Saint Xavier UNIVERSITY
Ludden Speech and Language Clinic

LUDDEN SPEECH AND LANGUAGE CLINIC AT SXU INTAKE & CONSENT

CLIENT FIRST NAME			MIDDLE INITIAL		PREFERRED NAME
CLIENT LAST NAME					
PERMANENT STREET ADDRESS					
CITY		STATE		ZIP CODE	DATE OF BIRTH
GENDER	CELL PHONE	CAN WE LEAVE A MESSAGE? Yes ❑ No ❑	Preferred Method of Contact (check one please) Phone Call ❑ Email ❑ Text ❑		
Authorizing Person (if not self)			Relationship		
Address (if different)			Phone (if different)		
EMAIL ADDRESS					
EMERGENCY CONTACT NAME & RELATIONSHIP			EMERGENCY CONTACT NUMBER		

Consent for Treatment or Participation in a Support Group	**INITIAL** ________	I request and consent to receive evaluation, treatment, and/or support at Ludden Clinic to provide care to me/my child as prescribed by a physician and/ or recommended by a Speech-Language Pathologist. I also consent and authorize Ludden Clinic to administer treatment under the direction and supervision of a certified Speech-Language Pathologist when required.
Policy and Procedure Acknowledgement	**INITIAL** ________	In consideration for the professional services rendered to me or my child, by Ludden Clinic, I acknowledge receipt of and agree to follow Ludden Clinic Office Policies outlined in the Client Handbook.
Privacy policy	**INITIAL** ________	Ludden Clinic is required by law to keep your health information safe. This information may include notes from your doctor, teacher, or other health care providers; your medical history; your test results; and treatment notes. Ludden Clinic is required by law to give you a copy of our privacy notice. This notice explains how your health information is used and/or shared. It also explains you how you can obtain your information and comment on it.
Consent for Teletherapy	**(check one please)** ❑ **ACCEPT or** ❑ **DECLINE**	I understand that I/my child may benefit from teletherapy, but that results cannot be guaranteed or assured. I have the right to withhold or withdraw my consent to teletherapy, in writing, at any time without affecting my right to future care or treatment.
Permission to observe therapy and diagnostic sessions	**INITIAL** ________	The clinic functions as a training center for student clinicians. Clients may be observed by other students in training, prospective students, department faculty, and/or by any person connected to clinical operations including quality assurance, accreditation, certification, licensing, and or credentialing.
Permission to audio and/ or video record	**INITIAL** ________	Consent to video/audio for each client is required to receive services. Recordings are only used for research and/or educational purposes, such as lectures, workshops and in-services. No client identifying information (e.g. last name, address or birthdate) will be included in presentations. Recordings are identified by first name/age only.

FOR MINOR CLIENTS ONLY

The following adult(s) over the age of 18 years may bring or pick up my child for therapy and/or diagnostic sessions, observe sessions, and receive information about the session, including homework.

1. ______________________________ ______________________________
Name **Relationship to Client**

2. ______________________________ ______________________________
Name **Relationship to Client**

INDIVIDUAL COMPLETING THIS FORM (PRINT NAME OR WRITE *SELF*): ______________________

SIGNATURE OF CLIENT (OR GUARDIAN IF <18 YEARS OLD): ______________________

IF GUARDIAN, RELATIONSHIP TO CLIENT: ______________________

DATE COMPLETED:______________________