

CCCD#

CALLIER CENTER  
PATIENT INFORMATION SHEET

Today's Date \_\_\_\_\_

Preferred Clinic Location: ☐ Callier Dallas ☐ Callier Richardson☐ Check here if patient is a UT Dallas employee, 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	
County	Translator Required <input type="checkbox"/> YES	Sign Language <input type="checkbox"/> YES	Preferred Language	
Email Address (Please print)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Ethnicity <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Decline to Specify			Gender Identity (optional) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Race <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Other			<input type="checkbox"/> Transgender _____ <input type="checkbox"/> Decline to Answer	
Marital Status <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		Driver's License Number		Driver's License State

## EMERGENCY CONTACT INFORMATION

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 INFORMATION ☐ Check if patient is responsible party*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 <input type="checkbox"/> Check if same as patient			
City/State/Zip		Relationship to Patient	

<b>Please tell us how you heard about Callier Center:</b> <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> ENT <input type="checkbox"/> Internet <input type="checkbox"/> Social Media <input type="checkbox"/> Friend/Family <input type="checkbox"/> Other _____	<b>Is there someone we can thank for the referral.</b> _____
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------

**ADULT SPEECH-LANGUAGE CASE HISTORY**

Today's Date \_\_\_\_\_

**I. Patient Information**Name of Patient \_\_\_\_\_  
Last First MiddleDate of Birth \_\_\_\_\_ Age \_\_\_\_\_ ☐ Male ☐ Female

Street Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Person Completing this Form \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Who referred you to Callier? \_\_\_\_\_ Relationship \_\_\_\_\_

What services are you seeking? ☐ Hearing ☐ Speech-Language

What information would you like to gain from your visit? \_\_\_\_\_

Please provide an emergency contact who is not attending the patient's appointment:

Emergency Contact Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Who is **legally** in charge of medical decisions for the patient?☐ Patient ☐ Legal guardian: \_\_\_\_\_Do you have court documentation stating the legal guardianship? ☐ Yes ☐ No ☐ N/A**II. Languages**What is the patient's primary language? ☐ English ☐ Spanish ☐ Sign Language ☐ Other \_\_\_\_\_

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

**III. Main Concerns**

What are the main concerns? \_\_\_\_\_

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)? \_\_\_\_\_

**IV. Speech-Language Information**

Patient communicates using:

☐ Pointing ☐ Sign Language ☐ Sounds ☐ Short Phrases  
☐ Gestures ☐ Signs & Speech ☐ Single Words ☐ Sentences

Estimate the percentage that the following people understand the patient:

Family ☐ 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 \_\_\_\_\_

**V. General Development**

Describe any conditions or findings during pregnancy, delivery, and early milestones: \_\_\_\_\_

Development milestones: ☐ Normal ☐ Delayed

Describe any delays: \_\_\_\_\_

**VI. Medical Information**

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

Diagnosed by \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Contact Information \_\_\_\_\_

List any other physicians following the patient:

<u>Name</u>	<u>Specialty</u>	<u>Contact Information</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

List current medications:

<u>Name</u>	<u>Dosage</u>	<u>Reason for use</u>
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:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Ear injury	<input type="checkbox"/> Kidney/Bladder Disease	<input type="checkbox"/> Sleep problems
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Swallowing problems
<input type="checkbox"/> Cytomegalovirus (CMV)	<input type="checkbox"/> Head injury	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Tubes in ears
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> Vision problems
<input type="checkbox"/> Digestive problems	<input type="checkbox"/> High fever	<input type="checkbox"/> Sensitivity to sounds	<input type="checkbox"/> Weakness in arms,
<input type="checkbox"/> Dizziness/Balance problems	<input type="checkbox"/> HIV positive	<input type="checkbox"/> 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 ☐ NoUses corrective lenses or glasses? ☐ Yes ☐ No Is the patient legally blind? ☐ Yes ☐ No

**VII. Hearing Information**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 \_\_\_\_\_

**VIII. Family History**

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

<u>Relationship to Patient</u>	<u>Condition</u>
1. _____	_____
2. _____	_____
3. _____	_____

**IX. Educational and Work Information**

Highest level of education completed: \_\_\_\_\_

Is the patient currently enrolled in an educational program? ☐ Yes ☐ No

Is the patient currently employed?

If yes:

Company: \_\_\_\_\_ Employed since: \_\_\_\_\_

Job responsibilities: \_\_\_\_\_

**X. Therapies and Services**

List all previous and current therapies and services received. If the patient has received a therapy or service from more than one provider, please continue list of providers by "Additional".

<u>Provider</u>	<u># Visits/Month</u>	
<input type="checkbox"/> Applied Behavior Analysis (ABA) _____	_____	<input type="checkbox"/> Previous <input type="checkbox"/> Current
<input type="checkbox"/> Occupational Therapy _____	_____	<input type="checkbox"/> Previous <input type="checkbox"/> Current
<input type="checkbox"/> Physical Therapy _____	_____	<input type="checkbox"/> Previous <input type="checkbox"/> Current
<input type="checkbox"/> Counseling _____	_____	<input type="checkbox"/> Previous <input type="checkbox"/> Current
<input type="checkbox"/> Speech Therapy _____	_____	<input type="checkbox"/> Previous <input type="checkbox"/> Current
<input type="checkbox"/> Additional _____	_____	<input type="checkbox"/> Previous <input type="checkbox"/> Current

**XI. Additional Background Information**

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

<input type="checkbox"/> Change in residence, school, or job	<input type="checkbox"/> Death of a family member	<input type="checkbox"/> Financial stress
<input type="checkbox"/> Job related problems	<input type="checkbox"/> Legal problems	<input type="checkbox"/> Marital stress/tension
<input type="checkbox"/> Other _____		

**Thank you for taking the time to complete this form.**

**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 \_\_\_\_\_





**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)*

## 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](http://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



## 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 cancellation 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#

PLEASE READ CAREFULLY  
**AUTHORIZATION FORM**



CALLIER CENTER  
FOR COMMUNICATION DISORDERS

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



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](mailto: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 DO NOT want to be contacted about research, read below:**

Initial here if you **DO NOT** want researchers to contact you for possible study participation. \_\_\_\_\_

Initial here if you **DO NOT** want to be included in the Callier Clinical Research Center Participant Registry. \_\_\_\_\_

(August 2021)



## Speech-Language-Feeding Service Agreement

CCCD# \_\_\_\_\_

Thank you for choosing the **UT Dallas Callier Center for Communication Disorders**.

We appreciate your trust in our services!

Here's what you can expect when you or your child enroll:

- **Treatment Plan Goals Review:** Regular reviews of treatment plan goals will ensure progress. Adjustments to goals will be communicated as needed.
- **Punctuality:** We strive to start appointments on time. If rescheduling becomes necessary, the clinician will provide advanced notice.
- **Session Discussions:** At the end of each therapy session, the clinician(s) will briefly discuss the session with you. For more in-depth conversations or sensitive topics, separate appointments will be scheduled. Patient or parent conferences are available for a fee.
- **Payment Information:** You will be informed about session fees before scheduling therapy. If there are changes to our therapy fees, you will be notified at least one month in advance.
- **Phone or Electronic Communication:** Phone calls exceeding 10 minutes will be billed per 15 minutes. Replies to lengthy patient portal messages may also require phone contact and follow the same billing structure.
- **Group Therapy Enrollment:** If recommended, enrollment in a group therapy program is secured upon payment of a nonrefundable enrollment fee. Please note that this fee cannot be billed to insurance.

What we expect:

- **Arrival and Timing:** Punctuality is crucial. If you arrive more than 15 minutes late for a group session, your child may not be able to attend. Exceptions require prior approval from your clinician. For individual therapy, late arrival may prevent you or your child from being seen.
- **Payment and Credit Card:** Payment is due on the day of your appointment, including co-payments. A **credit card** must be on file for therapy services.
- **Attendance Requirements:** Maintain at least **80% attendance** for therapy appointments per month. Missing 2 consecutive sessions without canceling 24 hours in advance may result in dismissal from the therapy program.
- **Health Considerations:** If you or your child is **sick**, do not come to the Center. You must be **fever-free**, without vomiting or diarrhea for 24 hours (without medication) to attend appointments. If illness prevents attendance, contact the front office promptly.
- **Cancellation Policy:** Call the front office at least **24 hours before** your therapy session to cancel or reschedule. Failure to do so will result in billing for "no-shows." Insurance does not cover missed sessions.
- **Remaining at the Center:** We prefer that you (or a designated adult) **stay at the Callier Center** during your child's therapy. Exceptions can be made based on individual circumstances or

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certain group programs. If you leave your child at the Center during the session, be on time for pickup. Late pickup incurs a fee for every 5 minutes beyond the scheduled time. This fee is not billable to insurance and must be paid before the next session.

- **Home Practice:** Actively participating in home program assignments and completing homework activities is crucial. Consistent practice at home reinforces newly learned skills and promotes progress.
- **Equipment Maintenance:** If you or your child wear hearing aids, cochlear implants, or use Assistive Technology, please attend appointments with working equipment. Without functional devices, we cannot provide effective therapy services.
- **Communication and Updates:** Keep us informed about any significant events or changes in your life. Updates could be related to school, including progress, challenges, or adjustments; changes at home, such as family dynamics, routines, or stressors; developments at work that may impact therapy sessions; or any other relevant information affecting you or your child.

### Reasons for Dismissal:

The decision to dismiss a patient from therapy services includes consideration of several factors. These include:

- **Type of Speech-Language Impairment:** The clinician evaluates how the impairment affects the patient's functioning in their home, school, and community environments.
- **Progress and Skill Application:** If the patient has ceased making progress or cannot apply new skills outside the clinic, the clinician may transition to a consultative role. In such cases, the patient might benefit from a different therapy setting, such as school-based or home-based services.
- **Patient Participation:** If the patient is unwilling to continue working on improvements, the clinician may explore alternative service delivery options or discuss other potential services.
- **Attendance and Family Involvement:** Adherence to attendance rules and family involvement is crucial. Examples of concerns include not following through with home program activities, excessive absences, late cancellations, or repeated tardiness to therapy sessions.

Please feel free to discuss any questions about this information with your clinician. We value your thoughts about our services and welcome your comments and questions at any time.

**I have read and agree to abide by the expectations for therapy services. I understand the initial enrollment fee and re-enrollment fee are nonrefundable.**

Patient Name *(please print)* \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent / Legal Guardian Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Patient/ Parent/ Legal Guardian Signature \_\_\_\_\_ Signature Date \_\_\_\_\_



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)