CALLIER CENTER
FOR COMMUNICATION DISORDERS

_____
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			**Gender Indentity** ☐ Male ☐ Female ☐ Other ☐ Transgender ☐ Decline to Answer	
Race (please select) ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Specify ☐ Other				
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:

☐ My primary care doctor ☐ My ENT

☐ Internet ☐ Social Media ☐ Friend/Family

☐ Other _____

Please let us know who we can thank for the referral.

_____

For Internal Use Only

☐ Patient Portal Web Enabled
☐ PSAC Activation

(Rev 2024-02)

Pediatric Case History

CCCD# _____ Today's Date_____

I. Patient Information

Name of Patient _____
Last First Middle

Date of Birth _____ ☐ Adopted ☐ Foster Child

Person Completing this Form_____ Relationship to Patient_____

What information would you like to gain from your visit?_____

_____

II. Family Information

Who has **legal** custody of the patient?

☐ Biological Parents (Both) ☐ Biological Mother Only ☐ Biological Father Only

☐ Other Relative_____ ☐ Other Guardian_____

Do you have court documentation stating the legal custody arrangement? ☐ Yes ☐ No ☐ N/A

Status of custodial guardians: ☐ Married ☐ Separated/Divorced ☐ Single/Never Married

List guardians living with patient:

1. Name_____ Relationship to Patient_____ Legal Guardian? ☐ Yes ☐ No

Age_____ Education_____ Type of Work_____

Phone: (check preferred) H☐_____ W☐_____ Cell☐_____

2. Name_____ Relationship to Patient_____ Legal Guardian? ☐ Yes ☐ No

Age_____ Education_____ Type of Work_____

Phone: (check preferred) H☐_____ W☐_____ Cell☐_____

List all other persons living with patient:

	Name	Age	Relationship
1.			
2.			
3.			
4.			
5.			
6.			

III. Languages

What is the patient's primary language? ☐English ☐Spanish ☐Sign Language ☐Other_____

Language(s) used in the home? ☐English ☐Spanish ☐Sign Language ☐Other_____

Language(s) used at daycare/school? ☐English ☐Spanish ☐Sign Language ☐Other_____

What additional language(s) is the patient regularly exposed to?_____

IV. Main Concerns

☐Hearing Loss ☐Nonverbal ☐Written Language ☐Difficulty with School

☐Hearing Aid(s) Issues ☐Language Use ☐Pronunciation ☐Behavior

☐Cochlear Implant Issues ☐Language Comprehension ☐Stuttering ☐Acts Young for Age

☐Sound Sensitivity ☐Reading Comprehension ☐Voice Quality ☐Feeding

☐Other_____

When did the problem(s) begin? _____

What do you think caused the problem(s)? _____

What have you already tried to help with the problem(s)?_____

V. General Development

Length of pregnancy in weeks _____ Patient's birth weight _____

Medications used during pregnancy (prescription or over-the-counter)_____

Check all that apply: ☐Cesarean Section ☐Congenital Rubella ☐Jaundiced ☐Transfusion

☐Atypical Facial Features ☐Congenital Heart Disease ☐Infant Blue ☐Seizures ☐Twin/Multiple

☐Antibiotics/Drugs_____ ☐Syndrome (specify)_____

☐Maternal CMV/Syphilis/Herpes_____ Anesthetics used_____

☐NICU/SCN Duration of stay _____ NICU/SCN Treatment(s)_____

Describe any conditions or findings during pregnancy, delivery, and the patient's stay in the hospital nursery (i.e., accidents, Rh incompatibility, etc.) ☐N/A_____

_____

Did the patient have any swallowing or sucking difficulties? ☐Yes ☐No Describe _____

At what age did the patient begin doing the following activities? (Indicate age in months or years)

Coo_____ ☐N/A Two-word sentences_____ ☐N/A Toilet independently_____ ☐N/A

Babble_____ ☐N/A Crawl_____ ☐N/A Feed self_____ ☐N/A

First word_____ ☐N/A Walk _____ ☐N/A Dress self _____ ☐N/A

At what age did the patient stop doing the following: (Indicate age in months or years)

Breast Feeding _____ ☐N/A Using a pacifier_____ ☐ N/A

Bottle Feeding _____ ☐ N/A Using a diaper/pull up _____ ☐ N/A

Has the patient had any problems with the following: (Indicate age in months or years when problems occurred)

Eating_____ ☐N/A Walking/Running_____ ☐N/A Sleeping_____ ☐N/A

Drinking_____ ☐N/A Muscle coordination_____ ☐N/A Social Skills _____ ☐N/A

Holding a spoon_____ ☐N/A Toilet training_____ ☐N/A

Please describe:_____

VI. Medical Information

Current diagnosed conditions (i.e., developmental delay, autism, syndromes, speech-language disorder, etc.)_____

_____

Diagnosed by _____

Primary Care Physician/Pediatrician_____Contact Information_____

List any other physicians following the patient:

Name	Specialty	Contact Information
1.		
2.		
3.		
4.		

List current medications:

Name	Dosage	Reason for use
1.		
2.		
3.		
4.		

Allergies to medications? ☐Yes ☐No Please list_____

Allergies to foods? ☐Yes ☐No Please list_____

Please list any other allergy (i.e. environmental, respiratory agents, latex, etc.)_____

Please check any conditions that apply to the patient:

☐Asthma	☐Ear injury	☐Kidney/Bladder Disease	☐Sleep problems
☐Anxiety	☐Ear infections	☐Measles	☐Stroke
☐Cancer	☐Frequent Colds	☐Meningitis	☐Swallowing problems
☐Cytomegalovirus (CMV)	☐Head injury	☐Ringing in ears	☐Tubes in ears
☐Diabetes	☐Hearing problems	☐Seizures	☐Vision problems
☐Digestive problems	☐High fever	☐Sensitivity to sounds	☐Weakness in arms,
☐Dizziness/Balance problems	☐HIV positive	☐Severe headaches	legs, and/or face

Other problem(s) not listed_____

Hospitalization or surgeries and dates_____

_____

Did the patient's hearing, speech-language, or behavior change after an illness or accident? Please explain_____

_____

Does the patient need assistance with walking or mobility? ☐Yes ☐No

Uses corrective lenses or glasses? ☐Yes ☐No Is the patient legally blind? ☐Yes ☐No

Please explain any other vision problems_____

VII. Hearing Information

Was a Newborn Hearing Screening completed? ☐ Yes—passed ☐ Yes—failed ☐ No ☐ Don't know

Hospital _____

Does the patient have a diagnosed hearing loss? ☐ Yes—bilateral ☐ Yes—unilateral ☐ No Age at diagnosis_____

Last hearing screening/test date_____ Location_____

Screening/test results_____

Has an MRI of the inner ear been completed? ☐ Yes ☐ No Results_____

Age received Hearing Aid(s)_____ Uses FM System? ☐ Yes ☐ No ☐ Don't know

Cochlear Implant surgery date(s)_____

Cochlear Implant activation date(s)_____

How many hours/day does the patient wear Hearing Aid(s) and/or Cochlear Implant(s)?_____

VIII. Speech-Language Information

Describe the patient's speech-language problem(s)_____

_____

Who first noticed the problem? ☐ Parents ☐ Teacher ☐ Relative ☐ Friends ☐ Other_____

Patient communicates using:

☐ Pointing ☐ Sign Language ☐ Sounds ☐ Short Phrases

☐ Gestures ☐ Signs & Speech ☐ Single Words ☐ Sentences

How many words are in the patient's vocabulary? ☐ Under 25 ☐ 25 -75 ☐ Over 75

Estimate the percentage that the following people understand the patient:

Parents	○ 0%	○ 25%	○ 50%	○ 75%	○ 100%
Unfamiliar Listeners	○ 0%	○ 25%	○ 50%	○ 75%	○ 100%

Does the patient generally understand what is said to him/her? ☐ Yes ☐ No If no, please explain_____

_____

IX. Behavioral

Describe the patient's ability to do the following:

Get along with other children_____

Concentrate/pay attention_____

Cooperate/obey_____

How many friends does the patient have? ☐ None ☐ A few (1-3) ☐ More than three

Describe any behavioral concerns_____

X. Family History

Please list any family members with speech, language, hearing, or mental health/behavior problems below.

	Relationship to Patient	Condition
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

XI. Educational Information

Is the patient currently enrolled in a daycare or school program? ☐Yes ☐No

If yes, please complete the following:

Name_____ Address_____

District_____ ☐N/A Grade/Class_____

Please list the patient's average grades: Reading_____ Spelling_____ Math_____ Conduct_____ ☐N/A

Has the patient ever repeated any school grade or class? ☐Yes ☐No If yes, please list: _____

Does the patient receive special services at school? ☐Yes ☐No Date of most recent ARD meeting?_____

Please attach copy of most recent ARD forms and Full Individual Evaluation (FIE) if receiving speech/language testing.
(Not necessary for hearing evaluations)

Special Education service(s):

☐Content Mastery ☐Deaf Education Oral Instruction ☐Resource

☐Counseling ☐Deaf Education Total Communication Instruction ☐Self-Contained Class

☐Deaf Education Interpreter ☐Occupational Therapy ☐Speech Therapy

☐Other_____

XII. Therapies and Services

List all previous and current therapies and services received outside of school, including provider (i.e., Early Childhood Intervention (ECI), Callier Center, Head Start, etc.). If the patient has received a therapy or service from more than one provider, please continue list of providers by "Additional".

	Provider	# Visits/Month	
☐Applied Behavior Analysis (ABA)			☐Previous ☐Current
☐Auditory Impairment Services			☐Previous ☐Current
☐Occupational Therapy			☐Previous ☐Current
☐Physical Therapy			☐Previous ☐Current
☐Special Skills Training			☐Previous ☐Current
☐Speech Therapy			☐Previous ☐Current
☐Tutoring			☐Previous ☐Current
☐Additional_____			☐Previous ☐Current
☐Additional_____			☐Previous ☐Current
☐Additional_____			☐Previous ☐Current

XIII. Additional Background Information

Has the patient or patient's family experienced any stressors or changes in the last 6 months?

☐Change in residence, school, or daycare ☐Death of a family member ☐Financial stress

☐Job related problems ☐Legal problems ☐Marital stress/tension

☐Other_____

Thank you for taking the time to complete this form.

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. _____	_____
Please choose one	_____
2. _____	_____
Please choose one	_____
3. _____	_____
Please choose one	_____
4. _____	_____
Please choose one	_____
5. _____	_____
Please choose one	_____

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

PEDIATRIC CASE HISTORY
Speech-Language Services Addendum: Feeding Evaluation

TODAY'S DATE _____

The following information is **for the speech-language pathologist** who will be **working with your child**. It will help to **determine the best tests** for the evaluation. Your opinion and information **is very helpful**. Please **complete this form** and **return it with your other paperwork**.
You will be asked to complete this information at the first visit if you are not able to complete it prior to the session.

IDENTIFYING AND MEDICAL INFORMATION

PATIENT NAME	**DOB**	**PATIENT AGE**
PERSON COMPLETING FORM		**RELATIONSHIP TO PATIENT**
REASON FOR REFERRAL		
PLEASE DESCRIBE ANY CUSTOMS, RELIGIOUS BELIEFS, OR WISHES THAT MIGHT AFFECT OUR CARE OF YOUR CHILD		
PLEASE DESCRIBE ANY PRECAUTIONS OR CONCERNS THAT WE SHOULD KNOW ABOUT		
DIAGNOSES AND DEVELOPMENTAL ISSUES		
PREFERRED METHOD OF INSTRUCTION ☐ PICTURES ☐ WRITTEN ☐ DEMONSTRATION ☐ NO PREFERENCE		

SPECIFIC BIRTH INFORMATION

WERE THERE ANY COMPLICATIONS DURING **PREGNANCY**?	☐ YES	☐ NO
IF YES, PLEASE DESCRIBE		
WERE THERE ANY COMPLICATIONS DURING THE **DELIVERY**?	☐ YES	☐ NO
IF YES, PLEASE DESCRIBE		
DID YOUR CHILD STAY IN THE HOSPITAL AFTER BIRTH, FOR ANY LENGTH OF TIME AFTER STANDARD RECOVERY?	☐ YES	☐ NO
IF SO, WHY AND FOR HOW LONG?		
WAS YOUR CHILD ON MECHANICAL VENTILATION AFTER BIRTH?	☐ YES	☐ NO
IF SO, WHY AND FOR HOW LONG?		

FEEDING HISTORY

HAS YOUR CHILD HAD A SWALLOW STUDY OR FEEDING EVALUATION BEFORE THIS APPOINTMENT?	☐ YES	☐ NO
IF SO, WHEN?		
WHERE?		
WHAT WERE THE RESULTS?		
WHAT WERE THE RECOMMENDATIONS?		

WHAT DOES YOUR CHILD EAT/DRINK?

(all that apply)

☐	THIN LIQUIDS (juice, water, milk)	
☐	THICKENED LIQUIDS (one best description)	☐ NECTAR/SYRUP THICK ☐ HONEY THICK ☐ MILKSHAKE THICK
☐	FOOD (all that apply)	☐ STAGE 1 ☐ STAGE 2 ☐ STAGE 3 ☐ MASHED SOFT TABLE FOOD ☐ REGULAR TABLE FOOD
DRINK METHOD	(all that is used)	☐ BOTTLE ☐ BREAST ☐ SIPPY CUP ☐ OPEN CUP ☐ SPECIAL METHOD
FOOD METHOD	(all that is used)	☐ SPOON ☐ FINGER FOODS ☐ FORK ☐ SPECIAL EQUIPMENT

PLEASE EXPLAIN ANY FEEDING PROBLEMS RELATED TO THE ABOVE

CCCD#

PEDIATRIC CASE HISTORY (continued)
Speech-Language Services Addendum: Feeding Evaluation

WHAT FOODS/LIQUIDS DOES YOUR CHILD EAT AND DRINK? AND HOW MUCH?

DURING	FOOD EXAMPLES	LIQUID EXAMPLES	TYPICAL AMOUNT
BREAKFAST			
LUNCH			
DINNER			
SNACKTIME			

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING BEHAVIORS DURING FEEDING?
(all that apply)

☐	CRYING	**IF SO, PLEASE EXPLAIN**
☐	GAGGING	**IF SO, PLEASE EXPLAIN**
☐	VOMITING	**IF SO, PLEASE EXPLAIN**
☐	SPITTING OUT FOOD/REFUSING FOOD	**IF SO, PLEASE EXPLAIN**
☐	COUGHING	**IF SO, PLEASE EXPLAIN**
☐	CONGESTION	**IF SO, PLEASE EXPLAIN**
☐	GURGLY, WET VOICE SOUNDS	**IF SO, PLEASE EXPLAIN**
☐	SNEEZING & RUNNY EYES	**IF SO, PLEASE EXPLAIN**
☐	BREATHING PROBLEMS	**IF SO, PLEASE EXPLAIN**
☐	COLOR CHANGES	**IF SO, PLEASE EXPLAIN**
☐	OTHER	**PLEASE EXPLAIN**

HOW LONG DOES A MEAL TIME LAST FOR YOUR CHILD?

WHICH TYPES OF FOODS ARE EASIEST FOR YOUR CHILD?

WHICH TYPES OF FOODS ARE HARDEST FOR YOUR CHILD?

WHICH OF THESE SKILLS DOES YOUR CHILD POSSESS? ☐ STRAW ☐ OPEN CUP ☐ BOTTLE ☐ SPOON ☐ FINGER FEEDING

SENSORY INFORMATION

DOES YOUR CHILD TOLERATE:

FACE/HANDS/FEET MESSY?	☐ YES	☐ NO
TOOTH BRUSHING?	☐ YES	☐ NO
HAVING FACE/HANDS WIPED?	☐ YES	☐ NO
HAVING TOENAILS/FINGERNAILS CLIPPED?	☐ YES	☐ NO
HAVING HAIRCUT?	☐ YES	☐ NO

PLEASE DESCRIBE ANY OTHER SENSORY SENSITIVITIES YOUR CHILD HAS

CCCD#

PEDIATRIC CASE HISTORY (continued)
Speech-Language Services Addendum: Feeding Evaluation

GASTROINTESTINAL HISTORY/CONCERNS

DOES YOUR CHILD HAVE A HISTORY OF **GI DEFICITS**? ☐ YES ☐ NO

(IF **YES**, WHICH OF THE BELOW. IF **NO**, SKIP TO **GI SURGERY**.)

(all that apply)

☐	ALTERED PERISTALSIS	**IF SO, PLEASE DESCRIBE**
☐	BOWEL OBSTRUCTION	**IF SO, PLEASE DESCRIBE**
☐	CROHN'S DISEASE	**IF SO, PLEASE DESCRIBE**
☐	CHRONIC DIARRHEA	**IF SO, PLEASE DESCRIBE**
☐	CONSTIPATION	**IF SO, PLEASE DESCRIBE**
☐	DEHYDRATION	**IF SO, PLEASE DESCRIBE**
☐	DIABETES	**IF SO, PLEASE DESCRIBE**
☐	ESOPHAGITIS (EOSINOPHILIC)	**IF SO, PLEASE DESCRIBE**
☐	ESOPHAGITIS (GENERAL)	**IF SO, PLEASE DESCRIBE**
☐	FAILURE TO THRIVE	**IF SO, PLEASE DESCRIBE**
☐	GI BLEEDING	**IF SO, PLEASE DESCRIBE**
☐	HYPOGYCEMIA	**IF SO, PLEASE DESCRIBE**
☐	REFLUX	**IF SO, PLEASE DESCRIBE**
☐	SLOW GASTRIC EMPTYING	**IF SO, PLEASE DESCRIBE**
☐	SHORT BOWEL SYNDROME	**IF SO, PLEASE DESCRIBE**
☐	VOMITING	**IF SO, PLEASE DESCRIBE**
☐	OTHER	**PLEASE DESCRIBE**

DOES YOUR CHILD HAVE A HISTORY OF **GI SURGERY**? ☐ YES ☐ NO

(IF **YES**, WHICH OF THE BELOW. IF **NO**, SKIP TO **CURRENT GI STATUS**.)

(all that apply)

☐	COLOSTOMY	**IF SO, PLEASE DESCRIBE**
☐	FUNDOPLICATION	**IF SO, PLEASE DESCRIBE**
☐	PYLOROTOMY	**IF SO, PLEASE DESCRIBE**
☐	SHORT GUT	**IF SO, PLEASE DESCRIBE**
☐	OTHER	**PLEASE DESCRIBE**

ANY PREVIOUS OR CURRENT TUBE FEEDS? ☐ YES ☐ NO

IF YES, WHAT TYPE ☐ NG-TUBE ☐ PEG TUBE ☐ PEJ TUBE ☐ G-TUBE ☐ J-TUBE

☐ **OTHER:**

WHEN? ☐ CURRENT ☐ PREVIOUSLY **(PLEASE PROVIDE DATES):**

WHAT IS YOUR CHILD RECEIVING

CURRENT RATE & VOLUME

CURRENT SCHEDULE/FREQUENCY

WHAT IS CHILD'S REACTION TO FEEDINGS?

TYPE OF FEEDING RECEIVED ☐ BOLUS ☐ CONTINUOUS DRIP ☐ COMBINATION ☐ OTHER

CCCD#

PEDIATRIC CASE HISTORY (continued)
Speech-Language Services Addendum: Feeding Evaluation

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING TESTS COMPLETED?

IF SO, PLEASE INDICATE THE DATES AND RESULTS OF THE TESTS. IF MULTIPLE TESTS COMPLETED ONLY PROVIDE THE MOST RECENT.

(all that apply)		
☐	MBS	**DATES? AND RESULTS?**
☐	FEES STUDY	**DATES? AND RESULTS?**
☐	UPPER GI	**DATES? AND RESULTS?**
☐	BARIUM SWALLOW	**DATES? AND RESULTS?**
☐	PH PROBE	**DATES? AND RESULTS?**
☐	SIALOGRAM	**DATES? AND RESULTS?**
☐	OTHER (DESCRIBE)	**DATES? AND RESULTS?**

HAS YOUR CHILD EVER PARTICIPATED IN **EARLY ORAL FEEDING TRIALS**? ☐ YES ☐ NO

IF YES, CHRONOLOGY OF FORMULAS
(IF CHILD IS LESS THAN 3, PLEASE INDICATE ALL FORMULAS TRIALED/UTILIZED) AND ANY COMMENTS ON POOR TOLERANCE

WHAT IS YOUR CHILD'S **CURRENT GI STATUS**?

(all that apply)		
☐	NO PROBLEMS	
☐	CURRENT ISSUES	**IF SO, PLEASE DESCRIBE**
☐	REGULAR FOLLOW-UP WITH GASTROENTEROLOGY	**IF SO, PLEASE PROVIDE PHYSICIAN INFORMATION**
☐	REGULAR FOLLOW-UP WITH PEDIATRICIAN FOR GI ISSUES	**IF SO, PLEASE PROVIDE PHYSICIAN INFORMATION**

DO YOU OR YOUR DOCTOR HAVE CONCERNS ABOUT RECENT WEIGHT GAIN OR WEIGHT LOSS? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE

HAS YOUR CHILD EVER HAD A NUTRITIONAL CONSULT? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE NAME OF THE CONSULTANT AND LAST VISIT DATE, NOTING ANY PERTINENT COMMENTS

HAS YOUR CHILD EVER HAD BLOOD TESTED TO DETERMINE NUTRITIONAL DEFICITS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE LAST VISIT DATE AND RESULTS

IF YOUR CHILD CURRENTLY HAS REFLUX, HAVE YOU EVER NOTED COUGHING OR A "GURGLY" VOICE AFTER THE EPISODE? ☐ YES ☐ NO

IF YOUR CHILD CURRENTLY SUFFERS FROM RECURRENT VOMITING, APPROXIMATELY HOW MANY TIMES DAILY DO THEY VOMIT?

ADDITIONAL CURRENT GI ISSUES (PLEASE EXPLAIN)

ADDITIONAL INFORMATION

IS THERE ANYTHING ELSE THAT YOU WOULD LIKE THE EVALUATOR TO KNOW ABOUT YOUR CHILD?

THANK YOU FOR COMPLETING THIS FORM

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#

CALLIER CENTER
FOR COMMUNICATION DISORDERS

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#

CALLIER CENTER
FOR COMMUNICATION DISORDERS

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

CALLIER CENTER
FOR COMMUNICATION DISORDERS

THE UNIVERSITY OF TEXAS AT DALLAS

Patient Name: _____ DOB: _____ CCCD#: _____

Email: _____ Phone number: _____

CALLIER CLINICAL RESEARCH CENTER
CALLIER CENTER RESEARCH PARTICIPATION AND RESEARCH REGISTRY

The mission of the Callier Center for Communication Disorders is "to transform the lives of those with communication disorders by providing outstanding, leading-edge clinical services; conducting meaningful and innovative basic and applied research into new treatments and technologies; and training the next generation of caring clinical providers and scientists." As a top clinical, research, and training center, individuals entering the Callier Center clinical programs, child development center, Center for Children and Families, and research laboratories may be invited to participate in research studies.

If contacted, individuals can choose to participate or not participate in any research study. Their services will not be affected whether they do or do not participate. Individuals will be provided with a flyer describing the Callier Clinical Research Center (CCRC), the CCRC Participant Registry, and their Rights as Human Research Participants.

You may also choose to be entered into the CCRC Participant Registry. If so, you will be asked to provide basic information for the CCRC Participant Registry, such as contact information, age, and, if applicable, any speech, language, and/or hearing concerns. A Callier Center researcher, who has a study approved by the Institutional Review Board (IRB), may then contact you to invite you to join a research study. You are not obligated to participate in any study. Choosing not to participate does not affect clinical care, child development services, or any other services you or your family engage in at the Callier Center.

If at any time you would like to be removed from the CCRC Participant Registry or to no longer be contacted for possible study participation, please inform any of your service providers at the Callier Center or the registry team by email: callierresearchregistry@utdallas.edu

Or by telephone: Callier Clinical Research Center, (972) 883-3600

Or by mail: Callier Clinical Research Center, Participant Registry, 811 Synergy Park Boulevard, Richardson, Texas 75080

_____
Print Parent or Guardian's name (if applicable)

_____ _____
Signature of Patient, Parent or Legal Guardian Date

If you <u>DO NOT</u> want to be contacted about research, read below:

Initial here if you **<u>DO NOT</u>** want researchers to contact you for possible study participation. _____

Initial here if you **<u>DO NOT</u>** want to be included in the Callier Clinical Research Center Participant Registry. _____

(August 2021)

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

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 <u>do</u> <u>not</u> 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)

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 Name _____ Date of Birth _____ CCCD# _____

Print Parent or Guardian's name (if applicable) _____ Phone number _____

CONSENT FOR TELEHEALTH SERVICES

WHO WE ARE The Clinical Division of the Callier Center for Communication Disorders provides a variety of hearing, speech and language services. It is also a training location for professional education in audiology and speech-language pathology at The University of Texas at Dallas. Services are provided by licensed, certified clinicians in audiology and speech-language pathology with a master's or doctoral degree. All services provided by clinicians-in-training are provided under the supervision of a licensed, certified professional.

CONFIDENTIALITY Patients and their families are assured that their contact with professional clinical staff and clinicians-in-training will remain confidential. Information about evaluation, treatment and current communication will not be disclosed without written authorization, except under situations mandated by law. Please see the UT Dallas Callier Center Notice of Privacy Practices for more information.

CONSENT FOR TREATMENT By signing this form, I authorize my Callier Center provider(s) or his or her designee(s) to provide diagnosis and/or treatment to the patient listed above via telehealth. I understand that the security of electronic communication such as telehealth cannot be guaranteed.

I have read and understood the policies described above. I authorize the Clinical Division of the Callier Center for Communication Disorders to provide evaluation and treatment services via telehealth.

_____ _____
Signature of Patient, Parent or Personal Representative Date

_____ _____
Signature of Witness Date

(Revised 03/2020)