OUR LADY OF THE LAKE UNIVERSITY
Woolfolk School of Communication Sciences and Disorders

HARRY JERISG CENTER, 411 S.W.24TH Street, San Antonio, Texas, 78207, Phone: 210.431.3938

Thank you for contacting the Harry Jersig Center regarding speech/language services and we hope to have the opportunity to address your child's communication needs. Please understand that this is a teaching clinic (Communication Sciences and Disorders) which requires that clients be admitted based upon the clinical experiences needed by our graduate students. Completion of the intake form will allow us to determine if/when your child will receive services in our clinic.

Completion of this form is the first step in the admittance process. You will be notified of your application status and further requirements via e-mail and/or phone.

Fees for Services.
Currently, there is no fee for services, however donations are welcome to help the clinic maintain materials, and clinic upkeep for client services.

Student involvement.
As part of the Woolfolk School of Communication Sciences and Disorders at Our Lady of the Lake University, the Harry Jersig Center is a training facility for graduate students studying to be speech pathologist. Therefore, most of our services are provided by university students under the supervision of state licensed and nationally certified speech-language pathologists. We operate on a university calendar, and services are provided on a semester basis, i.e. Fall (Sept-Dec), Spring (Jan-May), Summer (JunJul).

Admission Process.
After completing this intake for evaluations or treatment, please follow the procedures listed below:

1. Bring, mail, e-mail or fax the completed packet to the Harry Jersig Center at Our Lady of the Lake University.
    - E-mail: jersigcenter@ollusa.edu
    - Fax: 210.434.9360
2. If you are interested in services, you will be contacted to set up an appointment time.
3. If you have more questions about our services, please contact Rosa Lydia Martinez (Clinic Director at ext.6590).

Please note that admission is dependent on availability of appointment times.

We hope this information will be of use to you, and that you feel free to call us if you have any further questions.

Sincerely,

Rosa Lydia Martinez, M.S., CCC-SLP

Rosa Lydia Martinez

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Pediatric Intake Form

Please fill out this form as completely as possible, especially the items marked with an asterisk. If you need more space, attach another page, or write on the back. Call 431-3938 if you have additional questions regarding these forms.

Date Intake Completed: _____

Child's Name: _____

Date of Birth:_____ **Age:**_____ **Grade:**_____ **Gender:**_____

Guardian(s):_____ **Relationship:**_____

Cell Phone:_____ **E-mail:**_____

Referred By: _____

Pediatrician:_____ **Phone Number:**_____

Which of the following services are you requesting?

DIAGNOSTIC SERVICES	Please check services that apply	TREATMENT SERVICES	Please check services that apply
Speech-Language Evaluation	☐	Speech-Language Therapy	☐
HEARING EVALUATION	☐	Individual therapy	☐
HEARING AID EVALUATION	☐	Early intervention group	☐
SWALLOWING EVALUATION	☐	Aural rehabilitation	☐
VOICE EVALUATION	☐	Other:	

Please provide doctor's written referral if needed.

What are your expectations from this appointment?

☐ Speech-Language developmental level

☐ Recommendations for things I can do at home

☐ Enrollment in therapy or classes

☐ Other (Please explain below)

_____

_____

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Does your child have:

- ☐ Difficulty being understood
- ☐ Difficulty producing some speech sounds
- ☐ Difficulty understanding what is said
- ☐ Difficulty expressing wants, needs, thoughts, and/or
- ☐ ideas Academic difficulties/concerns
- ☐ Difficulty producing smooth and connected speech
- ☐ Hearing difficulties/concerns
- ☐ Difficulty feeding and/or swallowing
- ☐ Difficulty with behavior and/or self-regulation at home or school
- ☐ Difficulty with attention, memory, organization, task completion, and/or planning
- ☐ Difficulty interacting socially with others
- ☐ A need to use technology and/or AAC device to communicate

How did you become aware of the Harry Jersig Center?

- ☐ ENT
- ☐ Internet
- ☐ Teacher
- ☐ Pediatrician
- ☐ Friend
- ☐ Neurologist
- ☐ Speech-Language Pathologist
- ☐ Other (Please specify below)

_____

_____

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History of Problem

Describe present problem:_____

Who noted present problem:_____ **When?**_____

What is your child's reaction to the problem?

_____

_____

How does the family react to the problem?

_____

_____

Has there been any significant change in the last six months?_____

If so, what? _____

How well is your child understood by: (i.e., what percentage of the time)

Mom:_____ **Dad:**_____ **Younger siblings:**_____ **Older Siblings:**_____

Other children:_____ **Extended Family:**_____ **Unfamiliar Adults:**_____

Describe what it is like to have a conversation with your child:

_____

_____

Any previous assessments? ◯ **Yes** ◯ **No** **Where?**_____ **By whom?**_____

What kind? _____

What were the results?

_____

_____

Which tests were given? _____

Any previous therapy? ☐ **Yes** ☐ **No** **Where?**_____

With whom? _____

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Birth History

What was the length of the pregnancy? _____

Were there any illnesses or accidents during pregnancy? (Explain)

_____

_____

Were drugs or alcohol used during pregnancy? (aspirin and/or medication) ☐ **Yes** ☐ **No**

If so, what? _____

What was the length of labor? _____

Any difficulties at birth, including Caesarian? (describe):

_____

_____

Were drugs used?_____ **Instruments?**_____ **Bruises to head?**_____

What was the mother's age: _____

Mother's health at time of pregnancy and birth was? _____

What was the final Apgar Score? _____

Any jaundice? ☐**Yes** ☐**No** **Cyanosis?** ☐ **Yes** ☐ **No** **Rh incompatibility factors?** ☐**Yes** ☐**No**

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Medical History

***Please check if your child has had any of the following (and if so, at what age):**

☐ Seizures	☐ High Fevers	☐ Measles	☐ Mumps
☐ Chicken Pox	☐ Whooping Cough	☐ Diphtheria	☐ Bronchitis
☐ Pneumonia	☐ Tonsillitis	☐ Meningitis	☐ Encephalitis
☐ Rheumatic Fever	☐ Tuberculosis	☐ Sinusitis	☐ Chronic Cold
☐ Enlarged Glands	☐ Thyroid	☐ Asthma	☐ Heart Trouble
☐ Chronic Laryngitis	☐ Diabetes	☐ Head Injuries	

Please explain any checked items here:

_____

_____

Are immunizations current? ☐ **Yes** ☐ **No**

Current general health? _____

Has your child had any earaches/ear infections? ☐ **Yes** ☐ **No**

Please explain here: _____

Allergies? (Describe) _____

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Any other serious or recurrent illness? ☐ Y ☐ N **When?**_____

Any operations? ☐ Y ☐ N **When?**_____

Any accidents? ☐ Y ☐ N **When?**_____

Any medication? (Past)_____**(Current)** _____

Hearing difficulties?_____**Treatment:** _____

Vision problems?_____**Treatment:** _____

Dental problems?_____**Treatment:** _____

Other Medical History:

_____

_____

****** If your child has had chronic ear infections and/or had tubes placed in his or her ears, please attach or have a statement sent from you doctor regarding dates and results of treatment.***

Personal Medical Information

Personal Primary Physician: _____

Date of last visit: _____

Address or Location: _____

Ongoing Medical Care (Describe):

_____

_____

City of ongoing care:_____**Physician's Name:** _____

Current Medications:_____

Dosage: _____

Chronic Health Problems: _____

Handicaps: _____

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Developmental History

Age when child: (If you can't remember a specific time, please indicate if it occurred at the expected time or was delayed)

Sat up alone:_____Crawled:_____Walked:_____Toilet Trained: _____

Dressed Self:_____Tied Shoes:_____Fed Self Independently: _____

Is the child left or right-handed? _____

Attention span for self-directed activities:

Does your child respond to:

Light?_____Sound?_____People? _____

Does your child:

Play with others?_____Who? _____

Eat and sleep well?_____Smile?_____Cry appropriately?_____Laugh? _____

Make wants known?_____How? _____

Does your child show unusual behavior (explain)?

_____

_____

_____

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Speech and Language

Language(s) spoken in the home: _____

Age when your child spoke first word:_____ **Combined words:** _____

Spoke in sentences:_____

What was your child's first word(s)?_____ **First sentence?** _____

Which sounds (if any) are incorrect? _____

How many words can your child say? (list if fewer than fifteen)

_____

_____

How long are your child's sentences? _____

Does your child have any difficulty understanding you?

_____

_____

Does your child have difficulty following directions?

_____

_____

Any speech or hearing problems in the immediate or extended family? (explain)

_____

_____

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Social Development

Names and ages of siblings: _____

Other adults living in the home: _____

Moves prior to age 10: _____

Has your child attended day care?_____**Nursery School?**_____**Ages:** _____

Number of regular playmates: _____

Activities shared with parents/siblings: _____

How does your child handled:

Conflict? _____

Separation? _____

Regular Responsibilities? _____

What are your child favorite:

Places? _____

Toys?_____

Snacks? _____

Activities? _____

TV Program? _____

What motivates your child most?_____

What discipline methods work best?_____

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School History

School Experience: _____

How does your child's teacher describe his/her performance?

_____

_____

Has the teacher expressed any concern? If so, what?

_____

_____

Other

What are your expectations for this evaluation?

_____

_____

_____

Does the report need to be sent to specific agencies? _____

If so, where? _____

Anything else you would like us to know?

_____

_____

_____

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Client Contract for Services

I _____, have been accepted to participate in therapy sessions at the Harry Jersig Center clinic. I understand that if I do not comply with the following requirements listed there is a possibility that my sessions at the Harry Jersig Center maybe terminated for this semester and will need to be placed on the waitlist to continue services.

As a condition of my participation in the sessions at the Harry Jersig Center clinic, I agree to accept the following:

Session Requirements:

1. To give advanced notice, 24 hours' notice, if I must cancel an appointment.
2. To arrive on time for all my appointments.
3. To sign in at the reception window before each visit.
4. If I am tardy to a session, I understand that no extension will be given and my session will end at the regularly scheduled time.
5. If I am tardy and/or absent for more than 3 sessions, my enrollment will be evaluated and I may lose my appointment time, be placed on the waitlist, and services will be scheduled on the basis of the client selection process.
6. If at the end of the semester I have been present for less than 75% of the sessions, my treatment will be suspended for the following semester and will be placed back on the waitlist and selected based on the client selection process.

Parental/ Guardian Responsibility:

1. I will remain at the clinic while the child or adult I brought to the clinic is participating in an evaluation or therapy session.
2. I will supervise any additional children I bring to clinic.
3. I will understand that clinic is a part of a training program and that should a student not be available to provide that clinical services that the sessions may be reassigned to a different day or semester or referred out to a speech-language pathologist in the community.
4. I understand that all cellphone use must be conducted outside and cellphones must be on silent while in the clinic.

By signing and dating this agreement in the spaces provided below, I certify that I have read and understand the requirements to which I am subject during my participation as a client at the Harry Jersig center.

Client/Parent/Guardian Signature:_____

Date:_____

Client
Name:_____

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ATTENTION

In an effort to serve more individuals in need within our community, reduce wait-time for services, and enhance the educational opportunities for our students, the Jersig Center has implemented an application based client selection process.

Selection will be based on student training considerations in combination with client need. A limited number of pediatric and adult clients will be selected to participate in one of our short-term intervention programs. Intervention programs will run concurrent with OLLU's fall and spring academic semesters. Client applications will be accepted throughout the year and reviewed each semester to fill program openings. Once selected for a program, a client may qualify to receive up to four semesters of intervention prior to discharge**.** Consideration for discharge may include: meeting treatment goals, plateau of progress toward goals, and/or non-compliance of Client Contract for Services. **Clients may re-apply following discharge, with the understanding that our waiting list typically exceeds the number of available program openings.**

The Jersig Center will continue to offer services at no cost to clients. Donations of any amount are appreciated, tax-deductible, and help support our tradition of making quality care accessible to all in our community.

For more information on how to donate to the Harry Jersig Center or the client selection process, please contact the Main Office.

Client/Parent/Guardian Signature:_____ Date:_____

Client Name:_____

OUR LADY OF THE LAKE UNIVERSITY
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AUTHORIZATION OF RECORDING DURING TREATMENT OR ASSESSMENT

1. I hereby authorize the agents of the Harry Jersig Communication Disorders Program, exercising duediscretion, to use the following items (circled) of either myself or my child, for whom I am legally responsible.

   A. Make audio recordings of sessions. ☐ Yes ☐ No

   Make video recordings of sessions. ☐ Yes ☐ No

   Take photographs during sessions. ☐ Yes ☐ No

2. I authorize that you use these not only as a record of the session, but also for the following:

   A. For clinical purposes (e.g., verification of data collected) ☐ Yes ☐ No

   For educational observations (e.g., classroom demonstration) ☐ Yes ☐ No

   For professional research. ☐ Yes ☐ No

   For public meetings (e.g., high school career day programs, science fairs, club meetings or booth displays, HJC website, etc.) ☐ Yes ☐ No

   For purposes of public relations or news media (e.g., newspapers Website, newsletter, television, information brochures) ☐ Yes ☐ No

   Authorize live observations of sessions by students in the Communication Disorders Program at OLLU. ☐ Yes ☐ No

   To ALL of the above. ☐ Yes ☐ No

Signature of client, parent and/or guardian: _____

Relationship to client: _____

Release date authorized from:

☐ Start date of therapy and after the end date of therapy for reasons circled above

_____Start date of therapy to end date of therapy for reasons circled above

Client's name: _____

Date of Birth: _____

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CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize Harry Jersig Center at the Our Lady of the Lake University to release/request thefollowing information from the health record(s) of:

Patient Name:_____DOB:_____

Address:_____

City, State, & Zip Code: _____

Under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 {45 CFR &164.508}.

1. I authorize Harry Jersig Center, Our Lady of the Lake, to request copies of the followingtypes of records from:

   _____

   _____

   ☐ Complete health records

   ☐ Speech and Language evaluations

   ☐ Audiological and/or Ontological records

   ☐ Observation of child in classroom

   ☐ Educational records, including achievement test scores, individual Academic/Psychometric Evaluations, Psychological Evaluation, ARD/IEP

2. I authorize the Harry Jerisg Center at Our Lady of the Lake University to release the following type(s) of records to:_____

   ☐ Speech and Language records

   ☐ Audiological records

I understand this consent can be revoked, in writing, at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. Specification ofthe date, event, or condition upon which is consent expires _____

The facility, its employees and officers are released from legal responsibility or liability for therelease of the above information to the extent indicated and authorized herein.

_____

Signature (Self/Parent/Guardian)

Please Print Name: _____

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Client Pick-up Authorization Form

In an effort to continue to make Harry Jersig Center a secure and protected facility for our clients, we are asking that you let us know who has your permission to pick up your child from therapy. Please let these individuals know that they may be asked to show photo identification if a staff member is unfamiliar with them. Anyone coming to pick up your child who is not on the list will not be allowed to leave with your child unless we have received a prior notification from you.

I, _____(the natural parent or legal guardian) hereby give my permission and consent for my child, _____, to be picked up from the Harry Jersig Center/OLLU Campus by the following persons:

Name	**Relation**	**Contact Phone Number**
_____	_____	_____
_____	_____	_____

_____	_____	_____
Parents/Guardians Signature	Contact Phone Number	Date

OUR LADY OF THE LAKE UNIVERSITY
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Authorization Form

Consent to Appointment Reminders and Other Healthcare Communications via Email, Text Usage, and Phone.

Patients/Clients in our practice may be contacted via phone, email, and/text messaging* to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted. If this contact is to be made by phone, and I am not at home, a message will be left on my voicemail or with anyone who answers the phone. I consent to receiving appointment reminders and other healthcare communications/information via phone, at the email or text address provided from the Harry Jersig Center.

_____ (Patient/Client/Guardian initials) I consent to receive phone calls, email, text messages from the Harry Jersig Center at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The **cell phone number** (if different than Client Information Form) that I authorize to receive text messages* for appointment reminders, feedback, and general health reminders/information is_____.

The **email** (if different than Client Information Form) that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

**The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).*

_____ I **do not** consent to future communications via email and/or text. I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email/ text messages.

Consent for Photographing or Other Recording for Educational Purposes and/or Health Care Operations:

____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for the Harry Jersig Center's health care operations and educational purposes (e.g., quality improvement activities, research, classroom demonstrations). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations/educational purposes or otherwise permitted or required by law.

____ (Patient Initials) I **DO NOT** consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for the Harry Jersig Center's health care operations and educational purposes (e.g., quality improvement activities, research, classroom demonstrations).

HIPAA-Patient Acknowledgement of Receipt of Notice of Privacy Practices
The undersigned acknowledges receipt of a copy of the currently effective **Notice of Privacy Practices** for this facility. This Notice describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of health care operations. This form will be filed in the client's file.

*In signing this sheet, I acknowledge that I have received a copy of the **Notice of Privacy Practices** dispensed by the Harry Jersig Center.*

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Accident/Incident/Emergency Procedures
As per University policy, the Harry Jersig Center follows certain procedures for all incidences, accidents, and emergencies that take place on University property. It is important that you are aware of such procedures for future reference. The Harry Jersig Center staff, clinicians, and faculty are all First Aid and CPR certified and will follow the protocols outlined below.

Accident/Incident:
In the event of an accident or incident we are required to report it to the Campus Police Department and keep a record of the event for our office records even if it was a minor issue.
The Campus Police Department will send officers to document and report the incident/accident and ask for identification of the parent or guardian.
A copy of the HJC office's report will be given to the parent/guardian and another copy will be placed in the client's file.
If it is an emergency, EMS will be dispatched prior to contacting the Campus Police Department at the expense of the client (parent/guardian). Only in extreme circumstances or it is deemed necessary by the Campus Police Department, no other outside police force will be contacted.

Emergencies:
In the event of an emergency, OLLU Campus Police Officers are designated "first responders" for the University Community and will be contacted in ALL crisis situations. They will make the determination as to whether additional assistance is needed. In extreme emergencies where it is obvious that EMS or Fire Department assistance is necessary, staff may call 911 to report the situation, followed immediately by a call to Campus Police. The Harry Jersig Center's highest priority is to first evaluate and respond to the emergency and ensure the immediate safety of the client; and then to notify parents/guardians if the individual emergency dictates.

THE FACILITY, ITS EMPLOYEES, AND OFFICERS ARE RELEASED FROM LEGAL RESPONSIBILITY OR LIABILITY FOR THE RELEASE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN. BY SIGNING BELOW, YOU CERTIFY THAT YOU HAVE READ THIS AGREEMENT, KNOW AND UNDERSTAND THE MEANING AND INTENT OF THIS AGREEMENT, AND THAT YOU ARE ENTERING THIS AGREEMENT KNOWINGLY AND VOLUNTARILY.

Patient Name (Printed)

_____

Patient Representative/Guardian (Printed):

_____

Patient/Patient Representative Signature

_____ Date: _____

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HARRY JERISG CENTER, 411 S.W.24TH Street, San Antonio, Texas, 78207, Phone: 210.431.3938

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.

Each time you visit our center, a record of your visit is made. This record typically contains symptoms, evaluation results, diagnosis, treatment information and plans for further treatment. This information is commonly referred to as a health or medical record and serves as:

- **A basis for planning treatment**
- **A means of communication among health care professionals contributing to your care**
- **A legal document describing care received**
- **A means to verify that services were provided**
- **A source of data for research**
- **A source of information for public health officials**
- **A tool with which we can assess and work to improve the care we render**

Your Rights

Although your health record is the physical property of our center, the information belongs to you. You have the right to:

- **Request a restriction on certain uses and disclosures of information. The Harry Jersig Center is not required to agree to a restriction, except in limited circumstances**
- **Receive a paper copy of this notice, upon request and at any time**
- **Inspect and obtain a copy of the health records**
- **Amend the health record if the client believes it is incorrect or incomplete. Our center is not required to agree this correction, however if denied, the client will be provided with further information in writing within 60 days**
- **Request confidential communications; this includes by alternative means or at alternative locations and the clinic must accommodate reasonable requests**
- **Authorize use or disclosure of any protected health information**
- **Revoke authorization to use or disclose health information except to the extent that action has already been taken**

Your Choices

For certain health information, you have a right to preferences about how information is shared. Your choices are:

- **Share information with those involved in your care: If you are unable to communicate preferences, we may share information if we believe it is in your best interest**
- **Share information in a disaster relief situation**
- **Include your information in a hospital directory**
- **Share information (with written permission) for marketing or fundraising purposes**

Our Uses and Disclosures

The following areas describe the ways The Harry Jersig Center may use or disclose health information. Not every use or disclosure in the respective areas will be listed; however, all the ways The Harry Jersig Center is permitted to use and disclose information will fall within one of these areas.
We will use health information for:

- **Treatment**
- **Research**
- **Observation**
- **Classroom disclosures**
- **Public health risks and safety issues**
- **Bill for your services**
- **Comply with the law**

Our Responsibility

The Harry Jersig Center is required to:

- **Maintain the privacy of your health information as required by law**
- **Provide a Notice of our legal duties and privacy practice with respect to information we collect and maintain**
- **Abide by the terms of this Notice**
- **Provide information if we are unable to agree to a requested restriction**
- **Accommodate reasonable requests you may have in regard to confidential communications**