

Dear Prospective UMD Teen PEERS® Parents:

Thank you for your request to be a part of our University of Maryland Teen PEERS® program at the Department of Hearing and Speech Clinic. Before we can schedule an appointment, we request that the enclosed case history questionnaire and consent-to-participate form be completed and returned to us.

If applicable, we would also appreciate it if you would sign the request for authorization for release of information, mail it to any speech-language pathologist or physician you may have seen within the last 6-12 months, and have them mail us the result of any diagnostic test. If you have a copy of a relevant report, enclose it with the completed forms.

Upon receiving this information, we will send you an acknowledgment email. Please be aware that we may schedule a brief screening and interview to help us put you in the social skills group that best fits your interests and needs. We look forward to meeting you. If you have any questions, please feel free to contact me at (301) 405-4218.

Sincerely,

Kay Lopez
HESP Clinic Coordinator

Speech and Hearing Clinic
Department of Hearing and Speech Sciences
University of Maryland
0110 Lefrak Hall
College Park, Maryland 20742
(301) 405-4218

UMD PEER® Teen Case History Form

Please answer the following questions as best you can and mail the form to the address at the top of this page. If there are some questions you can not answer, leave them blank. Your answers will help us provide you with the best and most efficient evaluation and/or treatment.

General Information

Parent Name _____

Teen Name _____ DOB: _____ Age _____

Address: _____ Sex _____

City _____ State _____ Zip _____

Home Phone _____ Parent Work Phone _____ Cell Phone _____

Email Address _____ May we contact the parent at work? Yes No

What year are you at in school? (Please circle one)

Freshman Sophomore Junior Senior

School _____

Insurance:

We do not participate with any insurer (including Medicaid and Medicare).

Therefore, payment is due at the beginning of the program. Some insurance plans may reimburse for our speech-language pathology services and, as a courtesy, we can provide a summary of the individual and group sessions you attended. We cannot guarantee that you are eligible for coverage or reimbursement from them. Please contact your insurance company to verify benefits and reimbursement rates.

Employer (if applicable) _____

Name of person completing form _____ Relationship _____

Referred by _____

Race of Client* _____

0 = Not Reported

1 = American Indian/Alaska Native

2 = Black/African American

3 = Asian/Pacific Islander

4 = Hispanic

5 = White/Caucasian

* This information is requested because the University is a public teaching institution and will be used solely for the purpose of describing caseload diversity. Your response will not affect consideration of your application.

Educational History

Highest level of education achieved _____ Primary Language _____

Other languages spoken _____

Does your teen have any reading and/or learning difficulties? Yes No

If yes, please describe _____

Present Communication and Social History

As complete as possible describe your teen's communication strengths and difficulties _____

Is it difficult for your teen to navigate social situations/relationships? Please explain.

How has the problem changed through the years?

How do communication difficulties affect your teen? _____

Your family? _____

Socially? _____

Educationally? _____

Have you sought help for difficulties with social interactions elsewhere? Yes No
Where?

Please explain what worked and did not work

Please list the names of other clinics or agencies where you have been seen for evaluation or treatment of your communication problem.

Name	Location	Dates	Outcome
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1.

2.

3.

Name of Physician (if applicable) _____

Location _____ Phone _____

Do you have any other significant medical problems? Yes No

Describe _____

Describe _____

List of medications you are currently taking.

Please provide any additional information that might be helpful in our placing you in the most appropriate social interaction group.



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Consent Form

The Department of Hearing and Speech Sciences at the University of Maryland has three purposes: to train speech-language pathologists and audiologists, to render services to clients, and to conduct research in hearing, speech, and language. In order to meet these purposes, any of the following diagnostic, therapeutic, teaching, and/or research procedures may be used by authorized personnel within the department: direct observation, audio taping, video taping, photography, and review of client records. For research purposes, clients may be asked to participate in research projects conducted by authorized personnel. Client participation in any **research** project is strictly voluntary, and refusal to participate will in no way affect clinical services rendered to the client.

I consent to the participation of _____ in the clinical services of
Name of Client
the Department of Hearing and Speech Sciences at the University of Maryland.

In addition, I give permission for recordings (audio, video, photographic, transcripts, etc.) of clinical services to be permanently stored for review by authorized students and faculty of the Dept. of Hearing and Speech Sciences for the purposes of instruction/training for students and professionals in the discipline.

I grant this consent with the understanding that any use of privileged information, other than to meet the department's stated purposes, will not be undertaken without further written consent.

Signature: _____ Date: _____

Print Name: _____

Address: _____

Relationship to Patient: _____

The University of Maryland complies with all applicable federal, state, and local laws, including, but not limited to, the Americans with Disabilities Act of 1990, the Civil rights Act of 1964, the Equal Pay Act, the Age Discrimination in Employment Act, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 (to the Higher Education Act of 1965), the Rehabilitation Act of 1973, the Vietnam-era Veterans Readjustment Assistance Act 1974, and all amendments to the foregoing.



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Authorization for Release of Records from the University of Maryland

Patient Name: _____ DOB: _____

I hereby consent to the release of any and all hearing, language, and speech records for the individual named above to:

Name / Agency: _____

Address: _____

Name / Agency: _____

Address: _____

This information pertains to assessment and treatment by the Speech and Hearing Clinic, University of Maryland, College Park.

Signature: _____ Date: _____

Name: _____

Relationship To Patient _____

Witness: _____

FOR CLINIC USE ONLY – REPORTS TO BE MAILED

Report(s) Reports(s) Date Supv. Sig. Sent Sec

University of Maryland Speech and Hearing Clinic
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**Authorization for Release of Information
from Agency or Physician
to the University of Maryland**

Patient Name: _____ DOB: _____

Agency or Physician: _____

Address of Agency or Physician: _____

The above named person has requested the services of the University of Maryland Speech and Hearing Clinic. We understand that this individual was seen at your facility. Kindly forward any hearing, language, speech, medical, psychological, educational, or social information regarding the above named individual.

Please send your reply to the attention of Kay Lopez, Clinic Coordinator, University of Maryland Speech and Hearing Clinic, College Park, MD 20742.

Thank you for your prompt cooperation.

Date: _____

This will certify that you have my permission to release information concerning the individual named above to the University of Maryland Speech and Hearing Clinic.

Signature: _____

Name: _____

Address: _____

Relationship

To Patient: _____

BILLING POLICY

A **telephone or In-person** intake interview will be scheduled at a mutually-agreed upon time for a 30-minute time slot prior to the beginning of the UMD PEERS® teen program. **Full payment of \$1400 (if the \$300 deposit was provided by the student, then \$1100 will be due at the time of the start of the program) for the UMD PEERS® teen program is due at the time of the first group session unless specific alternate arrangements are made with the clinic coordinator or clinic director.**

Cancellations: Any sessions cancelled by parents (whether for vacation or illness) or social coaches are not subtracted from the fees. Attempts will be made to arrange make-up sessions at times mutually convenient to both the student and social coach.

Insurance: **Our clinic does not participate with any insurance plan (including Medicaid and Medicare).**

We encourage parents to investigate the possibility of insurance coverage for speech-language services. However, please note that parents are responsible for paying their bill according to the terms of their payment agreement contract and then requesting reimbursement from their insurance provider. Parents should request that their insurance company reimburse them directly. We cannot guarantee that any of our services are eligible for coverage and reimbursement from your insurance plan. If the insurance company sends a direct payment to the clinic, we will return it to the insurance company to be re-issued, to refund the client.

POLICY STATEMENT

The purposes of the University of Maryland Speech and Hearing Clinic are:

1. To provide a training facility for those students seeking to become certified speech pathologists and audiologists.
2. To provide an environment for research.
3. To provide speech and hearing services to the public.

All communication coaches conducting clinical sessions are supervised by Speech-Language Pathologist(s) licensed by the State of Maryland and certified by the American Speech and Hearing Association. The clinic operates by appointment only, and follows the academic calendar of the University of Maryland.

Since we have a commitment to provide varied experiences for students, acceptance into UMD PEERS® Teen program is of a selective nature and cannot be guaranteed for the selected semester. If accepted into the program, the teen & parent are expected to maintain regular and punctual attendance. If frequent absence or tardiness occurs, we reserve the right to dismiss the teen & parent from our program. If a group session is canceled due to clinic emergencies, every effort will be made to try to make up the group session at the end of the semester.

We trust that the above policy statements will contribute toward a smooth running, pleasant experience for all those who participate in the UMD PEERS® teen program at the University of Maryland Speech and Hearing Clinic.