

Dear Prospective UMD PEERS® & EFFECT Parents:

Thank you for your request to be a part of our University of Maryland Teen PEERS® and/or EFFECT program at the Department of Hearing and Speech Clinic. A pre-enrollment interview will be scheduled to determine if this program is a good fit for your student after you complete the enclosed case history questionnaire (pages 1-6) to us.

Upon enrollment, we would also appreciate it if you would sign the remaining content, authorization, and release forms (pages 7-15) in addition to any diagnostic test reports you think would be helpful for us to understand and work with your student.

Upon receiving this information, we will send you an acknowledgment email. Again, please be aware that we may schedule a brief screening and interview to help us put your student in the social interaction or executive function group that best fits your students interests and needs. We look forward to meeting you. If you have any questions, please feel free to contact me at (301) 405-4218.

Sincerely,

Tonya Carter
HESP Clinic Coordinator

Speech and Hearing Clinic
Department of Hearing and Speech Sciences
University of Maryland
0110 Lefrak Hall
College Park, Maryland 20742
(301) 405-4218

UMD PEER® & EFFECT Teen Case History Form

Please answer the following questions as best you can and mail the form to the address at the top of this page. If there are some questions you can not answer, leave them blank. Your answers will help us provide you with the best and most efficient evaluation and/or treatment.

General Information

Parent/Caregiver (s) Name (s) _____

Teen/Young Adult Name (also preferred) _____ DOB _____ Age _____

Address: _____ Sex _____

City _____ State _____ Zip _____

Home Phone _____ Parent/Caregiver #1 Cell Phone _____ #2 _____

Email Address _____ May we contact the parent at work? Yes No

What year are you at in school? (Please circle one)

Freshman Sophomore Junior Senior Graduated in Gap Year (s)

School (if applicable) _____ Location _____

Insurance:

We do not participate with any insurer (including Medicaid and Medicare).

Therefore, payment is due at the beginning of the program. Some insurance plans may reimburse for our speech-language pathology services and, as a courtesy, we can provide a summary of the individual and group sessions you attended. We cannot guarantee that you are eligible for coverage or reimbursement from them. Please contact your insurance company to verify benefits and reimbursement rates.

Name of person (s) completing form _____ Relationship _____

Referred by _____

Race/Ethnicity of Client (circle all that apply)* _____

0 = Prefer not to answer

1 = American Indian/Alaska Native

2 = Black/African American

3 = Asian/Pacific Islander

4 = Hispanic

5 = White/Caucasian

* This information is requested because the University is a public teaching institution and will be used solely for the purpose of describing caseload diversity. Your response will not affect consideration of your application.

Educational History

Highest level of education achieved _____ Primary Language _____

Other languages/dialects spoken _____

Does your teen (you, if a young adult) have any reading and/or learning difficulties? Yes No

If yes, please describe _____

Present Communication and Social History (teen or young adult is encouraged to fill out form)

As complete as possible describe your communication strengths and difficulties _____

Explain how you navigate social situations/relationships.

How has your social interactions changed through the years?

How do social situations affect you? _____

Your family?

Emotionally? _____

Educationally? _____

Executive Functioning

Explain how your ability to organize daily living (e.g., home, work) and/or school activities positively and/or negatively impact you.

How are you able to plan time for school, work, and/or social events?

How flexible are you with changes in plans or activities? Please explain.

How are you able to start and finish activities? Please explain.

How do you understand other people's...?

Humor:

Sarcasm:

Figurative Language:

Body Language/facial expression

How do you use...?:

Humor:

Sarcasm:

Figurative Language:

Body Language/facial expression

Have you had help to improve social interactions and/or executive functioning elsewhere? Yes No
Where?

Please explain what worked and did not work. _____

Please list the names of other clinics or agencies where you have been seen for evaluation or treatment of your communication problem.

Name	Location	Dates	Outcome
1.			
2.			
3.			

Name of Physician (if applicable) _____

Location _____ Phone _____

Do you have any other significant medical problems? Yes No

Describe _____

Describe _____

List of medications you are currently taking along with timing and dosage.

Please provide any additional information that might be helpful in our placing you in the most appropriate social interaction group.



HEARING AND SPEECH CLINIC
Student Involvement, Collection of Video, and Research Contact Consent/Waiver Form

The Hearing and Speech Clinic is a student training facility. As such:

1. Services may be provided by students who are working towards their Master's degree in speech-language pathology or their Doctoral degree in audiology. These students are closely supervised by experienced speech-language pathologists and audiologists, who are faculty members of the Department of Hearing and Speech Sciences, certified by the American Speech-Language and Hearing Association (ASHA) and licensed by the Board of Examiners of the State of Maryland.
2. Your information may be used for educational or training purposes, but will be kept confidential.
3. Recordings of sessions may be taken for training purposes. These videos are not considered part of your medical record, and may be destroyed once no longer useful for training purposes.
4. Authorized students may have access to your medical files.

By signing below, I acknowledge that I have read, understand, and agree to the above.

Signature of patient or personal representative

Date

Printed name of patient or personal representative and his/her relationship to patient

In addition to being a training facility, the Hearing and Speech Clinic is also associated with the Department of Hearing and Speech Sciences, whose mission includes not only clinical training and clinical services, but also research. We would like for students and faculty to be able to review your records for potential study eligibility, and to contact you about research opportunities for which you might be eligible and interested. You may decline to participate in research at any time, and this will have no impact on your treatment in our clinic. Please sign here if you allow our faculty and students to review your files.

Signature

Date

UNIVERSITY OF MARYLAND HEARING AND SPEECH CLINIC

NOTICE OF PRIVACY PRACTICES (Short Version)

As Defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCUSSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

I. CLINIC'S COMMITMENT TO YOUR PRIVACY

The University of Maryland Hearing and Speech Clinic (Clinic) is dedicated to maintaining the privacy of your protected health information (PHI). PHI is individually identifiable health information about you that relates to your past, present or future physical or mental health or other condition, as well as any related health care services. This Notice of Privacy Practices (NOPP) provides you with the following important information: our obligations concerning your PHI; how the Clinic may use and disclose your PHI; and your rights with regard to your PHI. **A longer version of this NOPP is available on the Clinic's website and the Clinic will provide a hard copy upon request.**

II. UNIVERSITY STUDENTS

HIPAA requirements for PHI generally exclude student health information, but the confidentiality of such information is protected under the federal Family Education Rights and Privacy Act (FERPA), Maryland state law, and/or University Policy, as applicable. The Clinic recognizes the need for confidentiality and privacy with respect to student health information, and will use, disclose and otherwise treat your health information accordingly, following the requirements of applicable law and University policy (see Section IV below).

III. NON-STUDENTS

A. Clinic's Obligation. Federal and state laws require that the Clinic maintain the privacy of your PHI. By complying with these laws, the Clinic is required to provide you with this notice regarding its privacy practices, its legal duties, and your rights concerning your PHI. Except for student records and certain records the University creates or receives in its role as an employer, this NOPP applies to all records containing your PHI that are created or retained by the Clinic. A copy of the NOPP is posted in a visible location in the Clinic waiting room at all times, and you may request a copy of the NOPP at any time.

B. How The Clinic Uses And Discloses Your PHI. This paragraph describes, in general terms, the different ways the Clinic may use and disclose your PHI; it does not cover all possible uses and disclosures. The Clinic may use and disclose your PHI (1) to provide treatment and related health care services to you; (2) to bill and collect payment for the services and items you receive; (3) in connection the Clinic's health care operations, including administrative, financial, and legal activities; (4) to third-party business associates (e.g., billing services); (5) for health related services, such as recommending treatment alternatives; (5) to individuals involved in your care, unless you object; (6) under limited circumstances, for research purposes in accordance with applicable law and University policy; (7) when required or allowed by law; and (8) with your written authorization. For further information or if you have questions, please consult with the Clinic Directors (see below).

IV. YOUR RIGHTS REGARDING YOUR PHI

A. Non-Students. You have the following rights regarding the your PHI, and you may request any of the following:

(1) confidential communication of your PHI in the manner of your choosing; (2) restriction on communications with certain individuals otherwise permitted by law to inspect your PHI; (3) inspection of records containing your PHI; (4) copies of your records; (4) amendments to your PHI if you believe the information is incorrect or incomplete; (5) a list of disclosures we have made of your PHI; and (6) a copy of this NOPP.

B. University Students. University students have similar rights regarding their health information, including the rights to request confidential communications, restrictions on use or disclosure, inspection and copies, amendments, accounting of disclosures, and copies of this Notice. Those rights may, however, be implemented in different ways under FERPA, Maryland law, and/or University policy, as applicable. If you have questions about your rights regarding your health information, please contact the Clinic Directors (see below).

C. COPIES OF MATERIALS. You have a right to all of your medical records. Written authorization is required; the Clinic's records release form is available from the Clinic office. The Clinic can fax records or provide them in paper form; for the latter, the Clinic will charge \$0.25/page if the records are more than 5 pages.

V. IMPLEMENTATION, QUESTIONS, AND COMPLAINTS

A. Implementation. This NOPP provides a general overview of our privacy practices. This NOPP and our privacy practices are implemented in accordance with applicable University policies and procedures and the requirements of HIPAA and other federal and Maryland laws, as applicable.

B. Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Clinic. All complaints must be submitted in writing. We will not retaliate against you in any way if you file a complaint with us.

VI. CONTACT INFORMATION. If you have any questions regarding this Notice or our health information privacy practices, please contact:

Nicole Nguyen, Au.D., CCC-A
Director of Audiology Services
nknguyen@umd.edu
(301) 405 - 4221
Clinic HIPAA Privacy Officer

Kristin Slawson, M.A., CCC-SLP
Director of Speech-Language Services
kslawson@umd.edu
(301) 405 - 8083



**ACKNOWLEDGEMENT OF RECEIPT
HEARING AND SPEECH CLINIC NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of the University of Maryland Hearing and Speech Clinic's Notice of Privacy Practices.

Printed Name

Date

Signature

Relationship to Patient

.....
FOR INTERNAL USE ONLY

Client declined to provide signature for acknowledging receipt of privacy practices

Clinic Staff Signature and Date

Client was not able to provide signature for acknowledging receipt of privacy practices

Clinic Staff Signature and Date



HEARING AND SPEECH CLINIC

Patient Contact Preferences

Name of Patient: _____

I would prefer to be contacted for appointment reminders, etc. via the following mechanisms:

Email: _____
(please note that email is not a secure form of contact)

Phone: _____

You may leave a voicemail message at this number

You may leave a message with another individual at this number

Signature of patient or personal representative

Date

Printed name of patient or personal representative and his/her relationship to patient

University of Maryland
Speech-Language Clinic
7251 Preinkert Dr., Ste 0110 Lefrak Hall
College Park, Maryland 20742
(301) 405-4218

BILLING POLICY

A **telephone or In-person** intake interview will be scheduled at a mutually-agreed upon time for a 30-minute time slot prior to the beginning of the UMD PEERS®-EFFECT teen program. **For PEERS®, full payment is \$1800 and for EFFECT full payment is \$2100 (if the \$300 deposit was provided by the parent, then that amount will be deducted from the total fee). The UMD PEERS®-EFFECT teen program fee is due at the time of the first group session unless specific alternate arrangements are made with the clinic coordinator or clinic director.**

Cancellations: Any sessions canceled by parents (whether for vacation or illness) or social coaches are not subtracted from the fees. Attempts will be made to arrange make-up sessions at times mutually convenient to both the student and social coach.

Insurance: Our clinic does not participate with any insurance plan (including Medicaid and Medicare).

We encourage parents to investigate the possibility of insurance coverage for speech-language services. However, please note that parents are responsible for paying their bill according to the terms of their payment agreement contract and then requesting reimbursement from their insurance provider. Parents should request that their insurance company reimburse them directly. We cannot guarantee that any of our services are eligible for coverage and reimbursement from your insurance plan. If the insurance company sends a direct payment to the clinic, we will return it to the insurance company to be re-issued, to refund the client.

Signature _____

Date _____

Yes, I have read and understood the Clinic's billing policy

Printed Name _____

POLICY STATEMENT

The purposes of the University of Maryland Speech and Hearing Clinic are:

1. To provide a training facility for those students seeking to become certified speech pathologists and audiologists.
2. To provide an environment for research.
3. To provide speech and hearing services to the public.

All communication coaches conducting clinical sessions are supervised by Speech-Language Pathologist(s) licensed by the State of Maryland and certified by the American Speech and Hearing Association. The clinic operates by appointment only, and follows the academic calendar of the University of Maryland.

Since we have a commitment to provide varied experiences for students, acceptance into UMD PEERS® Teen program is of a selective nature and cannot be guaranteed for the selected semester. If accepted into the program, the teen & parent are expected to maintain regular and punctual attendance. If frequent absence or tardiness occurs, we reserve the right to dismiss the teen & parent from our program. If a group session is canceled due to clinic emergencies, every effort will be made to try to make up the group session at the end of the semester.

We trust that the above policy statements will contribute toward a smooth running, pleasant experience for all those who participate in the UMD PEERS®-EFFECT teen program at the University of Maryland Speech and Hearing Clinic.



HEARING AND SPEECH CLINIC
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA))

1. Authorization

I authorize the **University of Maryland Hearing & Speech Clinic** to use and disclose the protected health information described below to: _____
(include address) _____

2. Effective Period

This authorization for release of information covers the period of healthcare from (check one):

- a. All periods until the present date
- b. All past, present, and future periods

3. Extent of authorization

- a. I authorize the release of my complete health record
- b. I authorize the release of specific information: _____

4. This medical information may be used by the person I authorize to receive it (listed above) for medical treatment or consultation, billing or claims payments, or other purposes as I may direct.
5. This authorization shall be in force and effect until such time as it is revoked.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Date

Printed name of patient or personal representative and his/her relationship to patient



HEARING AND SPEECH CLINIC
AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA))

1. Authorization

I authorize the **University of Maryland Hearing & Speech Clinic** to obtain protected health information (described below) from:

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

2. Effective Period

This authorization for release of information covers the period of healthcare from (check one):

a. All periods until the present date

b. All past, present, and future periods

3. Extent of authorization

a. I authorize the release of my complete health record

b. I authorize the release of specific information: _____

4. This medical information may be used by the **University of Maryland Hearing & Speech Clinic** for medical treatment or consultation, billing or claims payments, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Date

Printed name of patient or personal representative and his/her relationship to patient

Notification of Use of Protected Health Information for Fundraising Purposes

We hope you appreciate the wonderful service you receive from our clinic! We would like to be able to reach out to you in the future both to evaluate your experiences here, and to be a supporter of the clinic. This would allow us to continue providing these valuable services to others in the community who need them.

With that in mind, this form is a courtesy notification to inform you that the administrative staff of the University of Maryland Hearing and Speech Clinic within the Department of Hearing and Speech Sciences and associated development officers of the College of Behavioral and Social Sciences may use your contact information (which constitutes protected health information) for fundraising purposes **in support of the University of Maryland Hearing and Speech Clinic ONLY.**

The health information that we may use for fundraising purposes includes:

- Patient demographic data (name, address, phone/email, date of birth, age, gender, etc)
- Dates of patient services
- General type of department from which the patient/client received services (Speech or Hearing)
- Information about the clinical faculty who supervised your services

This information will only be used to identify and contact you regarding opportunities to support the University of Maryland Hearing and Speech Clinic.

The health information that we will not use or disclose are as follows:

- Health insurance status
- Outcome information
- Diagnosis
- Nature of services
- Treatment

If you do not wish to receive any fundraising information from the University of Maryland Hearing and Speech Clinic, it is your right to opt out of any and all solicitations. If you wish to opt out, please check to box below and provide your name and date; otherwise thank you for your time and consideration.

I do NOT wish to receive fundraising information from the University of Maryland Hearing and Speech Clinic.

Printed Name: _____

Signature: _____ Date: _____