CCCD# ____________

PATIENT INFORMATION SHEET

Today's Date ____________ Clinic Location: ☐ Callier Dallas ☐ Callier Richardson Received By ____________

☐ **Check here if patient is a UT Dallas employee or student, or a family member of an employee or student.**

Patient Information

Patient Last Name	**Patient First Name**	**Middle Initial**
Patient Date of Birth	**Preferred Name *Optional***	**Primary Care or Referring Provider**
Home Address	**Apt #**	**1. Home Phone**
City / **State**	**Zip Code**	**2. Mobile Phone**
Preferred Language / **Translator Required** ☐ YES	**Sign Language** ☐ YES	**3. Work Phone (optional)**

Email Address (Please print)	**Gender** ☐ Male ☐ Female
Ethinicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to Specify **Race (please select)** ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Specify ☐ Other	**Gender Indentity** ☐ Male ☐ Female ☐ Other ____ ☐ Transgender ☐ Decline to Answer

Marital Status ☐ Divorced ☐ Married ☐ Single ☐ Other	**Driver's License Number**	**Driver's License State**
Emergency Contact Name (1)	**Emergency Contact Phone Number (1)**	**Relationship to Patient (1)**
Emergency Contact Name (2)	**Emergency Contact Phone Number (2)**	**Relationship to Patient (2)**

Responsible Party (do not need to complete if s*ame as patient.)*

The parent or guardian of a minor patient (under 18 years) will be listed as the guarantor.

Last Name			First Name	
Date of Birth	Gender		Mobile Phone	Alternate Phone
Responsible Party Address or ☐ *Check here if same as patient*				
City/State/Zip			Relationship to Patient	

Please tell us how you heard about Callier Center:	***Please let us know who we can thank for the referral.***
☐ My primary care doctor ☐ My ENT ☐ Internet ☐ Social Media ☐ Friend/Family ☐ Other ____________	____________

For Internal Use Only

☐ Patient Portal Web Enabled
☐ PSAC Activation

(Rev 2024-02)

CALLIER CENTER
FOR COMMUNICATION DISORDERS

THE UNIVERSITY OF TEXAS AT DALLAS

CASE HISTORY UPDATE

Date: _______________ CCCD# _______________

Patient Name: ____
Date of Birth: _______________ Age: __________ Male / Female
Person completing this form: _______________________ Relationship to client: _______________
Clinician's Name: ________________________________

Medical History

Have there been any significant changes to your child's medical history? (e.g., development of allergies, wearing glasses, any surgical procedures, etc): ___________________________________

____

Physicians

Primary Care Physician	Provider Specialty	Telephone	Address

Other Physician/Service	Provider Specialty	Telephone	Address

Current Medications

Medication Name	Prescribed by:	For what purpose

Please describe benefits of these medications: ____

Please describe any side-effects: ____

Has your child had a hearing evaluation in the last year? Y/N Results? ______________________
Do you have any behavioral or developmental concerns? (e.g., toilet training, peer interactions, behavior problems, etc): ____

____

Educational and Therapeutic History

Current Educational Services

School: ________________________________ Grade: _________ Teacher: _________________

Special services provided at school (Speech, resource, OT, etc.)	Frequency of services	Contact info (Teacher, therapist, etc.)

Please list any educational/academic concerns: ____
____

Current Therapy Services

Type (PT, OT, etc.)	Date initiated	Agency/Service Provider	Therapist	Contact Number	Hrs/wk

Other Activities/Services (e.g. playgroups, Little Gym, etc.): ________________________________
____

Please list your main concerns regarding your child's speech and language skills: _______________
____

Does your child have other diagnoses? Y/ N If so, please list: ___________________________
Date of diagnoses: ___________ Agency/person providing diagnoses: _______________________
Do you have any questions/concerns about accuracy of diagnoses? Y/ N
If yes, please explain: ____

Has your child ever received treatment by a mental health professional? Y/ N

If so, who provided this treatment? ____

When? _____________ What was the purpose of the treatment? ____________________________

Thank you for taking time to complete this form.
This information will help us to provide the best services for your family.

(08/2014)

CALLIER CENTER
FOR COMMUNICATION DISORDERS

CALLIER CENTER DALLAS
1966 INWOOD ROAD
DALLAS, TEXAS 75235
972.883.3030

CALLIER CENTER RICHARDSON
2895 FACILITIES WAY
RICHARDSON, TEXAS 75080
972.883.3630

THE UNIVERSITY OF TEXAS AT DALLAS | CALLIERCENTER.UTDALLAS.EDU

Patient's Name: ____________________________ **DOB**_______ **CCCD#** _______

Please check one of the following:

_____ My child does not have any allergies.

_____ My child has the following allergies (e.g., food, materials, seasonal):

Please list any allergies below and indicate if contact, inhalation, or ingestion:	**Reaction if exposed:**
1. _________________________________	_________________________________
_________________________________	_________________________________
2. _________________________________	_________________________________
_________________________________	_________________________________
3. _________________________________	_________________________________
_________________________________	_________________________________
4. _________________________________	_________________________________
_________________________________	_________________________________
5. _________________________________	_________________________________
_________________________________	_________________________________

Does an exposure to the listed allergy require emergency medical attention/treatment, such as an Epipen? ____

If this is the case, an adult will be required to remain on the premises while the patient receives services.

________________________________ ____________________
Guardian Signature **Date**

CCCD# ____________________

CALLIER CENTER
FOR COMMUNICATION DISORDERS

AUTHORIZATION TO RELEASE RECORDS

Please complete this form in its entirety to have information disclosed from UT Dallas/Callier Center to another provider or requestor.
UT Dallas/Callier Center will not condition treatment, payment, enrollment or eligibility for benefits based on the completion of this form.

PATIENT NAME	DOB	DATE	
STREET ADDRESS	CITY	ST	ZIP
HOME PHONE	CELL PHONE		

I hereby authorize the UT Dallas/Callier Center to use and/or disclose my Protected Health Information (PHI).

I UNDERSTAND THE INFORMATION REQUESTED WILL BE RELEASED TO:

- ☐ **PHYSICIAN/PRIMARY CARE:** ____________________
  - **CONTACT INFORMATION:** ____________________
- ☐ **PHYSICIAN/ENT:** ____________________
  - **CONTACT INFORMATION:** ____________________
- ☐ **CURRENT SPEECH-LANGUAGE PATHOLOGIST:** ____________________
  - **CONTACT INFORMATION:** ____________________
- ☐ **Department Of State Health Services (DSHS)/Texas Early Hearing Detection and Intervention Program (TEHDI)**
- ☐ **Regional Day School Program for The Deaf (RDSPD):** ____________________
- ☐ **Educational Resource Center on Deafness (ERCOD)/Texas School for The Deaf (TSD)**
- ☐ **Department of Assistive and Rehabilitative Services (DARS)/Early Childhood Intervention (ECI)**
- ☐ **EARLY INTERVENTION SPECIALIST:** ____________________
- ☐ **PARENT SUPPORT GROUP: Texas Hands and Voices/Guide by Your Side**
- ☐ **LOCAL SCHOOL SYSTEM (ISD):** ____________________

ADDITIONAL RECIPIENTS

NAME OF PERSON(S) OR ORGANIZATION(S)		RELATIONSHIP TO PATIENT	
ADDRESS	CITY	ST	ZIP
TELEPHONE	FAX		

NAME OF PERSON(S) OR ORGANIZATION(S)		RELATIONSHIP TO PATIENT	
ADDRESS	CITY	ST	ZIP
TELEPHONE	FAX		

INFORMATION TO BE RELEASED (check all that apply and include time period or date of service):

- ☐ Audiology records _____
- ☐ Otology records _____
- ☐ Tinnitus records _____
- ☐ Speech-Language Pathology records _____
- ☐ Telephone consultation _____
- ☐ Other _____

I UNDERSTAND THAT THE INFORMATION IS TO BE RELEASED FOR THE FOLLOWING PURPOSE (check all that apply):

- ☐ Personal
- ☐ Meet Insurance/Third Party Payor Requirements
- ☐ Determine appropriate interventions/services
- ☐ SSI/Insurance Eligibility
- ☐ Legal proceedings
- ☐ Guide diagnosis
- ☐ Program placement
- ☐ Other _____

CCCD#

PATIENT ACKNOWLEDGEMENT

- I understand that the records used and disclosed pursuant to this authorization may include information relating to: Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection; history of drug or alcohol abuse; mental or behavioral health or psychiatric care; and/or other sensitive information.
- I understand that to the extent any recipient of this information, as identified above, is not a “covered entity” under the Federal or Texas privacy laws, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient, and therefore, may be subject to re-disclosure by the recipient.
- I understand that I may revoke this authorization in writing at any time, however, I also understand that such a revocation will not have any effect on any information already used or disclosed by the UT Dallas/Callier Center before receiving my written notice of revocation.
- Unless otherwise revoked, I understand that the date or event upon which this authorization expires is **365 days** from the date of signature.
- A copy of this release will have the same force as the original.
- If I am providing authorization for marketing purposes, I understand that UT Dallas/Callier Center may receive remuneration from a properly authorized business associate as a result of using or disclosing the patient’s PHI.
- I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form.
  (Texas law establishes nominal fees for copy charges of medical records)

____
SIGNATURE OF PATIENT OR SURROGATE DECISION MAKER

____
DATE

____
PRINTED NAME OF PATIENT

____
PRINTED NAME OF SURROGATE DECISION MAKER *(If applicable)*

CCCD# ____________________

CALLIER CENTER
FOR COMMUNICATION DISORDERS

Patient Communication Preferences

Please read carefully. The purpose of this document is to protect your privacy.

To protect your privacy and comply with HIPAA (Health Insurance Portability and Accountability Act) regulations, Callier Center wants you to know all the ways we might communicate with you and ensure you understand your right to request communications restrictions. We will say "yes" to all reasonable requests to restrict communication but may still use your information to help improve your care, run our practice, or contact you when necessary. Please see our Notice of Privacy Practices for more information at calliercenter.utdallas.edu.

As a patient of Callier Center, you:

- have access to a secure online patient portal and will be notified by email when you have a new visit summary, document, or message from your provider.
- will be sent appointment reminders via text message.
- may receive voicemail with appointment instructions or for Callier to run our healthcare operations.

You may opt out of any of these communications by selecting the options below.

Secure Access to my Electronic Health Record and Provider Messaging via the Patient Portal

_____ Check here if you do **NOT** want access to your patient portal with secure provider messaging and immediate access to health records and patient documents.

Patient Appointment Reminders via Text Message

Text Messaging is required to receive appointment reminders. Patients may opt-out anytime by responding "stop" to an appointment reminder or,

_____ Check here if you do **NOT** want appointment reminders via text message.

Communication via the Telephone

Detailed messages may be left on my voicemail at this phone number_____________________________

_____ Check here if you do **NOT** want detailed voicemail messages left on your phone. We may still leave a voicemail without patient information to help run our operations.

Patient Name (please print)	Patient Date of Birth
Patient Signature	Date
Parent (child under 18 years) or Guardian Name (please print)	Parent or Guardian Signature

CCCD# ________________

CALLIER CENTER
FOR COMMUNICATION DISORDERS

IMPORTANT NOTICE

Fee, Collection & Appointment Policy

Thank you for choosing **UT Dallas Callier Center**! We are committed to providing you with the best possible care.

FEES

I understand that:

- There is a **$25 service charge** for any check returned by my bank and, once notified, patients will have 10 days to make full payment by cash, credit card, cashier's check or money order
  Failure to comply will result in refusal by the Center to accept future personal checks
- Missed or canceled appointments with less than 24 hours' notice will be subject to a **$50 fee**
  Insurance does not pay for canceled appointment fees
- If patients require additional provider consultation by phone or email lasting over 10 minutes, and outside of a scheduled appointment time, patients will be billed at a rate of **$25 per 10-minute increments**.
  You will be informed when such charges apply
- Patients arriving late may have to be rescheduled and are subject to the **late cancelation fee**

COLLECTION POLICY

I understand that:

- Payment for all services is required **at the time of service**
- Patients are responsible for payment of outstanding claims **over 90 days old**
  If insurance denies payment, you will be required to pay the full balance of your account.
- **Past due** accounts will be referred to a collection agency, and services will be immediately terminated

APPOINTMENT POLICY

I understand that:

- Patients will **not** be seen until all required paperwork is completed
- New patients should arrive **20 minutes before** their scheduled appointment to complete necessary paperwork
- If I have been referred to the Center by an agency, school, or other third party that has agreed to pay for my services, a written referral is required prior to or at the time of my appointment; **otherwise, I am responsible for payment of services.**
- The Center will file insurance claims with commercial insurance companies and Medicaid carriers we are contracted with for services. Some insurance companies require a doctor's referral and preauthorization which does not guarantee payment.
  We strongly recommend that you contact your insurance carrier to verify your personal benefits.
- When possible, we recommend case history paperwork be returned five days prior to the appointment to help your provider plan for your evaluation and request any additional information in advance.

PATIENT ACKNOWLEDGEMENT

I have read and understand the Fee, Collection and Appointment Policy of the UT Dallas Callier Center.

____	____________________
SIGNATURE OF PATIENT OR SURROGATE DECISION MAKER	DATE
____	____________________
PRINTED NAME OF PATIENT	DATE OF BIRTH (PATIENT)
____	
PRINTED NAME OF SURROGATE DECISION MAKER *(If applicable)*	

CCCD# ____________________

CALLIER CENTER
FOR COMMUNICATION DISORDERS

PLEASE READ CAREFULLY

AUTHORIZATION FORM

Initial each section and sign at the bottom of this form to authorize Callier for the following:

Benefit Release Information: I authorize **Callier Center for Communication Disorders** to release any information necessary to my insurance carrier and/or their agents in order to determine benefits payable for related services. I authorize the payment of medical benefits for these services to be paid directly to **Callier Center for Communication** Disorders. I authorize the release of all clinical information to my referring physician and primary care physician so that he or she can be updated on my condition and the care I receive here.

Initials: __________

Authorization of Treatment: I authorize **Callier Center for Communication Disorders** to provide diagnosis and/or treatment to myself or to ______________________ (my legal dependent). I understand I have the right to refuse medical services at any time. I further understand no guarantees have been made by any representative of **Callier Center for Communication Disorders** as to the outcome of this service.

Initials: __________

Covered Health Care Operations: I understand that as part of the Center's health care operations, The University of Dallas Callier Center for Communication Disorders provides training in which students and trainees learn under supervision to practice or improve their skills as health care providers. (45 CFR § 164.501)

Initials: __________

PRINTED NAME OF PATIENT	PATIENT DATE OF BIRTH
PRINTED NAME OF SURROGATE DECISION MAKER *(If applicable)*	RELATIONSHIP
SIGNATURE OF PATIENT OR SURROGATE DECISION MAKER	DATE

Optional and intended for families whose children are transported by others:

Authorization for Transportation: I authorize the following person(s) permission to transport my child to and from Callier for patient services.

NAME OF AUTHORIZED PERSON	DRIVERS LICENSE INFORMATION (STATE AND #)
NAME OF AUTHORIZED PERSON	DRIVERS LICENSE INFORMATION (STATE AND #)

I authorize UT Dallas Callier Center employees to discuss services with persons providing transportation.

Initials: __________

__________________ CCCD#

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

I have had the opportunity to receive and/or review a copy of the Callier Center's Notice of Privacy Practices - located on the Callier Center website at **https://calliercenter.utdallas.edu/** to learn how patient confidential information will be used, disclosed, and protected. A printed copy may be requested at any Callier Center location.

PRINTED NAME OF PATIENT	PATIENT DATE OF BIRTH
PRINTED NAME GUARDIAN *(If applicable)*	RELATIONSHIP
SIGNATURE OF PATIENT OR GUARDIAN	DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not because:

_____ Individual Refused to Sign

_____ Communication Barrier

_____ Care Provided was Emergent

_____ Other____

EMPLOYEE	DATE
EMPLOYEE SIGNATURE	

SPEECH-LANGUAGE THERAPY AGREEMENT

Thank you for choosing the UT Dallas Callier Center for Communication Disorders.
Understanding and using the following information will help you make the most of your services.

What you can expect if you/your child enroll:

- The treatment plan goals will be reviewed with you regularly and you will be given changes in the goals as they occur.
- We will make every effort to begin your appointment on time. The clinician will give you as much advance notice as possible if an appointment needs to be rescheduled.
- The clinician(s) working with you or your child will talk with you briefly at the end of each therapy session. Other discussions that need more time or may not be appropriate for your child to hear will need to happen in a separately scheduled appointment. Thirty minute patient or parent conferences are $75.
- You will be given information regarding the payment for each session before therapy is scheduled. If our therapy fees change, you will be given at least one month's notice.
- We must bill you for phone contacts over 10 minutes at the rate of $37.50 per 15 minutes. Replies to long email messages may require phone contact to be billed in 15 minute units at $37.50.
- Once recommended, you/your child's enrollment in a group therapy program is not secured until an enrollment fee of $75, which is nonrefundable and is not billable to insurance, is paid.

What we expect:

- It is very important to be on time. If you arrive more than 15 minutes late for a group session, your child will not be able to attend the session. Any exception requires prior approval from your clinician. Late arrival for individual therapy may prevent you/your child from being seen for their session.
- Payment is due the day of your appointment, including co-payments.
- A credit card must be on file for therapy services.
- You must keep at least 80% of your therapy appointments per month. If you are unable to fulfill this 80% attendance or if you miss, without canceling, 2 consecutive sessions, it will be necessary to dismiss you from our therapy program.
- If you or your child is sick, we ask that you do not come to the Center. You and/or your child must be free of fever, vomiting and/or diarrhea for at least 24 hours without the use of medication to attend appointments. If you are unable to attend the appointment due to illness, please contact the clinician as soon as possible.
- You must call or email the clinician at least 24 hours before your therapy session to cancel or reschedule an appointment. You will be billed for "no shows" or appointments that are not cancelled 24 hours in advance. Insurance does not pay for missed sessions.
- We would like for you (or a designated, responsible adult) to remain at the Callier Center during your child's therapy. This requirement can be modified on an individual basis by your child's clinician and for certain group programs that meet for longer

periods of time. If an agreement is made that allows you to leave your child at the Center during the session, please be on time to pick them up. A fee of $37.50 will be charged if you are 5 minutes late to pick up your child and an additional $37.50 for each 15 minutes after that. This fee is not billable to insurance and must be paid prior to the next session.

- It is very important that you actively participate in following through with home program assignments and homework activities. This will allow continued progress and carryover of newly learned skills.
- If you/your child wear hearing aids/cochlear implants or use Assistive Technology, we expect you to attend appointments with working equipment. Without working equipment, we are unable to provide therapy services.
- You will keep us updated on any significant events going on at school, home, work, and other places that may be affecting you or your child.

Reasons for Dismissal:
The decision to dismiss you or your child from group therapy services is made not only when you or your child no longer qualify as speech-language impaired, but also takes into account the following:

- The type of the speech-language impairment and its effects on the patient's functioning in their home, school, and community environment.
- The patient has stopped making progress or is not able to use the new skills outside the clinic environment. The clinician may then serve as a consultant to others because your child may be better served in a different therapy setting (i.e., school-based services, home-based services).
- The patient is not willing to continue the work to make improvements. The clinician may then consider a change in service delivery or talk with you about other possible services.
- Following the attendance rules and/or lack of family involvement. Examples include: not following through with the home program activities, having too many absences, failing to show up, late cancellation of appointments, or being late too many times to therapy.

Please feel free to discuss any questions about the above information with your clinician. We value your thoughts about our services and welcome your comments and questions at any time. For cancelations/reschedules please contact the Appointment Desk at 972-883-3030 (Callier-Dallas), 972-883-3630 (Callier-Richardson).

I have read and agree to the above expectations for therapy services for me/my child. I understand that the initial enrollment fee and re-enrollment fee is nonrefundable.

Parent / Legal Guardian or
Adult Patient Signature: ____ Date:_____________

Preferred phone contact: ___________________________ (choose one) home work cell

Patient Name: ________________________ DOB: ________________ CCCD# _______________

(01/2014) (01/2016) (10/2017) (08/2018) (08/2023)