

Evaluation and Treatment Consent Form

I, _____, hereby consent and agree:

1. To permit the Barkley Speech-Language and Hearing Clinic, Department of Special Education and Communication Disorders of the University of Nebraska-Lincoln, to conduct assessments for the purpose of evaluation and/or develop and implement a treatment plan.
2. To make all reasonable effort to obtain any information or records requested by the Clinic.
3. To pay all bills within thirty (30) days of receipt unless otherwise agreed upon in writing with the Barkley Speech-Language and Hearing Clinic. **Account balances not kept current will require payment at time of service.**
4. To permit students of the University of Nebraska-Lincoln (under the supervision of a certified Speech-Language Pathologist, Audiologist, or other certified personnel) to observe and/or participate actively in the client's evaluation or treatment and that sponsors and/or contributors may observe and discuss clinical treatment or evaluation of the client.
5. To leave to the sole discretion of the clinical supervisor (or other appropriate faculty) the decision to allow such observation.
6. To permit Barkley Speech-Language and Hearing Clinic personnel to photograph, film, record, or in any manner reproduce the whole or any part of the client's evaluation or treatment program for educational purposes only.
7. That I have access to all final reports and records regarding the client's evaluation and treatment as stipulated under applicable state and federal laws.
8. To make every effort to assure that the client be present and on time for every evaluation or treatment session, understanding that I may be charged for missed appointments not cancelled in advance and that 3 missed appointments in a semester will be cause for terminating the treatment program. A minimum one hour advance notice of cancellation is desired.

I hereby certify that I have read and fully understand both sides of the Consent Form. I also certify that no guarantees or assurances have been made as to the results which are to be obtained from the evaluation or treatment program.

Signed: _____ Relationship: _____

Witness: _____ Date: _____

The Consent Form must be signed by the client. If the client is an unemancipated minor, the legal guardian or nearest relative must sign the Consent Form. This Consent expires one year after date signed.

7/03

253 Barkley Memorial Center / P.O. Box 830731 / Lincoln, NE 68583-0731 / (402) 472-2071

Accreditation in Speech-Language Pathology and Audiology
by the Council on Academic Accreditation in Audiology and Speech-Language Pathology

For your convenience, the Barkley Speech-Language and Hearing Clinic has enrolled in a number of insurance programs as a provider. Providing quality care for our clients and patients is our primary concern.

We are happy to provide that care within your insurance guidelines if you let us know **each** time the guidelines change.

- If you *do not* provide our billing personnel with this information and receive services that are covered, we will have no choice but to directly bill you.
- Payment for those charges is then your responsibility.

While we are pleased to provide this service for you, please be aware of the following:

- Each insurance plan has different stipulations regarding what speech, language, or hearing services are covered.
- Each plan has different stipulations regarding how often services may be provided.
- Some plans stipulate that services may only be provided in specific places such as, but not limited to, any of the following: hospitals, rehabilitation centers, skilled nursing facilities or similar sites.
- Even within the same insurance company, there are many different plans.

By signing the Evaluation and Treatment Consent form, you agree to accept responsibility as described.