Hearing Clinic
Phone: (813) 974-8804
Fax: (813) 905-9819
Email: hearingclinic@usf.edu

From I-275 (Downtown Tampa or Airport Area)

- Exit I-275 to Fletcher Avenue (exit 52)
- Drive east on Fletcher Avenue, past Busch Gardens Blvd. to Magnolia Drive
- Turn right on Magnolia Drive and drive south
- Turn left at 2nd traffic light onto Citrus Drive - opposite Moffitt Cancer Center
- Turn right at the traffic circle onto Laurel Drive. The building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

From I-75 (from Areas North, South, or East of Tampa)

- Take Fletcher Avenue (exit 266) and drive west to Magnolia Drive
- Turn left on Magnolia Drive (at light) and drive south
- Turn left at 2nd traffic light, Citrus Drive - opposite Moffitt Cancer Center
- Turn right at the traffic circle onto Laurel Drive. The building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

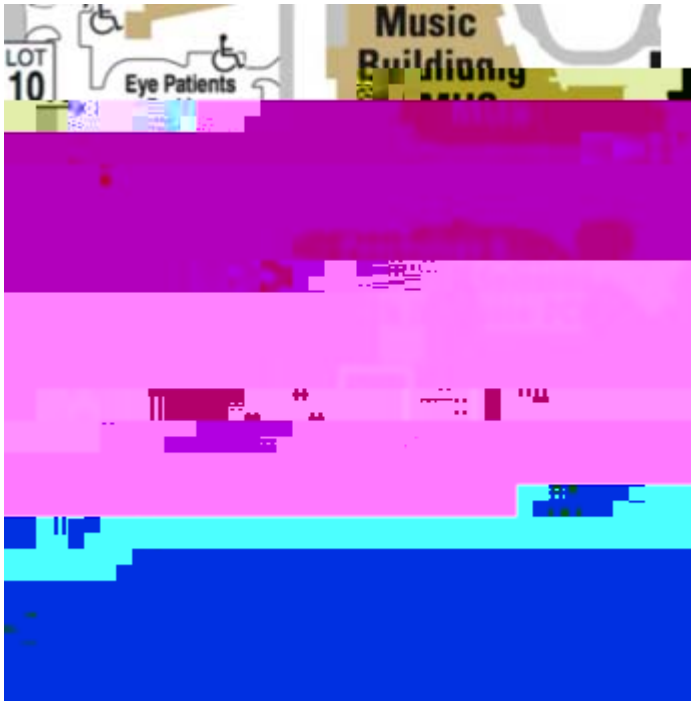
From Tampa International Airport Area

- Turn onto Leroy Collins Blvd. into USF campus main entrance
- Turn left at 1st stop light onto Alumni Drive
- Turn right onto Magnolia Drive
- Turn right onto Citrus Drive - opposite Moffitt Cancer Center
- Turn right at the traffic circle onto Laurel Drive. The building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

Please park in the reserved spots marked PSY/CSD in Lots 9A or 46.
Please display RED clinic parking pass on dashboard.

Lot 9A

- Lot 9A is located past the building on the Left (assigned reserved parking spaces are closest to the Psychology Building). When you exit your car, you will want to head back to the CSD Building which will be on your left.



UNIVERSITY OF SOUTH FLORIDA
DEPARTMENT OF COMMUNICATION SCIENCES AND DISORDERS
SPEECH, LANGUAGE, HEARING CENTER - PCD 1017
TAMPA, FLORIDA 33620-8150
Speech-Language: (813) 974-9844 **Audiology: (813) 974-8804**
Fax: (813) 905-8928

PRE-EVALUATION CASE HISTORY FORM FOR ADULTS - SPEECH/LANGUAGE PATHOLOGY

PLEASE READ CAREFULLY

Enclosed are several forms which **MUST** be completed and returned to this Center before an appointment can be scheduled. Please take the time to complete the case history form accurately and thoroughly. This information is for the Center records and will be treated as confidential. We cannot schedule an appointment until this completed form has been returned, **all release forms have been signed**, and all essential reports from other professionals and agencies have been received. You will then be contacted when an opening is available.

Please describe in your own words, your speech, language or hearing difficulty:

Date form completed:

Mr. Mrs. Dr.

IDENTIFICATION

Name of Client:

City State Zip

Home Phone: Cell Phone: Email:

Educational level attained: Elementary Middle/Jr. High High School College

Employer:

City State Zip Phone:

Referred by:

Name Address

Person to contact in case of emergency:

Relationship:

Is the problem consistent? Yes No

Have you consulted with anyone about your communication problem? Yes No If yes, when?

Where and with whom?

Results and recommendations:

Are you presently enrolled in therapy? Yes No How often?

Where and with whom?

MEDICAL HISTORY

Please indicate any of the following you have experienced:

Stroke	Ears Ringing	Dizziness	Vision Problems
Cancer	Heart Attacks	[redacted]	[redacted]

[redacted]

Are you under any medical treatment now? Yes No If yes, for what?

Are you under the care of a specialist? Yes No

If yes, state name (first and last) and specialty:

[redacted]

Please check all of the following which you have ever taken:

[redacted]

Please include any other information that might help us:

UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

Speech and Language Clinic
(813) 974-9844
(813) 905-8928 – FAX

Client/Patient Authorization regarding Research Studies, Media of

[redacted]

"I understand the above and hereby release to the University of South

[redacted]

USF CSD Speech
Hearing and
Bolesta Center Clinics

I. **Authorization for Medical Care.** I voluntarily consent to any Medical Care that may be considered necessary

C. **Self-Paying Patient (if applicable).** I have been informed that the USF Health does not have a contract to participate with my insurance plan or HMO, and/or the requested Medical Care has not been authorized by my insurance plan/HMO, as applicable. I am requesting Medical Care as a fee-for-service, self-paying patient. I agree that I am responsible for all charges incurred as a result of this visit, including but not limited to all medical/surgical professional services, laboratory, radiological, and any other ancillary services. I agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect this account.

V. Prior Express Consent for Communications for Debt Collection and Payment Purposes. I expressly agree and consent that, in order for USF Health or its employees, agents or affiliates to service my account (including debt collection and payment purposes) USF Health, or any of its employees, agents or affiliates, may contact me by telephone at any telephone number associated with my account, including any wireless/cellular telephone numbers, which could result in charges to me. USF Health, or any of its employees, agents or affiliates, may also contact me for debt collection and payment purposes by sending text messages or e-mails using any e-mail address or phone number I provide. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device.

VI. Acknowledgement of Receipt of Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement.

I acknowledge that I have been provided a copy of the USF Health Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement

USF SLHC Patient and Caregiver Policies

Client Name: _____ DOB: _____

Parking:

1. Your parking permit should be visible and you should only park in designated areas.

Caregivers/Parents/Guardians present during sessions:

2. Per USF (legal counsel) policies, for parents/guardians of minors, parents/guardians must be on-site while the patient is in our facilities.
3. For caregivers of adults with no ability to communicate immediate wants and needs, caregivers must be on-site while the adult patient is in our facilities OR the adult patient must have in his/her possession the contact information for us to reach the caregiver.

Tardiness, Attendance and Sick Policy:

4.

USF HEALTH

Patient Name:_____ MRN Number:_____

As a result of the American Recovery and Reinvestment Act, the USF Physicians Group is required to collect patient data regarding race, ethnicity and language

[redacted]

___ American Indian/Alaska Native ___ White

___ Asian ___ Declined

___ Black

___ Native Hawaiian/Other Pacific Islander

Ethnicity

___ Hispanic or Latino or Spanish Origin ___ Declined

___ Not Hispanic or Latino or Spanish Origin ___ Unknown

Please note that you have the option of indicating "decline" in any

Language_____

Other required data to offer better service to you:

**Preferred Method to Notify You of Upcoming Appointment (*if you currently subscribe to the FollowMyHealth patient portal, you will receive appointment reminders through*

[redacted]

BY:_____ (Initials)

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

E. Reason Medicare May Not Pay:

F. Estimated Cost

G. OPTIONS: Check only one box. We cannot choose a box for you.

[redacted]

Evaluation does not guarantee treatment

[redacted]

[redacted]

Providers, Clinical Instructors, and Students

Since this is a training facility, providers, clinical instructors and students work in our clinic. At any point in during your care in our clinic, you could be assigned to any of these individuals for evaluation and/or treatment. To meet training needs for our students, you or your child might be [redacted]

[redacted]

Patient Name **Patient DOB**

Patient/Caregiver (if patient is under 18) Signature **Date**

[redacted]

STANDARD USF PHOTOGRAPHY & VIDEO RELEASE

CHECK APPROPRIATE BOX: For an adult For a minor under age of 18

I, the undersigned, hereby grant to University of South Florida (USF), to those acting on its behalf with 8 6) ¶ permission and authority, and to USF's licensees, successors and assigns, the absolute, irrevocable, royalty-free, perpetual right and permission to use any and all photographs, videotape, likeness, biographical information, home town, voice, or other recordings of me ("Materials") in connection with my participation