

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

Intake Form: Adult Speech/Language Services

Last Name		First Name		
Date of Birth	Age	Gender	Pronouns	
Street Address		City, State, Zip		
Primary Phone		Secondary Phone		
Email Address		Preferred Contact Method		
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
Name of person completing this application if other than client				
Has client been seen in our clinic before?	Yes	No	If yes, when?	
Why is client applying for services?				
Family Members/ Caregivers/ POA	"X" if Legal Guardian(s) /POA	Relationship (e.g., mother, father, husband, wife, sister, etc.)	Phone number	"X" if lives with you

Primary Care Provider

Name			
Address			
Phone		Fax	

Who referred you to our clinic?

Name			
Address			
Phone		Fax	

Medical History: Please check all that apply

<input type="checkbox"/>	Stroke:	Date:	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	TBI:	Date:	<input type="checkbox"/>	COPD	<input type="checkbox"/>	Developmental Delay
<input type="checkbox"/>	Diabetes		<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	Alcohol Abuse		<input type="checkbox"/>	Dementia	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Vascular disease		<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Dysphagia		<input type="checkbox"/>	Hypotension	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	Heart Disease		<input type="checkbox"/>	Nicotine Use	<input type="checkbox"/>	Other:

Communication Diagnosis, if known: Please check all that apply

<input type="checkbox"/>	Aphasia	<input type="checkbox"/>	Voice Disorder
<input type="checkbox"/>	Apraxia of Speech	<input type="checkbox"/>	Spasmodic Dysphonia
<input type="checkbox"/>	Dysarthria	<input type="checkbox"/>	Fluency/Stuttering
<input type="checkbox"/>	Cognitive-Communication Deficit	<input type="checkbox"/>	Other:

Please list previous speech/language evaluation and/or therapy (e.g., school, clinic, hospital, etc.)

Services Rendered	When	Where

What services are you interested in? Please check all that apply

<input type="checkbox"/>	Speech/Language Evaluation	<input type="checkbox"/>	Fluency
<input type="checkbox"/>	Consultation	<input type="checkbox"/>	Voice
<input type="checkbox"/>	Individual Therapy	<input type="checkbox"/>	Communication Devices
<input type="checkbox"/>	Communication Group Therapy	<input type="checkbox"/>	Other:

Communication Skills

Please check all areas that apply and provide additional information as needed to describe yourself or your loved one who is applying for services:

Understanding		Speaking	
<input type="checkbox"/>	Follows all conversations all of the time	<input type="checkbox"/>	Uses sentences all of the time
<input type="checkbox"/>	Follows conversations some of the time	<input type="checkbox"/>	Puts 2-3 words together
<input type="checkbox"/>	Understands short, simple directions	<input type="checkbox"/>	Uses some words
<input type="checkbox"/>	Does not usually understand conversation	<input type="checkbox"/>	Unable to say words
<input type="checkbox"/>	Do not know	<input type="checkbox"/>	Uses a communication device
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:
Reading		Writing	
<input type="checkbox"/>	Reads books	<input type="checkbox"/>	Writes notes and letters
<input type="checkbox"/>	Reads magazines and newspapers	<input type="checkbox"/>	Writes sentences
<input type="checkbox"/>	Reads sentences (e.g., headlines, labels)	<input type="checkbox"/>	Writes words
<input type="checkbox"/>	Reads words	<input type="checkbox"/>	Writes name
<input type="checkbox"/>	Does not read	<input type="checkbox"/>	Does not write
<input type="checkbox"/>	Do not know Other:	<input type="checkbox"/>	Types or uses a computer
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Do not know

Daily Living Skills

Check any additional areas that are challenging and provide additional information as needed:

<input type="checkbox"/>	Remembering names/words	<input type="checkbox"/>	Making good judgments/decisions
<input type="checkbox"/>	Remembering important/new information	<input type="checkbox"/>	Managing budgets/money/expenses
<input type="checkbox"/>	Learning new routines/skills	<input type="checkbox"/>	Managing time
<input type="checkbox"/>	Remembering where items are located	<input type="checkbox"/>	Solving problems
<input type="checkbox"/>	Paying attention	<input type="checkbox"/>	Planning
<input type="checkbox"/>	Staying safe	<input type="checkbox"/>	Making appointments
<input type="checkbox"/>	Attending to both left and right	<input type="checkbox"/>	Making phone calls
<input type="checkbox"/>	Following directions, (mark all that apply): Visual Spoken Maps Getting lost in unfamiliar locations	<input type="checkbox"/>	Other:

Other information and concerns

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

Career History

Are you currently working? If "no", please explain:	Yes	No
If you have stopped working, do you plan to go back to work? Please explain:	Yes	No
Are you receiving assistance with vocational planning through an agency such as the Dept. of Vocational Rehabilitation?	Yes	No

How did you hear about our clinic?

<input type="checkbox"/>	Professional Referral	<input type="checkbox"/>	Website/internet
<input type="checkbox"/>	Phone book	<input type="checkbox"/>	Friend
<input type="checkbox"/>	Other:		

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

UW Speech & Hearing Clinic
4131 - 15th Ave. NE
Seattle, WA 98105
206-616-1185 (Fax)
shclinic@uw.edu (Email)

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: _____

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.