

University of North Texas
Augmentative and Alternative (AAC)
Case History Form

Client's Name: _____ Birthdate _____

Individual completing the form: _____ Relationship _____

(You/your refers to the client)

Please describe your goals for the assessment.

Please describe how you would like to improve your communication skills.

Please describe persons that you communicate with **on a regular basis**.

_____	_____
_____	_____
_____	_____
_____	_____

Please describe your current means of communication (check all that apply):

- Speech
- Yes/no responses
- Eye gaze/facial expression
- Pointing
- Gestures
- Sign language (number of signs) _____
- Picture communication board (number of pictures) _____
- Writing
- Electronic device (specify device) _____
- Other (describe) _____

Please check the best description of your communication success using **any method** of communication (speech, gestures, pointing, etc):

- Able to communicate easily with many different people
- Some difficulty communicating successfully, especially with new people
- Frequent difficulty communicating successfully
- Successful communication is limited to people who know me
- Successful communication is limited to basic needs/simple ideas
- Unable to communicate basic needs

Please describe how easily your **speech** is understood by others:

- Understood 75% of the time or more
- Understood 50-75% of the time
- Understood 25 – 50% of the time
- Understood less than 25% of the time

Which of the following describes your mobility (check all that apply)?

- Walk independently
- Walk with walker/cane or assistance
- Use a wheelchair part of the time
- Use a wheelchair all of the time
- Use an electric wheelchair

Which of the following describes your ability to use your arms (check all that apply)?

- No movement or sensation problems
- Limited movement on either side (describe) _____
- Limited fine motor coordination (describe) _____
- No functional movement

Do you have problems with any of the following:

- vision (describe) _____
- hearing (describe) _____
- sitting balance (describe) _____
- head control (describe) _____
- swallowing (describe) _____

Please describe your reading abilities:

Skill	Yes	No
Recognizes objects/pictures		
Recognizes letters		
Reads some (at least 50 words)		
Reads and understands sentences		
Reads and understands books		

Please describe your writing abilities:

Skill	Yes	No
Able to write name, address, some words		
Able to write sentences to communicate		
Legibility of writing is poor		
Able to type on a keyboard		

Have you ever tried using any methods of alternative/augmentative communication (for example, a communication board, a picture book, sign language)? If so, please describe your success with the method(s).

Are you interested in accessing technology for any of the following (check all that apply):

- Environmental control
- Computer/internet access
- Telephone access
- Word processing/written output
- Other (specify) _____

Please describe your interests/activities you enjoy.

Medical Insurance Information

Primary Insurance:

_____/_____/_____
Name of insurance company Insurance Company Street Address City, State, Zip Code

_____/_____/_____
Insurance company phone number Identification Number Policy or Group number

Policyholder name

Policyholder: Male: _____ Female: _____

Policyholder's date of birth

Patient's relationship to policyholder: Self: _____ Spouse: _____ Child: _____ Other: _____

Secondary Insurance:

_____/_____/_____
Name of insurance company Insurance Company Street Address City, State, Zip Code

_____/_____/_____
Insurance company phone number Identification Number Policy or Group number

Policyholder name

Policyholder: Male: _____ Female: _____

Policyholder's date of birth

Patient's relationship to policyholder: Self: _____ Spouse: _____ Child: _____ Other: _____

Tertiary Insurance:

_____/_____/_____
Name of insurance company Insurance Company Street Address City, State, Zip Code

_____/_____/_____
Insurance company phone number Identification Number Policy or Group number

Policyholder name

Policyholder: Male: _____ Female: _____

Policyholder's date of birth

Patient's relationship to policyholder: Self: _____ Spouse: _____ Child: _____ Other: _____

Billing Information Insurance Release Form

Patient Information:

/	/					
Last name	First name	Middle				
Street Address	Apt/Lot #	City	State	Zip Code	Home Phone #	
/						
Social Security #	Date of Birth	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Student: <input type="checkbox"/>	Full-time <input type="checkbox"/>	Part-time <input type="checkbox"/>
Single	Married	Divorced	Separated	Widowed	Employed	Retired
/	/	()				
Physician	City	Phone number				

Responsible Party:

/	/				
Full Name	Social Security number	Date of Birth			
Street Address	Apt/Lot #	City	State	Zip Code	Home Phone #
/					
Employer	Position				
/	/	/	/		
Employment street Address	Apt/Lot #	City	State	Zip Code	Work Phone #
/					
Spouse's full name	Social Security number	Date of birth			
/	/	/	/		
Street Address	Apt/Lot #	City	State	Zip Code	Home Phone #
/					
Employer	Position				
/	/	/	/		
Employment street Address	Apt/Lot #	City	State	Zip Code	Work Phone #
/					
Nearest relative or friend/Emergency contact		Relationship to patient			Phone number

Private Insurance and Medicare/Medicaid Authorization

I authorize payment of medical/Medicare/Medicaid benefits to University of North Texas Speech and Hearing Center for any services furnished to me by the licensed professionals in the clinic. I also authorize you to release to my insurance company or Medicare/Medicaid Administrator any information concerning my health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date _____ Signature _____

I understand that I am responsible for payment of all charges incurred on behalf of myself and my family regardless of insurance benefits.

Date _____ Responsible Party _____

**University of North Texas
Speech and Hearing Center**

Authorization

Client Name: _____

The University of North Texas Speech and Hearing Center is a training facility designed to provide speech-language pathology and audiology student clinicians with clinical experience. Student clinicians are involved in all aspects of client service delivery. All clinical services are provided under the guidance/supervision of clinical supervisors who hold current state licensure and national certification in Speech-Language Pathology or Audiology. Additionally, student observers may be assigned to observe evaluation/treatment sessions conducted in the center. At times, videotapes of evaluation/therapy sessions are made to assist student clinicians/supervisors in evaluating and planning therapy activities. These videotapes are viewed only by students/clinicians of the Center involved in the case.

_____ **I hereby authorize the University of North Texas Speech and Hearing Center to render Speech-Language Pathology/Audiology services to me.**

_____ **I hereby authorize students of the Department of Speech and Hearing Sciences to observe evaluation/treatment sessions.**

_____ **I hereby authorize videotaping of sessions for use by the student/supervisor assigned to me.**

Signature: _____

Date: _____

**University of North Texas
Speech and Hearing Center**

**Authorization to Release
Protected Health Information**

I hereby authorize the University of North Texas Speech and Hearing Center to release my protected health information to:

Agency/Individual Name

Address

Phone Number

Fax Number

For the purpose of:

I authorize release of the following:

I understand that I may revoke this authorization by submitting a written request to the Center. Such a revocation does not apply to releases prior to the date of the request.

Client or Legal Guardian

Date

For Internal Purposes
Only:

**University of North Texas
Speech and Hearing Center**

Information Regarding Protected Health Information

I have read the Notice of Health Information Practices provided by the University of North Texas Speech and Hearing Center. I understand how the Center will utilize my protected health information (PHI) and my rights regarding my protected health information.

Client or Parent/Guardian

Date

University of North Texas Speech and Hearing Center

Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

The UNT Speech and Hearing Center is committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit the UNT Speech and Hearing Center, a record of your visit is made. Typically, this record contains documentation of treatment you received and recommendations for future treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the other health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided

How Your Protected Health Information (PHI) is Used or Disclosed

The following information describes how we may use your PHI without your written consent. Your PHI will be used by the UNT Speech and Hearing Center for treatment, payment, or healthcare operations (TPO). Some specific examples include:

Treatment – Your PHI may be shared with other Health Care professionals in order to provide you the best care. These Health Care professionals may be other clinicians within the UNT Speech and Hearing Center or other providers outside of the Center who are involved in your treatment.

Payment – Your PHI may be shared with billing personnel in order to assure that you are properly charged for services provided. PHI may also be shared with your medical insurance plan administrators to assure payment of a claim.

Health Care Operations – Your PHI may be shared with the UNT Speech and Hearing Center personnel to schedule appointments, order hearing aides, and for quality assurance/improvement efforts. Your PHI may be disclosed to others outside the Center as required by state or federal laws.

The Center may also disclose PHI:

- In order to contact you regarding appointments
- For activities related to supervision of student clinicians involved in your care
- To you, the patient, or if the patient is a minor, to the legal guardian
- To others involved in your care – such as family members
- For law enforcement purposes
- To correctional institutions
- For national security or intelligence
- For fund raising activities for the Speech and Hearing Center, or for UNT

Release of Protected Health Information (PHI)

Except for the situations described above, you must sign an authorization to release your PHI. This authorization will specify who the information will be released to and for what purpose. The Speech and Hearing Center will maintain records of authorized release of your PHI. You may request an accounting of those releases in writing, and you may receive one copy of the accounting detailing all release over the past 12 month period (subsequent to April 14, 2003) free of charge. You may also request specific restrictions for release of your PHI although the center is not required to agree to all requested restrictions. You may revoke an authorization by submitting a written request to the center; however, such a revocation is only valid from the date of the written request and does not include releases prior to that date.

Your Rights to Access/Amend Your PHI

You have the right to inspect and copy your PHI. Requests for inspection must be submitted to the Center in writing, and the Center must respond within 15 days or request a 30-day extension with cause for extension stated. Request to change or amend PHI must be made in writing. Such requests may be denied by the Center.

Responsibilities of the Speech and Hearing Center Regarding Your PHI

The Speech and Hearing Center is required to:

- Maintain the privacy of your health information
- Provide you with this notice of our legal duties and privacy practices regarding your health information
- Allow you access to your health information
- Notify you if we are unable to agree to a restriction regarding release of your information

The Speech and Hearing Center is required by law to provide public notice that assures privacy of PHI is maintained. The Center is required to provide clients with notice of the Center's privacy practices for PHI. The Center may make changes to the privacy practices; however, those changes must be described in an updated Privacy Notice before changes are implemented. The updated Privacy Notice will be available to patients upon request.

Your Rights to Report a Complaint or Problem

You have the right to report a complaint if you believe your privacy rights have been violated. The complaint should be submitted in writing and should specify how the privacy policies were violated. The complaint must be filed within 180 days of the act or omission. The complainant will not be subject to any retaliation for filing a complaint.

To obtain further information on the UNT Speech and Hearing Center policies regarding Protected Health Information

Or

To file a complaint regarding Protected Health Information contact:

Kathy Thomas
Director, Speech and Hearing Center
PO Box 305010
Denton, TX 76203-5010
940-369-7339
kathyt@unt.edu

The UNT Speech and Hearing Center welcomes the opportunity to serve a diverse clientele. We do not discriminate with regard to gender, sexual orientation, age, race, creed, national origin or, disability.