



## Intensive Aphasia Program

The UCF Communication Disorders Clinic is pleased to offer the Intensive Aphasia Program (IAP) with Dr. Amy E. Engelhoven, Ph.D., CCC-SLP, Director of the Aphasia House. The IAP is an innovative and intensive 6-week therapy program for stroke survivors. This life-enhancing program is offered five times a year.

### What is aphasia?

Aphasia is the loss of language from some type of neurologic injury, whether it is a stroke, tumor, disease or traumatic brain injury. Aphasia can affect the ability to communicate through speaking, listening, reading, writing and gesturing. There are approximately 400,000 strokes a year in the U.S. and 80,000 stroke survivors have aphasia. Approximately one million people, or one out of every 275 adults in the U.S., have some type of aphasia, according to the National Aphasia Association (NAA).

### Why is aphasia a chronic condition?

Aphasia is “life-altering”. There is no known cure for aphasia, yet its impact is felt for the rest of a person’s life. Because aphasia disrupts communication, it affects every aspect of daily living. According to the NAA, ninety percent of people with aphasia feel isolated. Seventy percent of people surveyed felt others avoided contact with them, because they could not speak well.

### Aphasia House Participants



“I couldn’t talk at all. I used to never go out to the store or to eat,” Uriah Nelson said about the first six months after his stroke in 2006. “People weren’t patient. It was embarrassing. Now I go to store. The therapist here, they do good.”

“It’s helped me a lot, I am very grateful,” said Dr. Renato Parungao.

### How can the Intensive Aphasia Program help?

The IAP is an intensive 6-week program, Monday through Thursday, for 4 hours per day. The goal of the program is to increase communication skills. In total, participants will receive 96 hours of clinical service, with 4 hours designated for pre- and post-evaluation. Participants receive an individualized therapy program based on their assessment performance. Therapy will consist of individual and group sessions under the direction of the IAP clinical educators and assisted by master-level student clinicians. Therapeutic intervention is based on the latest evidence-based practice and will be complimented by assistive technologies and weekly community re-engagement activities.

### Who is the Prospective Participant?

Participants must be adults with aphasia, at any level of impairment, that are medically stable as verified by their family physician. They must also be cognitively and physically able to endure the intensity of the program and must not demonstrate behavioral problems indicative of poor motivation or lack of cooperation. Finally, they must be a minimum of 6 months post onset of their neurologic injury.

**UCF Communication Disorders Clinic**  
3280 Progress Dr, Suite 500, Orlando, Florida 32826  
Phone: 407-882-0468 Fax: 407-882-0483  
Website: [www.aphasiahouse.com](http://www.aphasiahouse.com)



**Intensive Aphasia Program Application**

**General Information**

Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell or Work Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M or F

**Emergency Contact:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

Do you live alone? Yes or No

If no, whom do you live with? (Name and Relationship) \_\_\_\_\_

\_\_\_\_\_

What was the highest grade level you completed in school? \_\_\_\_\_

Is English your first language? Yes or No

Were you (the applicant) able to complete this form independently? Yes or No

If no, who helped you and how much. \_\_\_\_\_

\_\_\_\_\_

**Employment History:**

Occupation: \_\_\_\_\_ Workplace: \_\_\_\_\_

Past Occupations: \_\_\_\_\_

Were you employed at the time of your stroke/accident/illness? Yes or No

Are you on a leave of absence? Yes or No How long? \_\_\_\_\_

Are you retired? Yes or No How long? \_\_\_\_\_

Are you retired due to your stroke/accident/illness? Yes or No

**Medical Information:**

What is the nature of your illness? Date of incident \_\_\_\_\_

Stroke Accident Other: \_\_\_\_\_

Were you unconscious? Yes or No If yes, how long?

Were you paralyzed? Yes or No If yes, where?

Were you right or left handed before the incident?

Did you have swallowing issues as a result? \_\_\_\_\_

Do you have any longstanding health conditions/problems? \_\_\_\_\_

\_\_\_\_\_

Please list any current medications and dosages you are currently taking:

Medication	Dosage	Frequency
_____		
_____		
_____		
_____		

Are you on a special diet?

Yes or No If yes, describe \_\_\_\_\_

Do you have any allergies?

Yes or No If yes, describe \_\_\_\_\_

Do you wear glasses? Yes or No

Do you wear hearing aids? Yes or No If yes, how long? \_\_\_\_\_

Are you ambulatory?

Yes or No If no, how far can you go independently? \_\_\_\_\_

\_\_\_\_\_

Do you use a wheelchair? Yes or No If yes, describe type \_\_\_\_\_

\_\_\_\_\_

Do you need assistance with the restroom? Yes or No

**Primary Care Physician**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Speech-Language Assessment/Therapy**

Clinician: \_\_\_\_\_

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Dates attended: \_\_\_\_\_

**Psychology/Counseling/Social Work**

Clinician: \_\_\_\_\_

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Dates attended: \_\_\_\_\_

**Occupational**

Clinician: \_\_\_\_\_

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Dates attended: \_\_\_\_\_

**Other Health Care**

Clinician: \_\_\_\_\_

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Dates attended: \_\_\_\_\_

## Language/Communication Skills

To assist us in establishing functional communication goals, please complete the following questions:

1. Rank which ways you are most successful in conveying your message, with 1 being the most successful and 5 being the least successful. You may use N/A for “not applicable” if appropriate.

\_\_\_\_\_ Speaking                      \_\_\_\_\_ Writing                      \_\_\_\_\_ Gesturing  
\_\_\_\_\_ Facial Expressions                      \_\_\_\_\_ Drawing

2. Please check all that apply:

\_\_\_\_\_ Speaks in single words  
          \_\_\_\_\_ phrases  
          \_\_\_\_\_ sentences  
  
\_\_\_\_\_ Formulates questions  
  
\_\_\_\_\_ Carries on conversations  
  
\_\_\_\_\_ Comprehends single words  
          \_\_\_\_\_ yes/no questions  
          \_\_\_\_\_ wh-questions  
          \_\_\_\_\_ conversations  
  
\_\_\_\_\_ Reads single words  
          \_\_\_\_\_ newspaper  
          \_\_\_\_\_ novels  
  
\_\_\_\_\_ Writes name  
          \_\_\_\_\_ single words  
          \_\_\_\_\_ sentences

3. List situations where you are most successful in communicating.

**Language/Communication Skills (Continued)**

4. List situations where you are least successful in communicating.

5. What do you hope to gain from therapy?

6. What activities do you want to be able to do?  
(For example: play golf, go to the movies, go out to lunch with friends.....)

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Client Signature or Representative

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Date

Thank you for completing this packet. Please forward to:

UCF Communication Disorders Clinic  
3280 Progress Dr, Suite 500,  
Orlando, Florida 32826  
407-882-0468 or 407-882-0483 (fax)



# Communication Disorders Clinic

## Intensive Aphasia Program

### 2017 Program Cost and Insurance Reimbursement Notice

The cost of the UCF Intensive Aphasia Program is \$7,500.00. This covers individual and group therapy for a total of 96 therapy hours over a period of 6 weeks, along with pre and post-evaluations.

**Payment is expected as follows:**

\$2,500.00 is expected four weeks prior to the start date of the session.

\$2,500.00 on the first day of the first week.

\$2,500.00 on the first day of the fourth week – less possible insurance reimbursement.

**Insurance Reimbursement:**

The Deficit Reduction Act (DRA) of 2005 limited certain numbers of units for outpatient therapy per day for physical therapy, occupational therapy, and speech-language pathology, to control inappropriate billing. This means that UCF may only bill your insurance for one therapy hour per day or a maximum of \$1,920.00. The reimbursement from your insurance will depend on your benefit, co-insurance, and deductibles.

Please sign and return this form with your application packet, to acknowledge that you understand the payment schedule. Should you have further questions, please contact: Joanne Bradburn, Office Manager, at 407-882-0472.

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Signature of Client or Representative

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Date

3280 Progress Dr, Suite 500, Orlando, FL 32826

Telephone (407) 882-0468 Fax (407) 882-0483

*An Equal Opportunity and Affirmative Action Institution*



<b>Section I:</b>	<b>Patient Information</b>	<b>Date</b> _____
Name: _____ Prefer to be called: _____		
Address: _____ City: _____ State: _____ Zip _____		
Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____		
The best time to contact me is: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. on my <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell phone		
Date of Birth: _____ Last 4 digits of SSN#: _____		
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
If Student, Name of School _____ City/State _____ <input type="checkbox"/> FT <input type="checkbox"/> PT		
Spouse or Parent's Name: _____ Employer _____ Work Phone _____		
Whom may we thank for referring you? _____		
Person to contact in case of emergency _____ Phone _____		
Referring Physician: _____ Address: _____		
Phone: _____ Fax: _____		

<b>Section II</b>	<b>Responsible Party</b>
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____	
Name: _____	
Address (if different from above): _____	
City: _____ State: _____ Zip: _____ Phone: (____) _____	
Employer _____ Work Phone (____) _____ Last 4-digits of SSN# _____	

<b>Section III</b>	<b>Insurance Information</b>
Name of Insured _____ DOB _____ Relationship to Patient _____	
Last 4 digits of SSN#: _____ Name of Employer: _____ Work Phone: (____) _____	
Address of Employer: _____ City _____ State: _____ Zip _____	
Insurance Company _____ Grp # _____ ID# _____	
Ins. Co. Address: _____ Ins. Co. Phone: _____	
<b>***DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, COMPLETE THE SECTION BELOW***</b>	
Name of Insured _____ DOB _____ Relationship to Patient _____	
Last 4 digits of SSN#: _____ Name of Employer: _____ Work Phone: (____) _____	
Address of Employer: _____ City _____ State: _____ Zip _____	
Insurance Company _____ Grp # _____ ID# _____	
Ins. Co. Address: _____ Ins. Co. Phone: _____	



## **UCF COMMUNICATION DISORDERS CLINIC DRIVING DIRECTIONS**

The University of Central Florida's Communication Disorders Clinic is located in the Central Florida Research Park in the Innovative Center at 3280 Progress Drive, Orlando, FL 32826.

### **From Winter Park**

Take University Boulevard east to Alafaya Trail, then right (south) to Research Parkway. Turn left (east) at Bank of America, entering Central Florida Research Park. Turn left onto Progress Drive, you will see a Tropical Smoothie sign on the corner. If you pass through the light at Technology Parkway you will have gone too far. The Innovative Center will be on the left side, just at the entry to the round-about.

### **From Orlando – Using SR 50**

Take Colonial Drive (State Road 50) east to Alafaya Trail. Turn left (north) onto Alafaya Trail. At the third traffic light (Bank of America's on the corner), turn right (east) on Research Parkway, entering Central Florida Research Park. Turn left onto Progress Drive, you will see a Tropical Smoothie sign on the corner. If you pass through the light at Technology Parkway you will have gone too far. The Innovative Center will be on the left side, just at the entry to the round-about.

### **From Orlando – Using East-West Expressway**

Take the East-West Expressway east. Do not exit to the left where there is a sign indicating that you should go left to UCF but continue on the expressway until you reach the Alafaya Trail exit. After exiting, turn left (north) on Alafaya Trail. After crossing Colonial Drive (State Road 50), proceed to the third traffic light (Bank of America's on the corner), turn right (east) on Research Parkway, entering Central Florida Research Park. Turn left onto Progress Drive, you will see a Tropical Smoothie sign on the corner. If you pass through the light at Technology Parkway you will have gone too far. The Innovative Center will be on the left side, just at the entry to the round-about.

### **From North of Orlando**

Take the toll road SR-417 South to University Boulevard East (exit 37) towards UCF. Turn right onto SR-434S (Alafaya Trail) in approximately 2.7 miles. From SR-434S you will turn left onto Research Parkway in approximately 0.7 miles, there will be a Bank of America on the corner. Turn left onto Progress Drive, you will see a Tropical Smoothie sign on the corner. If you pass through the light at Technology Parkway you will have gone too far. The Innovative Center will be on the left side, just at the entry to the round-about.

### **From South of Orlando**

Take the Florida Turnpike North or I-4 east to toll road SR-417 North (towards Orlando/Sanford). Merge onto toll road SR-408 East (exit 33a, towards Titusville). Take the Alafaya Trail exit (number 21). After crossing Colonial Drive (State Road 50), proceed to the third traffic light (Bank of America's on the corner), turn right (east) on Research Parkway, entering Central Florida Research Park. Turn left onto Progress Drive, you will see a Tropical Smoothie sign on the corner. If you pass through the light at Technology Parkway you will have gone too far. The Innovative Center will be on the left side, just at the entry to the round-about.

If you would prefer to use Map Quest for directions, our address is:  
3280 Progress Drive, Suite 500, Orlando, FL 32826  
Phone: 407-882-0468



## Communication Disorders Clinic

### **AUTHORIZATION TO VIDEO TAPE, AUDIO TAPE, PHOTOGRAPH AND/OR OBSERVE**

The University of Central Florida's Communication Disorders Program, in addition to providing services to the Central Florida community, functions as a training clinic for graduate students in the Communication Disorders Program. The Florida Alliance for Assistive Services and Technology (FAAST) also provides similar training and supervision in conjunction with the University Communication Disorders program. Because of this, you may encounter certain situations in the clinic that you might not be exposed to in another treatment setting.

In order for the student clinician to receive thorough supervision, it may be necessary for the clinician to tape (Audiotape and Videotape) the sessions. In addition, there is a one-way mirror in each therapy room, and an observation room adjoining. From time to time, the student clinician's session may be observed by the supervisor or by other student clinicians. At times, video and audio tape(s) may be used for educational purposes.

A fully qualified professional supervises each client's program at the Clinic. Graduate Students may be assigned to work with certain clients. A qualified faculty member, however, will be responsible for the professional services. This professional will supervise, counsel and direct the clinical activities.

*In hereby authorize clinical personnel from the [ ] Communication Disorders Clinic and/or [ ] FAAST to video tape, audio tape, photograph, and/or observe clinical sessions for:*

\_\_\_\_\_  
*(Client's name)*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Signature of Parent/Guardian



**PERMISSION TO RELEASE INFORMATION**

I hereby grant the Communication Disorders Clinic of the University of Central Florida permission to release information from the records of \_\_\_\_\_ to FFAST and the agencies listed below. (Client's name)

Send to:

FFAST, Florida Alliance for Assistive Services and Technology

325 John Knox Road, Building 400, Suite 402 · Tallahassee, Florida 32303

Solely for the purposes of evaluating the services provided by the FFAST Regional Demonstration Center

[ ] (Parent/Guardian initial here)

Send to:

Agency/Business Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Agency/Business Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Agency/Business Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Agency/Business Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Signature of Parent/Guardian



## **PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS**

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I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professional who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will post information of this change. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I authorize UCF Communication Disorders Clinic to use or disclose to UCF Foundation for purposes of fundraising for the benefit of UCF Communication Disorders Clinic the following: my name, address, phone number, date of birth, gender, the outcome of care, health insurance status and the service dates. I understand when I receive such fundraising communication, I have a right to opt-out of receiving future fundraising communications.

I authorize UCF Communication Disorders Clinic to use an automated telephone system and/or email and to use my name, address and phone number; the name of my scheduled treating physician; and the time of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare-related communication. I also authorize Communication Disorders Clinic to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voicemail system or answering machine.

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Signature of Patient or Personal Representative

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Date

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Printed Name of Patient or Personal Representative



### General Medical Records Request

Please complete the following information:

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### Provider/Entity to Release Records

Practice/Group Name: \_\_\_\_\_

Treating Provider(s): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I authorize the custodian of records of the above named provider(s) or other person/entity (specifically described) to disclose/release the following information (check all applicable):

- |  |   |
|--|---|
| <input type="checkbox"/> All records (Diagnosis and Treatment) | <input type="checkbox"/> Abstract/Summary (Diagnosis and Treatment) |
| <input type="checkbox"/> Laboratory/pathology records          | <input type="checkbox"/> Pharmacy/prescription records              |
| <input type="checkbox"/> X-ray/radiology records               | <input type="checkbox"/> Other (describe specifically)              |

These records are for services provided on the following date(s): \_\_\_\_\_

Please send the records listed above to:

**UCF Communication Disorders Clinic (Attn:  
Medical Records)**  
3280 Progress Dr, Suite 500, Orlando, FL 32826  
407-882-0468 Fax: 407-882-0483

This authorization shall expire no later than: \_\_\_\_/\_\_\_\_/\_\_\_\_ or upon the following event \_\_\_\_\_ (whichever is sooner) and may not be valid for greater than one year from the date of signature for Florida medical records. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Date

*You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Liaison, 3280 Progress Dr, Suite 500 Orlando, FL 32826.*



## **NOTICE OF PRIVACY PRACTICES**

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.

### **WHO WILL FOLLOW THIS NOTICE**

This notice describes our Communication Disorders Clinic's practices and that of:

- Any health care professional authorized to enter information into your Clinic chart.
- All departments of the Communication Disorders Clinic.
- All employees, staff and other Clinic personnel
- In addition, Business Associates of the Communication Disorders Clinic may share medical information with each other for treatment, payment or Clinic operations purposes described in this notice.

### **OUR PLEDGE REGARDING MEDICAL INFORMATION**

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Communication Disorders Clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Communication Disorders Clinic, whether made by Communication Disorders Clinic personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

### **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:**

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

#### **For Treatment**

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians or other Communication Disorders Clinic personnel who are involved in taking care of you at the Communication Disorders Clinic. Different departments of the Communication Disorders Clinic also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Communication Disorders Clinic who may be involved in your medical care after you leave the Communication Disorders Clinic in the case of referrals or hospital transfers.

### **For Payment**

We may use and disclose medical information about you so that the treatment and services you receive at the Communication Disorders Clinic may be billed to and payment may be collected from you, an insurance company or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

### **For Health Care Operations**

We may use and disclose medical information about you for Communication Disorders Clinic operations. These uses and disclosures are necessary to run the Communication Disorders Clinic and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Communication Disorders Clinic patients to decide what additional services we should offer, what services are not needed and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians and other Communication Disorders Clinic personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Communication Disorders Clinics to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it without learning who the specific patients are.

### **Appointment Reminders**

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment at the Communication Disorders Clinic.

### **Treatment Alternatives**

We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

### **Health-Related Benefits and Services**

We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

### **Individuals Involved in Your Care or Payment for Your Care**

We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

### **As Required By Law**

We will disclose medical information about you when required to do so by federal, state or local law.

### **To Avert a Serious Threat to Health or Safety**

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

### **Public Health Risks**

We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

### **Health Oversight Activities**

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, inspections and licensure.

### **Fundraising**

We may use or disclose your information for fundraising campaigns, programs and events to benefit UCF Communication Disorders Clinic. We may use or disclose your information, such as your name, address, phone number, date of birth, gender, the outcome of your care, health insurance status and the dates you received services at UCF Communication Disorders Clinic, for fundraising efforts. We may contact you about fundraising and you may opt-out of receiving fundraising communications in the future by contacting us at [insert phone number].

### **Lawsuits and Disputes**

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you 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 released.

### **Law Enforcement**

We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Student Health Center; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

## **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

You have the following rights regarding medical information we maintain about you:

### **Right to Inspect and Copy**

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request, in writing, to the Communication Disorders Clinic Medical Records department.

### **Right to Amend**

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Communication Disorders Clinic. To request an amendment, your request must be made, in writing, and submitted to the Communication Disorders Clinic Privacy Compliance Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by Communication Disorders Clinic;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

### **Right to an Accounting of Disclosures**

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you.



To request this list or accounting of disclosures, you must submit your request in writing to the Communication Disorders Clinic Privacy Compliance Officer. Your request must state a time period, which may not be longer than six years and may not include dates before April 1, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically).

### **Right to Request Restrictions**

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information 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 do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing, to the Communication Disorders Clinic Privacy Compliance Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

### **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. To request confidential communications, you must make your request, in writing, to the Communication Disorders Clinic Privacy Compliance Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

### **Right to Paper Copy of This Notice**

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, [www.shs.ucf.edu](http://www.shs.ucf.edu). To obtain a paper copy of this notice, go to the Communication Disorders Clinic at 3280 Progress Drive, Suite 500, Orlando, FL 32826.

## **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 medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the Communication Disorders Clinic. The notice will contain on the first page, in the top right-hand corner, the effective date.

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the Communication Disorders Clinic. To file a complaint with the Communication Disorders Clinic, contact Dr. Charlotte Harvey, Privacy Compliance Officer, Communication Disorders Clinic, 3280 Progress Drive, Suite 500, Orlando, FL 32826. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

## **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.