_____
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** ☐ YES / **Sign Language** ☐ YES	**Preferred Language**	
Email Address (Please print)		**Gender** ☐ Male ☐ Female	
Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to Specify		**Gender Identity** *(optional)* ☐ Male ☐ Female ☐ Other ☐ Transgender _____ ☐ Decline to Answer	
Race ☐ 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 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 ☐ *Check if same as patient*				
City/State/Zip			Relationship to Patient	

Please tell us how you heard about Callier Center: ☐ Primary Care Provider ☐ ENT ☐ Internet ☐ Social Media ☐ Friend/Family ☐ Other _____	**Is there someone we can thank for the referral.** _____

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/Unmarried

List guardians living with patient:

1. Name_____Relationship to Patient_____Legal Guardian? ☐Yes ☐No

Age_____Education_____Type of Work_____

2. Name _____ Relationship to Patient_____Legal Guardian? ☐Yes ☐No

Age _____Education_____ Type of Work_____

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

Describe any concerns with child's speech, language, communication, hearing, and/or feeding: _____

_____

_____

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 _____

Describe any atypical conditions or findings during pregnancy, delivery, and the patient's stay in the hospital nursery (i.e., twin/multiple birth, jaundice, mechanical ventilation, antibiotics) ☐N/A _____

_____

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

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

Describe any concerns regarding gross motor, fine motor, and/or self-help skills (e.g., issues walking/running, sleeping, drinking, holding a spoon, toilet training, etc) ☐N/A _____

_____

VI. Medical Information

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

_____

Diagnosed by _____

Primary Care Physician/Pediatrician _____

List any other physicians following the patient:

	Name	Specialty
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Current Medication Name(s): Reason for use

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Other medical 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

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

Last hearing screening/test date _____ Screening/test results _____ Location _____

Age received Hearing Aid(s) _____

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) _____

_____

Patient communicates using: ☐Pointing ☐Sounds ☐Sign Language ☐Short Phrases ☐Gestures ☐Single Words ☐Signs & Speech ☐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 any behavior concerns (e.g., difficulty getting along with others, with sustaining attention, with following rules, regulating emotions, etc): _____

_____

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

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

Patient's school/daycare name: _____ District: _____ ☐N/A

Describe any academic concerns or difficulties with school work: _____

_____

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

XII. Therapies and Services

List any previous and current therapies:

	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
☐Feeding Therapy	_____	_____	☐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-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

CCCD#_____

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)