Edward D. Mysak Clinic for Communication Disorders

Teachers College, Columbia University

Communication Sciences and Disorders

Clinic Packet

Edward D. Mysak Clinic for Communication Disorders
Teachers College, Columbia University

Welcome

Welcome to the Edward D. Mysak Clinic for Communication Disorders at Teachers College, Columbia University! We are honored that you have chosen us to support your communication needs and are grateful for the trust you've placed in our clinical services.

At the Mysak Clinic, we are committed to delivering the highest quality care while fostering a supportive and inclusive environment. All evaluation and treatment services are evidence-based and are provided by graduate clinicians in the Program in Communication Sciences and Disorders under the direct supervision of licensed, ASHA-certified speech-language pathologists.

Please take time to review the enclosed forms and materials. Your assigned graduate clinician will review this information with you during your first session, answer any questions you may have, and ensure you are comfortable with the process. Copies of your signed documents will be securely maintained in your clinical record, and blank copies are always available upon request.

Your satisfaction is important to us. If you have questions or concerns about your care at any time, please do not hesitate to contact us directly.

We look forward to working with you and supporting your communication goals!

Sincerely,

Bernadine Gagnon, M.S., CCC-SLP
Clinic Director
Department of Biobehavioral Sciences
Program in Communication Sciences and Disorders
Edward D. Mysak Clinic for Communication Disorders

525 West 120th Street
Macy Hall 101
212-678-3889 | brg15@tc.columbia.edu

Edward D. Mysak Clinic for Communication Disorders

Teachers College, Columbia University

Nondiscrimination Statement

The Edward D. Mysak Clinic for Communication Disorders is committed to creating and sustaining an environment of equity, dignity, and respect for all individuals. In accordance with Teachers College, Columbia University's Equal Opportunity and Nondiscrimination Policy, we do not discriminate on the basis of race, color, ethnicity, national origin, sex, sexual orientation, gender identity or expression, disability, religion, age, veteran status, or any other protected characteristic.

Our clinic strives to ensure all clients, students, staff, and faculty are treated equitably and respectfully. We uphold the principles of Title IX, Section 504 of the Rehabilitation Act, and the Americans with Disabilities Act (ADA) to ensure a safe, inclusive, and welcoming learning and care environment for all.

I have been given the opportunity to review the Nondiscrimination Statement. I acknowledge this by my signature below.

____
Printed Client Name

______________________________________ ________________
Client Signature (or legal guardian for minors) Date

Edward D. Mysak Clinic for Communication Disorders
Teachers College, Columbia University

CLINIC RELEASE FORM

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 or via Zoom; 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. ****

____

Printed Client Name

______________________________________ ________________

Client Signature (or legal guardian for minors) Date

Edward D. Mysak Clinic for Communication Disorders

Teachers College, Columbia University

NOTICE OF PRIVACY PRACTICES

The ECMCCD is not a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and is not required by law to follow the requirements of the HIPAA. However, we are committed to protecting the privacy of our client s information and have created specific Confidentiality Policies that must be upheld by all clinic staff and graduate clinicians. 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 services you receive at the EDMCCD and can collect payment from you. The EDMCCD does not accept insurance and does not directly bill third party payers.

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 Communication Sciences and Disorders 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 worker's 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 email 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 Mrs. Bernadine Gagnon, the EDMCCD 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 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. To file a complaint with the EDMCCD, contact Mrs. Bernadine Gagnon the EDMCCD Privacy Officer, at the address listed at the beginning of this document. You will not be penalized for filing a complaint.

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

____
Printed Client Name

______________________________ ______________
Client Signature (or legal guardian for minors) Date

Edward D. Mysak Clinic for Communication Disorders
Teachers College, Columbia University

EMAIL CONSENT

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.
- E-mail does not provide attached documents including Protected Health Information.

Contact the EDMCCD via phone (212) 678-3409 with any unanswered questions before communicating with the EDMCCD via e-mail.

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 email between the EDMCCD and me.

By checking the box below I indicate that I DO NOT give e-mail consent and information WILL NOT be exchanged through e-mail.

□ I DO NOT give e-mail consent, information WILL NOT be exchanged through e-mail

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

____
Printed Client Name

____________________________________ ________________
Client Signature (or legal guardian for minors) Date

Edward D. Mysak Clinic for
Communication Disorders
Teachers College, Columbia University

CLIENT AUTHORIZATION REGARDING OBSERVATIONS AND SESSIONS VIA ZOOM

Client's Name: ____________________________________

Acknowledgement of the recording of sessions (audio and video):
The Edward D Mysak Clinic for Communication Disorders is a clinical facility primarily for the training of future professionals in Speech- Language Pathology, Audiology, and Aural (Re)Habilitation. Appropriate safeguards related to privacy and confidentiality will be utilized for the provision of services using telehealth.

"I understand the above and hereby release Teachers College, Columbia University, Department of Communication Sciences and Disorders, the right to provide telehealth services using their approved platform (ZOOM). I understand that students are providing services with the supervision of a licensed clinician. I understand that other students of the program may participate in the session as observers. It is further agreed that in the event the Department of Communication Sciences and Disorders of Teachers College, Columbia University or its assigns shall become a party defendant to litigation by said persons as a result of the legitimate use of said platform, (I/We) shall hold harmless and indemnify it or its assigns from any judgment which may be entered against it or its assigns."

Initials ___________

____
Printed Client Name

____________________________________ ________________
Client Signature (or legal guardian for minors) Date

Edward D. Mysak Clinic for Communication Disorders

Teachers College, Columbia University

CLINICAL MEDIA RELEASE FORM
Client Authorization regarding Research Studies, Mode of Communication and Educational Use of Recorded Sessions

Client's Name: ___________________________________

Acknowledgement of the recording of sessions (audio and video):

The Edward D Mysak Clinic for Communication Disorders is a clinical facility primarily for the training of future professionals in Speech Language Pathology, Audiology, and Aural (Re)Habilitation. All clients/patients seen in the clinic for diagnostic and therapeutic services must agree to the recording of sessions. Recordings may be reviewed and used by faculty, staff and students as part of a client/patient's plan of care, as part of a research project and/or to facilitate instructional objectives for students enrolled in the program. Appropriate safeguards related to privacy and confidentiality will be utilized for the use and storage of such recordings and this specific authorization regarding the recordings is attached below and must be signed by each patient.

"I understand the above and hereby release Teachers College, Columbia University, Department of Communication Sciences and Disorders, the right to make audio and video recordings or to photograph said person in any and all phases of the educational or remedial process and to put the audio and video recordings or photographs to any legitimate educational or training uses. All recordings, photographs and their reproductions shall remain the property of the Department of Communication Sciences and Disorders of Teachers College, Columbia University. It is further agreed that in the event the Department of Communication Sciences and Disorders of Teachers College, Columbia University or its assigns shall become a party defendant to litigation by said persons as a result of the legitimate use of said audio and video recordings, photographs, and/or descriptive literature or sound tracks, (I/We) shall hold harmless and indemnify it or its assigns from any judgment which may be entered against it or its assigns."

Edward D. Mysak Clinic for Communication Disorders
Teachers College, Columbia University

<u>Electronic communication and transmission of service related information:</u>

Authorization is given to the Edward D Mysak Clinic for Communication Disorders of the Department of Communication Sciences and Disorders, Teachers College, Columbia University, 525 W 120th Street, Box 191, New York, NY 10027, to communicate with me via **email, telephone (voice/text) and/or fax,** regarding therapy and/or assessment for the above-named client. I acknowledge that the Edward D Mysak Clinic for Communication Disorders of the Department of Communication Sciences and Disorders cannot be responsible for non-secured communication.

Initials___________

<u>Participation in research projects:</u>

Clients/patients may be asked by researchers in the Department 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. The researcher must provide all consent and approval forms related to the IRB study. If the client agrees to participate in a research study, IRB and other consent forms will be necessary. Clients/patients who do not wish to be contacted regarding opportunities to participate in research may opt out at any time by contacting the clinic <u>or by checking the statement below</u>.**

Initials___________

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

____

Printed Client Name

_____________________________________ _______________

Client Signature (or legal guardian for minors) Date

Edward D. Mysak Clinic for Communication Disorders
Teachers College, Columbia University

FERPA CONFIDENTIALITY AGREEMENT FOR PATIENTS

Client's Name: ____

Services are provided by graduate student clinicians and is important for all clients to understand and be aware of FERPA regulations. FERPA is an acronym for the Family Educational Rights and Privacy Act. FERPA is a Federal law that is administered by the Family Policy Compliance Office in the U.S. Department of Education that protects the confidentiality of student records and information.

To maintain the confidentiality and security of student information in the clinic, clients must agree to:

- uphold the confidentiality and integrity of all student information and records to which they are exposed directly or indirectly including written, verbal, electronic communication, and intentional or unintentional public exposure of information and records (e.g., information in session plans and observation of sessions);
- never remove from the clinic any records or materials containing student information or leave that information open or exposed inadvertently or intentionally (e.g., session plans);
- never release student information to a third party outside of Teachers College without the student's written permission;
- understand that "information", "records", or "materials" includes information utilized during clinical session;
- and, not to take pictures or video of the session without the student's permission.

I understand that if I violate the privacy policies and/or this agreement, I will be subject to immediate termination of clinical services. My signature affixed below indicates that I understand and will comply with this agreement.

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

** This form remains in effect until services are terminated by the EDMCCD. **

____
Printed Client Name

____________________________________ ____________________
Client Signature (or legal guardian for minors) Date

Edward D. Mysak Clinic for Communication Disorders
Teachers College, Columbia University

FEE POLICY

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. It is your responsibility to submit all the documentation to your insurance. We cannot submit any documents to your insurance company.

Link for payments:
https://commerce.cashnet.com/cashneti/selfserve/EditItem.aspx?PC=MYSAK-BILPAY&ItemCount=1

- Fees for all 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 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 per hours 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.

- Fees for evaluation must be paid accordingly. Clients who do not pay the evaluation fee, won't receive a report of the evaluation until the fees have been paid.

- 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.

____
Printed Client Name

____________________________________ ________________
Client Signature (or legal guardian for minors) Date

Edward D. Mysak Clinic for Communication Disorders
Teachers College, Columbia University

BILLING FORM

Date: _________________ Semester: _____________________

Client: ___________________________

Date of Birth: _____________________

Name of person responsible for payments: _________________________

Relationship to client: ____

Address:

____

____

Home Phone: ______________________________

Work Phone: ________________________________

Cell Phone: _________________________________

Email Address: _________________________________

Person who will be bringing client to therapy:

____

FOR OFFICE USE ONLY – TO BE COMPLETED BY STUDENT

Treatment CPT: _________

____ Articulation ____ Language ____ Fluency ____ Voice ____ Accent reduction

____ Augmentative Communication

ICD-10: Code: _______

Edward D. Mysak Clinic for Communication Disorders
Teachers College, Columbia University

FOR MYSAK CLINIC USE ONLY

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of the EDMCCD Notice of Privacy Practices but was unable to for the following reason:

☐Patient refused to sign

☐Patient unable to sign

☐Other ___________________

_________________________________ _________________________
Graduate Clinician's Signature Date

____
Graduate Clinician's Print name

_________________________________ _________________________
Clinical Instructor's Signature Date