SALUS UNIVERSITY
Speech-Language Institute

T 215.780.3150
F 215.780.3169

8380 Old York Road, Suite 2100
Elkins Park, PA 19027-1539

CONSENT FOR EVALUATION AND TREATMENT

I consent to evaluation and treatment services (or, for my child, ______________________) by the students and clinical educators of the Speech-Language Institute at Salus University.

I understand that services will be provided by speech-language pathologists licensed in the Commonwealth of Pennsylvania and certified by the American Speech-Language Hearing Association and graduate students, working under the direct supervision of licensed and certified speech-language pathologists. I acknowledge that no guarantee has been made as to evaluation or treatment outcomes for me (or for my child) and that I may terminate services with the Speech-Language Institute at Salus University at any time.

ATTENDANCE

Consistent attendance is the foundations for helping a client make progress in therapy. I understand that it is my responsibility to ensure that I (or my child) receiving services miss therapy sessions as infrequently as possible.

If I (or my child) miss 3 or more appointments without notice in a 3-month period, the Speech-Language Institute at Salus University reserves the right to discontinue treatment.

CANCELLATIONS & NO SHOWS

Appointments with the Speech-Language Institute at Salus University must be cancelled no later than 8:00 a.m. the day of the session by calling the clinic.

With the exception of emergency situations, all appointments that are not cancelled by 8:00 a.m. the day of the scheduled session may be subject to a $25.00 late cancellation fee.

Appointments that are missed without advance notice to the Speech-Language Institute at Salus University are considered a “no show” and may be charged a $50.00 no show fee.

By signing this form, I acknowledge that I have read, understand and agree to its contents and that I have had the opportunity to ask questions and request clarifications.

Client (or Parent/Caregiver) Signature: ____ Date: ___________

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ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

By signing this form, I am acknowledging receipt of the Notice of Privacy Practices of the Speech-Language Institute at Salus University. I have the right to review the Notice of Privacy Practices prior to signing this form. If I do not sign this form, the Speech-Language Institute may decline to provide treatment to me (or my child).

The Speech-Language Institute at Salus University reserves the right to revise its Notice of Policy Practices at any time. A copy of such revisions will be available upon written request.

CONSENT FOR AUDIO/VIDEO RECORDING AND PICTURE IMAGES

I consent to the Speech-Language Institute at Salus University to take audio/video recordings and/or picture images of me (or my child) to aid in the evaluation/treatment process.

I understand that all audio/video recordings and images collected during my (or my child's) sessions are used solely for clinical purposes and will remain confidential. The Speech-Language Institute will not use the audio/video recordings or images for any other purposes (i.e., education and training) without your written consent.

I authorize the use and disclosure of the audio/video recording and images of my (or my child's) diagnostic and/or therapy sessions which may include health information for each purpose I have checked below. I also understand that these audio/video recordings and images will contain identifiable information such as voice and full facial images.

- ☐ Review by only clinical educator(s) of the Speech-Language Institute and any student(s) involved in administering my (or my child's) evaluation and therapy sessions. These recordings will be used for assessing the student for quality of care and not for educational purposes.
- ☐ Review and use by the Speech-Language Institute staff, faculty and students for educational and professional training purposes.
- ☐ Use outside of the Speech-Language Institute for educational and professional training purposes. I understand that such purposes may include, but are not limited to, the compilation of recordings to be used within professional training manuals and DVDs, the presentation of recordings as part of lectures, seminars, presentations, or similar professional and/or educational sessions to speech-language pathologists and other professionals. I understand that such purposes shall not include commercial use.

By signing this form, I acknowledge that I have read, understand and agree to its contents and that I have had the opportunity to ask questions and request clarifications.

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PARTICIPATION IN RESEARCH PROJECTS

Clients may be asked by students and/or researchers at Salus University 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 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.

☐ Please do NOT contact me with opportunities to participate in research.

INSURANCE REIMBURSEMENT

I understand that the Speech-Language Institute at Salus University is not billing my (or my child's) insurance, including Medicare and Medicaid, for services rendered.

I understand that I may request a service invoice containing the necessary information to obtain reimbursement from a third party payer/insurance company. I understand that it is my responsibility to request an insurance invoice at the time of service and that the Speech-Language Institute may not be able to provide service invoices retroactively.

Medicare Beneficiary Statement:

Due to difficulty with adhering to the Medicare Billing and Coverage requirements, we do not treat Medicare beneficiaries.

If a beneficiary, of his/her own free will, instructs the Speech-Language Institute to not submit a claim to Medicare on his/her behalf, the Speech-Language Institute may evaluate/treat the client outside of Medicare. However, there are two significant complications:

- A beneficiary must make this demand *truly of his/her own free will.*
- A beneficiary is free to change his/her decision at any time and request that the claim be submitted to Medicare for current and/or past services rendered.

By signing this form, I acknowledge that I have read, understand and agree to its contents and that I have had the opportunity to ask questions and request clarifications.

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EXCHANGE OF INFORMATION

I give permission to the Speech-Language Institute at Salus University to exchange information about my (or my child's) services via the following methods:

Email: ____

Mobile Phone: ____

Home Phone: ____

Mail: ____

RELEASE OF INFORMATION

I give the Speech-Language Institute at Salus University permission to consult and provide information about my (or my child's) evaluation results, treatment plan and ongoing progress in therapy with the following professional:

Pediatrician/Physician: ____

Director of School/Program: ____

Teacher(s): ____

Educational Specialist/Speech-Language Pathologist: ____________________________

Other: ____

I understand that this release is valid for the length of time that I (or my child) is receiving services at the Speech-Language Institute at Salus University, unless a written request for termination of this agreement is made.

By signing this form, I acknowledge that I have read, understand and agree to its contents and that I have had the opportunity to ask questions and request clarifications.

Client (or Parent/Caregiver) Signature: ___________________________________ Date: ___________

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AUTHORIZATION FOR RELEASE OF INFORMATION FROM AGENCY OR PHYSICIAN TO THE SPEECH-LANGUAGE INSTITUTE AT SALUS UNIVERSITY

Client Name:_______________________________________ DOB: ______________

Agency or Physician: ____

Address of Agency or Physician: ____

____

The above named person has requested the services of the Speech-Language Institute at Salus University. We understand that this individual was seen at your facility. Kindly forward any hearing, language, speech, medical, psychological, educational, and/or social information regarding the above named individual. Please send your reply to the attention of:

Name of Supervisor: _____________________________ Title: ____________________

Thank you for your prompt cooperation.

Date: ______________

This will certify that you have my permission to release information concerning the individual named above to the Speech-Language Institute at Salus University.

Signature: ____

Name: ____

Address: ____

____

Relationship
To Client: ____

By signing this form, I acknowledge that I have read, understand and agree to its contents and that I have had the opportunity to ask questions and request clarifications.

Client (or Parent/Caregiver) Signature: __________________________________ Date: __________