EASTERN KENTUCKY UNIVERSITY
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EKU Speech-Language-Hearing Clinic
Communication Disorders Program
Department of Special Education
College of Education
www.eku.edu

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Eastern Kentucky University Speech-Language-Hearing Clinic
POLICY ACKNOWLEDGEMENT and CONSENT FOR SERVICES
Services cannot be provided without written permission

Date:	
Client Name:	**Client's Date of Birth:**

Please read this form and submit to the clinic office associate. If you wish to have the information presented in an alternative format, please contact the clinic office for assistance. If you have any questions about this consent form, please speak with your treating clinician or contact the Clinic Director.

1. **Student Clinicians:** I understand and accept that services at the EKU Speech-Language-Hearing Clinic (EKU SLHC) are provided by student clinicians under the supervision of licensed and certified Speech-Language Pathologists and/or Audiologists.

2. **Observation:** I understand that EKU SLHC is a teaching and research facility. It is a condition of service that the client consent to observation by faculty, staff and students in the Communication Disorders Program or other College of Education students approved by the Clinic Director. All observers have signed professionalism and confidentiality statements and agree to comply with guidelines outlined in EKU SLHC policies and procedures.

   All children enrolled in therapy under the age of 18 must have a parent/legal guardian or other designated responsible adult remain in the EKU SLHC for the entire time of the therapy session. Consideration of others is requested in the observation areas; noises and lights (talking above a whisper, children playing, use of technology, etc.) are able to be heard and seen in the therapy rooms.

3. **Attendance:** I understand that attendance to each scheduled therapy session is expected. If an absence is expected, please make every effort to contact the EKU SLHC as soon as possible prior to the absence. The EKU SLHC will consider client discharge after three absences without prior notice or chronic inconsistent attendance. Arriving more than 5 minutes prior to scheduled appointments does not benefit you, as the clinicians may not be available to begin early. Sessions may be cancelled by the EKU SLHC if you arrive more than 15 minutes late for any scheduled appointment; please call the EKU SLHC if you are running late. When sessions begin later than scheduled, session length cannot be extended. Please plan to meet clinician(s) in the waiting area before sessions. Children should not be left unattended or unsupervised in the EKU SLHC waiting room.

   Sessions cancelled by the clinician will be offered to be made-up at a mutually agreeable time between the client, clinician, supervisor and EKU SLHC availability. Sessions cancelled or not-attended by the client will not be made-up.

   Clinic Closing due to University Closings: When classes at EKU have been cancelled or placed on a delay, clinic services will be canceled due to scheduling conflicts. Announcements will be made on local television and EKU website (eku.edu). We follow EKU main-campus cancellations only, not county/city school districts. Cancellations due to university closings will not be made-up.

4. **Payment:** I understand that payment for services is expected, each semester, prior to the initiation of treatment. Payment is non-refundable for university closing, delays or sessions cancelled/unattended by clients. Payment is non-refundable if the client is discharged mid-semester by the EKU SLHC, with exceptions granted by the Clinic Director.

5. **Confidentiality and Communication:** I understand that health records generated at the EKU SLHC contain my protected health information and every effort will be made to maintain the privacy and confidentiality of such information. The EKU SLHC is compelled to maintain privacy of health records by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. In communications, oral and written, with my clinician and supervisors, all efforts will be made to maintain confidentiality, including conversations regarding diagnosis and treatment. A private space is available for clinical discussions, upon request. Electronic medical records maintained by the EKU SLHC are maintained on a secure server. Paper records that contain identifying information are secured within the EKU SLHC. A copy of the EKU Notice of Privacy Practices has been provided for me, as well as posted within the EKU SLHC, and I have been informed of my rights regarding how the EKU SLHC may use and disclose my protected health information.

   Contact: I understand that I may be contacted by any phone number and/or email address that I provide to the EKU SLHC.

   Disclosure of Protected Health Information: My protected health information will not be disclosed outside of the EKU SLHC without my written consent.

6. **Release for Clinical Education Purposes:** I give permission to the Communication Disorders Program at Eastern Kentucky University to use information about the above named person for client therapy and clinical education purposes. Such information may include case histories, clinical records, test results, treatment outcomes, and audio/video/photographic or digital media. The information may be used for classroom teaching, clinical practicum meetings, and clinical observation.
   The following precautions will govern all such clinical records:

   - *All client identifying information will remain confidential.*
   - *All records are kept secured in the EKU Speech-Language-Hearing Clinic office*
   - *Any use of clinical records allowed by this release will meet guidelines of the Code of Ethics of the Kentucky Speech-Language-Hearing Association and the American Speech-Language-Hearing Association; Eastern Kentucky University Privacy Practices Guidelines; and the Federal Health Information Portability and Accountability Act (HIPAA);* Health Information Technology for Economic and Clinical Health (HITECH) Act.
   - *This release expires 10 years from the date of signature.*

My signature confirms that I am aware that my consent is given for EKU Speech-Language-Hearing Clinic students and faculty to provide services to_____ (name of client) and agree to adhere to the policies and procedures outlined in this document.

I have received a Notice of Privacy Practices from Eastern Kentucky University that informed me of my rights regarding how my health care provider may use and disclose my protected health information and Eastern Kentucky University's legal duties and privacy practices with respect to protected health information.

Signed: _____Date: _____
Signature of Client or Authorized Signature (if client is under 18 or had an appointed guardian for other reasons)

_____ _____
Name of individual signing form (please print) *Relationship to client; if signed by person other than client*