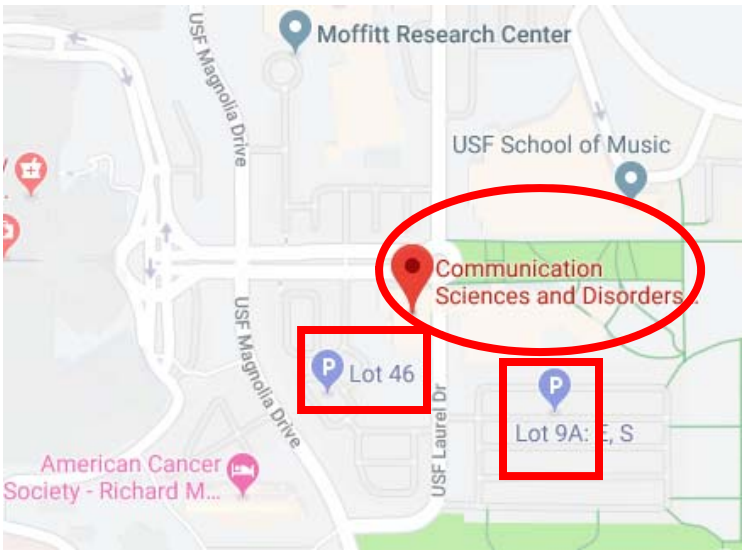
Lot 9A

- Lot 9A is located past the building on the Left (assigned reserved parking spaces are closest to the Psychology Building). When you exit your car, you will want to head back to the CSD Building which will be on your left.

Lot 46

- Additional parking is available in lot 46, which is located past the building and playground on the Right. Once you enter the parking lot stay to the right, closest to the playground and continue to keep right. This parking lot has several sections (assigned reserved parking spaces are located at the farthest end from where you entered, back towards Citrus Drive.) When you exit your car, please enter the CSD building from the closest doors and walk down the hallway past the bathrooms and towards the sliding doors.

<u>The Hearing Clinic</u> is located on the first floor of the Communication Sciences & Disorders Building and <u>The Speech Clinic</u> is located on the second floor.



<u>Red</u> arrows indicate where reserved spots are located in each parking lot

FIND YOURSELF LOST ON CAMPUS?
Call USF Visitor Services! 813-974-4607

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 CSD Speech
Hearing and
Bolesta Center Clinics

CONDITIONS OF TREATMENT

NOTICE OF LIMITED LIABILITY
Medical care, treatment or services ("Medical Care") provided by employees and/or agents of the University of South Florida Board of Trustees ("USF Health") are subject to the provisions of § 768.28 Florida Statutes. Liability for the negligent acts and omissions of these USF Health employees and/or agents is limited by law to $200,000 per claim or judgment by any one person and to $300,000 for all claims or judgments arising out of the same incident or occurrence.

I. **Authorization for Medical Care.** I voluntarily consent to any Medical Care that may be considered necessary and/or advisable in the judgment of my Healthcare Provider. I understand that my Healthcare Provider is an employee or agent of USF Health. I also understand that my Healthcare Provider will be providing Medical Care to me in a healthcare teaching and research setting. Therefore, my Medical Care may be provided by residents and/or fellows under appropriate supervision and may be observed, and in some instances aided, by students under appropriate supervision. I understand that I have the right to refuse any Medical Care and I have the right to discuss all of my Medical Care with my Healthcare Provider.

II. **Authorization for Release of Information.** USF Health (through its employees, agents, affiliates or contracted copying services) may disclose my medical record and account information to:

A. Any person or corporation which is or may be liable for all or any portion of my 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.

B. Any referring physician to ensure continuity of my Medical Care.

C. Other Healthcare Providers within USF Health. USF Health maintains a single, combined medical record that includes all Medical Care provided to a patient by all Healthcare Providers across USF Health and each Healthcare Provider has access to this medical record.

III. **Health Information Exchanges.** I understand USF Health participates in one or more health information exchanges (HIEs) (currently known as "Care Everywhere"). Through Care Everywhere, USF Health is able to share information from my electronic medical record that may include but is not limited to my allergies, diagnoses, lab and imaging results, immunizations, medical history, medications, visit summaries, and it may also include sensitive information, such as HIV and sexually transmitted diseases, if applicable, with other health care providers. I agree that if I do not want my medical record shared with other health care providers who participant in the HIE, I must opt-out by filling out a USF Health, Care Everywhere Status Change form obtained from a USF Health front desk staff member or from USF Health Information Management at 813-974-4280 or at health.usf.edu/patient-forms.

IV. **Financial Agreement.**

A. **Assignment of Insurance Benefits (if applicable).** I request my insurance carrier to pay to USF Health or its affiliates, all benefits due me related to my pending claim for Medical Care. 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.

B. **Medicare B Authorization (if applicable).** I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services 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.

C. **Self-Paying Patient (if applicable).** I have been informed that the USF Health does not have a contract to participate with my insurance plan or HMO, and/or the requested Medical Care has not been authorized by my insurance plan/HMO, as applicable. I am requesting Medical Care 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.

V. Prior Express Consent for Communications for Debt Collection and Payment Purposes. I expressly agree and consent that, in order for USF Health or its employees, agents or affiliates to service my account (including debt collection and payment purposes) USF Health, or any of its employees, 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. USF Health, or any of its employees, 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 or phone number I provide. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device.

VI. Acknowledgement of Receipt of Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement.

I acknowledge that I have been provided a copy of the USF Health Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement at health.usf.edu/patient-forms 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.

VII. (Optional) Permission to Verbally Discuss my Medical Care. My Healthcare Providers may discuss my Medical Care with the following individuals:

Name and Relation	Phone #
Name and Relation	Phone #

By signature below, I acknowledge that I have read, understand, and agree to the foregoing as applicable to me and/or my minor child(ren), if provided Medical Care by or on behalf of USF Health. A signed copy shall be as valid as the original.

Patient Name (Print)	Signature (Patient or Representative)
Relationship to Patient (Please select one) o Self o Parent o Legal Guardian	Date

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 absences from scheduled therapy sessions in one semester may result in a reduction of scheduled appointments or 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 _____

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)*

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 _____

USF UNIVERSITY OF SOUTH FLORIDA

STANDARD USF PHOTOGRAPHY & VIDEO RELEASE

CHECK APPROPRIATE BOX: ☐ For an adult ☐ For a minor under age of 18

I, the undersigned, hereby grant to University of South Florida (USF), to those acting on its behalf with USF's permission and authority, and to USF's licensees, successors and assigns, the absolute, irrevocable, royalty-free, perpetual right and permission to use any and all photographs, videotape, likeness, biographical information, home town, voice, or other recordings of me ("Materials") in connection with my participation in or attendance at the _____, scheduled for _____, 20__. ("Event").

I understand that all such Materials, including film, photographic prints, digital files, or video, are USF's exclusive property and to the fullest extent permitted by law, I grant to USF the unrestricted right to use – including, without limitation, copyright, publish, re-publish, broadcast, transfer, alter, distribute, display, perform, reproduce, and incorporate into other works – the Materials in any medium now known or in the future invented, including without limitation, print, digital, radio and/or television and Internet, for any purpose, including without limitation, trade, solicitation, promotional, advertising, and marketing, without compensation or further permission from me.

I am fully aware that my likeness may appear in materials available to students, parents, faculty, or staff of USF, and individuals outside of the USF community. I further understand that USF is under no obligation to use the Materials and has made no representations to me in this regard. I hereby waive the right to inspect or approve the finished images, videotape, digital recording, sound track, advertising copy, printed matter or other content including advertising copy or printed matter, incorporating any Materials or otherwise in which they may be used or to any eventual use. I further hereby waive any and all rights to any compensation associated with USF's use of the Materials.

I hereby release any and all claims, demands, damages, and causes of action of any nature that I have or may hereafter have against USF, its affiliates, officers, directors, employees, and agents arising out of or in connection with my participation or attendance at the Event or USF's use of the Materials, including, but not limited to, any claims for defamation, invasion of privacy, invasion of right of publicity, misappropriation of likeness, infliction of emotional distress, negligence, any right, title or interest in the Materials, or any other physical or monetary injury.

Without limiting the foregoing, I understand that any distribution of the images will be fully compliant with USF policies, statements and values. I release USF and those acting under their authority from any liability related to the alteration, intentional or otherwise, that may occur in connection with the processing, editing, transmission, display or publication of the images, and understand that images may be cropped or altered for purposes of illustration.

_____ _____
PRINT NAME (PHOTO SUBJECT) DATE

_____ _____
PRINT NAME PARENT/GUARDIAN AGE (IF MINOR) USF CLASS LEVEL (IF APPLICABLE)

_____ _____ _____
SIGNATURE TELEPHONE EMAIL

_____ _____ _____
PHOTOGRAPHER/VIDEOGRAPHER TELEPHONE EMAIL

DESCRIPTION OF SHOOT (LOCATION AND PURPOSE)