SALUS UNIVERSITY
The Eye Institute
Pennsylvania Ear Institute
Speech-Language Institute

By signing this form, I am acknowledging receipt of the Notice of Privacy Practices of Salus University. I have the right to review the Notice of Privacy Practices prior to signing this form. If I do not sign this form, Salus University may decline to provide treatment to me (or my child/care recipient). Salus University reserves the right to revise its Notice of Privacy Practices at any time. A copy of such revisions will be available upon request.

Client Name: _____

Client Date of Birth: _____

Signature: _____ **Date:** _____

Printed Name (if signing on behalf of the Client): _____

Relation to Client: _____

SALUS UNIVERSITY
Speech-Language Institute

T 215.780.3150
F 215.780.3169

8380 Old York Road, Suite 2100
Elkins Park, PA 19027-1539

CONSENT FOR EVALUATION AND TREATMENT

I consent to evaluation and treatment services (or, for _____ if signing on behalf of the client) by the students and clinical educators of the Speech-Language Institute (SLI) at Salus University.

I understand that services will be provided by speech-language pathologists licensed in the Commonwealth of Pennsylvania and certified by the American Speech-Language Hearing Association and graduate students, working under the direct supervision of licensed and certified speech-language pathologists. I acknowledge that no guarantee has been made as to evaluation or treatment outcomes for me (or for my child/care recipient) and that I may terminate services with SLI at any time.

ATTENDANCE

Consistent attendance is the foundation of helping a client make progress in therapy. I understand that it is my responsibility to ensure that I (or my child/care recipient) attend my regular scheduled therapy sessions. If you must cancel a therapy appointment, please call the clinic d no later than 8:00 a.m. the day of your scheduled session.

If I (or my child/care recipient) miss 3 or more appointments without notice in a 3-month period, SLI reserves the right to discontinue treatment.

INSURANCE REIMBURSEMENT

I understand that the Speech-Language Institute at Salus University is not billing my (or my child's/care recipient's) insurance, including Medicare and Medicaid, for services rendered.

OBSERVATIONS

I understand that the Speech-Language Institute at Salus University is a learning institution and will occasionally have prospective students, graduate students from other Salus University programs, and other professionals observe therapy sessions. My signature acknowledges my consent to be observed during sessions (or to observe my child/care recipient).

By signing this form, I acknowledge that I have read, understand and agree to its contents and that I have had the opportunity to ask questions and request clarifications.

Client (or Parent/Caregiver) Signature: _____ Date: _____

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CONSENT FOR AUDIO/VIDEO RECORDING AND PICTURE IMAGES

I give consent to SLI to take audio/video recordings and/or picture images of me (or my child/care recipient) to aid in the evaluation/treatment process. I understand that all audio/video recordings and images collected during my (or my child's/care recipient's) sessions are used for clinical and educational purposes and will remain confidential. SLI will not use the audio/video recordings or images for any other purposes outside of the university setting without my written consent.

I authorize the use and disclosure of the audio/video recording and images of my (or my child's/care recipient's) diagnostic and/or therapy sessions which may include health information. I also understand that these audio/video recordings and images will contain identifiable information such as voice and full facial images. I understand the recordings and images may be used in the clinic and classroom for teaching purposes.

PARTICIPATION IN RESEARCH PROJECTS

Clients may be asked by students and/or researchers at Salus University if they would be interested in participating in a research study pertaining to their condition. When contacted, clients will be given an opportunity to review information about the study in order to decide whether or not they wish to participate. Participation in any research study is always optional and will not affect the clinical care delivered to the client. Clients who do not wish to be contacted regarding opportunities to participate in research may opt out at any time by contacting the clinic or by checking the statement below.

☐ Please do NOT contact me with opportunities to participate in research

By signing this form, I acknowledge that I have read, understand and agree to its contents and that I have had the opportunity to ask questions and request clarifications.

Client (or Parent/Caregiver) Signature: _____ Date: _____