_____
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.** _____

CALLIER CENTER
FOR COMMUNICATION DISORDERS

THE UNIVERSITY OF TEXAS AT DALLAS

CASE HISTORY UPDATE

Date: _____ CCCD# _____

Patient Name: _____

Date of Birth: _____ Age: _____ Male / Female

Person completing this form: _____ Relationship to client: _____

Clinician's Name: _____

Medical History

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

_____

Physicians

Primary Care Physician	Provider Specialty	Telephone	Address

Other Physician/Service	Provider Specialty	Telephone	Address

Current Medications

Medication Name	Prescribed by:	For what purpose

Please describe benefits of these medications: _____

Please describe any side-effects: _____

Has your child had a hearing evaluation in the last year? Y/N Results? _____

Do you have any behavioral or developmental concerns? (e.g., toilet training, peer interactions, behavior problems, etc): _____

_____

Educational and Therapeutic History

Current Educational Services

School: _____ Grade: _____ Teacher: _____

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

Please list any educational/academic concerns: _____
_____

Current Therapy Services

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

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

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

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

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

If so, who provided this treatment? _____

When? _____ What was the purpose of the treatment? _____

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

(08/2014)

CALLIER CENTER
FOR COMMUNICATION DISORDERS

CALLIER CENTER DALLAS
1966 INWOOD ROAD
DALLAS, TEXAS 75235
972.883.3030

CALLIER CENTER RICHARDSON
2895 FACILITIES WAY
RICHARDSON, TEXAS 75080
972.883.3630

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

Patient's Name: _____ DOB_____ CCCD# _____

Please check one of the following:

☐ My child does not have any allergies.

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

Please list any allergies below and indicate if contact, inhalation, or ingestion:	**Reaction if exposed:**
1. _____	_____
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

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 _____

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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

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**_____