Alabama A&M University

Communicative Sciences and Disorders

Carver Complex North, Rm 104

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 are a *Case History Form* and other 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
Att: Esther Phillips-Embden
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-Embden

Esther Phillips-Embden MA,CCC/SLP/L
Director of Clinical Services
Communicative Sciences and Disorders Clinic
Alabama A&M University

Alabama A&M University

Communicative Sciences and Disorders Clinic

Fee Payment Contract

Client Name:_____

I,_____have read the *AAMU CSD Client Handbook* and I 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:_____ Parent, Guardian, Client: _____

Clinical Director: _____

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

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

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

Comprehensive Speech and Language Assessment $50.00
(Includes assessments of Voice, Fluency, Aural Rehabilitation, Aphasia, Augmentative Communication, Cognition, Articulation, Myofunctional (tongue thrust), Accent/Dialect Modification, Dysphagia)

Specialized Assessment (Reading) $50.00

Speech and/or Language Screening $35.00

School of Education Screenings…… $10.00

Audiology

Comprehensive Audiological Assessment $50.00

Hearing Screening $15.00

Intervention (Therapy) Fee Schedule

Individual Intervention Session $30.00

Group Intervention Session $22.50

Other

Consultations $25.00

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SLIDING FEE SCALE

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.

Income Category (Circle One)	**Annual Income Before Taxes** For Amounts Between:	**Number in Household** (Circle One)				
		1	**2**	**3**	**4**	**5+**
A	$0 - $4,999	G	G	G	G	G
B	$5,000 - $8,999	10%	10%	G	G	G
C	$9,000 - $10,999	30%	25%	10%	G	G
D	$11,000 - $12,999	35%	30%	25%	20%	15%
E	$13,000 - $14,999	40%	35%	30%	25%	20%
F	$15,000 - $19,999	50%	40%	35%	30%	25%
G	$20,000 - $24,999	60%	50%	40%	35%	30%
H	$25,000 - $29,999	70%	60%	50%	40%	35%
I	$30,000 - $34,999	80%	70%	60%	50%	40%
J	$35,000 - $39,999	90%	80%	70%	60%	50%
K	$40,000 - $44,999	100%	90%	80%	70%	60%
L	$45,000 - $49,999	100%	100%	90%	80%	70%
M	$50,000 - $54,999	100%	100%	100%	90%	80%
N	$55,000 - $59,999	100%	100%	100%	100%	90%
O	$60,000 - $64,999	100%	100%	100%	100%	100%

Alabama A&M University

Communicative Sciences and Disorders Clinic

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, and language records concerning the above-named individual to:

Name/Agency: _____

Address: _____

_____

_____

Signature: _____ Date: _____

Alabama A&M University

Communicative Sciences and Disorders Clinic

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: Ms. Esther Phillips-Embden, Director of Clinical Services
P O Box 357
Normal, AL 35762
esther.phillips@aamu.edu

Thank you for you 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)

Signature: _____ Date: _____

Alabama A&M University

Communicative Sciences and Disorders Clinic

AUTHORIZATION FOR VIDEO/AUDIOTAPING
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 video and/or audio taping of evaluation and/or therapy sessions of the above-named individual to be used for teaching purposes only.

I require the following exception(s): _____

Signature: _____

Relationship to Client: _____

Witness: _____

Date: _____

Alabama A & M University

Speech-Language-Hearing Clinic
REQUEST FOR CLINICAL SERVICES
SPRING 2010

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
❒11:00-11:50 am ❒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
❒11:00-11:50 am ❒3:00-3:50pm

❒Wednesday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒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
❒11:00-11:50 am ❒3:00-3:50pm
❒4:00-4:50 pm

Secondary Option

❒Monday
❒ 9:00-9:50am ❒10:00-10:50
❒11:00-11:50 am ❒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
❒11:00-11:50 am ❒3:00-3:50pm

❒Wednesday
❒ 9:00-9:50am ❒10:00-10:50 am
❒11:00-11:50 am ❒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
❒11:00-11:50 am ❒3:00-3:50pm
❒4:00-4:50 pm

____ I do not know my schedule for Spring '10 (for AAMU students only).

We will **attempt** to accommodate your preferred and secondary options. Please return these forms the clinic as soon as possible, with a current email address as we be sending updates re: clinical service via this venue. The Clinic is scheduled to open January 26th thru May 1st. 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.

Sincerely,
Ms. Esther-Phillips-Embden

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

For Clinic Use Only: Dx _____ Tx _____ Case Hx _____ Referral _____
Comments: