



LUDDEN SPEECH AND LANGUAGE CLINIC AT SXU INTAKE & CONSENT

CLIENT FIRST NAME		MIDDLE INITIAL	PREFERRED NAME
CLIENT LAST NAME			
PERMANENT STREET ADDRESS			
CITY		STATE	ZIP CODE
DATE OF BIRTH			
GENDER	CELL PHONE	CAN WE LEAVE A MESSAGE? Yes or No	Preferred Method of Contact (check one please)
			Phone Call <input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/>
Athorizing Person (if not self)			Relationship
Address (if different)			Phone (if different)
EMAIL ADDRESS			
EMERGENCY CONTACT NAME & RELATIONSHIP			EMERGENCY CONTACT NUMBER
Consent for Treatment or Participation in a Support Group	INITIAL _____	I request and consent to receive evaluation, treatment, and/or support at Ludden Clinic to provide care to me/my child as prescribed by a physician and/or recommended by a Speech-Language Pathologist. I also consent and authorize Ludden Clinic to administer treatment under the direction and supervision of a certified Speech-Language Pathologist when required.	
Policy and Procedure Acknowledgement	INITIAL _____	In consideration for the professional services rendered to me or my child, by Ludden Clinic, I acknowledge receipt of and agree with Ludden Clinic Office Policies outlined in the Client Handbook.	
Privacy policy	INITIAL _____	Ludden Clinic is required by law to keep your health information safe. This information may include notes from your doctor, teacher, or other health care providers; your medical history; your test results; and treatment notes. Ludden Clinic is required by law to give you a copy of our privacy notice. This notice explains how your health information is used and/or shared. It also explains you how you can obtain your information and comment on it.	
Consent for Teletherapy	(check one please) <input type="checkbox"/> ACCEPT or <input type="checkbox"/> DECLINE	I understand that I/my child may benefit from teletherapy, but that results cannot be guaranteed or assured. I have the right to withhold or withdraw my consent to teletherapy, in writing, at any time without affecting my right to future care or treatment.	
Permission to observe therapy and diagnostic sessions	INITIAL _____	The clinic functions as a training center for student clinicians. Clients may be observed by other students in training, prospective students, department faculty, and/or by any person connected to clinical operations including quality assurance, accreditation, certification, licensing, and or credentialing.	
Permission to audio and/or video record	INITIAL _____	Consent to video/audio for each client is required to receive services. Recordings are only used for research and/or educational purposes, such as lectures, workshops and in-services. No client identifying information (e.g. last name, address or birthdate) will be included in presentations. Recordings are identified by first name/age only.	

FOR MINOR CLIENTS ONLY

The following adult(s) over the age of 18 years may bring or pick up my child for therapy and/or diagnostic sessions, observe sessions, and receive information about the session, including homework.

1. _____
Name _____ **Relationship to Client** _____

2. _____
Name _____ **Relationship to Client** _____

INDIVIDUAL COMPLETING THIS FORM (PRINT NAME OR WRITE *SELF*): _____

SIGNATURE OF CLIENT (OR GUARDIAN IF <18 YEARS OLD): _____

IF GUARDIAN, RELATIONSHIP TO CLIENT: _____

DATE COMPLETED: _____