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.
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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Client</th>
<th>Age</th>
<th>Gender</th>
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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.

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<tr>
<th>Illness, Injury or Operation</th>
<th>Date</th>
<th>Description</th>
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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.
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
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