Dear Sir/Madam:

Thank you for your interest in choosing Alabama A&M University, *Communicative Sciences and Disorders Clinic* for speech-language services. We are conveniently located on Alabama A&M University’s main campus in Carver Complex North, room 104. Attached is the *New Client Manual* which has a number of important forms that need to be filled out in preparation for the evaluation process. Please complete the forms and send to:

Alabama A&M University  
Attn: Esther Phillips-Ross  
Communicative Sciences and Disorders  
PO BOX 357  
Normal, AL  35762  
esther.phillips@aamu.edu  
256-372-4055 (fax)

These forms must be returned as soon as possible due to the current waiting list. You may also bring the forms with you to the appointed time for services. If you have further questions regarding this matter, please feel free to contact me via my direct line-372-4044.

Sincerely,

*Esther Phillips-Ross*

Esther Phillips-Ross MA,CCC/SLP/L  
Director of Clinical Services  
Communicative Sciences and Disorders Clinic  
Alabama A&M University
ALABAMA A & M UNIVERSITY
Communicative Sciences & Disorders Clinic
(Carver Complex North 104)

NEW CLIENT HANDBOOK

2012-2013

We are proud to be an ASHA-Accredited Program!

We are accredited by the Council for Academic Accreditation (CAA) in Audiology and Speech-Language Pathology of the American Speech-Language-Hearing Association (ASHA).

To Contact ASHA:
2200 Research Boulevard
Rockville, MD 20850

1-800-498-2071 or http://www.asha.org
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<tr>
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<td>6</td>
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CLINICAL FACULTY/STAFF

Michele Brown, AAMU CSD Secretary
372-5541

Esther Phillips-Ross, Assistant Professor, Director of Clinical Services
M.A., CCC-SLP/L
372-4044

Cynthia Lewis, Assistant Professor, Clinical Supervisor
M.S., CCC-SLP/L

Jennifer Vinson, Professor, Program Director
Ed.D., CCC-SLP/L
372-4035

Hope Reed, Associate Professor, Orofacial Myologist
CCC-SLP-D
372-4036

Carol Deakin, Associate Professor, Clinical Supervisor, TBI Specialist
Ph.D, CCC-SLP/L
372-4043

Barbara Bush, Associate Professor, Audiologist
Au.D,CCC-A
372-4038

STATEMENT OF PURPOSE

Alabama A&M Communicative Sciences and Disorders Clinic is a training clinic. Our clinic provides hands-on training for our students as they progress through our program, learning to apply information gained in the classroom. All students are supervised by ASHA-certified faculty. As our student clinicians develop clinical skills, they are placed in a position to serve the speech-, language-, and hearing needs of individuals in our community and enhance the effectiveness and quality of communication.

SHARED COMMITMENTS

We will . . .

1. Prepare quality professionals who will be employed in both the public and private sectors (e.g., hospitals, schools, nursing homes) emphasizing transdisciplinary experiences with physicians, nurses, social workers, case managers, teachers, psychologists, and other specialists in health care fields,

2. Provide quality speech-, language-, and hearing clinical services to clients at Alabama A & M University and its surrounding communities,

3. Disseminate information regarding speech, language, and hearing behaviors through research and collaborative scholarly activities (e.g., presentations, consultations, and publications), and

4. Provide community service programs focusing on awareness, education, and prevention of speech-, language-, and hearing disorders.
CLINICAL SERVICES

Clinical services are provided by both undergraduate and graduate students in the Communicative Sciences and Disorders program while being supervised by nationally certified clinical faculty. (i.e., faculty who hold the Certificate of Clinical Competency from ASHA).

Specific services offered by the Alabama A & M University Communicative Sciences and Disorders Clinic include the diagnostic evaluation and remediation/treatment of speech-, language-, and hearing disorders. Prior to enrollment in any of the therapy programs, a current speech and language evaluation must be completed, as well as a hearing screening. Some voice clients may be required to present a physician’s written referral. If a prior evaluation has been completed by another speech-language pathologist/audiologist, the client or guardian may request that the evaluation records be released to us. However, an evaluation will be administered to all new and returning clients. In addition, each client, (or guardian), must complete and sign the appropriate forms, which include:

1. Case history form,
2. Fee payment contract,
3. Authorization for video/audio taping, and student observations and chart review for educational purposes,
4. Authorization for release of information TO another agency or physician (if applicable), and
5. Authorization for release of information FROM another agency or physician (if applicable).

Therapy will not be initiated until these forms have been completed. These forms can be located on-line under “client forms and manuals”, at http://www.aamu.edu/csd/csdclinic.aspx and in appendix A of this document.

EVALUATION

The evaluation of the client’s communication skills addresses . . .

1. The ability to understand and produce language,
2. The ability to produce speech sounds,
3. Voice characteristics,
4. Speech fluency,
5. Oral-motor structures and functions, and
6. Auditory (hearing) skills.

Following the evaluation, recommendations may include enrollment for therapy, referral to another professional agency, or a re-evaluation at a later date.
SERVICE PROVISION POLICIES

Services are provided to clients of all ages. No client will be refused services on the basis of race, gender, ethnic origin, or religion. This policy is in compliance with Title VI of the Civil Rights Act of 1964 and other current regulations that safeguard against discrimination. The Alabama A & M University Communicative Sciences and Disorders Clinic reserves the right to refuse services to clients who may be considered inappropriate candidates in this clinical setting.

The Alabama A & M University Communicative Sciences and Disorders Clinic serves the educational and training needs of students. In order for the student clinicians to better understand the nature of a client’s communication disorder, audiotapes and/or digital tapings may be made. These media are considered confidential and are solely for the purpose of education. They will be used only by student clinicians, clinical faculty, and clients. The client or guardian must sign an Authorization for video/audio taping for educational purposes form to allow these services to be performed. Occasionally, clients may be requested to participate in ongoing research. Such participation is formally requested, and proceeds only with the client's or guardian’s consent.

CONFERENCES

Conferences with the family will be scheduled periodically. These conferences usually take place at the beginning and end of the semester. However, a client or family may request a conference at any time by contacting the client’s faculty clinical supervisor.

PERIODIC RE-EVALUATIONS

Periodic re-evaluations will be performed throughout the therapy process to continually assess speech-, language-, and hearing skills. This allows for assessment of progress and the planning and development of future therapy goals.

OBSERVATION

Observation of diagnostic and therapy procedures is available to the client’s family members in the AAMU CSD observation suites. To prevent client distraction, it is preferred that the family does not sit in the therapy room during a diagnostic or therapy session. In this educational/training environment, sessions may be observed by other students in training.

CONFIDENTIALITY OF RECORDS

A clinic/working folder is maintained for all clients seen at the Alabama A & M University Communicative Sciences and Disorders Clinic. Included in this folder are diagnostic findings/reports, therapy reports, case history information, consent forms, as well as other
pertinent information. This information is considered confidential. Access to the folder is granted to client’s family members, faculty, and student clinicians. When specifically requested in writing by the client or guardian using this clinic's forms (one form per request), the clinic will supply relevant information to specified entities such as physicians, schools, or other professionals.

A permanent record is kept for each client of activities in this clinic. No information which could potentially identify the client leaves the clinic. All such information is carefully guarded within the clinic. For more details, contact your faculty supervisor.

____________

WAITING ROOM

The waiting room is for families of the clients enrolled in clinical services. Donations of books, magazines, and toys are greatly appreciated. Parents are asked to please keep the waiting area clean by returning items to their proper places when leaving. Children are to be supervised at all times. This is a “No smoking” area.

____________

ATTENDANCE

Most clients are seen twice per week for 50-minute sessions. Therapy is most effective when attendance is regular. It is important that every effort be made to be present for ALL scheduled therapy sessions and to arrive on time. THREE absences in a semester or TWO consecutive absences could result in dismissal from therapy for the remainder of the semester. Extenuating circumstances may allow for exceptions at the discretion of the supervisor.

Upon dismissal from the program for absences, the client will be expected to call to request being placed back on the waiting list for the following semester. We begin taking clients for the upcoming semester approximately 1 month before the close of the current semester.

   Fall semester – call in July
   Spring semester – call in November
   Summer semester – call in March

If you must be absent for any reason, please contact the clinical supervisor(s) -- Mrs. Phillips-Ross, 372-4044; Dr. Jennifer Vinson, 372-4035; or The clinic secretary Mrs. Michele Brown, 372-5541--as soon as you know that you will not be able to attend. If the supervisor is unavailable, please leave a voice mail message.

____________

CLINIC FEES

Fees agreed upon at the beginning of the client’s therapy program will remain in effect until the beginning of the next Fall semester. A new fee contract will be signed each Fall. Eligibility for reduced fees will be reviewed before the opening of the clinic each Fall. The amount designated as full fee for evaluation and therapy will not be changed by the Clinic Director except immediately prior to the beginning of the Fall clinic session. No change in
fee will be in effect without prior notice in writing or by phone call to the client or his/her caregiver.
Each client or client caregiver and the Clinic Director will sign a contract on the date of the client's first therapy session to verify the agreed-upon fees for service and the payment schedule. A copy of this contract will be kept on file in the Alabama A & M University Communicative Sciences and Disorders Clinic account files.

All fees for evaluation must be paid on the date of the evaluation or as previously arranged by the director of clinical services. For therapy/treatment sessions, payment is expected at the end of the period in question (e.g., the end of the week). If circumstances make payment on these terms challenging, the client or client's caregiver is responsible for notifying the Clinic Director so that payment may be negotiated.

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**GRIEVANCE PROCEDURE AND POLICY**

The clinical faculty welcomes any comments or suggestions that may prove beneficial to the client during the diagnostic or therapy process. Complaints related to clinical services should be directed to the Clinic Director, Mrs. Phillips-Ross.

---

**PARKING**

All clients will be given a clinic parking pass during the first week of service. All clients must display a parking pass in the windshield or rearview mirror of their vehicle. If for some reason you are not given a parking pass, please do not hesitate to request one. The parking pass will expire at the end of each semester, and a new one will need to be obtained for following semesters. Clients are permitted to park in the lots adjacent to either clinic (CCN, CCE, and CCS). You are permitted to park in spaces designated for CSD Patient Parking and in UN-NUMBERED faculty/staff parking spaces ONLY.

---

**TRANSPORTATION**

Clients needing transportation to the AAMU CSD Clinic may make arrangements through Handi Ride. There is an application process/fee and not all applicants will qualify. If you desire to inquire about the services Handi Ride provides, they may be contacted at 256-427-6857 (scheduling) or 256-532-RIDE.

---

**POLICY FOR COMMUNICABLE DISEASES**

In the attempt to control the transmission of the communicable diseases listed below, the following policy will be adhered to in the Alabama A&M CSD Clinic:

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>MINIMUM PERIOD OF ISOLATION OF THE CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken Pox (varicella)</td>
<td>Individual must remain at home until all lesions are crusted and dry.</td>
</tr>
</tbody>
</table>
Susceptible child exposed to chicken pox will be excluded from the 10th through the 21st day after exposure. Anyone who has received V12G will be excluded for 28 days.

Conjunctivitis (Pinkeye) Individual must remain home until 24 hours after treatment (antibiotic eye drops) is initiated.

German Measles Individual must remain at home for at least five (5) days after onset of rash. Susceptible child will be excluded from the 7th to the 21st day after exposure.

Impetigo Individual must remain at home until 24 hours after treatment is initiated.

Influenza Individual must remain home until no fever is detected for 24 hours.

Lice (Pediculosis) Individual must remain at home until the morning after treatment.

Measles (Rubella) Individual must remain at home for four (4) days after the appearance of rash. Susceptible child will be excluded from the 5th exposure.

Mumps Individual must remain at home for nine (9) days after onset of swelling. Susceptible person will be excluded from the 12th to the 26th day after exposure.

Scabies Individual must remain at home until treatment has been completed.

Streptococcus (strep) Individual must remain home until 24 hours after the first dose of antibiotics is given and be free of fever.

REFERENCE: Isolation and Quarantine Regulations


We wish you the best possible success here in the clinic. Together, we can make a difference!
CONFIDENTIALITY STATEMENT
Client Handbook

I understand that information regarding clients and or students in the CSD Program, (including anything observed in the clinic, and information heard re: other families, clients, faculty, staff or student clinicians) is to be held strictly confidential.

Printed Name __________________________ Signature ____________________________ Today’s Date ____________________

***Please sign and submit this document to the Program Secretary, Mrs. Michele Brown during initial visit to the clinic.
APPENDIX A
AAMU CSD CLIENT CLINIC FORMS

1. Child Case History Form
2. Adult Case History Form
3. Fee Payment Contract
4. Fee Sliding Scale
5. Authorization form Release of Information to Another Agency or Physician
6. Authorization form Release of information from Another Agency or Physician
7. Authorization form Video/Audio Taping for Educational Purposes
Alabama A & M University
Communicative Sciences and Disorders Clinic
P.O. Box 357
Normal, Alabama 35762
Phone: (256)372-5541 or (256)372-4044

CASE HISTORY FORM – CHILD

IDENTIFYING INFORMATION

Child’s Name _________________________________________________ Sex ___________
Birthdate _________________ Age ___________ Today’s Date ______________________
Name by which your child is called ___________________________ Handedness Right Left
(circle)
Address: _________________________________________________ Home Phone __________
City ___________________ State _____ Zip ___________ Cell phone _______________
Parents: Name Age Occupation Education Work #
Father ____________________________________________________
Mother ____________________________________________________
If address of either parent is different from that of child, please indicate:

Is the child adopted? _______ yes _______ no If so, at what age? ________________________

List children, in order of birth:
Name             Sex   Age        Grade/School
____________________________________     _____     _____     _________________________
____________________________________     _____     _____     _______________________________
____________________________________     _____     _____     _______________________________

Do any siblings have any speech or language difficulties? _______ yes _______ no
Specify ________________________________________________________________________________

Who referred you to the AAMU Speech and Hearing Clinic? ______________________________________
Address (if professional) _________________________________________________________________
Child’s Doctor: Name ___________________________________________________________________
Address of Dr. _________________________________________________________________________

Do you want a copy of our report(s) sent to your child’s doctor? _______ yes _______ no

To what other professional person(s) or agency (ies) do you want a report sent? Please include names of
professionals and addresses:__________________________________________________________________
_______________________________________________________________________________________
STATEMENT OF THE PROBLEM

Describe in your own words what problem(s) your child is/are having with speech, language, and/or hearing.
__________________________________________________________________________________________________________

Why did you want your child evaluated by the AAMU Speech and Hearing Clinic? ________________________________
__________________________________________________________________________________________________________

When was the problem first noticed? ______________________________________________________________________

Who first noticed the problem? __________________________________________________________________________

What reactions does the child, parent, siblings, relatives, and/or friends have towards the problem? ________
__________________________________________________________________________________________________________

What have you done to help your child’s speech? ______________________________________________________________________
__________________________________________________________________________________________________________

If your child’s speech varies, under what circumstances does it become:

Better: ____________________________________________________________________________________________

Worse: ______________________________________________________________________________________________

Have you sought professional advice about your child’s speech, language, and/or hearing problem before?

Evaluation ________  Therapy ________  When? __________________________

Whom did you see? _________________________________________________________________________________

Length of therapy __________________________________________

Results ____________________________________________________________________________________________

What recommendations were made? __________________________________________________________________

What has been done since then? _______________________________________________________________________

How does your child feel about his/her speaking ability? ________________________________________________

Has your child ever been diagnosed as a “poor reader”? ________ yes ________ no

By whom was the diagnosis made? ____________________________________________________________________

Check the items that your child seems to do more than other children the same age:

____ 1. Avoids speaking at school.

____ 2. Avoids speaking in play situations.

____ 3. Avoids speaking at home.

____ 4. Avoids speaking to children (male _____, female _____).

____ 5. Avoids speaking to adults (male _____, female _____).

____ 6. Avoids saying certain words. (List ____________________________________________________________)

____ 7. Cries when unable to communicate.

____ 8. Becomes aggressive when unable to communicate.
GENERAL DEVELOPMENTAL HISTORY

Was this your first pregnancy? ______ yes ______ no
If not, how many pregnancies have you had? _____ Which pregnancy was this child? _______
Any medical problems prior to this pregnancy? ______ yes ______ no
If so, please describe: ________________________________________________________________
Did you have an illness during pregnancy? ______ yes ______ no
If so, please explain: ________________________________________________________________
Did you have to take medication during pregnancy? ______ yes ______ no
If so, what medications? _____________________________________________________________
Did your baby come more than two weeks early? ______ yes ______ no
Did your baby come more than two weeks late? ______ yes ______ no
Was labor longer than 24 hours? ______ yes ______ no
Was the birth by Cesarean? ______ yes ______ no
Were forceps used during the birth? ______ yes ______ no
Birth weight ____________ pounds, ____________ ounces
Did your baby have trouble in the hospital? ______ yes ______ no
______ blue spell ______ yellow jaundice ______ breathing problems
______ required oxygen ______ infection diagnosed ______ required transfusion
Other: ______________________________________________________________________________
How long were mother and child in the hospital? ____________
Physician’s Name ____________________________   Hospital ________________________________

Did you bottle feed your baby? ______ yes ______ no
Did your baby cry more than average? ______ yes ______ no
Did your baby spit a lot? ______ yes ______ no
Did your baby have any feeding problems? ______ yes ______ no
Did your baby have nasal stuffiness? ______ yes ______ no
Did your baby have rattling when breathing? ______ yes ______ no
Did your have any major concerns in the first three months of your baby's life? ______ yes ______ no

Give ages at which the following first occurred:
   Held head up ____________ Crawled ____________ Reached for objects ____________
   Stood ____________ Walked unaided ____________ Ran ____________
   First tooth ____________ Bladder trained ____________ Bowel trained ____________

SPEECH AND LANGUAGE DEVELOPMENT

Did your child make babbling or cooing sounds during the first 6 months? ______ yes ______ no

At what age did your child say his/her first word? ________________________________
What were the child’s first words? __________________________________________

Did your child keep adding words once he/she started talking? ______ yes ______ no

At what age did your child begin using 2- and 3-word sentences? ________________________________
Examples ______________________________________________________

Does your child talk frequently? ______ occasionally? ______ never?
Does your child prefer to talk? ______ gesture? ______ both talk and gesture?
Does your child most frequently use sounds? ______ single words ______ 2-word sentences ______ 3-word sentences ______ more than 3-word sentences ______
Does your child make sounds incorrectly?  
________ yes  ________ no
If so, which ones?

Does your child hesitate, “get stuck”, or repeat or stutter on sounds or words? ________ yes  ________ no
If so, describe.

Describe any recent changes in your child’s speech:

Can your child say a nursery rhyme?  
________ yes  ________ no
Can your child tell a simple story?  
________ yes  ________ no
How well can your child be understood by his/her parents?  
________ yes  ________ no
Siblings?  
Friends?
Relatives?  
Strangers?

Does your child understand what you say to him/her?  
________ yes  ________ no
Can he/she follow simple commands?  
________ yes  ________ no
Will he/she get common objects when asked to do so?  
________ yes  ________ no
Does your child have trouble remembering what you have told him/her?  
________ yes  ________ no
If so, when does this seem to happen?

Does your child use any books or games?  
________ yes  ________ no
How often do you read to your child?  

BEHAVIORAL INFORMATION

Check these as they apply to your child:

<table>
<thead>
<tr>
<th>Eating problems</th>
<th>Yes</th>
<th>No</th>
<th>Explain: give ages, if possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet training problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needed a lot of discipline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underactive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excitable</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Laughs easily</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cried a lot</td>
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<td></td>
<td></td>
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<tr>
<td>Difficult to manage</td>
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<tr>
<td>Overactive</td>
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<tr>
<td>Sensitive</td>
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<td></td>
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<tr>
<td>Personality problem</td>
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<td></td>
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<tr>
<td>Gets along with children</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Gets along with adults</td>
<td></td>
<td></td>
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<tr>
<td>Emotional</td>
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<tr>
<td>Stays with an activity</td>
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<tr>
<td>Makes friends easily</td>
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<tr>
<td>Happy</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Irritable</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Prefers to play alone</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Describe any other type of behavior you consider to be a problem:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
EDUCATIONAL HISTORY

Does your child do average _____ below average _____ or above average _____ work in school?
What are your child’s best subjects? ________________________________________________________
What are your child’s poorest subjects? ______________________________________________________
Does your child receive any special assistance or help at school? _______ yes ______ no
   If so, describe: _______________________________________________________________________
Has he/she repeated a grade? _______ yes ______ no
   If so, which one(s)? ________________________________________________________________
What is your impression of your child’s learning abilities? ______________________________________

Describe any speech, language, hearing, psychological, and special education services that have been
   performed, including where this was done. Include how often your child was seen in this service. ______

OTHER

What games and toys does your child prefer? _________________________________________________

How many hours each day does your child watch television? _________________________________
   Which programs does he/she watch? ______________________________________________________
   ____________________________________________________________________________________

Please list what you would consider your child’s favorite food(s) and snack food(s). _________________
   ____________________________________________________________________________________

What may we use for reinforcement for your child (i.e., candy, raisins, stickers, etc.)? ______________
   ____________________________________________________________________________________

EMERGENCY CONTACT INFORMATION

Name ____________________________ Relationship to client ____________________________
Address ____________________________________________ Home phone _______________________
City __________________________ State ______ Zip __________ Cell phone _______________________


**CASE HISTORY FORM – ADULT**

**IDENTIFYING INFORMATION**

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Marital Status</th>
<th>Birthdate</th>
<th>Age</th>
<th>Today’s Date</th>
<th>Handedness</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Home Phone</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Cell phone</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Place of Employment or Previous Employment</th>
<th>Address:</th>
<th>Home Phone</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Cell phone</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of alternate contact person</th>
<th>Relationship</th>
<th>Address:</th>
<th>Home Phone</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Cell phone</th>
</tr>
</thead>
</table>

Who referred you to the AAMU Speech and Hearing Clinic?  
Address (if professional)  
Doctor  
Address of Dr.  
Do you want a copy of our report(s) sent to your doctor?  
Yes  
No  
To what professional person(s) or agency(ies) do you want a report sent? Please include names of professionals and addresses:
List names and ages of person(s) in your home:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
</tr>
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EDUCATIONAL HISTORY

<table>
<thead>
<tr>
<th>School</th>
<th>Location</th>
<th>Highest Grad or Degree Completed</th>
<th>Date</th>
</tr>
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</tr>
</tbody>
</table>

DESCRIBE YOUR PRESENT HEALTH

List periods of hospitalization or medical treatment:

<table>
<thead>
<tr>
<th>Hospital/City/State</th>
<th>Dates</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

List all surgical procedures

List all prescription and nonprescription medication currently used

Have you had a neurological examination? If so, by whom, when, and where?
Is there a history of:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td>Heart trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinus infections</td>
<td></td>
<td></td>
<td>Numbness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td>Paralysis/paresis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>Incoordination of face or tongue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broken nose</td>
<td></td>
<td></td>
<td>Influenza</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchitis</td>
<td></td>
<td></td>
<td>Mouth-breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic colds</td>
<td></td>
<td></td>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic laryngitis</td>
<td></td>
<td></td>
<td>Pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic ear infections</td>
<td></td>
<td></td>
<td>Physical defect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleft palate</td>
<td></td>
<td></td>
<td>Poliomyelitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Psychological counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria</td>
<td></td>
<td></td>
<td>Rheumatic fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear disease</td>
<td></td>
<td></td>
<td>Scarlet fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glandular imbalance</td>
<td></td>
<td></td>
<td>Tremor/twitching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing problem</td>
<td></td>
<td></td>
<td>Ulcers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing aid</td>
<td></td>
<td></td>
<td>Visual problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hormone therapy</td>
<td></td>
<td></td>
<td>Glasses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperthyroidism</td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional difficulty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
<td>Amount Per Day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drinking</td>
<td></td>
<td></td>
<td>Amount Per Day?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the answer to any of the above items is “yes”, give the relevant details (e.g., how frequent are these episodes, how severe are these episodes, etc.)

If you speak a language other than English, please state the language ________________
Please describe in your own words the nature of your communication problem(s).

What do you think caused the problem? _______________________________________
When did you first notice the problem? _______________________________________
What were the circumstances? _______________________________________________
Have any members of your family had hearing or speech problems? ____________________
If so, whom and what was the problem? ____________________

How do you feel your communication problem has affected your occupation? ____________________

How do you feel your communication problem has affected your social life? ____________________

If you didn’t have a communication problem, how would your life be different? ____________________

Describe the reaction of people, including your immediate family, to your communication problem. ____________________

List any specific communication situations that present difficulty for you. ____________________

List any specific communication situations that you avoid. ____________________

List interests you have or activities you engage in (clubs, hobbies, organizations, etc.) ____________________

What, if anything, have you tried to do to correct your communication problem? ____________________

Are you coming to AAMU Speech and Hearing Clinic on your own? _______ Or by the advice of another person? _______
Have you ever received any prior speech, language, or hearing evaluations? Therapy? ___
If so where?

Agency ____________________
Address ____________________
Dates ____________________
Results ____________________

Agency ____________________
Address ____________________
Dates ____________________
Results ____________________
Did prior evaluation or therapy relate to the present problem? 
How effective has prior therapy been in helping with your problem (What helped the most? least?)

Why was therapy terminated?
Has the nature of the problem changed any time? Explain
List any additional information that may be helpful to us in assisting you with our problem(s).
Fee Payment Contract

Client’s Name: ________________________________

I, __________________________, have read the AAMU CSD Client Handbook and I (Name of guardian if client is a minor) agree to pay $ 50.00* for evaluation and $ 30.00* for each therapy session. I agree to pay the evaluation fee at the time that said services are provided. I will pay for therapy on the following schedule:

_____ at the time of the last weekly session
_____ on a bi-weekly basis

I am aware of and agree to abide by the rules and regulations developed by the Clinic regarding payment for services provided.

Date of Contract: __________ Client/Guardian Signature: ________________________________

(signature of guardian required if client is under 18 years)

Clinical Director: ____________________________

Esther J. Phillips- Ross MA,CCC/SLP/L

* Fees are subject to change if client is eligible for sliding scale fee reduction

Updated 8/30/2011
Alabama A&M University
Communicative Sciences and Disorders Clinic
FEE SCHEDULE

Note: Prices listed below are the maximum rate possible, and could be less depending on the information submitted on the Sliding Fee Scale.

### Diagnostic (Evaluation) Fee Schedule

#### Speech and Language

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Speech and Language Assessment</td>
<td>$50.00</td>
</tr>
<tr>
<td>(Includes assessments of Voice, Fluency, Aural Rehabilitation, Aphasia, Augmentative Communication, Cognition, Articulation, Myofunctional (tongue thrust), Accent/Dialect Modification, Dysphagia)</td>
<td></td>
</tr>
<tr>
<td>Specialized Assessment (Reading)</td>
<td>$50.00</td>
</tr>
<tr>
<td>Speech and/or Language Screening</td>
<td>$35.00</td>
</tr>
<tr>
<td>School of Education Screenings</td>
<td>$10.00</td>
</tr>
</tbody>
</table>

#### Audiology

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Audiological Assessment</td>
<td>$50.00</td>
</tr>
<tr>
<td>Hearing Screening</td>
<td>$15.00</td>
</tr>
</tbody>
</table>

### Intervention (Therapy) Fee Schedule

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Intervention Session</td>
<td>$30.00</td>
</tr>
<tr>
<td>Group Intervention Session</td>
<td>$22.50</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations</td>
<td>$25.00</td>
</tr>
</tbody>
</table>
Circle the NUMBER in your household and the LETTER corresponding to your income to obtain the percentage. Your charge will be that percentage of the regular fee listed on the first page for the service being provided. For example: A $40.00 hearing test for a client with an income of “J” and a household of “5+” would correspond at 50%, so the actual charge would be 50% of $40.00 or $20.00.

<table>
<thead>
<tr>
<th>Income Category (Circle One)</th>
<th>Annual Income Before Taxes For Amounts Between:</th>
<th>Number in Household (Circle One)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$0 - $4,999</td>
<td>1</td>
</tr>
<tr>
<td>B</td>
<td>$5,000 - $8,999</td>
<td>10%</td>
</tr>
<tr>
<td>C</td>
<td>$9,000 - $10,999</td>
<td>30%</td>
</tr>
<tr>
<td>D</td>
<td>$11,000 - $12,999</td>
<td>35%</td>
</tr>
<tr>
<td>E</td>
<td>$13,000 - $14,999</td>
<td>40%</td>
</tr>
<tr>
<td>F</td>
<td>$15,000 - $19,999</td>
<td>50%</td>
</tr>
<tr>
<td>G</td>
<td>$20,000 - $24,999</td>
<td>60%</td>
</tr>
<tr>
<td>H</td>
<td>$25,000 - $29,999</td>
<td>70%</td>
</tr>
<tr>
<td>I</td>
<td>$30,000 - $34,999</td>
<td>80%</td>
</tr>
<tr>
<td>J</td>
<td>$35,000 - $39,999</td>
<td>90%</td>
</tr>
<tr>
<td>K</td>
<td>$40,000 - $44,999</td>
<td>100%</td>
</tr>
<tr>
<td>L</td>
<td>$45,000 - $49,999</td>
<td>100%</td>
</tr>
<tr>
<td>M</td>
<td>$50,000 - $54,999</td>
<td>100%</td>
</tr>
<tr>
<td>N</td>
<td>$55,000 - $59,999</td>
<td>100%</td>
</tr>
<tr>
<td>O</td>
<td>$60,000 - $64,999</td>
<td>100%</td>
</tr>
</tbody>
</table>
AUTHORIZATION FOR RELEASE OF INFORMATION

TO ANOTHER AGENCY OR PHYSICIAN

Client’s Full Name: ________________________    Birthdate: __________________

I, _____________________________ hereby consent to the release of any and all hearing, speech, (Name of guardian if client is a minor) and language records concerning the above-named individual to:

Name/Agency: ____________________________

Address:

____________________________________

____________________________________

____________________________________

Client/Guardian Signature: ____________________________    Date: __________________

(updated 8/30/2011)
AUTHORIZATION FOR RELEASE OF INFORMATION FROM ANOTHER AGENCY OR PHYSICIAN

The person named below has requested services from our facility, Alabama A & M University Communicative Sciences and Disorders (CSD) Clinic. We understand that this individual has received professional services from you. Kindly forward any hearing, speech, language, medical, psychological, educational, or social records regarding this individual to aid us in better serving this client. Below is written authorization for the release of these records. Please send this information to the following:

Alabama A & M University CSD Clinic
Attention: Mrs. Esther Phillips-Ross, Director of Clinical Services
P O Box 357
Normal, AL 35762
esther.phillips@aamu.edu

Thank you for your cooperation.

This will certify that you have my permission to release information to Alabama A & M Communicative Sciences and Disorders Clinic concerning:

________________________________________________________
(Client’s full name)

Name of guardian authorizing release: __________________________________________________________
(Print full name)

Client/Guardian Signature: ___________________________________ Date: ____________________________
(signature of guardian required if client is under 18 years)

Updated 8/30/2011
AUTHORIZATION FOR
OBSERVATION/VIDEO/AUDIOTAPING/PHOTOGRAPHS
FOR EDUCATIONAL PURPOSES

Client’s Full Name: ________________________________ Birthdate: _____________

I understand that the Alabama A & M University Communicative Sciences and Disorders Clinic is housed in an educational environment. I hereby consent to the following for teaching purposes only:

- Live Observation
- Video/Digital Recording
- Still photographs

I require the following exception(s): ________________________________________________

______________________________________________________________________________

Client/Guardian Signature: _______________________________________________________
(signature of guardian required if client is under 18 years)

Relationship to Client: __________________________________________________________

Witness: ______________________________________________________________________

Date: _________________________________________________________________________

Updated 8/30/2011
CONFIDENTIALITY STATEMENT
Client Handbook

I understand that information regarding clients and or students in the CSD Program, (including anything observed in the clinic, and information heard re: other families, clients, faculty, staff or student clinicians) is to be held strictly confidential.

_________________________     ______________________________
Printed Name                                Signature

____________________________________
Today’s Date

***Please sign and submit this document to the Program Secretary, Mrs. Michele Brown during initial visit to the clinic.
**REQUEST FOR CLINICAL SERVICES**

**FALL 2012**

Client’s Name: ____________________  DOB: __________  Age: __________

Spouse’s/Parent’s Name, if applicable: __________________________________________

Email address: _______________________________________________________________

Address: ___________________________________________________________________

City: _____________________________  State: __________  Zip: _______________________

Phone number: home _______________  work ________________  other _______________

Please circle/check the following information:

- Number of days per week you would prefer: 1 or 2
- Prefer: Individual Therapy or Group Therapy
- Preferred day(s) and time: Select BOTH preferred option and secondary option

<table>
<thead>
<tr>
<th>Preferred Option</th>
<th>Secondary Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday</strong></td>
<td><strong>Monday</strong></td>
</tr>
<tr>
<td>9:00-9:50am</td>
<td>9:00-9:50am</td>
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<tr>
<td>10:00-10:50am</td>
<td>10:00-10:50am</td>
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<tr>
<td>11:00-11:50am</td>
<td>11:00-11:50am</td>
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<tr>
<td>2:00-2:50 pm</td>
<td>2:00-2:50 pm</td>
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<tr>
<td>3:00-3:50pm</td>
<td>3:00-3:50pm</td>
</tr>
<tr>
<td>4:00-4:50 pm</td>
<td>4:00-4:50 pm</td>
</tr>
</tbody>
</table>

| **Tuesday**            | **Tuesday**            |
| 9:00-9:50am            | 9:00-9:50am            |
| 10:00-10:50am          | 10:00-10:50am          |
| 11:00-11:50am          | 11:00-11:50am          |
| 3:00-3:50pm            | 3:00-3:50pm            |

| **Wednesday**          | **Wednesday**          |
| 9:00-9:50am            | 9:00-9:50am            |
| 10:00-10:50am          | 10:00-10:50am          |
| 11:00-11:50am          | 11:00-11:50am          |
| 1:00-1:50 pm           | 1:00-1:50 pm           |
| 2:00-2:50 pm           | 2:00-2:50 pm           |
| 3:00-3:50pm            | 3:00-3:50pm            |
| 4:00-4:50 pm           | 4:00-4:50 pm           |

| **Thursday**           | **Thursday**           |
| 9:00-9:50am            | 9:00-9:50am            |
| 10:00-10:50am          | 10:00-10:50am          |
| 11:00-11:50am          | 11:00-11:50am          |
| 3:00-3:50pm            | 3:00-3:50pm            |
| 4:00-4:50 pm           | 4:00-4:50 pm           |

_____ I do not know my schedule for Fall ‘12 (for AAMU students only).

We will attempt to accommodate your preferred and secondary options. Please return these forms to your current student clinician as soon as possible, with a current email address as we be sending updates re: clinical service via this venue. We MUST have these forms back to include you on the list for the coming semester by July 20th.

The Clinic is scheduled to open September 10th thru December 7th. Make every effort to attend all therapy sessions to get the maximum benefit of therapy. Also be aware that attendance will be taken into consideration when scheduling for future semesters. A graduate clinician will be contacting you to confirm therapy times for Fall ‘12 during the last week in August, through September 5th. If you have any questions or concerns, please call or leave a voice mail message at 372-4044/5541. Feel free to write any more information that we may need in scheduling on the back of this form. Thank you for your continued support of our clinic. We look forward to working with you again.

Sincerely,

Mrs. Esther Phillips-Ross
Mrs. Esther Phillips-Ross MA, CCC/SLP/L
Clinic Director
esther.phillips@aamu.edu
AAMU Communicative Sciences and Disorders Clinic
REQUEST FOR CLINICAL SERVICES
SPRING 2013

Client’s Name: ___________________________ DOB: ___________ Age: ___________

Spouse’s/Parent’s Name, if applicable: ____________________________________________

Email address: ________________________________________________________________

Address: _____________________________________________________________________

City: ___________________________________ State: _________ Zip: ___________

Phone number: home __________________ work __________________ other _____________

Please circle/check the following information:
• Number of days per week you would prefer: 1 or 2
• Prefer: Individual Therapy or Group Therapy
• Preferred day(s) and time: Select BOTH preferred option and secondary option

Preferred Option
☐ Monday
☐ 9:00-9:50am ☐ 10:00-10:50 am
☐ 11:00-11:50am ☐ 1:00-1:50 pm
☐ 2:00-2:50 pm ☐ 3:00-3:50pm
☐ 4:00-4:50 pm

☐ Tuesday
☐ 9:00-9:50am ☐ 10:00-10:50 am
☐ 11:00-11:50am ☐ 3:00-3:50pm

☐ Wednesday
☐ 9:00-9:50am ☐ 10:00-10:50 am
☐ 11:00-11:50am ☐ 1:00-1:50 pm
☐ 2:00-2:50 pm ☐ 3:00-3:50pm
☐ 4:00-4:50 pm

☐ Thursday
☐ 9:00-9:50am ☐ 10:00-10:50 am
☐ 11:00-11:50am ☐ 3:00-3:50pm
☐ 4:00-4:50 pm

☐ Secondary Option
☐ Monday
☐ 9:00-9:50am ☐ 10:00-10:50 am
☐ 11:00-11:50am ☐ 1:00-1:50 pm
☐ 2:00-2:50 pm ☐ 3:00-3:50pm
☐ 4:00-4:50 pm

☐ Tuesday
☐ 9:00-9:50am ☐ 10:00-10:50 am
☐ 11:00-11:50am ☐ 3:00-3:50pm

☐ Wednesday
☐ 9:00-9:50am ☐ 10:00-10:50 am
☐ 11:00-11:50am ☐ 1:00-1:50 pm
☐ 2:00-2:50 pm ☐ 3:00-3:50pm
☐ 4:00-4:50 pm

☐ Thursday
☐ 9:00-9:50am ☐ 10:00-10:50 am
☐ 11:00-11:50am ☐ 3:00-3:50pm
☐ 4:00-4:50 pm

____ I do not know my schedule for Spring ’13 (for AAMU students only).

We will attempt to accommodate your preferred and secondary options. Please return these forms to your current student clinician as soon as possible, with a current email address as we be sending updates re: clinical service via this venue. We MUST have these forms back to include you on the list for the coming semester by January 13th.

The Clinic is scheduled to open February 4th thru April 19th. Make every effort to attend all therapy sessions to get the maximum benefit of therapy. Also be aware that attendance will be taken into consideration when scheduling for future semesters. A graduate clinician will be contacting you to confirm therapy times for Spring 2013 during the last week in January.

If you have any questions or concerns, please call or leave a voice mail message at 372-4044/5541. Feel free to write any more information that we may need in scheduling on the back of this form. Thank you for your continued support of our clinic. We look forward to working with you again.

Sincerely,
Mrs. Esther Phillips-Ross
Mrs. Esther Phillips-Ross MA,
CCC/SLP/L
Clinic Director
esther.phillips@aamu.edu
AAMU Communicative Sciences and Disorders Clinic
Client's Name: ___________________________  DOB: ___________  Age: __________

Spouse's/Parent's Name, if applicable: __________________________________________

Email address: _______________________________________________________________

Address: ________________________________________________________________

City: __________________________  State: _________  Zip: ________________

Phone number: home _______________  work ________________  other _______________

Please circle/check the following information:

• Number of days per week you would prefer: 1 or 2
• Prefer: Individual Therapy or Group Therapy
• Preferred day(s) and time: Select BOTH preferred option and secondary option

<table>
<thead>
<tr>
<th>Preferred Option</th>
<th>Secondary Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Monday 9:00-9:50am ☐ 10:00-10:50 am</td>
<td>☐ Monday 9:00-9:50am ☐ 10:00-10:50 am</td>
</tr>
<tr>
<td>☐ 11:00-11:50am ☐ 1:00-1:50 pm</td>
<td>☐ 11:00-11:50am ☐ 1:00-1:50 pm</td>
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<td>☐ 2:00-2:50 pm ☐ 3:00-3:50pm</td>
</tr>
<tr>
<td>☐ Wednesday 9:00-9:50am ☐ 10:00-10:50 am</td>
<td>☐ Wednesday 9:00-9:50am ☐ 10:00-10:50 am</td>
</tr>
<tr>
<td>☐ 11:00-11:50am ☐ 1:00-1:50 pm</td>
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</tr>
<tr>
<td>☐ 2:00-2:50 pm ☐ 3:00-3:50pm</td>
<td>☐ 2:00-2:50 pm ☐ 3:00-3:50pm</td>
</tr>
</tbody>
</table>

☐ I do not know my schedule for Summer ‘13 (ONLY for clients who are AAMU students).

We will attempt to accommodate your preferred and secondary options. Please return these forms to your current student clinician as soon as possible, with a current email address as we be sending updates re: clinical service via this venue. **We MUST have these forms back to include you on the list for the coming semester by May 3rd.**

The Clinic is scheduled to open June 6th thru July 19th. Make every effort to attend all therapy sessions to get the maximum benefit of therapy. Also be aware that attendance will be taken into consideration when scheduling for future semesters. A graduate clinician will be contacting you to confirm therapy times for Summer ‘13 during the last week in May. If you have any questions or concerns, please call or leave a voice mail message at 372-4044/5541. Feel free to write any more information that we may need in scheduling on the back of this form. Thank you for your continued support of our clinic. We look forward to working with you again.

Sincerely,

Mrs. Esther Phillips-Ross

Mrs. Esther Phillips-Ross MA,  
CCC/SLP/L  
Clinic Director  
esther.phillips@aamu.edu  
AAMU Communicative Sciences and  
Disorders Clinic