Explanation of Services

To Whom This May Concern:

Thank you for your inquiry into our clinical services. The University Hearing and Speech Clinic is a training facility for graduate students preparing for careers in speech-language pathology. As such, it operates on a semester system, with short breaks between semesters during which speech and hearing services are not provided. We make every effort to accept clients for evaluation and/or treatment soon after referrals are received and, if a client is accepted for therapy, we attempt to maintain service until the treatment issues are resolved. The number of clients seen, however, is determined, in part, by student enrollment, therefore availability and continuity of service cannot be guaranteed. If we are unable to accommodate you, a list of other agencies which provide speech-language and/or audiology services will be made available at your request. We are committed to the fair and equitable treatment of our clients. No individual shall be discriminated against on the basis of race, color, creed, religion, national origin, gender, sexual orientation, age, marital status, disability, or status as a disabled veteran or Vietnam era veteran.

***

I have read this explanation of services and understand that enrollment in and continuation of therapy cannot be guaranteed.

Please sign, date and return this form to the clinic office.

_____ _____

Signature Date

☐Client ☐Parent/Guardian ☐Care Provider

University Speech and Hearing Clinic
University Programs in Communication Disorders
Eastern Washington University • Washington State University

CARE AGREEMENT

CONSENT TO AUDIO/VIDEO TAPE/OBSERVATION

The University Hearing & Speech Clinic is a student training and community service facility. As such, all patients are seen by graduate student clinicians who are directed and observed by licensed and certified faculty. The student clinicians may sometimes be required to videotape and/or audio tape part, or all, of the session for their training as Speech-Language Pathologists. These photographs, videotapes, and/or audio recordings of patients also may be used to keep a record of the patient's care and as an assessment and/or treatment tool during evaluation or treatment. In addition, some evaluation or treatment sessions may be observed by fellow student clinicians for educational purposes.

I understand that I am authorizing the University Hearing and Speech Clinic to take and use photographs, videotapes, and/or audio recordings from my sessions, or the sessions of my child/ward, for the purpose of serving as a record of patient care, a treatment tool during evaluation or treatment, and for educational purposes and training of student clinicians.

This authorization will expire on 12/31/2099 **OR** when I revoke this consent by notifying the clinic in writing. Should I withdraw my consent, I understand it would not apply to the photographs, videotapes, and/or audio recordings that had already been collected under the prior consent.

CONSENT TO TREAT

I, as a patient or representative thereof, give permission to graduate student clinicians of the University Hearing & Speech Clinic (UPCD) to provide necessary speech, language, and audiometric evaluations and to make instructional therapy plans in my best interest as a patient, or for the patient I represent. I understand that these graduate student clinicians will be working under the supervision of a state licensed and American Speech and Hearing Association (ASHA) certified Speech-Language Pathologist or Audiologist. I understand that the results of testing or therapy will be kept confidential and will be made available only to the professional staff and other professional personnel concerned with this case for whom I have signed a separate release of information form.

SIGNATURE

*If any part of this form is unclear or not fully understood please ask questions **prior** to signing.*

By signing below I acknowledge that I am over the age of 18, have read this document (or had it read to me) and fully understand and accept the terms of this agreement, and agree to receive healthcare from the University Hearing and Speech Clinic.

_____ _____

Patient or Authorized Representative Signature Date

310 North Riverpoint Blvd • Box "V" • Spokane, WA 99202-1675
e-mail: upcd@wsu.edu
Phone 509-828-1323 • FAX 509-368-6890

University Speech and Hearing Clinic

University Programs in Communication Disorders
Eastern Washington University ♦ Washington State University

CLINICAL SERVICE AGREEMENT:

Patient:_____ **Date of Birth:**_____

Current Address: _____ **City** _____ **State**_____

Phone: (home)_____ **(work)** _____ **Zip Code**_____

Contact Person (if different): _____

Please Indicate Your Method of Payment* (✓):
**Please note: Our facility is not a Medicare Provider*
_____ Self Pay

_____ Insurance (Carrier) _____

Insurance ID #: _____ Subscriber: _____

Referring Physician/Primary Care Physician: _____

No Show/Cancellation Policy:
Please notify us 24 hours in advance if you must cancel. Failure to attend three (3) sessions without at least 24 hours advance notice may result in forfeiture of scheduled appointment days and times and/or discharge from treatment.

Child Supervision Policy:
Parents/legal guardians are responsible for the supervision of their children during clinic visits. Parent/legal guardians are required to **remain in the clinic area** during treatment, in case of an emergency. The clinic does not assume responsibility for the care or supervision of children before or after sessions or the care of siblings during the session. Your cooperation is appreciated. Failure to provide adequate supervision may result in discharge from treatment.

Please Read Carefully:
If services are covered by your insurance company, the clinic will, as a courtesy, bill for you; however, you are ultimately responsible for the total cost of services. Medicare patients please note that services provided by the clinic are not covered. If your insurance company requires a referral, it is your responsibility to obtain the referral from your medical doctor. It is also your responsibility to fully understand your own insurance benefits and to keep track of both the number of visits allowed and number of visits used. Any benefit quotes provided to you by our office are solely based on information provided by your insurance carrier, and **do not guarantee** coverage for services. _____ ***(Initials)***

All co-pay and deductible amounts are expected to be paid on the date of service unless other arrangements have been made in advance. If you have a balance due after insurance has processed our bill, a statement will be sent to you. It will be your financial responsibility to pay this balance due and failure to do so may result in additional fees including late fees or collection fees. **You will be held financially responsible to pay additional charges or fees associated with the collection of any unpaid accounts.**
_____ ***(Initials)***

I authorize the release of any medical records that might be necessary to facilitate payment, treatment, operations, public health activities, workers' compensation, or disasters and authorize my insurance company to make payments directly to us. I also understand that the Speech-Language Pathologists and Audiologists within the clinic have access to each other's records without further authorization and that my records may be released to these other providers who are directly involved in my care.
_____ ***(Initials)***

By signing below I acknowledge that I am over the age of 18, have read this document (or had it read to me), and fully understand and accept its terms and conditions.

Patient's Signature (or responsible party) _____ ***Date*** _____

Reviewed & Revised September 2017,
Reviewed August 2018

University Speech and Hearing Clinic

University Programs in Communication Disorders
Eastern Washington University • Washington State University

SLIDING FEE APPLICATION

The University Hearing and Speech Clinic offer a sliding fee schedule for persons with limited incomes. Health insurance coverage will be sought first. The fee adjustment is based on gross income and household size and is good for one university/academic year. Persons with extenuating financial circumstances may also be eligible for a temporary fee adjustment.
Please complete this form only if you are interested in applying for the sliding fee.
Please note that the sliding fee is not available for the purchase of a hearing aid or durable medical equipment.

To apply for a fee adjustment, the client or responsible party must provide the clinic with a copy of their most recent income tax return *and* a copy of their past two months pay stubs. The standard base fee will be in effect until the clinic has received the required financial documentation. *As we are not a Medicare provider, Medicare patients are eligible for a specific fee adjustment. Please call the Patient Care Coordinator for details.*

Name of Client:_____ SS#_____

Responsible Party:_____ Relationship:_____

Average income: $_____ per_____ # of persons in household _____

Verification Attached - Copies are satisfactory

_____Past 2 Months Pay stubs **AND** _____Past Year's Tax Return _____Other_____

Other financial information you would like to report or explain:

_____

To the best of my knowledge, the above information is correct.

_____ _____
Date of Application Signature of Applicant

********** **FOR OFFICE USE ONLY** **********

Income/household size (SFS) ☐
Extenuating circumstance ☐
Student Educational Training ☐

Projected Annual Income:
Wage Earner 1 $_____
Wage Earner 2 $_____
TOTAL $_____

Effective date of adjustment_____

Academic Term_____

_____ (Initial) ☐ Evaluation fee: $_____

_____ (Initial) ☐ Therapy fee per semester: $_____

_____ (Initial) ☐ Other (Hearing, etc.): $_____

_____ _____
Signature of client / representative Date

_____ _____
Signature of Clinic Director Date

Speech and Language Services

Date form completed: _____

Name of person completing form (if other than patient): _____

Has patient been seen in our clinic before? _____ Yes _____ No

If "yes", when ? _____

Reason for seeking Speech-Language Pathology services: _____

_____

PATIENT INFORMATION

Name: _____ Birthdate: _____ _____ Male _____ Female

Street Address: _____

City, State, Zip: _____

Home Phone: _____

Alt/ Work Phone: _____ Cell: _____

Email Address: _____

Family Members/ Caregivers	"X" if Legal Guardian(s)	Relationship (e.g. mother, father, spouse, sibling, etc.)	Phone Number	"X" if lives with you

REFERRAL INFORMATION

How did you hear about our clinic?

_____ Professional referral: Name? _____

From what institution? _____

_____ Website _____ Phone Book _____ Friend

_____ Other: _____

Current Physician

Name: _____ Phone: _____

Address: _____

MEDICAL HISTORY

_____ Stroke: (Date): _____
_____ Diabetes
_____ Alcohol Abuse
_____ Vascular Disease
_____ Dysphagia
_____ Hypertension
_____ COPD
_____ Drug Abuse
_____ Dementia
_____ Multiple Sclerosis
_____ Hypotension
_____ Heart Disease
_____ Nicotine use
_____ Pneumonia
_____ Developmental Delay
_____ Kidney Disease
_____ Cancer
_____ Depression
_____ Parkinson's Disease
_____ Other: _____

Hearing and Vision History

Have you ever had a known hearing loss? _____ Yes _____ No
If "Yes", do you wear hearing aids? _____ Yes _____ No
Do you have any visual impairments? _____ Yes _____ No
If "Yes", do you wear glasses? _____ Yes _____ No
Are you right handed of left handed? _____ Right _____ Left

Communication Diagnosis, if known *- please check appropriate box(es)*

_____Aphasia
_____Spasmodic Dysphonia
_____Apraxia of Speech
_____Cognitive-Communication Deficit
_____Voice Dysfunction
_____Fluency/Stuttering
_____Dysarthria
_____Other: _____

CURRENT MEDICATIONS

Please check the appropriate box(es) and list the name(s) of any medication(s)

_____Diabetes: _____
_____Pain Management: _____
_____High Blood Pressure: _____
_____Low Blood Pressure: _____
Blood Thinner: _____
Anxiety: _____
Depression: _____
Other: _____

HISTORY OF SPEECH, LANGUAGE, VOICE, HEARING, COGNITION

Do you have a history of speech, language, hearing, or cognition difficulties from birth to present?

_____Yes _____No

Comments: _____

Please list any previous speech-language evaluation(s) and/or therapy received (e.g. school, clinic, hospital, home health):

Services Rendered	When	Where

Are you currently or have you been seen for other types or evaluation(s) and/or therapy? Please check the appropriate box(es) below:

_____Physical Therapy
_____Vocational Rehabiltation Counselor
_____Occupational Therapy
_____Psychologist
_____Other: _____

Please send copies of any evaluation and/or treatment reports that you have received

EDUCATIONAL AND VOCATIONAL HISTORY

Schools you have attended - *Please check all that apply:*

_____Elementary School
_____Junior High / Middle School
_____High School
_____2yr / 4yr College
_____Graduate School
_____Doctorial Program
_____Vocational Program
_____Other: _____

Briefly please list your employment/work setting, starting with the most recent:

Job Title	Years Worked

Are you currently working? _____Yes _____No

If "No", please explain: _____

If you have stopped working, do you plan to return to work? _____Yes _____No

COMMUNICATION

Current Activities and Interests *- please check appropriate box(es)*

_____ Socializing
_____ Watching televison
_____ Exercising
_____ Shopping
_____ Being outdoors
_____ Photography
_____ Travel
_____ Gambling/Casinos
_____ Church
_____ Reading
_____ Music
_____ Woodworking
_____ Painting/Art
_____ Pets
_____ Cooking
_____ Sports
_____ Senior Center
_____ Gardening
_____ Crafts
_____ Book Club
_____ Computers
_____ Board games
_____ Other: _____

Life Impact

On a scale of 1-10, with "1" being "not at all" and "10" being "devastating", please rate how your communication and/or cognitive difficulty impacts your daily life:

1 2 3 4 5 6 7 8 9 10
"Not at all" *"Devastating"*

Communication and Cognitive Skills

Check all areas that apply and provide additional information as needed to describe yourself or your loved one (if other

Understanding

_____ Follows all conversation all of the time
_____ Follows conversation some of the time
_____ Understands short, simple directions
_____ Does not usually understand conversation
_____ Other: _____
_____ Do not know
Describe: _____
_____

Speaking

_____ Uses sentences all the time
_____ Puts 2-3 words together
_____ Uses some words
_____ Unable to say words
_____ Other: _____
_____ Do not know
Describe: _____
_____

Reading

_____ Reads books
_____ Reads magazines or newspapers
_____ Reads sentences (e.g. headlines, labels)
_____ Reads Words
_____ Does not read
_____ Other: _____
_____ Do not know
Describe: _____
_____

Writing

_____ Writes notes and letters
_____ Writes words
_____ Writes sentences
_____ Writes name
_____ Does not write
_____ Other: _____
_____ Do not know
Describe: _____
_____

What activities of daily living are challenging?

_____ Medication management
_____ Staying alone
_____ Cooking
_____ Shopping
_____ Driving
_____ Finances
_____ Managing appointments
_____ Telephone
_____ Household management
_____ Planning tasks / daily activities
_____ Other: _____

OTHER INFORMATION / CONCERNS

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

_____
_____
_____
_____

University Speech and Hearing Clinic
University Programs in Communication Disorders
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CASE HISTORY FORM SUPPLEMENT

Ethnic/Racial Information

Submitting ethnic or racial information is voluntary. Information obtained will be used by the University Programs in Communication Disorders Clinic to facilitate bias-free assessment and management of culturally and linguistically diverse individuals. This information will be kept confidential.

Please check the category(ies) which you identify as the primary ethnic or racial group(s) of the individual to be served by the U.P.C.D. Clinic.

- ☐ American Indian or Alaska Native -- Origins in any of the original people of North America who maintain cultural identification through tribal affiliation or community recognition.
- ☐ Asian or Pacific Islander -- Origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or Pacific Islands.
- ☐ Black, not Hispanic origin -- Origins in any black racial group.
- ☐ Hispanic -- Origins of Mexican, Puerto Rican, Cuba, Central or South American or other Spanish culture, regardless of race.
- ☐ White, not of Hispanic origin --Origins in any of the original people in Europe, North Africa of the Middle East.
- ☐ Other -- Please specify._____.

Indicate name of individual to receive or received services through the U.P.C.D. Clinic.

_____ NAME

_____ DATE

310 North Riverpoint Blvd • Box "V", Hearing & Speech • Spokane, WA 99202-1675
e-mail: upcd@wsu.edu
Phone 509-828-1323 • FAX 509-368-6890

University Speech and Hearing Clinic

University Programs in Communication Disorders
Eastern Washington University • Washington State University

HIPAA NOTICE OF PRIVACY PRACTICES
UNIVERSITY SPEECH AND HEARING CLINIC
EFFECTIVE DATE: APRIL 14, 2003

Acknowledgement of receipt of this Notice:

By signing this sheet you acknowledge that you have read or received a copy of EWU Notice of Privacy Practices. This acknowledgement will become part of your records.

Print Name:_____

Date:_____

_____

Signature (patient or person authorized to give consent)

_____

If signed by person other than patient – provide reason and relationship to patient

University Speech and Hearing Clinic

University Programs in Communication Disorders
Eastern Washington University • Washington State University

Request for Alternate Communications of Patient Information

I hereby request the following alternate communication method for communicating individually identifiable health information regarding me or another (if different, name of other patient: _____) from The University Hearing and Speech Clinic.

Alternate Communication Method Requested:

❑ I do give my permission for **phone messages** regarding appointments, cancellations, and other clinic related issues to be left on voice mail or answering machine at the following number(s):
Home_____ Work_____ Cellular_____

❑ I do give my permission for **email messages** regarding appointments, cancellations, and other clinic related issues to be sent to the following email address(es):

_____

_____

_____

Signature _____ Date _____

Printed name _____

Relationship if not patient _____

Personal representative address _____
(if applicable)

The University Hearing and Speech Clinic must honor your request if the alternate communication method that you are requesting is reasonable. If The University Hearing and Speech Clinic finds the method that you have requested to be unreasonable, we will promptly notify you that it is unreasonable and why.

_____

Signature of Designated Official or Designee Date

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e-mail: upcd@wsu.edu
Phone 509-828-1323 • FAX 509-368-6890

Reviewed/ Revised Sept 2018

University Speech and Hearing Clinic

University Programs in Communication Disorders
Eastern Washington University • Washington State University

Email Informed Consent Form

Introduction

Eastern Washington University-Washington State University (University Speech and Hearing Clinic) provides patients the opportunity to communicate with their physicians, other health care providers, and administrative services by email. Transmitting confidential patient information by email, however, has a number of risks, both general and specific, that patients should consider before using email.

Risk Factors

- Among general email risks are the following:
  - Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
  - Recipients can forward email messages to other recipients without the original sender's permission or knowledge.
  - Users can easily misaddress an email.
  - Email is easier to falsify than handwritten or signed documents.
  - Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
- Among specific patient email risks are the following:
  - Email containing information pertaining to a patient's diagnosis and/or treatment must be included in the patient's medical records. Thus, all individuals who have access to the medical record will have access to the email messages.
  - Employees do not have an expectation of privacy in email that they send or receive at their place of employment. Thus, patients who send or receive email from their place of employment risk having their employer read their email.
  - If employers or others, such as insurance companies, read an employee's email and learn of medical treatment, particularly mental health, sexually transmitted diseases, or alcohol and drug abuse information, they may discriminate against the employee/patient. For example, they may fire the employee, not promote the employee, deny insurance coverage, and the like. In addition, the employee could suffer social stigma from the disclosure of such information.
  - Patients have no way of anticipating how soon Eastern Washington University-Washington State University (University Speech and Hearing Clinic) and its employees and agent will respond to a particular email message. Although Eastern Washington University-Washington State University (University Speech and Hearing Clinic)and its employees and agents will endeavor to read and respond to email promptly, Eastern Washington University-Washington State University (University Speech and Hearing Clinic) cannot guarantee that any particular email message will be read and responded to within any particular period of time. Physicians, nurses, and other health care workers rarely have time during rounds, surgery, consultations, appointments, staff meetings, meetings away from the facility, and meetings with patients and their families to continually monitor whether they have received email. ***Thus, patients should not use email in a medical emergency.***

University Speech and Hearing Clinic • 310 North Riverpoint Blvd; Box "F" • Spokane, Washington 99202-1675
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Phone 509-828-1323 • FAX 509-368-6890

Reviewed 9/2018

Conditions for the Use of Email

- It is the policy of Eastern Washington University-Washington State University (University Speech and Hearing Clinic) that Eastern Washington University-Washington State University (University Speech and Hearing Clinic) will make all email messages sent or received that concern the diagnosis or treatment of a patient part of that patient's medical record and will treat such email messages with the same degree of confidentiality as afforded other portions of the medical record. Eastern Washington University-Washington State University (University Speech and Hearing Clinic) will use reasonable means to protect the security and confidentiality of email information. Because of the risks outlined above, Eastern Washington University-Washington State University (University Speech and Hearing Clinic) cannot, however, guarantee the security and confidentiality of email communication.
- Thus, patients must consent to the use of email for confidential medical information after having been informed of the above risks. Consent to the use of email includes agreement with the following conditions:
  - All emails to or from the patient concerning diagnosis and/or treatment will be made a part of the patient's medical record. As a part of the medical record, other individuals, such as other physicians, nurses, physical therapists, patient accounts personnel, and the like, and other entities, such as other health care providers and insurers, will have access to email messages contained in medical records.
  - Eastern Washington University-Washington State University (University Speech and Hearing Clinic) may forward email messages within the facility as necessary for diagnosis, treatment, and reimbursement. Eastern Washington University-Washington State University (University Speech and Hearing Clinic)will not, however, forward the email outside the facility without the consent of the patient or as required by law.
  - If the patient sends an email to [name of facility], one of its physicians, another health care provider, or an administrative department, Eastern Washington University-Washington State University (University Speech and Hearing Clinic)will endeavor to read the email promptly and to respond promptly, if warranted. However, Eastern Washington University-Washington State University (University Speech and Hearing Clinic) can provide no assurance that the recipient of a particular email will read the email message promptly. **Because Eastern Washington University-Washington State University (University Speech and Hearing Clinic) cannot assure patients that recipients will read email messages promptly, patients must not use email in a medical emergency.**
  - If a patient's email requires or invites a response, and the recipient does not respond within a reasonable time, the patient is responsible for following up to determine whether the intended recipient received the email and when the recipient will respond.
  - Because some medical information is so sensitive that unauthorized disclosure can be very damaging, **patients should not use email for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; mental health or developmental disability; or alcohol and drug abuse.**

- Because employees do not have a right of privacy in their employer's email system, patients should not use their employer's email system to transmit or receive confidential medical information.
- Eastern Washington University-Washington State University (University Speech and Hearing Clinic) cannot guarantee that electronic communications will be private. Eastern Washington University-Washington State University (University Speech and Hearing Clinic)will take reasonable steps to protect the confidentiality of patient email, but Eastern Washington University-Washington State University (University Speech and Hearing Clinic)is not liable for improper disclosure of confidential information not caused by [name of facility]'s gross negligence or wanton misconduct.
- If the patient consents to the use of email, the patient is responsible for informing Eastern Washington University-Washington State University (University Speech and Hearing Clinic) of any types of information that the patient does not want to be sent by email other than those set out above.
- Patient is responsible for protecting patient's password or other means of access to email sent or received from Eastern Washington University-Washington State University (University Speech and Hearing Clinic) to protect confidentiality. Eastern Washington University-Washington State University (University Speech and Hearing Clinic)is not liable for breaches of confidentiality caused by patient.
- **Any further use of email by the patient that discusses diagnosis or treatment by the patient constitutes informed consent to the foregoing.** You may withdraw consent to the use of email at any time by email or written communication to [name of facility], attention: Director of Health Information.

University Speech and Hearing Clinic

University Programs in Communication Disorders
Eastern Washington University • Washington State University

Email Informed Consent Form

I have read the above risk factors and conditions for the use of email, and I hereby consent to the use of email for communications to and from Eastern Washington University-Washington State University (University Speech and Hearing Clinic) regarding my medical treatment.

_____ _____

Signature of Patient Date of Signature

_____

Printed Name of Patient

_____ _____

Signature of Witness Date of Signature

_____

Printed Name of Witness

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Reviewed 9/2018

University Speech and Hearing Clinic
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Research Consent Form

Purpose and Benefits

This consent seeks your permission to use your or your child's/family member's assessment and treatment information for educational and research purposes to further our understanding of the effectiveness of our treatment efforts. The primary purpose of the consent is for graduate students to have access and use of data from previously seen clients at our clinic to analyze and report in their master's papers/projects. Very occasionally a student or faculty member may want to use the client file data for a retrospective study.

Procedures

We are requesting your permission to use assessment and treatment information from your or your child's/family member's clinic file from treatment received at the University Programs in Communication Disorders (UPCD) clinic under the supervision of certified Speech-Language Pathologists and/or Audiologists. Graduate students at UPCD are required to critically review assessment and/or treatment information about clients seen at the UPCD clinic. When students are making class presentations or writing papers, your or your child's/family member's name is not used. The file data are used to demonstrate the effectiveness of certain assessment or treatment methods. In this research, it is not necessary to reveal the identity of the person(s) being treated or assessed, so you or your child/family member will be treated anonymously in any reporting of the data.

Risk, Stress or Discomfort

No stress or discomfort is involved for you or your family member if you sign this permission. There is minimal risk of breech of confidentiality but we (the faculty and staff at UPCD) will ensure that no personal identifiers are shared in class or on written documents. This is standard procedure in our courses and all students have signed a confidentiality agreement.

Other Information

You are free to withdraw this permission at anytime without penalty or jeopardizing future care at UPCD or at any other facility. We appreciate your cooperation as we seek to improve our methods of assessment and treatment for communication and hearing disorders. Please feel free to discuss this consent with me, Doreen Nicholas, when you are at UPCD or call me at 509-828-1323.

Agreement for Voluntary Participation in the Study

The use of assessment and treatment information for research purposes has been explained to me and I voluntarily consent to allow my or my child's/family member's clinic file to be reviewed in the future. I have had the opportunity to ask questions about the purpose of this review. I am not waiving any of my legal rights by signing this form. I understand that if I decline participation, I will still be entitled to receive services at UPCD without penalty or prejudice. I understand that upon request, I will receive a signed copy of this consent form.

_____ _____
Name of Client (please print) Date

_____ _____
Signature of Client or Parent/Legal Guardian Date

_____ _____
Doreen Nicholas, MS, MHPA CCC-SLP, Clinic Director Date

Parking: Parking is available in the Clinic lot adjacent to the Health Science Building, 310 North Riverpoint Blvd. The current rate is $1.00 per hour. You will need cash (dollar bills only) or credit card for the kiosk. There is also limited free (1 hour) street parking available along Riverpoint Blvd.

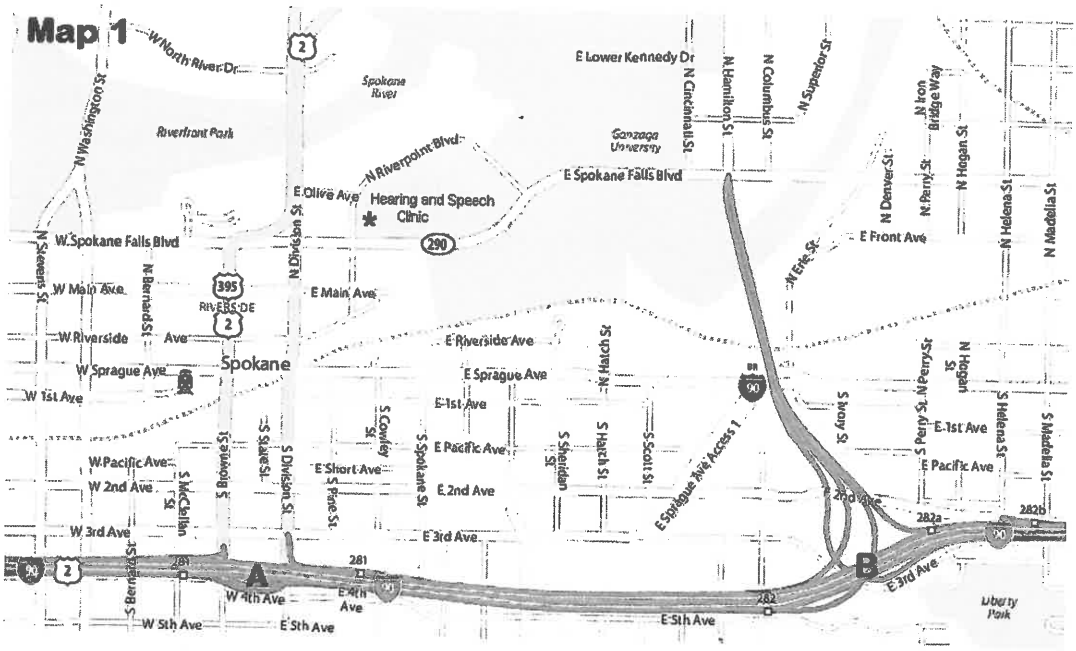
Driving Directions:

From Interstate 90: (Map 1)

(A) Division (Exit 281) street northbound to Spokane Falls Blvd. Right on Spokane Falls Blvd. Left on N.Riverpoint Blvd.

or

(B) Hamilton (Exit 282 or 282A) street northbound to Spokane Falls Blvd. Left on Spokane Falls Blvd (to four way stop). Right (staying on Spokane Falls Blvd). Right on N. Riverpoint Blvd.



From N. Spokane: (Map 2)

(A) Division St. southbound across bridge (turns into Browne St.). Left on Main Ave. Left on Division St. Right on Spokane Falls Blvd. Left on N. Riverpoint Blvd.

or

(B) Hamilton St. southbound. Right on Spokane Falls Blvd (to four way stop). Right (staying on Spokane Falls Blvd.) Right on N. Riverpoint Blvd.