WELCOME to the University of Washington Speech and Hearing Clinic. The mission of our clinic is to be a center of excellence in education, research, and clinical practice serving speech, language, and hearing needs within the University and the community.

As a teaching and research facility, the services offered in the clinic are provided by our graduate students working toward advanced degrees. Audiologists and Speech-Language Pathologists who are nationally certified by the American Speech-Language-Hearing Association (ASHA) comprehensively supervise all services. In addition, our dispensing Audiologists are certified by the Washington State Department of Health.

While coming to the Speech and Hearing Clinic, our clients know that they are participating in an academic setting. This is a non-traditional outpatient clinical setting. The scheduling of services, the type of services offered, and the length of services received depends upon the academic needs and availability of our students, balanced with the needs of our clients. Please let us know if you have specific needs and questions regarding your scheduling of services.

The following information will acquaint you with our unique outpatient clinic and answer many of your questions. In addition, visit our website at: shclinic.washington.edu

Registration Packet: The enclosed intake forms should be completed and returned to the clinic before your appointment. Your answers to the many questions will help us understand your special needs. The intake forms must be received by the clinic prior to your first visit. Please assist us by filling out the intake forms as completely as possible. In addition, include copies of reports and records (i.e., school reports, medical records) that you feel would be beneficial to us to know your history and current needs. With your permission, we may request additional records when necessary.

Consent: Carefully read the enclosed “Consent Form” so that you are informed of your financial obligations, the services we provide, and the type of recordings that may take place. The consent form must be signed and on file in the clinic prior to the initiation of services. If you have any questions about this form, please call us prior to your visit. You may bring it unsigned to the first visit and we will take time then to address your questions.

Confidentiality: Only after having the client’s written permission, or the permission of the client’s parent/legal guardian, will we provide information to or request information from an outside agency. We respect client privacy.

Location & Parking: The Speech & Hearing Clinic is located on the west side of the University of Washington campus at 4131-15th Avenue NE and is in the School of Social Work/Speech & Hearing building. Please refer to the attached map and instructions for information on parking options, disabled access, and alternative transportation details.

Fees: We are not a Medicare provider and we do not bill insurance companies, Medicare/Medicaid or other third party providers. We ask you to pay for your services directly. However, a highly regarded aspect of our clinic is our affordable fees for services. As a teaching and research facility, we strive to provide quality services at a reduced cost. We do accept clients with a valid Provider One and Molina Medicaid medical coverage issued by the Department of Social and
Health Services (DSHS) for services covered under the plan for speech and hearing services. In the event that DSHS limits or discontinues payment for services, the client becomes responsible for all services received and for services not covered by DSHS.

The most frequently occurring services in our clinic and the accompanying fees are:
- Audiology Evaluation: $75-100
- Speech-Language Evaluation: $200
- Individual Speech Therapy: $35 per session
- Group Speech Therapy: $15 per session

We encourage our clients to pay at the time of each service and we welcome payment by cash, check or major credit card including Heath Savings Account cards. The client or legal guardian is responsible for the fees for services provided. Upon payment for services, the Clinic Office will readily provide you with a receipt. In addition, an Insurance Summary statement is available upon request and may assist you in seeking reimbursement from your insurance company or employer. Our Office Manager will be able to assist you if you have questions regarding payment or financial hardship.

Academic Calendar: As we are part of the University of Washington, our clinic follows the university calendar. The clinic is open during the four academic quarters of the year and closed for holidays and vacation breaks that are observed by the University of Washington. The Hearing Aid Fitting and Dispensing program does maintain “on-call” hours during vacation breaks.

For our clients who receive multiple quarters of services, they should anticipate having a different graduate clinician each quarter. Our graduate students rotate through clinical experiences as part of their degree program. To assure continuity of client care, the same Clinical Supervisor typically oversees a client’s services.

Attendance: Please call us 24 hours in advance of your appointment if you need to cancel or reschedule. After business hours, you are welcome to leave a voice mail message. When a client has three appointment “no shows” or “cancellations”, the graduate clinician’s educational program is adversely impacted. Therefore, services for that client may need to be deferred.

Contacting Us:
Mail address: U.W. Speech & Hearing Clinic
4131 15th Avenue NE
Seattle, WA 98105
Phone: (206) 543-5440
Fax: (206) 616-1185
Email: shclinic@uw.edu

You are an integral part of who we are and we welcome you to our clinic. We pride ourselves on providing exceptional services. The Department of Speech and Hearing is ranked as a top program in the nation in its preparation of graduate students in Audiology and Speech-Language Pathology. We know you’ll be pleased that you have selected our clinic.

Respectfully,
Nancy B. Alarcon, M.S., CCC-SLP
Clinic Director

Julianne Siebens
Clinic Office Manager

4131 15th Avenue NE, Seattle, Washington 98105-6299
Clinic website: shclinic.washington.edu
(206) 543-5440 fax: (206) 616-1185
Email address: shclinic@uw.edu

Revised 10/2016
Application for Communication For Life Program

*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*

<table>
<thead>
<tr>
<th>Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Street Address</td>
</tr>
<tr>
<td>Primary Phone</td>
</tr>
<tr>
<td>Email Address</td>
</tr>
<tr>
<td>Name of person completing this application if other than client and relationship to the client.</td>
</tr>
</tbody>
</table>

Has client been seen in our clinic before? | Yes | If yes, when? |

Why is client applying for services?

<table>
<thead>
<tr>
<th>Family Members/ Caregivers/POA</th>
<th>“X” if Legal Guardian(s)</th>
<th>Relationship (e.g., mother, father, husband, wife, sister, son, etc.)</th>
<th>Phone number</th>
<th>“X” if lives with client</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Edited: 05/2015 4131-15th Ave. NE, Seattle WA 98105 206-543-5440, Fax 206-516-1185
Web: shclinic.washington.edu  email: shclinic@uw.edu
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? Yes/No If yes, please explain:
☐ None

Hearing
Have you ever had concerns about the client’s hearing?
No
Yes
Please Comment/Explain If Yes

Does the client use any amplification or other devices to aid hearing?

Vision
Have you ever had concerns about the client’s vision?
No
Yes
Please Comment/Explain If Yes

Does the client currently wear corrective lenses?
Communication Diagnosis, if known: Please check all that apply

<table>
<thead>
<tr>
<th>Expressive/Receptive Language Disorder</th>
<th>Voice Dysfunction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apraxia of Speech</td>
<td>Social Communication Disorder</td>
</tr>
<tr>
<td>Speech Sound Disorder</td>
<td>Fluency/Stuttering</td>
</tr>
<tr>
<td>Cognitive-Communication Deficit</td>
<td>Other:</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Understanding</th>
<th>Speaking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follows conversation all of the time</td>
<td>Communicates primarily in complete sentences</td>
</tr>
<tr>
<td>Follows conversation some of the time</td>
<td>Puts 2-3 words together</td>
</tr>
<tr>
<td>Does not usually understand conversation</td>
<td>Uses some words</td>
</tr>
<tr>
<td>Understands short, simple directions</td>
<td>Unable to say words</td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reading</th>
<th>Writing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reads books</td>
<td>Writes notes and letters</td>
</tr>
<tr>
<td>Reads magazines and newspapers</td>
<td>Writes sentences</td>
</tr>
<tr>
<td>Reads sentences (e.g., headlines, labels)</td>
<td>Writes words</td>
</tr>
<tr>
<td>Reads words</td>
<td>Writes name</td>
</tr>
<tr>
<td>Does not read</td>
<td>Does not write</td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
</tr>
</tbody>
</table>

Digital Literacy

<table>
<thead>
<tr>
<th>Uses social media (e.g. Twitter, Facebook, Instagram)</th>
<th>Uses a cell phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicates via email</td>
<td>Uses a tablet</td>
</tr>
</tbody>
</table>
**Daily Living and Transition Readiness:**

Please indicate if you have had in the past or currently have any concerns in the following areas:

<table>
<thead>
<tr>
<th>Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vocational Skills (readiness to work)</td>
</tr>
<tr>
<td>Self-help (e.g., dressing, toileting)</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
<tr>
<td>Leisure/Social (friendships, hobbies, interests)</td>
</tr>
<tr>
<td>Safety</td>
</tr>
<tr>
<td>Learning new routines/Skills</td>
</tr>
<tr>
<td>Remembering important information</td>
</tr>
<tr>
<td>Making appropriate judgments and decisions</td>
</tr>
<tr>
<td>Paying attention</td>
</tr>
<tr>
<td>Managing time</td>
</tr>
</tbody>
</table>

Please explain any concerns indicated:

**School/Vocation Information**

Is the client currently in any kind of school/transition/employment program?  

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
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<table>
<thead>
<tr>
<th>Name of School/Agency</th>
<th>Grade</th>
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<table>
<thead>
<tr>
<th>Teacher/Job Coach Name</th>
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<tr>
<th>Teacher/Job Coach Email</th>
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</table>

<table>
<thead>
<tr>
<th>Agency Address</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Agency Phone</th>
<th>Fax</th>
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</table>

<table>
<thead>
<tr>
<th>Type of Classroom/Program*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition Program through school district, DVR, School-to-Work</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does the Client currently have an IEP?</th>
<th>No</th>
<th>Yes</th>
<th>If yes, please provide a copy of most</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Dates</td>
<td>Provider Name and Contact Info</td>
<td></td>
</tr>
<tr>
<td>---------</td>
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</table>

Comments:

<table>
<thead>
<tr>
<th>Service</th>
<th>Dates</th>
<th>Provider Name and Contact Info</th>
</tr>
</thead>
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</table>

Comments:

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

<table>
<thead>
<tr>
<th>Whom may we thank for referring you to us?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Payment policies and insurance information

We are not a Medicare provider and we do not bill insurance companies, Medicare or other third party providers. However, we do accept clients with valid Provider One and Molina Medicaid medical coverage issued by the Department of Social and Health Services (DSHS) for services covered under the plan for speech and hearing services. In the event that DSHS limits or discontinues payment for services, the client becomes responsible for all services received and for services not covered by DSHS.

<table>
<thead>
<tr>
<th>Provider One or Molina Coverage</th>
<th>Please bring your card to your first appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Card Number:</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
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</tbody>
</table>

Thank you for taking the time to fill this application. It will help us provide the best services we can for you. Upon receipt of your application, you will be contacted to inform you of your application status. Return this application including Consent for Care Form and Mutual Exchange of Information Form (if we need to request records from other providers) to:

UW Speech & Hearing Clinic, 4131 15th Ave. NE, Seattle, WA 98105 or fax to 206-616-1185

We ask you to pay for your services directly by cash, check or credit card at the time of service. A highly regarded aspect of our clinic is our affordable fees for services. As a teaching and research facility, we strive to provide quality services at an affordable cost.

<table>
<thead>
<tr>
<th>I/we have read and understand the clinic's payment policy</th>
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<tbody>
<tr>
<td>Signed:</td>
</tr>
<tr>
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</tbody>
</table>

|                                                          |
| Date:                                                     |

Upon receipt of your application, you will be contacted to inform you of your application status. Return this application including Consent for Care Form and Mutual Exchange of Information Form (if we need to request records from other providers) to:

UW Speech & Hearing Clinic, 4131 15th Ave. NE, Seattle, WA 98105 or fax to 206-616-1185

Edited: 05/2015 4131-15th Ave. NE, Seattle WA 98105  206-543-5440, Fax 206-516-1185
Web: shclinic.washington.edu   email: shclinic@uw.edu
Patient Authorization to Disclose, Release and/or Obtain Protected Health Information

Patient Name: ___________________________ Date of Birth: ___________________________ Telephone #: ___________________________

Purpose of Disclosure:
☐ Attorney ☐ Insurance ☐ Provider ☐ Personal ☐ Other (specify) ___________________________

INFORMATION TO BE RELEASED FROM:
☐ UW Speech & Hearing Clinic
☐ Harborview Medical Center & Clinics
☐ UW Medical Center & Clinics
☐ Northwest Hospital and Medical Center & Clinics
☐ Valley Medical Center & Clinics
☐ Hall Health Primary Care Center
☐ UW Neighborhood Clinics
OR: ____________________________________ (Org/Person)

______________________________________ (Address)

______________________________________ (City, ST, Zip)

______________________________________ (Phone/Fax)

INFORMATION TO BE RELEASED TO:

______________________________________ (Org/Person)

______________________________________ (Address)

______________________________________ (City, ST, Zip)

______________________________________ (Phone/Fax)

OR: ____________________________________ (Org/Person)

______________________________________ (Address)

______________________________________ (City, ST, Zip)

______________________________________ (Phone/Fax)

If requesting a copy of your own records, how would you like to receive the information? ☐ Paper ☐ CD

Type of Information (check appropriate box):
☐ Summary of Visit/Chart notes from date: ___________ to date: ___________

☐ All Medical Records from date: ___________ to date: ___________

☐ All Medical Records

☐ Images (specify type – radiology, endoscopy, e.g.) ___________________________

☐ Other (specify type – discharge summary, operative reports, lab reports, billings, e.g.) ___________________________

☐ I authorize VERBAL COMMUNICATION about my medical history and care.

OR:

☐ I authorize VERBAL COMMUNICATION ONLY about my medical history and care. (Checking this box means no physical records will be sent.) ___________________________

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric condition. I give my specific authorization for this information to be released: Yes ___ No ___

This authorization is valid until ___________ (date) OR when the following event occurs: ___________________________

(If UW Medicine is no longer authorized to disclose my information based on this authorization, if no date or event is listed above, this authorization is valid for three years from the date on which it is signed.) ___________________________

Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of one-year from the date signed by you.

By signing this page, I acknowledge that I have read and agreed to the terms on both sides of this form.

Signature (Patient or Person Authorized To Give Authorization) ___________________________ Date: ___________

If signed by Person Other Than Patient, Provide Reason, Relationship to Patient, Description of Their Authority ___________________________
Summary of Notice of Privacy Practices
UW Speech and Hearing Clinic
Effective May 15, 2013

This is a summary of the Notice of Privacy Practices – It does not replace the Notice of Privacy Practices for UW Speech and Hearing Clinic.

Summary
UW Speech & Hearing Clinic has a responsibility to protect the privacy of your health information.

We keep a record of the healthcare services we provide you. You may ask us 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 at "Your Individual Rights About Patient Health Information" section of the Notice.

Your rights:
1. You may request the following: a. restricted use of your health information (note: we may not be able to grant your request)
   b. that we not disclose to your health plan those items or services that you self-pay in full
   c. that we contact you in an alternate way
   d. an amendment (change or addition) to your record
   e. a list of disclosures of your health information
2. You may view and receive copies of your health record.
3. You may make complaints related to the privacy of your health information.
4. You may object to being listed in our directory of patients, also called the facility directory, during your hospital stay.
5. You may tell us not to share information with your family members.

We may use and disclose your health information in the following circumstances:
• to perform treatment, obtain payment, or carry out operational activities
• to teach and train staff and students
• to conduct research (an Institutional Review Board must approve research projects)
• when required or allowed by law or when you give us written permission

There are extra legal protections for health information about:
• Sexually transmitted diseases
• Drug and alcohol abuse treatment
• Mental health
• HIV/AIDS
• Reproductive health for minors

For more detail, please read the Notice of Privacy Practices of the UW Speech & Hearing Clinic.

Questions? Contact UW Medicine Compliance
Main telephone line: 206.543.3098 or 855.211.6193
Compliance Anonymous Hotline: 206.616.5248 or 866.964.7744
Email: comply@uw.edu
Address: 850 Republican Street, Box 358049, Seattle, WA 98195
Notice of Privacy Practices Acknowledgment

The Notice of Privacy Practices of UW Speech and Hearing Clinic handout describes how medical information about you may be used and disclosed, how you can get access to this information and who to contact if you have questions, concerns or complaints.

We have a responsibility to protect the privacy of your information, provide a Notice of Privacy Practices and follow the information practices that are described in this notice. If you have any questions, please contact: UW Medicine Compliance 1-866-964-7744 (toll free).

Please do not write comments on this form; refer to the at "Your Individual Rights About Patient Health Information."

We may change our policies at any time. Any significant policy change will be posted. You may request a copy of this notice from UW Medicine Compliance 1-866-964-7744 or at www.uwmedicine.org

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birt:</th>
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</table>

By signing below, I agree that I have received the Notice of Privacy Practices of UW Speech & Hearing Clinic.

SIGNATURE(Patient or Person Authorized to give Authorization)     DATE

IF OTHER THAN PATIENT, PRINT NAME OF PERSON SIGNING

IF SIGNED BY PERSON OTHER THAT PATIENT, CHECK RELATIONSHIP TO PATIENT:


☐ 4. Adult Child(ren)  ☐ 5. Parent(s)  ☐ 6. Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:

☐ 1. Guardian/Legal Custodian   ☐ 2. Court-authorized person for child in out-of-home placement

☐ 3. Parent(s)  ☐ 4. Holder of signed authorization from parent(s)

☐ 5. Adult representing self to be a relative responsible for the minor's health
AUTHORIZATION TO USE OR DISCLOSE PHOTOGRAPHY/VIDEO & CONSENT for CARE AGREEMENT

PLEASE READ AND COMPLETE THE ENTIRE FORM IN ORDER FOR UW MEDICINE TO PROCESS THIS REQUEST

AUTHORIZATION TO USE OR DISCLOSE PHOTOGRAPHY/VIDEO

I, ______________________, authorize the following UW Medicine entity: • UW Speech & Hearing Clinic

(Patient Name)

To take and or reproduce photos/video of my face or body for: EDUCATION & TRAINING (Purpose/disclosure of info)

Description of photos/video to be taken: SESSIONS OF MY EVALUATION AND/OR TREATMENT IN THIS CLINIC

Person / Organization to receive the information:

UW SPEECH & HEARING CLINIC & THE DEPT. OF SPEECH & HEARING SCIENCES

Information to be used or disclosed: Photographs, video and/or electronic media

This authorization expires on 01/01/2060 OR when the following event occurs: ____________________________________________

(State when you want UW Medicine to stop disclosing information according to this authorization)

Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of 90 days from the date signed by you.

POTENTIAL FOR REDISCLOSURE: Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information.

Revocation: I understand I may revoke this authorization by submitting the revocation in writing to:

UW Speech & Hearing Clinic 4131 15th Ave NE Seattle, WA 98105, at any time.

Any revocation will not be effective to the extent that action has already been taken based on the original authorization or where UW Medicine requires the information in order to be paid for treatment provided to me.

I understand I have the following rights:

(a) To inspect or to receive a copy of my protected health information,
(b) To receive a copy of this signed authorization, and
(c) To refuse to sign this authorization.

I also understand: UW Medicine will not condition treatment or payment based on receipt of this signed authorization, except:

(1) UW Medicine may condition research-related treatment on provision of an authorization for the use or disclosure of my information for such research; or

(2) UW Medicine may condition health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party, for example, when a non-UW employer contracts with UW Medicine to conduct TB testing for purposes of employee health screening.

Continue on Page 2
CONSENT for CARE AGREEMENT

This form contains facts you should know about your health care at UW Medicine and from The UW Speech and Hearing Clinic. If there is any part of this form that is unclear you can ask questions about it. At the bottom of the form there is a place for you to sign your name so that we know you have read this form (or had it read to you) and agree to receive health care from us.

Your team consists of Graduate Student Clinicians, Speech Language Pathologist Supervisors, & Audiologists. By choosing to receive your speech and audiology services at the University of Washington Speech and Hearing Clinic, you will not only receive excellent care, but you are contributing to the education of future Audiologists and Speech Therapists. They will work together to diagnose and treat you.

*Photographs, videotapes, or other images of you may be used to keep a record of your care and treatment (including surgery). These images may become part of your medical record.

UW Medicine includes:
- UW Speech and Hearing Clinic
- Harborview Medical Center and Clinics
- UW Physicians Sports Medicine Clinic
- Hall Health Primary Care Center
- University of Washington Medical Center and Clinics
- UW Medicine Neighborhood Clinics
- UW Medicine Eastside Specialty Center
- UW Physicians

By signing below, I have read and agree to the terms on both sides of this form.

<table>
<thead>
<tr>
<th>PATIENT NAME (PRINTED)</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIGNATURE (Patient or Person Authorized to give Authorization)</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

IF OTHER THAN PATIENT, PRINT NAME OF PERSON SIGNING

IF SIGNED BY PERSON OTHER THAT PATIENT, CHECK RELATIONSHIP TO PATIENT:
- 1. Guardian
- 2. Durable Power of Attorney for Health Care
- 3. Spouse/registered domestic partner
- 4. Adult Child(ren)
- 5. Parent(s)
- 6. Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:
- 1. Guardian/Legal Custodian
- 2. Court-authorized person for child in out-of-home placement
- 3. Parent(s)
- 4. Holder of signed authorization from parent(s)
- 5. Adult representing self to be a relative responsible for the minor's health

FOR OFFICIAL USE ONLY

<table>
<thead>
<tr>
<th>TYPE OF PHOTOGRAPH</th>
<th>SITE/DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PHOTOGRAPH</td>
<td>UW SPEECH AND HEARING CLINIC</td>
</tr>
<tr>
<td>2. VIDEO</td>
<td>UW SPEECH AND HEARING CLINIC</td>
</tr>
<tr>
<td>3. CLOSED CIRCUIT TELEVISION</td>
<td>UW SPEECH AND HEARING CLINIC</td>
</tr>
</tbody>
</table>

COMPLETED BY: Date: ________________________

UW Medicine Workforce Member
Signature: ________________________ Date: ________________________
Parking Alternatives

For your appointment, you are welcome to use one of our 8 parking spaces (including 2 disabled spots) located in the alley behind our clinic that display the sign below. Enter the one-way alley from NE 41st Street. Parking spaces are available on a first come, first served basis. When you arrive, we will provide you with a dated parking placard to display on your dashboard. Parking lots and street parking are also available to use at your own expense.
Driving Directions

From I-5:
Exit at 45th Street NE
Go east on 45th Street toward the University of Washington
Turn right onto 15th Ave NE, traveling south 3 blocks
Our building is located between NE 42nd and NE 41st Street
It is a brick building with the front entrance located in the middle of the building (Disability accessible)

From 520:
Exit at Montlake
Cross over the Montlake Bridge
Stay in the left lane
Turn left at the stop light onto NE Pacific Street
Travel west on NE Pacific Street
Turn right onto 15th Ave NE
Travel north on 15th Ave NE
Our building is located between NE 41st & NE 42nd street
It is a brick building with the front entrance located in the middle of the block. (Disability accessible)