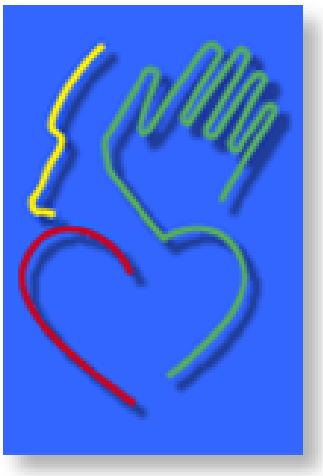
# CALIFORNIA STATE UNIVERSITY LOS ANGELES

## The Robert L. Douglass Speech and Language Clinic



Department of
Communication Disorders

**Our goal is to serve individuals with communication disorders in the most effective and humane manner possible.**

At the Robert L. Douglass Speech-Language Clinic we provide a full range of diagnostic and therapeutic services in a university environment. Our clients include adults, preschoolers, and school-age children with a variety of communication disorders. We do not discriminate on the basis of race, color, national origin, disability, sex, gender, or sexual orientation.

The Clinic is part of a graduate degree program that is accredited by the Council on Academic Accreditation (CAA). As such, we maintain high standards in the provision of comprehensive assessment and intervention services.

### Clinical Philosophy

The Department of Communication Disorders here at Cal State LA embraces a philosophy of clinical service delivery that is consistent with the ethical standards, scope of practice, and current standards of practice of the American Speech-Language-Hearing Association (ASHA). Our goal is to serve individuals with communication disorders in the most effective and humane manner possible, and to ensure that our students commit themselves to this fundamental clinical value. In training our students we emphasize the importance of holding paramount the well-being of clients as well as their families and caregivers. The importance of involving families and caregivers in all aspects of the therapeutic process is also stressed.

### Services Offered

We provide services for both children and adults with speech sound, language, cognitive, voice, fluency, and hearing disorders.

### The Staff

All services are provided by graduate clinicians who are supervised by faculty and clinic staff members holding California licensure and ASHA's certificate of clinical competence.

### Fees

The Clinic offers fees that are based on a sliding scale depending on income and number of dependents. Individual insurance policies may cover part of the cost of assessment and intervention, and we are happy to assist clients in processing the necessary paperwork. Free, convenient parking is provided.

For More Information – To receive additional information or to inquire about the services offered, please call (323) 343-4690. The Clinic is open from 9am to 6pm Monday Through Thursday, and 9am to 12 Noon on Friday. The Clinic is located in the basement level of King Hall on the inner campus of Cal State LA adjacent to Parking Lot 8 on Circle Drive.

**CALIFORNIA STATE UNIVERSITY, LOS ANGELES**

Department of Communication Disorders
5151 State University Drive
Los Angeles, CA 90032
(323) 343-4754 or 343-4690

*Confidential*

DATE: _____

**THE ROBERT L. DOUGLASS SPEECH-LANGUAGE CLINIC**

CASE HISTORY FORM – ADULT

Client: _____ Sex: M ____ F ____

Date of Birth: _____ Age: _____ Marital Status: M ___ S ___ D ___ W ___

Place of Birth:_____

Home Address: _____ _____ _____
Number/Street City Zip

Home Phone Number:( ) _____

Work Phone Number: ( ) _____

Cell Phone Number: ( ) _____

If you check your email daily and it is OK for us to contact you this way, fill in your address below:

_____

Name of person completing this form if other than the client: _____

Relationship to client:_____

Name of person who referred you to this clinic: _____

Professional position:_____

**PRIMARY CONTACT PERSON(S) (if not the client)**

1. Name: _____

   Relationship to client:_____

   Cell phone number: (_____)_____ Work phone number: (_____)_____

   If you check your email daily and it is OK for us to contact you this way, fill in your address below:

   _____

2. Name: _____

   Relationship to client:_____

   Cell phone number: (_____)_____ Work phone number: (_____)_____

   If you check your email daily and it is OK for us to contact you this way, fill in your address below:

   _____

**REFERRAL INFORMATION**

State the client's reasons for consulting the Speech-Language Clinic. Include a description of the client's communicative and/or cognitive (e.g., memory, attention, concentration) difficulties with as much detail as possible.

_____

_____

_____

_____

_____

_____

Has the client had previous speech, language, hearing, or vision testing? Yes ___ No ___

If yes, describe (include where, when, and diagnosis): _____

_____

_____

Has the client had previous speech, language, hearing, or vision therapy? Yes ___ No ___

If yes, describe (include where and when): _____

_____

_____

**LANGUAGE PROFICIENCY**

Primary Language of Client: _____

Other Language(s) Spoken:

_____ Level of Proficiency: _____

_____ Level of Proficiency: _____

_____ Level of Proficiency: _____

**HOME INFORMATION**

List all persons currently living in the client's home:

| Name | Relationship to Client | Age | Gender |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**EDUCATION/OCCUPATION**

Highest grade completed: _____

Are you currently attending college? Yes ___ No ___

If yes, where? _____

What is your current occupation? _____

Name of Employer: _____

If currently unemployed or retired, what was your previous occupation?

_____

**MEDICAL/HEALTH INFORMATION/HISTORY**

Name of Physician: _____ Phone Number: ( ) _____

Address: _____ _____ _____
Number/Street City Zip

List operations and serious illnesses and injuries. Give dates and length of disability.

| Illness, Injury or Operation | Date | Description |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Does the client currently have a physical disability? Yes ___ No ___

If yes, describe (e.g., use of a wheelchair, cane, etc.): _____

_____

Is the client under any medication at present time? Yes ___ No ___

If yes, what medication(s) (include dosage and frequency)? _____

_____

_____

Note: Please include/attach most recent relevant medical report(s), if applicable.

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Los Angeles, CA 90032-8170
(323) 343-4754 or (323) 343-4690

*FINANCIAL WORKSHEET*

Client's Name: _____ Date: _____

Person(s) financially responsible:_____

Address: _____
Number/Street City State Zip Code

Phone number: (____)_____ Relationship to client: _____

Clinic fees are $120 for a diagnostic evaluation and $840 for treatment (14 week semester).

- ☐ I request a reduction in fees (complete reverse side of form, sign and return)
- ☐ I will pay full fees for services (sign form and return)

_____ _____
Signature of Person Financially Responsible Date

**SPEECH-LANGUAGE CLINIC USE ONLY:**

Fee set by: _____

Diagnostic Fee: $_____ (Per Session)

Therapy Fee: $_____ (Per Semester)

PLEASE COMPLETE THE FOLLOWING FINANCIAL INFORMATION
(if requesting a reduction in fees)

Employment Information of Person Financially Responsible:

Employed by: _____

Address: _____
Number/Street City State Zip Code

Phone number: (____)_____ **Monthly Salary**: $_____

Employment Information of Another Person Who Contributes to Household Income:

Employed by: _____

Address: _____
Number/Street City State Zip Code

Phone number: (____)_____ **Monthly Salary**: $_____

Source of Other Household Income: _____

**Amount (Monthly)**: $_____

**TOTAL YEARLY INCOME**: $_____

Number of persons dependent on this income: _____

Other information relevant to fee reduction (loans, credit card debt, balance due to doctors and other clinics/hospitals, etc.):

_____

_____

_____

_____

_____

_____

I hereby affirm that each of the answers in the foregoing application are true and correct and authorize you to obtain information from any source(s) to which you may apply relative to this application.

_____ _____
Signature of Person Financially Responsible Date

**CALIFORNIA STATE UNIVERSITY, LOS ANGELES**
**ROBERT L. DOUGLASS SPEECH AND LANGUAGE CLINIC**

# PRIVACY NOTICE AND CONSENT FORM

The Robert L. Douglass Speech and Language Clinic is a training service agency. Our services to clients are provided by students who are supervised by faculty members. In order to provide this supervision and promote student learning through observation, our clinic rooms have special equipment – one-way observation windows, TV monitors, and audio and/or video recording devices. Occasionally a video or audiotape will be saved beyond the time of direct services because it is considered a good example for training purposes. These tapes are subject to all the confidential restrictions mentioned below.

Keeping client information confidential and secure, and using it only as our clients would want us to, is a top priority for all of us at the Robert L. Douglass Speech and Language Clinic. Here, then, is our promise to our clients and their families:

1. We will safeguard, according to strict standards of confidentiality and security, any information that clients share with us. What is discussed as part of the therapy process is confidential unless and until you give consent to its release.
2. We will permit only authorized employees, students, and instructional staff who are trained in the proper handling of client information to have access to that information.
3. We will not reveal client information to any external organization unless we have previously informed the client in disclosures or agreements, have been authorized by the client to share the information, or are required by law to reveal that information.
4. We will always maintain control over the confidentiality of our client information.

In short, any personal information that we collect about you or your family will be protected by physical, electronic, and procedural safeguards that meet or exceed applicable law. Finally, information obtained from clients may be used for research purposes. If this occurs, information will be handled professionally, treated confidentially, and any identifying information about the client is removed.

***I have read the above policy statements and agree to these conditions.***

| | |
|---|---|
| _____ | _____ |
| Signature of Client | Signature of Parent or Legal Guardian |
| _____ | _____ |
| Print Client's Name | Date |