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 (Jun-Jul).

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.

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 431-8938 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			

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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Sciences and Disorders

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: _____

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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	[redacted]
☐ Pneumonia	☐ Tonsillitis	☐ Meningitis	☐ Encephalitis
☐ Rheumatic Fever	☐ Tuberculosis	☐	☐
☐	☐	☐	☐
☐	☐	☐	

411 S.W. 24th Street - San Antonio, Texas 78207-4689 - t 210.431.3938 f 210.434.9360 - e-mail: jersigcenter.olnnor-.:

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:

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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?

_____

_____

_____

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:_____

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		

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: _____

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: _____

411 S.W. 24th Street - San Antonio, Texas 78207-4689 - t 210.431.3938 f

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 Iho meno (ad)-12.no (ad)-Coebacemheh I m_M2

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,