ADMISSION PROCEDURES

1. **Please submit the following application online. Completed applications can also be faxed to 214- 689-6614 or 214-689-6592, emailed to strokecenter@twu.edu, or mailed to the following address:**

   The Stroke Center –Dallas
   Texas Woman's University
   5500 Southwestern Medical Avenue
   Dallas, TX 75235-7299

   Please note that you will be put on our waiting list when your application is received.

   All information is confidential under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2. **Please complete an Authorization for Release of Medical Information for the hospital you were in, any rehabilitation facilities, your neurologist, and your primary care physician. If you have copies of these records, please include them with your application to expedite the admission process.**

3. **Clinical supervisors will review all applications and medical records to determine if an applicant can benefit from services. If accepted, you will be contacted to arrange a date for testing and evaluation. If declined, you will be contacted by the clinical staff to discuss.**

If you have any questions or concerns about the application, please contact The Stroke Center – Dallas at 214-689-6592 or at strokecenter@twu.edu.

Please note that The Stroke Center – Dallas follows the calendar of Texas Woman's University with two 6-week sessions in the spring semester, one 6-week session in the summer semester, and two 6-week sessions in the fall semester.

Our waiting list is prioritized based on the date the application is received.

PERSONAL INFORMATION

Name of Applicant: **Date:**

Social Security Number: *-**-** **(last four digits)** **Date of Birth:**

How did you hear about The Stroke Center – Dallas? Who referred you?

Street Address:

City: **State:** **Zip:**

Preferred Phone: **Alternate Phone:**

Marital Status: **Sex:**

Email Address:

Are you currently employed? **If YES, where:**

What was your most current occupation?

Indicate highest level of education:

Is English your first language?

What language(s) do you speak fluently?

How will you get to The Stroke Center – Dallas?

Drive own car **Driven by family member or friend**

DART **If DART, please provide ID number**

Other

CAREGIVER INFORMATION

Name of Caregiver:

Relationship to Applicant:

Preferred Phone: **Alternate Phone:**

Email Address:

Will someone accompany the applicant to The Stroke Center – Dallas?

If YES, name and relationship to client:

EMERGENCY CONTACT INFORMATION

Name:

Relationship to Applicant:

Preferred Phone: **Alternate Phone:**

Email Address:

MEDICAL AND REHAB INFORMATION

What caused your communication problems (stroke, accident, tumor, traumatic brain injury, etc.)?

Do you have a pacemaker or any other implanted electronic devices?

Before the illness/ accident, were you right or left handed?

Check all that apply:

Hemiparesis?

Medical issues:

Are you independent in toileting?

Do you have difficulty swallowing?

Can you walk independently?

Do you use a

Use independently? **Transfer?**

Please list all hospitals and rehabilitation centers where you were treated:

	Name	Dates	Telephone	Fax Number
Hospital				
Rehab Center				
Speech Therapist				
PCP				
Neurologist				

PRESCRIPTION AND NON-PRESCRIPTION MEDICINES

Medication	Purpose	Dosage	Frequency

Known Allergies:

Additional Information or Comments:

THE STROKE CENTER – DALLAS

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Dallas, TX 75235
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AUTHORIZATION FOR RECORDING AND USE OF EVALUATION / TREATMENT PROCEDURES

I hereby authorize evaluation and/or treatment of at The Stroke Center – Dallas at Texas Woman's University.

I hold The Stroke Center – Dallas, Department of Communication Sciences and Oral Health and Texas Woman's University, its Board of Regents, officers, agents, employees harmless and waive any liability for injury, accident or illness to the patient, caregivers, siblings, family members, or any other persons accompanying the client or family to the evaluation or therapy which may occur during or as the possible result of the course of evaluation/treatment.

It is my understanding that the examination findings and therapy reports will be treated as confidential material and released only to such additional professional persons or agencies as I may authorize.

Please read and initial in the spaces below and check "yes" or "no":

I authorize that the evaluation / treatment procedures of the above patient may be recorded and / or photographed at The Stroke Center – Dallas.

(Initial)

I authorize that the recorded evaluations / treatment procedures may be observed, recorded, and / or photographed for educational, research, and / or advertising purposes including Distance Education and Online Instruction both within and outside the University.

(Initial)

I authorize that the evaluations / treatment procedures may be observed and discussed by students in disciplines related to the Department of Communication Sciences and Oral Health and the College of Health Sciences for academic purposes.

(Initial)

Furthermore, due to patient and student education privacy laws, audio or video recordings of clients or students are not permitted except when made for student education purposes by clinical personnel.

(Initial)

Client, Guardian, or Spouse: Date:

Street Address: City: State: Zip:

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PATIENT NAME: **DATE OF BIRTH:**

COMMUNICATION AUTHORIZATION, CONFIDENTIALITY NOTICE, AND DISCLOSURE FORM

Please read and initial in the space provided.

I recognize that the evaluation and/or treatment procedures and information regarding these procedures may need to be e-mailed back and forth between Texas Woman's University and the client and family, between the supervisors and students, and between Texas Woman's University and other healthcare providers. I authorize that this communication process may be used to further the understanding between clinical personnel and client and family. Should I choose not to authorize this communication process, students and supervisors will communicate via an in-house secured network communication accessible only to personnel of the clinic, but will not use email to communicate with me. (Initial)

I recognize that the evaluation and/or treatment procedures might be observed in the rooms where observation monitors are located or in the observation room by other family members, students, or caregivers. I understand that privacy and confidentiality will be observed and maintained to the best extent possible. I understand that I am expected to respect the privacy of others while in the observation room. (Initial)

DISCLOSURE FORM

I understand that, by federal law, Texas Woman's University may not use or disclose my health information, except as provided in the University's Notice of Privacy Practices, without my authorization. (Initial)

I understand that my signature on this disclosure form indicates that I am giving permission for the uses and disclosures of the protected health information. I hereby release Texas Woman's University, its Board of Regents, officers, agents, employees from any and all liability that may arise from the release of information as I have directed. (Initial)

I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing, and address it to the institution as named above. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization. (Initial)

THE STROKE CENTER – DALLAS

I understand that copies of Texas Woman's University Department of Communication Sciences and Oral Health HIPAA Privacy Practices are available to me in the clinic office. (Initial)

I understand that once information is disclosed in accordance with this authorization, it is possible that the information will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it. (Initial)

I understand that I may refuse to sign this disclosure form. I also understand that the institution named above cannot deny treatment if I refuse to sign this disclosure form. (Initial)

I have read and understand the information in this form.

This disclosure expires automatically upon

(Specify upon revocation, date, event, or one year from date of signature)

Print Client's Name: Date:

Client (or Caregiver) Signature: Relationship to Client:

THE STROKE CENTER – DALLAS

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TELETHERAPY CONSENT

Due to COVID-19, the Speech, Language and Hearing Clinic and the Stroke Center – Dallas (herein referred to as "the Clinic") are offering telepractice to clients who would like to continue therapy services during this time. Below is information about telepractice and consent to receive services using this platform.

Telepractice (the act of providing telehealth services) is defined as "the application of telecommunications technology to deliver professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation." This means that we are able to provide therapy services through digital meetings via various methods of telepractice. This includes but is not limited to Zoom. This mode of service delivery, when implemented correctly, is noted to have similar outcomes to face-to-face interventions. The client, graduate clinician, and supervisor would join a computer-based session at the designated therapy time and would work on the same goals and objectives as they do at the Clinic. We term this "teletherapy."

Before starting the telepractice sessions, the Clinic requests that you review the following consent form. If you consent, please print, sign and date, and return as soon as possible. Do not hesitate to contact us should you have any questions.

It is important that each client understands and agrees to the following information with regards to teletherapy:

1. I understand the following with respect to teletherapy: I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential.

2. I understand that I must be available at the designated time. If I am not available at the scheduled time, I will contact my clinician and or supervisor to cancel the day's session, preferably giving at least 24 hours' notice.

3. The Clinic is currently using various methods of telepractice. This includes but is not limited to Zoom. Any internet-based communication is not 100% guaranteed to be secure/confidential. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the graduate clinician and supervisor, that the transmission of my information could be disrupted or distorted by technical failures or could be interrupted by unauthorized persons. I agree that the Clinic will not be held responsible if any outside party gains access to Zoom or another online platform's personal or confidential information by bypassing their security measures.

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4. I have represented to the Clinic staff that I am currently residing in the State of Texas and I understand the Clinic staff have no reasonable means to know my actual location other than my representation of it. I understand that services can only be provided when I am in the State of Texas as a matter of licensure laws.

5. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. If these items are not available, other modes of service delivery may be implemented. Measures to increase security may include: (a) using a computer in a private room/area with the door closed, and if possible, using some type of sound blocking device; (b) when possible, connecting to the internet directly (as opposed to using Wi-Fi; this also helps with transmission); (c) making sure to turn Zoom off, not just disconnect from the call, when the session is over.

6. In order to facilitate a successful session, I should (a) log into the teletherapy session a couple minutes before the session time so that we can start promptly; (b) limit distractions by turning off cell phones, avoiding having other windows open on the computer, using a quiet room, etc.; and (c) have a caregiver present during the session to assist with activities and/or any logistical issues.

7. I understand technical problems may occur. If the call is disrupted, the student clinician and supervisor will do their best to reconnect.

8. I understand that if at any point teletherapy is not deemed as effective, I will be notified, and sessions might be suspended until face-to-face sessions are available.

I hereby consent that the Client named below may facilitate and engage in teletherapy services with the Clinic. I further consent to this form being electronically delivered to the Clinic.

Print Client’s Name: Date:

Client (or Caregiver) Signature: Relationship to Client:

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ATTENDANCE POLICY

Because The Stroke Center – Dallas is a part of a teaching program, attendance to all therapy sessions is important to both client and the clinician. We ask that you provide us 24 hour notice by phone for any cancellation of sessions. If you miss more than 25% of your sessions in any one semester, we will take you off the therapy schedule for that semester so that we can put someone from our waiting list into the schedule. If you want therapy for the next semester, you could be scheduled if time is available after current therapy clients have been placed. I understand this attendance policy and agree to abide by it.

Print Client's Name: Date:

Client (or Caregiver) Signature: Relationship to Client:

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FOR HOSPITAL

I hereby authorize

(Physician, Hospital, Rehab facility)

(Patient's Name) **(Date)**

ALL
(Treatment Dates)

*****-**- (last four digits)**
(Social Security Number)

Information to be released:

- X Physical and History
- X Speech Therapy Report
- X Radiology Report
- X Discharge Summary
- X Written copy of radiology reports of the brain

Other:

I further authorize that a photocopy of this authorization form will be fully acceptable as an original.

Signature of Patient, Spouse, or Legal Representative:

Please Print Name: **Date:**

For Personal Representative of the Participant (if applicable):

Printed Name of Personal Representative:

Describe Personal Representative Relationship:

(Spouse, parent, guardian, person with power of attorney, etc.)

I certify that I have the legal authority under applicable law to make this Authorization on behalf of the Participant identified above.

Signature of Personal Representative: **Date:**

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FOR REHAB FACILITY

I hereby authorize

(Physician, Hospital, Rehab facility)

(Patient's Name) **(Date)**

ALL
(Treatment Dates)

*****-**- (last four digits)**
(Social Security Number)

Information to be released:

- **X Physical and History**
- **X Speech Therapy Report**
- **X Radiology Report**
- **X Discharge Summary**
- **X Written copy of radiology reports of the brain**

Other:

I further authorize that a photocopy of this authorization form will be fully acceptable as an original.

Signature of Patient, Spouse, or Legal Representative:

Please Print Name: **Date:**

<u>For Personal Representative of the Participant (if applicable):</u>

Printed Name of Personal Representative:

Describe Personal Representative Relationship:
(Spouse, parent, guardian, person with power of attorney, etc.)

I certify that I have the legal authority under applicable law to make this Authorization on behalf of the Participant identified above.

Signature of Personal Representative: **Date:**

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FOR PCP

I hereby authorize

(Physician, Hospital, Rehab facility)

(Patient's Name) (Date)

ALL
(Treatment Dates)

***-**- (last four digits)
(Social Security Number)

Information to be released:

- X Physical and History
- X Speech Therapy Report
- X Radiology Report
- X Discharge Summary
- X Written copy of radiology reports of the brain

Other:

I further authorize that a photocopy of this authorization form will be fully acceptable as an original.

Signature of Patient, Spouse, or Legal Representative:

Please Print Name: Date:

__For Personal Representative of the Participant (if applicable):__

Printed Name of Personal Representative:

Describe Personal Representative Relationship:

(Spouse, parent, guardian, person with power of attorney, etc.)

I certify that I have the legal authority under applicable law to make this Authorization on behalf of the Participant identified above.

Signature of Personal Representative: Date:

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FOR NEUROLOGIST

I hereby authorize

(Physician, Hospital, Rehab facility)

(Patient's Name) **(Date)**

ALL
(Treatment Dates)

*****-**-** **(last four digits)**
(Social Security Number)

Information to be released:

X	Physical and History	X	Speech Therapy Report
X	Radiology Report	X	Discharge Summary
X	Written copy of radiology reports of the brain		

Other:

I further authorize that a photocopy of this authorization form will be fully acceptable as an original.

Signature of Patient, Spouse, or Legal Representative:

Please Print Name: **Date:**

<u>For Personal Representative of the Participant (if applicable):</u>

Printed Name of Personal Representative:

Describe Personal Representative Relationship:

(Spouse, parent, guardian, person with power of attorney, etc.)

I certify that I have the legal authority under applicable law to make this Authorization on behalf of the Participant identified above.

Signature of Personal Representative: **Date:**

:

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ACKNOWLEDGEMENT OF RECEIPT OF TEXAS WOMAN'S UNIVERSITY COMMUNICATION HEARING AND ORAL HEALTH SCIENCES CLINICS

NOTICE OF PRIVACY PRACTICES AUTHORIZATION

I, (Print name) , hereby verify that I have received a copy of the Notice of Privacy Practices of Texas Woman's University Communication Hearing and Oral Health Sciences Clinics.

Authorization to use or disclose protected health information:

• I understand that by federal law, Texas Woman's University Communication Hearing and Oral Health Sciences Clinics may not use or disclose my health information, except as provided in the Communication Hearing and Oral Health Sciences Clinics Notice of Privacy Authorization, without my authorization. My signature on the authorization indicated that I am giving permission for the uses and disclosures of the PHI described above. I hereby release Texas Woman's University and its employees from any and all liability that may arise from the release of information as I have directed.

• I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing and address it to the person or institution name above that I am authorizing to disclose my information. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

• I understand that I may refuse to sign this authorization, I also understand Submit if Texas Woman's University School of Communication Hearing and Oral Health Sciences Clinics does not have the necessary radiographs and, or medical clearance needed for treatment I may be refused treatment in the clinic.

• I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receivesit.

• I understand that I may be charged a fee for copies of patient records and or duplicates ofradiographs.

My signature below means that I have read a copy of Texas Woman's University Notice of Privacy Practices and **I have no changes** to the names of doctors, dentists, and/or contacts to which my health or medical information may be revealed/discussed via phone, email, fax or mail. The names of doctors, and/or dentist given at the top of the Health History or Case History Forms are the ones that TWU Communication Hearing and Oral Health Sciences Clinics may contact concerning my medical and/or my health concerns. If you have had changes to your doctors who we should contact please let us know. (Initial)

Signature: Printed Name: