CALIFORNIA STATE UNIVERSITY, EAST BAY
DEPARTMENT OF COMMUNICATIVE SCIENCES AND DISORDERS
NORMA S. AND RAY R. REES SPEECH, LANGUAGE, AND HEARING CLINIC

CLIENT'S AGREEMENT AND RELEASE FORM

I hereby authorize the Speech Pathology and Audiology Program, California State University, East Bay, to provide speech, language and/or audiology services to:
 ____________________________________________  (Client's Name)

I understand that the services indicated above may be provided by student clinicians as part of their preprofessional and professional clinical training. Such services will be supervised by a certified or licensed Speech Pathologist or Audiologist. I understand, further, that the assignment of student clinicians is at the discretion of the supervisory staff and that services may be interrupted or terminated according to the training requirements of the clinical training program and/or the availability of clinical personnel. I understand that every effort will be made to refer clients for appropriate services when those services cannot be provided by this program. I understand that, due to the design of the observation facilities, services delivered could be observed by other individuals. I am aware that special arrangements for privacy can be made upon request.

I agree that the State of California, the Trustees of the California State University and Colleges, California State University, East Bay, and each and every officer, agent and employee of them (hereafter collectively referred to as the State) shall not be responsible for any injury, damage, or loss which occurs from any cause beyond the control of the State or which does not occur from the sole negligence of the State. I further agree to hold harmless, defend and indemnify the State from any and all claims, injuries, damages, losses, causes of action and demand and all costs and expenses incurred in connection therewith (hereafter collectively referred to as liability) resulting from or in any manner arising out of or in connection with any negligence on the part of the Speech Pathology and Audiology Program, its agents or employees, in the performance of the services, irrespective of whether such liability is also due to any negligence on the part of the State but not if such liability is due to the sole negligence of the State.

I understand that no client information can be released to any person or agency without my specific written authorization.

Date: ___________________________ 20____
 Month   Day

Client's Signature

__________________________
Relationship to Client
(If signing for dependent child or disabled adult)
Authorization for Release of Information

I authorize the Speech, Language and Hearing Clinic, Cal State East Bay to release SPEECH-LANGUAGE-AUDIOLOGY records and information pertaining to

Name of client: ____________________________________ Date of Birth: ________________
______________________________________________________________________________
Address      City  State   Zip Code      Telephone

to the following:  □  the client, or

Name: ____________________________ Facility, if applicable ___________________________
______________________________________________________________________________
Address      City  State   Zip Code      Telephone

AUTHORIZATION - You must have legal authority to request information. If you are acting as a legal representative to another individual, you must describe the legal relationship to act for the individual.
DURATION - This authorization shall become effective immediately and remain in effect for one year from the date of signature, unless otherwise indicated below.
REVOCATION - You may revoke this authorization, in writing, at any time. The written revocation will be effective upon receipt, but will not be effective to the extent that the person requesting information or others have acted in reliance upon this authorization.
REDISCLOSURE - You may not lawfully further use or disclose the health information to another unless another authorization is obtained or unless such disclosure is specifically required or permitted by law.
COPIES - You have a right to receive a copy of this release authorization form.
FEES - A fee of $1.00 per page will be charged for each page in excess of ten.

USE OF INFORMATION: The information will be used for the following purposes:

Speech language assessment, therapy, or treatment for related medical conditions.

Printed Name of Person Signing Release ____________________________ Signature   Date ____________

Legal Relationship to Client,  or  □ self Expiration Date for Authorization
PERMISSION TO OBSERVE AND RECORD

The Speech, Language and Hearing Clinic at California State University, East Bay, is both a teaching and clinical service facility. It serves the training needs of students preparing for careers in Speech-Language Pathology and Audiology. It also provides diagnostic and remedial services to individuals with speech, language or hearing disorders.

Diagnostic evaluations and therapy done by student clinicians must be observed by the professional staff of the department. In addition, students enrolled in courses in the department are often required to observe diagnostic and therapy sessions. Audio and video recordings of evaluations and therapy sessions are frequently made for supervisory and training purposes.

With this information in mind, I agree to permit observation of my diagnostic and/or therapy sessions by staff supervisors and others in the professional training programs of the Clinic. I also agree to the audio or video recording of my diagnostic/therapy sessions to be used for educational purposes. I understand that these recordings will not be used outside of the Speech Pathology and Audiology Program without my express permission and that everything will be done to protect my privacy.

______________________________   __________________
Client's Signature      Date
(Parent or Guardian, if a minor)

ABSENCE POLICY

In order to complete their course requirements, student clinicians are required to complete a minimum of 15 hours of therapy with each assigned client each quarter. Regular attendance is therefore very important. When clients do not keep their appointments, it is difficult or impossible for students to complete their requirements. In addition, it makes it very difficult for clients to meet their therapy goals.

Please notify the clinician or the clinic office (510-885-3241) if you will be unavoidably detained or absent. After two absences, the clinician or supervisor will discuss attendance with the client and issue a warning. After three absences within one quarter, we reserve the right to terminate therapy. I understand the attendance policy as stated and agree to these terms.

______________________________   __________________
Client or Guardian's Signature     Date
### How many minutes across disorders?

*Note: Rees clinic Tx sessions are 55 minutes max.*

<table>
<thead>
<tr>
<th>DATE</th>
<th>A</th>
<th>F</th>
<th>V</th>
<th>SW</th>
<th>AAC</th>
<th>L</th>
<th>C</th>
<th>S</th>
<th>H</th>
<th>Dx</th>
<th>Tx</th>
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<tbody>
<tr>
<td>10/5</td>
<td>20</td>
<td>35</td>
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<td>55</td>
<td>25</td>
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**TOTAL MINUTES**

- **SUP OBS. MIN.**
- **CONSULTATION MINUTES**
  - with Client and Family only
  - plus Sprvisor Feedback

**Logged into CALIPSO**

- **W**
- **V**
- **ITP**
- **Self-Eval**
- **SOAP Notes**
- **Data**

**FOR SUPERVISORS ONLY**

- In this box, put an "X" when hours are submitted to supervisor in CALIPSO at the end of the term.

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To convert minutes to hours, divide by 60.

Ex: 990/60 = 16.5, or 16 hrs, 30 min.
Intended Therapy Plan for ________________________________  Date: ____________

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<thead>
<tr>
<th>Performance</th>
<th>Conditions</th>
<th>Criterion</th>
<th>Rationale</th>
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Clinician : ________________________________