FSU | L.L. SCHENDEL SPEECH & HEARING CLINIC
COMMUNICATION SCIENCE & DISORDERS

CONSENT FOR DIAGNOSTIC AND TREATMENT SERVICES

Client's Name: _____ **Client's DOB:** _____

Parent/Legal Guardian's Name (if client is a minor): **Clinic Number:** _____

I,_____, HEREBY AUTHORIZE Florida State University Speech and Hearing Clinic audiologists, speech-language pathologists, or students under the direct supervision of licensed certified personnel, to conduct requested services at the Florida State University Speech and Hearing Clinic.

I understand that any evaluation and treatment will be completed by a licensed and certified audiologist or speech-language pathologist or by a student under direct supervision.

I understand that evaluations and treatment may be completed using telepractice. I also understand telepractice involves the communication of my medical information both orally and visually.

I have the right to withhold or remove consent at any time without affecting my right to future care or treatment.

I agree that for training and research purposes, therapy or evaluation sessions may be observed by clinical educators, faculty, student clinicians, and associated team members.

I agree that sessions may be audio-recorded, videotaped or stored in an electronic format, and recordings of sessions may be used for training, supervision, research, or for educational purposes in professional settings. I also authorize the use of clinical case discussion and review of records for professional and/or teaching purposes.

Information obtained during the course of service(s) will remain confidential, to the extent allowed by law. My participation in service(s), as well as that of my child or family member, is voluntary and I or my child or family member can withdraw from the service(s) at any time.

I understand my clinician must be in compliance with child abuse reporting laws and court mandated rulings regarding release of confidential information.

I acknowledge that I have read and fully understand the above explanation of the consent for diagnostic and treatment services, all questions have been satisfactorily answered, and I give my permission for participation in these services.

I know that I may contact Dr. Tricia Montgomery (Director of Clinical Education) at 850-644-9143, my clinical supervisor at 850-644-2238 at the L. L. Schendel Speech and Hearing Clinic, or a representative of the Human Subjects Committee at 850-644-8633 for answers to questions about service, research, or rights.

- **AUTHORIZATION FOR CONSENT:** I fully understand and *consent to engaging in telepractice with the FSU Speech and Hearing Clinic* as a part of my therapy process. Telepractice will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

_____ Date: _____
Signature of Client (representative or parent/legal guardian if a minor)
Authority of Representative to Act on Behalf of Client _____

- **AUTHORIZATION FOR CONSENT:** I fully understand and accept the terms of this *Consent for Diagnostic and Treatment Services*.

_____ Date: _____
Signature of Client (representative or parent/legal guardian if a minor)
Authority of Representative to Act on Behalf of Client _____

- **AUTHORIZATION FOR CONSENT:** *I consent to be contacted regarding future research opportunities.*

_____ Date: _____
Signature of Client (representative or parent/legal guardian if a minor)
Authority of Representative to Act on Behalf of Client _____

- **AUTHORIZATION FOR CONSENT:** I acknowledge that I have received The Speech and Hearing Clinic *Notice of Health Information Privacy Practices.*

_____ Date: _____
Signature of Client (representative or parent/legal guardian if a minor)
Authority of Representative to Act on Behalf of Client _____

Client safety and security Policy for minors (children under the age of 18)

For initial evaluations and first therapy sessions, we require parent/guardian or other authorized individual over the age of 18 to stay with the client the entire time. Based upon the safety and needs of the client, we reserve the right to request that someone remain on premise the entire time during subsequent sessions.

I authorize my child to participate in clinical services at the FSU Speech & Hearing Clinic without parental supervision. In the case of an emergency, I authorize the FSU Speech & Hearing Clinic to act as a surrogate to make decisions in my absence, contacting me immediately to inform me of the incident. I waive my right to pursue legal action in such cases.

_____ _____
Parent/Guardian Printed Name Parent/Guardian Signature

_____
Date