

Informed Consent for Treatment

Client _____ Date of Birth ____/____/____ Age _____

Address _____ Phone (____) _____

City _____ State _____ Zip _____

Authorizing Person _____ Relationship _____

Address (if different) _____ Phone (____) _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Other _____

Email Address _____

I, _____, authorize for _____
(Name of person granting authorization) (Name of client)

to receive from the students and faculty at the Ludden Speech and Language Clinic at Saint Xavier University diagnostic evaluations and/or therapy designed to evaluate and/or remediate communication deficits.

I understand that I may only sign for consent for treatment for myself or for a client under the age of 18 if I am that client's parent or legal guardian, and that upon granting this authorization, I am indicating my understanding of the following:

Treatment & Evaluation:

1. I understand that the therapy may be helpful in remediating a speech or language problem, but enrollment in a therapy program does not imply or guarantee that the client will acquire normal speech or language.
2. I understand that the Ludden Speech and Language Clinic is a training center for speech-language pathology students and a provider of clinical services to the community.
3. I understand that diagnostic and therapeutic procedures are performed by graduate and undergraduate students in training under the direct supervision of faculty certified by ASHA and licensed by the State of Illinois, and that students and faculty will have access to all information concerning the client.
4. I understand that a "clinical hour" is fifty-five (55) minutes in length and a "clinical half-hour" is twenty-five (25) minutes in length.

Client/Parent/Guardian's Initials

5. I understand that clients must receive a diagnostic evaluation at the Ludden Clinic prior to receiving services and a re-evaluation on a yearly basis according to the recommendations of the clinical supervisor and the Clinic Director.
6. I understand that clients must provide all previous speech and language evaluations completed within the last year at other facilities (e.g., school IEP's, private clinical evaluations, early intervention evaluations, hospital evaluations) with the application.
7. I understand that applicants will be assigned to a specific speech and language clinic within the Ludden Clinic based on information provided on the client intake form, information from previous reports and evaluations, and the primary speech/language/hearing diagnosis assigned at the evaluation in the Ludden Clinic.

Specialty Clinics will include:

- Speech Sound Disorders
- Early Language Delays
- Developmental Language Disorders
- Social Language Disorders
- AAC (Augmentative and Alternative Communication)
- Voice and Resonance
- Fluency/Stuttering
- Adolescent/Young Adult Speech and Language Disorders
- Acquired Neurogenic Disorders
- Hearing and Processing Impairments
- Accent Modification
- Adults with Intellectual and Communication Disabilities

I understand that there will be a limited number of available spots in each specialty clinic. Once the specialty clinic is filled, new applicants will be placed on a waiting list until further openings in that clinic occur.

8. I understand that, as the clinic functions in its role as a training center for student clinicians, the client may be observed by other students in training, by prospective students, by University faculty involved in the education of students, and/or by any persons connected to clinical operations including quality assurance, accreditation, certification, licensing, and or credentialing.
9. I understand that all written information created or maintained by the Ludden Speech and Language Clinic will be kept in a confidential file in a locked file room and on a secured electronic server. This information includes clinical logs, clinical summary reports, and diagnostic evaluation reports as well as any additional information provided by the client/parent/legal guardian.
10. I understand that diagnostic and therapy sessions may be video and/or audio recorded for educational purposes and/or research purposes.

Client/Parent/Guardian's Initials

11. I understand that I (as client/parent/legal guardian) must sign a written Release of Information Form in order for the Ludden Speech and Language Clinic to share the client's health information, including speech and language information, with other medical providers who work on the client's behalf (e.g., physicians, therapists, service coordinators, medical equipment companies, etc.).

Attendance:

12. I understand that upon enrolling for treatment I am committing to client attendance at assigned sessions for the entire 12-week semester under reasonable circumstances. **Clients missing three unexcused sessions in one semester may be dismissed and will not be eligible for continued services.**
13. I understand that if I need to cancel, a telephone call to the Ludden Speech and Language Clinic must be made prior to the scheduled time. Upon accumulation of **three** unexcused absences, a client may be considered for termination of services. An unexcused absence is one not canceled at least one hour prior to the appointment time. The contact number is 773-298-3561. Messages may be left by voicemail.
14. I understand that the client must be on time for all sessions. Clients who arrive 15 or more minutes late three times in one semester may be dismissed and will not be eligible for continued services.
15. I understand that clients, caregivers, and accompanying family members, shall not appear for scheduled sessions when they have a temperature above normal or other symptomatic illnesses. Clients/parents/guardians are expected to notify the Clinic at least one hour prior to the scheduled session each day that the client will be absent.
16. I understand that if the client/family cancels a clinical session for any reason, the session will not be re-scheduled. If the session is cancelled by the Ludden Speech and Language Clinic, it will be re-scheduled.
17. We reserve the right to terminate services. I understand that the Ludden Speech and Language Clinic is a speech and language clinic only, and that other services such as co-treatment, occupational therapy, physical therapy, psychological services, etc., are not available. If the client requires comprehensive services, another treatment facility may be more appropriate and he or she may be advised to pursue services elsewhere.

Observation (Parents/Legal Guardians Only)

18. I understand that, as a parent or legal guardian, I am expected to observe the majority of the diagnostic and/or therapy sessions and to interact with the supervisor and student clinician relative to assisting the clinical process.
19. I understand that, as a parent or guardian, I will not leave the building during the time that my child is in a session if that child is under the age of 16.

Client/Parent/Guardian's Initials

- 20. I further understand that there may be some occasions when students may be observing sessions for educational purposes. I acknowledge that overcrowding of the observation rooms may interfere with client performance. In those instances, students will have priority over family members for observing sessions as determined by the clinical supervisor.
- 21. I understand that only adults 16 years of age or older are permitted in the observation or treatment rooms. Family members (children) may be present in the Clinic's waiting areas with direct adult supervision only.

I have read and/or had the above information explained to me, and I fully understand this information.

(Signature of Person Completing Form)

(Date)
