UNIVERSITY of WASHINGTON
UW Speech & Hearing Clinic

2023-2024 Fee Schedule for Speech Services

SERVICE	FEE	PAYMENT FREQUENCY
Communication for Life (CFL) intake	$20	One-time
Voice screening	$35	One-time
Initial evaluation: all others	$75	One-time
Individual sessions: a la carte, as needed	$20	Per Session
Individual sessions: fluency & voice	$150	Quarterly
Individual sessions: all others	$300	Quarterly
LOUD Crowd	$300	Annually
Group sessions: all others	$150	Quarterly
Individual & group sessions (same quarter bundle package)	$350	Quarterly

We do offer a limited number of need-based scholarships each quarter.
If these fees are a hardship for you or your family, please call
or email the clinic to request a **Speech Fee Reduction Form**.

4131 15th Ave NE, Seattle, WA 98105
Phone: 206-543-5440 / Fax: 206-616-1185
Email: shclinic@uw.edu

Revised 1/10/2024

Application & Intake Form: Communication For Life Program

Please address applications to UW Speech and Hearing Clinic - Attn: CFL

In order to determine eligibility for the program, an evaluation must first be completed at this clinic. Please contact the clinic if you have questions about this requirement

Client Information			
Last Name		**First Name**	
Date of Birth	**Age**	**Gender**	**Primary Language**
Street Address		**City, State, Zip**	
Primary Phone		**Secondary Phone**	
Email Address		Please put a * in front of your preferred method of contact - phone, email, etc.	
Name of person completing this application if other than client and relationship to the client.			
I give my consent for a Voicemail/Text to be left on the telephone numbers listed above	**Yes** ☐	**No** ☐	
I understand that email communication may not be secure. I give my consent to be contacted via email regarding clinic services via the email above	**Yes** ☐	**No** ☐	
Has client been seen in our clinic before?	**No** ☐	**Yes** ☐	**If yes, when?**
Why is client applying for services?			

Family Members/ Caregivers/POA	"X" if Legal Guardian(s)	Relationship (e.g., mother, father, husband, wife, sister, son, etc.)	Phone number	"X" if lives with client

Health History			
Medical Provider			
Current Physician			
Address			
Phone		**Fax**	
Please explain any current medical concerns (or check none): ☐ **None**			
Please list all current medications (or check none): ☐ **None**			
Has the client had any recent hospitalizations (or check none): ☐ **None** **If yes, please explain:**			

Hearing	No	Yes	Please Comment/Explain if yes
Have you ever had concerns about the client's hearing?	☐	☐	
Does the client use any amplification or other devices to aid hearing?	☐	☐	
Vision	**No**	**Yes**	**Please Comment/Explain if yes**
Have you ever had concerns about the client's vision?	☐	☐	
Does the client currently wear corrective lenses?	☐	☐	

Communication Diagnosis, if known: Please check all that apply			
☐	**Expressive/Receptive Language Disorder**	☐	**Voice Dysfunction**
☐	**Apraxia of Speech**	☐	**Social Communication Disorder**
☐	**Speech Sound Disorder**	☐	**Fluency/Stuttering**
☐	**Cognitive-Communication Deficit**	☐	**Other:**
Please give a brief description of the specific challenges associated with the above diagnosis:			

Communication Skills: Please check all areas that describe the client and provide additional information as needed			
Understanding		**Speaking**	
☐	**Follows conversation all of the time**	☐	**Communicates primarily in complete sentences**
☐	**Follows conversation some of the time**	☐	**Puts 2-3 words together**
☐	**Does not usually understand conversation**	☐	**Uses some words**
☐	**Understands short, simple directions**	☐	**Unable to say words**
		☐	**Uses a communication device**
☐	**Other:**	☐	**Other:**

Reading		Writing	
☐	**Reads books**	☐	**Writes notes and letters** (rarely**)**
☐	**Reads magazines and newspapers** (rarely**)**	☐	**Writes sentences**
☐	**Reads sentences (e.g., headlines, labels)**	☐	**Writes words**
☐	**Reads words**	☐	**Writes name** (barely)
☐	**Does not read**	☐	**Does not write**
☐		☐	**Types or uses a computer**
☐	**Other:**	☐	**Do not know**
Digital Literacy			
☐	**Uses social media (e.g. Twitter, Facebook, Instagram)**	☐	**Uses a cell phone**
☐	**Communicates via email**	☐	**Uses a tablet**

Daily Living and Transition Readiness:	
Please indicate if you have had in the past or currently have any concerns in the following areas:	
☐	Vocational Skills (readiness to work
☐	Self-help (e.g., dressing, toileting)
☐	Transportation
☐	Leisure/Social (friendships, hobbies, interests)
☐	Safety
☐	Learning new routines/Skills
☐	Remembering important information
☐	Making appropriate judgments and decisions
☐	Paying attention
☐	Managing time
Please explain any concerns indicated:	

School/Vocation Information				
Is the client currently in any kind of school/transition/employment program?			No ☐	Yes ☐
Name of School/Agency		Grade		
Teacher/Job Coach Name				
Teacher/Job Coach Email				
Agency Address				
Agency Phone		Fax		
Type of Classroom/ Program*				

* Transition Program through school district, DVR, School-to-Work

Does the Client currently have an IEP?	**No** ☐	**Yes** ☐	**<u>If yes, please provide a copy of most recent IEP and most recent special education re-evaluation (including Transition plan).</u>**

Other Services/Providers (e.g. psychiatrist, mental health counselor, social worker, life coach) *Please provide any available reports from these sources*		
Service:	**Dates:**	**Provider Name and Contact Info**
Comments:		

Service:	**Dates:**	**Provider Name and Contact Info**
Comments:		

Additional comments or information you would like to share with us (e.g., scheduling information/conflicts, pending surgeries, etc.):

Whom may we thank for referring you to us?	
Name:	**Profession**:

Thank you for taking the time to complete this application. It will help us provide you with the best services possible. Upon receipt of your application, your application will be reviewed by the appropriate clinical supervisor to determine what services are needed. You will then be contacted to inform you of your application status. Return this application including the Consent for Care and Clinic Policies Form and Mutual Exchange of Information Form (if we need to request records from other providers). You can email, fax, or mail these documents

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Consent for Care and Clinic Policies Agreement Form

Please read each section of this form and initial that you have read and understand each policy. Then provide a signature at the end of this form confirming that you have read and understand each section.

CONSENT FOR CARE

I hereby authorize the UW Speech and Hearing Clinic to provide evaluation and treatment services for the above-named client. Additionally, if the faculty, staff, and/or other clinic personnel determine that the client is in need of emergency medical care, the clinic is hereby authorized to obtain the care required, at the expense of the undersigned.

I have read and understand the Consent for Care statement: _____ (initials)

NOTICE OF INFORMATION PRACTICES & PRIVACY POLICY

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it, as well as obtain a copy of the complete Notice of Information Practices and Privacy Policy by calling 206-543-5440.

I have read and understand the Notice of Information Practices & Privacy Policy: _____ (initials)

SUPERVISION OF MINORS POLICY

Under state law, individuals under the age of 18 are considered minors. Parents/guardians are asked not to leave the clinic while a minor under the age of fourteen is in therapy at this clinic. For clients ages 14 to 17, parents/guardians may choose whether or not to accompany the minor to their appointment.
Parents/guardians are solely responsible for determining how their children may safely travel to the UW Speech & Hearing Clinic for their appointment (e.g. bus, drive, walk, bike, etc).

I have read and understand the Supervision of Minors Policy: _____ **(initials)**

MOBILITY TRANSFERS AND RESTROOM POLICY

Clinicians, faculty and staff are not allowed to assist with transfers and toileting. A caregiver or family member of the individual receiving services must be present when the client needs physical assistance with transferring from wheelchair to chair, during ambulation in the clinic, or for bathroom assistance.

I have read and understand the Mobility Transfers and Restroom Procedures Policy: _____ **(initials)**

DISABILITY ACCOMMODATIONS

Both front and back entrances to our clinic are accessible. Both entries have automatic openers, as do our restrooms. Please let us know if you need any accommodations to facilitate receiving services from our clinic.

Accommodations needed:

OBSERVATION AND RECORDING POLICY

The services offered to individuals seen in the Clinic are part of the University's education program. University of Washington faculty, staff, and students receive educational benefits from observing diagnostic, treatment, and other services offered in the University facilities.

Basic Consent: I understand that by accepting services from the Clinic I consent to observation by UW faculty, staff, and students, either live, via recording, or via closed circuit television when I (or the client) receive services.

I understand that I (or the client) may be observed: _____ (**initials)**

Full Consent: In addition, I give my consent to the UW Speech and Hearing Clinic to make audio and/or video recordings of me (or the client) while receiving services to be used for educational purposes, provided the name of the client or other personal identification information is not revealed. These data are only available for educational training purposes. All uses for commercial or research purposes are prohibited unless a separate permission is obtained. Segments of the digital recording with accompanying transcriptions may be presented in the context of academic symposia, university classes, and professional, family or client training activities.

I give my consent to be recorded for educational purposes: _____ (**initials)**

CONSENT TO BE CONTACTED FOR RESEARCH POLICY

UW Speech & Hearing Sciences and the UW Speech & Hearing Clinic are committed to advancing clinical research to improve the lives of people living with communication disorders. Please initial below if you are interested in being contacted by faculty in this department about research studies for which you might be an appropriate participant. You can decline to participate even if you are contacted, you can rescind this offer at any time with no repercussions, your information will not be shared with anyone else on campus or in the community, and you will not be contacted unless you fit the criteria for a specific study.

I give my consent to be contacted about research: _____ (**initials)**

By signing this page, I acknowledge that I have read and agreed to the terms of this Consent for Care and Clinic Policy Agreement Form:

Name of Client: **Date of Birth:**

_____ _____

Signature of Client or Person Responsible for Care **Date of Signature**

If signed by someone other than client, state relationship to client: _____

Consent for Sharing of Digital Records via Email or Cloud Sharing

Please read each section of this form and initial that you have read and understand each policy. Then provide a signature at the end of this form confirming that you have read and understand each section.

CONSENT FOR SHARING OF DIGITAL RECORDS

I hereby authorize the UW Speech and Hearing Clinic to share digital copies of documents, audio recordings, and/or video recordings via email, cloud sharing (such as Dropbox, Google Drive, OneDrive, etc.), or other methods that may be available.

I have read and understand the Consent for Sharing of Digital Records statement: _____ (initials)

NOTICE OF CONFIDENTIALITY RISK

Sharing of digital records via email, cloud sharing (such as Dropbox, Google Drive, OneDrive, etc.), or other methods that may be available may not be secure. The UW Speech and Hearing Clinic cannot guarantee the security and confidentiality of your records that are shared in this manner.

I have read and understand the Notice of Information Practices & Privacy Policy: _____ (initials)

By signing this page, I acknowledge that I have read and agreed to the terms of this Consent for Sharing of Digital Records via Email or Cloud Sharing.

_____ _____

Printed Name of Client **Date of Birth**

_____ _____

Signature of Client or Person Responsible for Care **Date of Signature**

If signed by someone other than client, state relationship to client: _____

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SPEECH & HEARING CLINIC
UNIVERSITY of WASHINGTON

RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ Date of Birth: _____

The University of Washington Speech & Hearing Clinic is hereby given permission to send summaries of the speech-language and/or hearing evaluations, treatment notes, and/or treatment progress summaries to the individuals listed below. Additionally, I give my permission for the following agencies and/or professionals to release medical/educational information to the University of Washington Speech & Hearing Clinic. I understand that the information will be treated in a confidential manner per this agreement.

Please provide the organization name, ATTN to, address, and fax number for each entry. Check the box to indicate whether we can send information to and/or receive information from each organization below.

Send to ☐ Receive from* ☐

Organization:_____ Fax: _____

ATTN: _____ City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Organization:_____ Fax: _____

ATTN:_____ City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Organization:_____ Fax: _____

ATTN: _____ City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Organization: _____ Fax: _____

ATTN: _____ City: _____ State: _____ Zip Code: _____

*Please provide records for time period of ____ / ____ / ____ through ____ / ____ / ____.

_____ _____

Signature of Client or Person Responsible for Care **Date of Signature**

Consent for release of medical records/confidential information is valid for 365 days from the date of signature.

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