MONMOUTH UNIVERSITY | SPEECH-LANGUAGE PATHOLOGY

ADULT CASE HISTORY FORM

Name:_____ Date of Birth:_____

Address:_____

City:_____State:_____Zip:_____

Client Email: _____ Caregiver email: _____

Home Phone:_____ Cell Phone:_____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name:_____

Names of Children & Ages:_____

Who lives in the home:_____

Primary language spoken:_____

Additional languages spoken:_____

Employer:_____

Job Title/Occupation:_____

Are you still employed?_____ Do you intend on returning to work? _____

What is the highest/grade/diploma/degree you earned:

_____

What social activities do you engage in? Hobbies?

_____

_____

_____

Describe your speech/language problems:

_____

_____

_____

_____

_____

What do you think is the cause/reason for the problem:

_____

_____

_____

Has the problem changed since it was first noticed:

_____

_____

_____

Have you seen any other speech-language specialists? If so, who/when? What were their conclusions or suggestions?

_____

_____

_____

_____

Have you been treated by a specialized physician/psychologist/neurologist, etc? If yes, indicate the type of specialist, when you were seen, and the doctor's recommendations:

_____

_____

_____

_____

_____

Do you have any eating/swallowing difficulties?:_____

Have you had a Modified Barium Swallow Study (MBS)?_____

If so, where?_____

Have you had any major surgeries/hospitalizations? If so, when/where for what procedure

_____

_____

_____

_____

What are your personal goals? (e.g., improve naming ability, increase conversational skills, increase memory, and learn organizational strategies). Provide any additional information that might be helpful in the evaluation or recommendation process.

_____

_____

_____

_____

List any medications you are taking.

_____

_____

Are you having any negative reactions to these medications? If yes, describe.

_____

Person completing form: _____

Relationship to client: _____

Signed: _____ Date: _____

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Authorization for Release of Information

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

1. I hereby request and authorize Monmouth University to release information from the evaluations in the area of speech, language and other related areas of:

   Name: _____

   Street Address: _____

   City, State, Zip: _____

   I understand that this authorization includes permission to release information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV).

2. The requested information is to be sent to (name of doctor, hospital, person or organization where records should be sent):

   Name: _____

   Address: _____

3. The information to be released is and the records to-be sent include (please provide dates of treatment and specific records):

   _____

   _____

4. Purpose/reason for release of records:

   Medicare ☐ Insurance ☐ Legal Matters ☐ Marketing ☐ Fundraising ☐

   Other (explain) _____

5. I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has already been made prior to receipt of the revocation.
6. I understand that the client's treatment is not conditioned on obtaining this authorization.
7. I understand that this authorization is specific for release only to the above party and expires (90) days following the date of signature.
8. I understand that information used or disclosed may no longer be protected by the federal privacy laws.
9. If the requested information involves mental health Information, I acknowledge that I am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed psychologist and that release of such information may waive this privilege.

Signature of Client: _____ Date: _____

Printed Name of Client: _____

If client is under 18 years of age or unable to sign on his/her own behalf:

Signature of Parent/Guardian/Caregiver: _____ Date: _____

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INFORMED CONSENT FORM

Client/Patient Name: _____

Parent/Guardian Name: _____

This is to certify that I give my consent for the above-named client to receive speech-language services from a student (or students) from Monmouth University who is (are) authorized by the clinical staff to administer services under the direct supervision of a member of the Speech-Language Pathology faculty. As part of the clinical program, a hearing screening, as well as other types of diagnostic testing, may be administered by student clinicians.

In consideration of allowing the client to participate in the clinical program, I hereby assume all risks and responsibilities surrounding his/her participation in the clinical program. I, on behalf of myself, my personal-representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend and indemnify Monmouth University, their respective officers, directors, agents and employees from any and all liabilities, claims, actions or demands for damages, including reasonable costs and attorney's fees, for personal injury, disability, death, property loss or damage, wrongful death, loss of services or other loss of any kind that I or the client sustain as a result of the client's participation in the clinical program, from any cause whatsoever, except to the extent that such loss or damage is caused solely or in part by the gross negligence or intentional acts of Monmouth University, its employees or agents.

Signature: _____

Relationship to the client: _____

Address: _____

_____

Date: _____

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INFORMED CONSENT-TELETHERAPY

Client/Patient Name: _____

This document is an addendum to the Department of Speech-Language Pathology's Consent for speech therapy services. This form covers the use of telehealth/teletherapy services.

Teletherapy is an option for conducting remote sessions over the internet where you will be able to speak to and see your therapist(s) on a screen. Teletherapy means the use of interactive audio, video, or other telecommunications or electronic media by a therapist to deliver services. teletherapy does not include an audio-only conversation between the therapist and the client, an electronic email message between the therapist and the client, or a text message or other type of message sent between the therapist and the client.

Should the University experience disruption of services-as-usual at the university due to COVID- 19 closures, the Department of Speech-Language Pathology will do our best to continue offering teletherapy services. The decision to offer teletherapy services will be made by your therapist(s) and their supervisor, based on client's needs, and will be reevaluated as necessary. In situations in which the therapist(s) and their supervisor determine that teletherapy is not recommended, your therapist(s) will assist you in identifying appropriate alternative services, including in-person options. At the time of your teletherapy session(s), you or your therapist will be located in the State of New Jersey.

At the Department of Speech-Language Pathology, we use Zoom for Healthcare, a secure video- conferencing platform approved by Monmouth University. In keeping with privacy laws and regulations that apply to the Department of Speech-Language Pathology, your therapist will continue to follow the Department of Speech-Language Pathology's procedures for record- keeping and all records will be discarded as required by applicable law. Monmouth University is a teaching and research facility; any clinical sessions that are typically recorded will continue to be digitally recorded and/or observed by Department of Speech-Language Pathology personnel.

In case teletherapy becomes an option of service for you, your therapist(s) will give you detailed directions regarding how to log in securely and proceed. The Department of Speech- Language Pathology strongly suggests that you only communicate through

a computer or device that you know is safe *(e.g.,* has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). Your therapist(s) will be using secure electronic medium in a private location.

You understand that the implementation of teletherapy is innovative at the University, as such, the Department of Speech-Language Pathology may experience some challenges. Although teletherapy offers the advantage of continuation of care when in-person services are not possible, there could be some limitations to teletherapy including but not limited to technological failure and miscommunication. Your therapist will provide you instructions on how to proceed in each of those Situations and will discuss such instructions with you. You are responsible for securing privacy in terms of the location where you will connect to the session. In case of an emergency, please go to the nearest hospital or dial 911.

You will not be charged any late or cancellation fees if cancelling due to illness.

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INFORMED CONSENT FOR TELETHERAPY SIGNATURE PAGE

If possible, you should sign the attached consent form and (1) use a smartphone app to scan the document, or (2) use your cell phone or digital camera to take a photo or your signed consent form and return the signed form to the Department of Speech-Language Pathology. You may also digitally sign the consent form using a program like Adobe Acrobat.

If you do not have access to a smartphone, digital camera, or scanning device, and you consent to teletherapy, please reply to this email with the following: "By replying to this email, I [insert your name] am affirmatively consenting to teletherapy services and I agree to sign and return a physical or digital copy of this consent for to the Department of Speech-Language Pathology as soon as I am able to do so."

By signing my name and inserting the date, I acknowledge and agree that I am submitting an electronic signature indicating that I have read and agree to accept all of the terms and conditions set forth in this Informed Consent Form. I further acknowledge and agree that a facsimile copy, PDF or photocopy of my signature hereto shall be valid and shall have the full force and effect as an original. I understand and agree that it is recommended that I print a copy of this Form and If I do not wish to submit an electronic signature, I may request that a paper copy be provided to me for my signature.

I,_____, consent to teletherapy sessions.

_____ _____
Client/Caregiver Signature* Date

_____ _____
Practitioner Signature Date

_____ _____
Supervisor Signature Date

*This consent may be signed in several counterparts and all counterparts, combined, shall constitute a valid consent even though all parties have not signed the same counterpart.

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PHOTO/VIDEO CONSENT AND RELEASE FORM

I,_____, do hereby give Monmouth University the right to record and use in perpetuity my name, likeness, voice and statements/quotations in connection with my participation in_____. I also give Monmouth University the right to use such recordings as a resource for University and archival purposes. I understand and agree that the University shall be entitled to use my picture, statements, or quotations as stated above subsequent to my participation in _____ and that my picture, statements or quotations may be used in print, electronic and/or digital form in a published book or otherwise.

I understand and agree that this release includes, without limitation, the right to use, reproduce, exhibit, distribute, publish and broadcast worldwide, in full or in edited version, such images and information in Monmouth University's newsletters, on the Monmouth University website, on internet sites and in social media, including, but not limited to YouTube, Apple iTunes U, and in public relations/promotional materials such as marketing and admissions publications, advertisements, fundraising materials and any other Monmouth University-related publications for any purpose that Monmouth University and those acting pursuant to its authority deem appropriate. Such images and information may appear in any of the wide variety of formats and media now available and that may be available in the future, including but not limited to all mediums, including without limitation the following: electronic/online media (for example, websites and electronic mailings); radio; television (local, public, cable, satellite, and/or digital TV); video (DVD); print media (lyrics); and successor technologies (any other media, method, system, form or manner now or hereafter known invented or used). I understand and agree that all such recordings, in whatever medium, shall remain the property of Monmouth University. I understand and agree that I shall not be entitled to any compensation of any nature, monetary or otherwise, from Monmouth University in return for allowing this use.

I release Monmouth University and those acting pursuant to their authority from liability for any violation of any personal or proprietary right I may have in connection with such use.

I certify that I have carefully read and fully understand this Consent and Release form before signing it, and I represent that I am voluntarily signing this Form.

By signing my name and inserting the date, I acknowledge and agree that I am submitting an electronic signature indicating that I have read and agree to accept all of the terms and conditions set forth in this Consent and Release Form. I further acknowledge and agree that a facsimile copy, PDF or photocopy of my signature hereto shall be valid and shall have the full force and effect as an original. I understand and agree that it is recommended that I print a copy of this Consent and Release Form for my file. If I do not wish to submit an electronic signature, I may request that a paper copy be provided to me for my signature.

Signature:_____
Printed Name: _____
Date:_____
Signature of Parent/Guardian:_____
(if Participant is under 18 years of age)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice please contact
Robyn Salvo, Director of Human Resources, by calling 732-263-5228 or by email at rsalvo@monmouth.edu

This Notice of Privacy Practices describes how Monmouth University may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" (or PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, future physical or mental health or condition and related health services.

Monmouth University is required to abide by the terms of the Notice of Privacy Practices. Monmouth University may change the terms of this notice, at any time. This new notice will be effective for all protected health information that we maintain at that time. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF HEALTH INFORMATION:

Treatment: Information about you may be used by the personnel (including Monmouth University students in the field of speech-language pathology) who are associated with Monmouth University for diagnosis, treatment planning, and treatment. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or client's legal guardian or personal representative. It is the policy of Monmouth University to release private health information only to clients or the parents/guardians of clients if clients are minors. In rare cases, should Monmouth University need to send information to another professional, a signed Release of Information form is required.

Payment: Monmouth University does not bill directly to insurance companies. There is a registration fee of $295.00 per semester.

Monmouth University will communicate with you only in ways you have provided on the Contact Information form you completed prior to starting therapy. It is the client's responsibility to update contact information with Monmouth University.

OTHER DISCLOSURES:

Monmouth University may use or disclose your protected health information in some situations without your authorization or providing you the opportunity to agree or object. Some of these situations will include:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Disease: **We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.**

Health Oversight: **We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee health care systems, government benefit programs, other government regulatory programs and civil rights laws.**

Abuse or Neglect: **We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.**

Food and Drug Administration: **We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance as required.**

Legal Proceedings: **We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.**

Law Enforcement: **We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as result of criminal conduct, (5) in the event that a crime a occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.**

Research: **We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.**

Criminal Activity: **Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.**

YOUR RIGHTS:

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. Under federal law, however, you may not inspect or copy records related to information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. Depending on the circumstances, a decision to deny access may be reviewable.

You have the right to revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You have the right to request that information about you be communicated by other means or to another location.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

COMPLAINTS:

If you believe your rights have been violated by Monmouth University, please bring the problem to the University's attention as soon as possible. You can do this by contacting the Director of Human Resources, Robyn Salvo, at 732-263-5228 or by email at rsalvo@monmouth.edu. Your concerns will be addressed in a timely manner. If you are not satisfied with the manner in which the University handles a complaint, you should submit a formal complaint to the Office of Civil Rights:

Attn: Director
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

This notice was published and becomes effective on the date on which it was signed. It will remain in effect for two years from this date.

_____ _____
Signature of Parent/Guardian/Caregiver or Client if Client is 18 years of age Date

_____
Printed Name of Parent/Guardian/Caregiver or Client if Client is 18 years of age