Dear Prospective Client:

Thank you for your interest in receiving services at the Edward D. Mysak Clinic for Communication Disorders (EDMCCD). The EDMCCD is an integral part of the graduate training program in speech and language pathology at Teachers College. The Clinic offers a wide range of diagnostic and therapeutic services to individuals of all ages with communication disorders. These services are provided by advanced graduate students who are enrolled in the Speech and Language Pathology program at the College. Graduate clinicians provide these services under the direct supervision of the Clinical Faculty. All of our Clinical Faculty are certified through the American Speech-Language-Hearing Association and hold New York State Licensure.

If you are interested in scheduling an evaluation or inquiring about beginning therapeutic services, please fill out the intake forms included in this document. Once completed, the forms can be scanned and returned via email at mysakclinic@tc.columbia.edu, mailed to the address above, or delivered to the clinic. **Please do not fax these confidential forms.** If you have received previous evaluations, please include these reports with your intake forms.

We look forward to hearing from you.

Thank you,
The Mysak Clinic
EDWARD D. MYSAK CLINIC FOR COMMUNICATION DISORDERS

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
BOX 191/ 525 WEST 120TH STREET / 101 MACY HALL
NEW YORK, NEW YORK 10027
TEL: (212) 678-3409

PEDIATRIC INTAKE FORM

Date Form Completed: _________________

Client’s Name: ____________________________________________________________

Date of Birth: ___________ Age: _______ Parents/ Caregivers: ______________________

Parents are: ☐ Married/Partnership ☐ Separated ☐ Divorced

How many siblings? _________ Ages: _______________

Address: ________________________________________________________________

Preferred Phone: _____________ Home: _______________ Cell: ________________

E-mail Address: __________________________________________________________

Person filling out this form: _______________ Relationship to child: _______________

Referred by: ___________________________________________________________________

Has the child had a prior speech/language evaluation? ☐ Yes ☐ No
If yes, where & when? ___________________________________________________________________

Has the child received any previous speech/language therapy? ☐ Yes ☐ No
If yes, where & when? ___________________________________________________________________

Has the child ever been evaluated by any other specialist? ☐ Yes ☐ No
If yes, please note the type of specialist(s), date(s) and reason(s): ______________________
______________________________________________________________________________

**If the child has received any other evaluations please submit a copy of these reports with this form.
History:
Is there a family history of:

- Speech/language concerns?  □ Yes  □ No  Family member: ______________________
- Learning disabilities?  □ Yes  □ No  Family member: ______________________
- Reading problems?  □ Yes  □ No  Family member: ______________________

Language best spoken & understood: ____________________________________________
Other languages spoken & understood: __________________________________________

What are the primary concerns regarding this child’s speech and/or language?
_____________________________________________________________________________

When was the problem first noticed? ________________________ By whom? ____________
Is the child aware of the problem?  □ Yes  □ No
How does the child react? ______________________________________________________

Over the last 6 months, has the problem: □ improved  □ worsened  □ remained the same?
Does the child prefer to:  □ talk  □ gesture
Does the child most frequently use: □ sounds  □ words  □ sentences
Does the child make sounds incorrectly?  □ Yes  □ No
If yes, please explain: __________________________________________________________

Is the child’s voice different from other children of the same age?  □ Yes  □ No
If yes, please explain: __________________________________________________________

Does the child stutter on words/sounds? □ Yes  □ No

Does the child:
- Tell a simple story  □ Yes  □ No
- Express thoughts & ideas  □ Yes  □ No
- Understand what is said  □ Yes  □ No
- Follow directions  □ Yes  □ No
- Get along with other children  □ Yes  □ No
- Prefer to play alone  □ Yes  □ No
- Like to read  □ Yes  □ No
- Listen to stories  □ Yes  □ No

What games/toys does the child enjoy? ____________________________________________
What television programs does the child enjoy? ______________________________________

Does the child attend:  □ daycare  □ preschool  □ grade school (if so, what grade___)
Is the teacher concerned?  □ Yes  □ No
Birth and Delivery Information:

This child is: □ biological □ adopted □ foster

Were there medical problems during the pregnancy? □ Yes □ No

If yes, please describe: ____________________________________________________________

List any medications taken during the pregnancy or the delivery: _________________________

________________________________________________________

Was the child born at full term? □ Yes □ No If no, how many weeks gestation? _______

Were there complications during delivery? □ Yes □ No After delivery? □ Yes □ No

If yes, please describe: ____________________________________________________________

Were there: Feeding problems? □ Yes □ No

Low birth weight? □ Yes □ No

Problems gaining weight? □ Yes □ No

Development:

Please list the ages that the child first met these developmental milestones:

Sitting _____ Crawling_____ Walking____

Babbling____  First Word _________ Sentences_____ Toilet Training____

Did the child stop talking for a period of time? □ Yes □ No If yes, when: _________________

Does the child have trouble hearing? □ Yes □ No

Has the child ever had a hearing test? □ Yes □ No

If yes, where and when? ___________________________________________________________

Has the child had “tubes” in his/her ears? □ Yes □ No

Are the “tubes” still in? □ Yes □ No

Which hand does the child use most frequently? □ Left □ Right

Would you describe the child as coordinated? □ Yes □ No

List all current medications:

______________________________________________________________________________

______________________________________________________________________________
Medical history (please check all that apply):

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenoidectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed wetting</td>
<td></td>
<td></td>
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<tr>
<td>Chickenpox</td>
<td></td>
<td></td>
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<tr>
<td>Chronic colds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convulsions/seizures</td>
<td></td>
<td></td>
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<tr>
<td>Dental problems</td>
<td></td>
<td></td>
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<tr>
<td>Difficult to manage</td>
<td></td>
<td></td>
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<tr>
<td>Diphtheria</td>
<td></td>
<td></td>
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<tr>
<td>Drooling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear infections</td>
<td></td>
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<tr>
<td>Encephalitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
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<tr>
<td>Head injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High fevers</td>
<td></td>
<td></td>
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<tr>
<td>Meningitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
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<tr>
<td>Nasal regurgitation</td>
<td></td>
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<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic fever</td>
<td></td>
<td></td>
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<tr>
<td>Rubella</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scarlet fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tonsillitis/tonsillectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision problems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please describe any other health issues (accidents, injuries, operations):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Your patient has requested the service of a speech language pathologist and/or audiologist. The patient will be receiving these services at the Edward D. Mysak Clinic for Communication Disorders at Teachers College, Columbia University. We appreciate your informing us about your patient’s general health and immunization status. Thank you.

Patient’s Name:______________________________ Date: ________________

If the patient is a child, is his/her immunization up to date? Yes No

Please describe any medical conditions that may affect the patient’s ability to participate in a speech, language, and hearing evaluation or therapy?

Is there a history of seizures or other sudden changes in consciousness that we should be aware of?

Is the patient taking any medications regularly? If so, what for and are there side effects we should be aware of?

Please describe any pertinent medical conditions or findings:

M.D. ________________________________
Address: ________________________________
Phone: ________________________________
FEE POLICY

<table>
<thead>
<tr>
<th>Communication</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluation, Children and Adults</strong></td>
<td></td>
</tr>
<tr>
<td>Fall, Spring, or Summer</td>
<td>$300.00</td>
</tr>
<tr>
<td><strong>Therapy, Children and Adults</strong></td>
<td></td>
</tr>
<tr>
<td>Fall or Spring: Twice weekly</td>
<td>$600.00</td>
</tr>
<tr>
<td>Fall or Spring: Once weekly</td>
<td>$300.00</td>
</tr>
<tr>
<td>Summer: Twice weekly</td>
<td>$300.00</td>
</tr>
<tr>
<td>Summer: Once weekly</td>
<td>$150.00</td>
</tr>
<tr>
<td><strong>Accent Modification</strong></td>
<td></td>
</tr>
<tr>
<td>Fall, Spring, or Summer (Once weekly including evaluation)</td>
<td>$1,500.00</td>
</tr>
<tr>
<td><strong>Aphasia Group</strong></td>
<td></td>
</tr>
<tr>
<td>Fall, Spring, or Summer</td>
<td>$25.00</td>
</tr>
<tr>
<td><strong>Aphasia Group and Individual Sessions</strong></td>
<td></td>
</tr>
<tr>
<td>Fall or Spring</td>
<td>$100.00</td>
</tr>
<tr>
<td>Summer</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

| Audiology                              |                      |
| **Complete Audiological Evaluation**   |                      |
| Children and Adults                    | $125.00              |
| **Follow-up Evaluations**              | $60.00               |

Fees are payable to Edward D. Mysak Clinic for Communication Disorders by using our online CashNet system. Payments are not accepted at the clinic. Directions for paying your bill online will be provided with your first statement. We do not accept insurance; however, after payment is made, we will be happy to provide you with copies of documentation for you to submit to your insurance carrier.

- Evaluation fees must be paid within two weeks of scheduling. If the fee is not paid, the evaluation will be cancelled. All cancellations and changes must be made at least two weeks in advance. Evaluations cancelled within one week of the scheduled evaluation will be refunded 50% of payment. Evaluations cancelled within 48 hours of the scheduled evaluation are non-refundable. Payment will not be refunded for clients who do not attend a scheduled evaluation.
• Fees for all therapeutic services are charged by the semester, not by the session. Fees are not refunded for absences. Please refer to the attendance policy for more detail.

• Fees for all therapeutic services will be billed at the start of each semester. Fees are due by mid-semester. Clients who have not paid their bill in full by the end of the semester will not be scheduled for further therapeutic sessions.

• The Edward D. Mysak Clinical Staff will prepare specialized reports upon request. A consultation fee of $100.00 will be billed for requests that require preparation beyond the duplication of file documents.

• A sliding fee scale is available for clients with a documented need. Please contact the Mysak Clinic for an application.

• The fee policy is subject to modifications each semester.

I have read the above fee policy and agree to comply with the terms and conditions of the policy.

______________________________
Name

______________________________
Signature

______________________________
Date

Updated 1/2013
BILLING FORM

Date: ___________________________  Semester: ___________________________

Client: __________________________ Date of Birth: _______________________

Person responsible for payments: (Name) ___________________________________

Relationship to client: ___________________________________________________

Address: __________________________________________________________________

Home Phone #: ___________________________
Work Phone #: ___________________________
Cell Phone #: ___________________________
E-mail Address: __________________________________________________________________

Person who will be bringing client to therapy: _________________________________

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

(For Office Use Only)

Treatment   CPT- 92507

____ Articulation  ____ Language  ____ Fluency  ____ Voice  ____ Accent Reduction

Treatment CPT-G0197

____ Augmentative Communication

ICD-9 Code: ________________________________

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Updated 1/2013
I understand that as part of my health care, the Edward D. Mysak Clinic for Communication Disorders (EDMCCD) at Teachers College, Columbia University maintains records about my health as related to my speech, language, hearing and/or swallowing abilities. These records describe my health history, symptoms, examination and test results, diagnoses, and any plans for care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals at the EDMCCD who contribute to my care;
- a source of information for applying my diagnosis and medical treatment information to my bill;
- a means by which a third-party payer (i.e. insurance company) can verify that services billed were actually provided should I decide to submit a claim to my insurance company;
- and a tool for routine health care operations within the EDMCCD, such as assessing quality and reviewing the competence of health care professionals.

The attached Notice of Privacy Practices gives a more complete description of how my health information may be used or disclosed by the EDMCCD at Teachers College. The Notice of Privacy Practices also explains my rights regarding my personal health information, including the right to access my own records and the right to request restrictions as to how my health information is used or disclosed.

I understand it is my responsibility to notify the EDMCCD of any restrictions to the disclosure of my health information regarding this or any subsequent visit.

I have been provided a Notice of Privacy Practices and have been given the opportunity to review this information. I acknowledge this by my signature below.

_________________________  _________________________
Printed Patient Name                  Date

_________________________  _________________________
Signature of Patient or Legal Representative                  Date
NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) which was instituted by the U.S. Department of Health and Human Services on April 14, 2003, this notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

How we may use and disclose health information about you:

The Edward D. Mysak Clinic for Communication Disorders (EDMCCD) is committed to protecting the privacy of all health information we create and maintain as a result of the health care we provide you. Your “protected health information” (PHI) includes information about your past, present, or future health, health care we provide you and payment for services that we provide to you. The purpose of this notice is to explain who, what, when, where, and why your PHI may be disclosed and assist you in making informed decisions when authorizing anyone to use or disclose your PHI. We may use and disclose your PHI for the following purposes:

Treatment
We may use and disclose your PHI to provide you with clinical treatment and services. We may disclose PHI to graduate clinicians, certified Speech-Language Pathology supervisors, academic faculty, or other personnel in the EDMCCD who are involved in taking care of you.

Payment
We may use and disclose PHI so that we may bill for treatment and services you receive at the EDMCCD and can collect payment from you. Although the EDMCCD does not accept insurance, at your request, we will send your information to an insurance company or another third party so that you can be reimbursed for services.

Health Care Operations
We may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary to make sure that all of our clients receive quality care and for our operation and management purposes. For example, we may use PHI to review the treatment and services you receive and/or to check on the performance of our staff in caring for you. We also may disclose PHI to students and/or faculty in the Speech-Language Pathology Program for educational and learning purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services
We may use and disclose PHI to contact you to remind you that you have an appointment for evaluation or treatment. We may also contact you to tell you about possible treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care
We may disclose PHI to family or others identified by you or who are involved in your care or payment of your care.
Legally Required Disclosures and Public Health
We may disclose PHI as required by law, including to government officials to prevent or control disease; to report child, adult or spouse abuse; or to report reactions or problems with products used in the EDMCCD.

Health Oversight Activities
We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include but are not limited to audits, investigations, inspections, academic accreditation, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Workers Compensation
We may disclose PHI for workers compensation or similar programs.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Your Rights Regarding Health Information About You
You have the following rights, subject to certain limitations, regarding the PHI we maintain and disclose:

Right to Inspect and Copy
You have the right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Request Amendments
If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information; however, you must disclose to us the reason for your request. A request for amendments must be submitted, in writing, to the EDMCCD at the address listed at the beginning of this document.

Right to an Accounting of Disclosures
You have the right to request an “accounting of disclosures” of PHI. This is a list of certain disclosures we have made of PHI. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list.

Right to Request Restrictions
You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment. All restriction requests must be submitted, in writing, to the EDMCCD at the address listed at the beginning of this document.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by e-mail or only by phone. Your request must specify how or where you wish to be contacted and must be submitted, in writing, to the EDMCCD at the address listed at the beginning of this document. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You
may request a copy of this Notice at any time by contacting the EDMCCD at the address or phone number at the beginning of this document.

**How to Exercise Your Rights**
To exercise your rights described in this Notice, send your request, in writing, to Dr. Kathleen M. Youse, our Privacy Officer, at the address listed at the beginning of this document.

**Changes to This Notice**
We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for PHI we already have as well as any information we receive in the future. We will post a copy of the current Notice in the lobby of the EDMCCD. The end of our Notice will contain the Notice’s effective date.

**Complaints**
If you believe your privacy rights have been violated, you may file a complaint with the EDMCCD or with the Secretary of the Department of Health and Human Services. To file a complaint with the EDMCCD, contact Dr. Kathleen M. Youse, our Privacy Officer, at the address listed at the beginning of this document. To contact the Department of Health and Human Services, please refer to www.hhs.gov. You will not be penalized for filing a complaint.
1. RISK OF USING E-MAIL

The Edward D. Mysak Clinic for Communication Disorders (EDMCCD) offers clients the opportunity to communicate by e-mail. Transmitting client information by e-mail, however, has a number of risks that clients should consider before using e-mail. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- E-mail senders can easily misaddress an e-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

The EDMCCD will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the Risks outlined above, the EDMCCD cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper use and/or disclosure of confidential information (including Protected Health Information that is the subject of the federal Health Insurance Portability and Accountability Act of 1996) that is not caused by the EDMCCD’s intentional misconduct. Thus, clients must consent to the use of e-mail for client information. Consent to the use of e-mail includes agreement with the following Conditions:

- All e-mails to or from the client concerning diagnosis or treatment will be printed out and made part of the client’s record. Because they are a part of the client’s record, other individuals authorized to access the record, such as staff and billing personnel, will have access to those e-mails.
- The EDMCCD may forward e-mails internally to the EDMCCD’s staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. The EDMCCD will not, however, forward e-mail to independent third parties without the client’s prior written consent, except as required by law.
- Although the EDMCCD will endeavor to read and respond promptly to an e-mail from the client, the EDMCCD cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the client shall not use e-mail for emergencies or other time-sensitive matters, including cancellations and schedule changes within 48 hours.
- If the client’s e-mail requires or invites a response from the EDMCCD, and the client has not received a response within a reasonable time period, it is the client’s responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- The client is responsible for informing the EDMCCD of any type of information the client does not want to be sent by e-mail.
- The client is responsible for protecting his/her password or other means of access to e-mail. The EDMCCD is not liable for breaches of confidentiality caused by the client or any third party.
- The EDMCCD shall not engage in e-mail communication that is unlawful.
- It is the client’s responsibility to follow up and/or schedule an appointment if warranted.
3. INSTRUCTIONS
To communicate by e-mail, the client shall:

a. Limit or avoid use of his/her employer’s computer or other public computers.
b. Inform the EDMCCD of changes in his/her e-mail address.
c. Put the client’s initials in the body of the e-mail.
d. Include the category of the communication in the e-mail’s subject line, for routing purposes (e.g., billing question).
e. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to the EDMCCD.
f. Inform the EDMCCD that the client received an e-mail from the EDMCCD.
g. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
h. Withdraw consent only by e-mail or written communication to the EDMCCD.
i. Contact the EDMCCD via phone (212) 678-3409 with any unanswered questions before communicating with the EDMCCD via e-mail.

4. CLIENT ACKNOWLEDGMENT AND AGREEMENT
The names and e-mail addresses listed remain in effect until termination of services at the EDMCCD. In the event that changes are made; a new consent form must be completed.

I acknowledge that I have read and fully understand the information the EDMCCD has provided me regarding the Risks of using e-mail. I understand the Risks associated with the communication of e-mail between the EDMCCD and me, and consent to the Conditions outlined on the previous page. In addition, I agree to the Instructions outlined, as well as any other Instructions that the EDMCCD may impose regarding e-mail communications.

I give permission for the EDMCCD to communicate by email with the following individuals:

<table>
<thead>
<tr>
<th>Name</th>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____________________</td>
<td>______________</td>
</tr>
<tr>
<td>_____________________</td>
<td>______________</td>
</tr>
<tr>
<td>_____________________</td>
<td>______________</td>
</tr>
</tbody>
</table>

By signing this contract, I indicate that I have read this document and understand the contents.

__________________________  ____________________________  ____________
Signature                     Print Name                         Date

**************

My signature below indicates that I DO NOT give e-mail consent and information WILL NOT be exchanged through e-mail.

__________________________  ____________________________  ____________
Signature                     Print Name                         Date
The Edward D. Mysak Clinic for Communication Disorders has two major objectives. The first is to provide professional services in the areas of speech, language, and hearing and the second is to train graduate clinicians in the Department of Speech Language Pathology and Audiology. Services rendered are provided by graduate clinicians working under the supervision of licensed and qualified clinical staff and faculty. As this is a center housed within and associated with an academic institution, it is necessary that clients be willing to cooperate with educational and research activities as indicated below. Clients are assured that such activities will in no way interfere with the quality of the services provided.

- Services rendered will be provided by graduate clinicians, working under the supervision of licensed and qualified clinical staff and faculty.

- Any and all contact with clients may be observed through one-way mirrors; these will be recorded and videotaped for teaching purposes.

- Data collected during any interaction with the client may be used for research purposes, but identifying information will be kept confidential at all times.

If you have any questions, please inquire before signing this document.

**This document remains in effect until services are terminated.**

_____________________________________
Client Name

_____________________________________
Client Signature (legal guardian for those <18) Date