UNIVERSITY of VIRGINIA
SCHOOL of EDUCATION and HUMAN DEVELOPMENT
Sheila C. Johnson Center

Sheila C. Johnson Center
417 Emmet Street South
Box 400270
Charlottesville, VA 22904-4270
Phone: 434-924-7034 • Fax: 434-924-4621
education.virginia.edu/research-initiatives/sheila-c-johnson-center

1. Download form to your computer desktop.
2. Open form with Adobe Reader, available at https://acrobat.adobe.com/us/en/acrobat/pdf-reader.html
3. Save form after filling in the fields.
4. Return form via OnPatient

Consent for Services

Welcome to the Sheila C. Johnson Center (SJC) at the University of Virginia. The following is an overview of our services and policies. Please review this information prior to your appointment. If you have been referred or recommended for treatment by another individual, you have the right to accept or refuse these services.

Services and Client Rights

SJC is a multidisciplinary clinic providing comprehensive psychological and educational assessments; psychological treatment; speech-language and audiology services; reading intervention and assessment; and Autism spectrum services. Services are provided by licensed University faculty or by graduate students under the supervision of licensed clinicians in their fields of study. Services are offered to children, adolescents, college students, and adults. Student clinicians typically complete their clinical rotation at SJC in one year, and therefore are not available for long-term services or communication/consultation after their rotation.

The Sheila C. Johnson Center for Clinical Services does not discriminate on the basis of race, color, religion, gender, sexual orientation, gender identity, national origin, ancestry, age, relationship status, disability, difference, or other individual characteristics. It is important to us that everyone who seeks services at SJC is treated in a respectful, culturally informed, and welcoming way.

You have the right to ask questions and receive feedback regarding your services. You also have the right to refuse the use of specific techniques and request referrals to other providers. SJC reserves the right to refuse or terminate services in the event that the requested and/or recommended services cannot be provided in a manner that ensures the safety and wellbeing of the client and/or clinician. Services may also be refused or terminated if SJC cannot adequately support the needs of the client with available resources and/or therapeutic supports. Finally, SJC reserves the right to terminate services and refer elsewhere in the case of frequent cancellations, no-shows, tardiness, or non-participation in recommended care.

Some assessment and intervention procedures include the provision of services outside of SJC's physical location in Bavaro Hall. Though providers will do their best to ensure your privacy when outside SJC, this may not always be possible. You and your provider will collaborate to maintain privacy in such situations as needed.

Training and Video Recording

SJC operates as a service for the community and as a teaching and training program for graduate students at the University of Virginia. Sessions are recorded for video and sound and are used for supervisory, consultation, and training purposes. Written and recorded records are maintained and destroyed in accordance with Virginia law and University record retention policies. I hereby give the Sheila C. Johnson Center for Clinical Services the right and permission to use video in which my image or my child's image appear for purposes restricted to training and education, inclusive of internal or external clinical supervision, consultation, grand rounds, clinician education workshops, and internal student, staff, and faculty education products or presentations.

Shared Custody and Guardianship

In cases of shared custody or legal guardianship, SJC recognizes the importance of collaboration across caregivers to improve outcomes for clients. For this reason, SJC requests that written consent be provided by all legal guardians. If only one legal guardian provides consent, it is assumed that this consent represents all legally interested parties. Therefore, SJC will communicate as needed regarding treatment with all legal guardians except in the case of court order or if clinically indicated for the safety of the client. If existing court orders preclude the sharing of information with any legally interested party, it is your responsibility to share this information with SJC so that we may proceed accordingly. To provide the best care possible, SJC uses a team approach to clinical intervention. Thus, client information may be shared among SJC providers for the purposes of consultation, care coordination, and to facilitate intra-clinic referrals.

Revised: 6/20/2024

Information obtained during the course of treatment is kept confidential. At your request and with your express, written consent, we may release assessment and treatment records to outside individuals and organizations, and participate in ongoing communication and treatment planning with agencies and schools. Any electronic communication or transmission of records over email or fax is not guaranteed to be private or secure. Please note that no information regarding clients ages 18 and over can be shared with family members without explicit, written permission of the young adult, regardless of the individual(s) identified as the responsible party for payment or insurance purposes.

Under state and Federal law, disclosure of health information may occur without your consent. These disclosures may include, but are not limited to, the following circumstances: as required by law; in the case of imminent harm to self or another person; in response to a subpoena; if you or your child is being evaluated by order of a court of law; and if there is current evidence of abuse, neglect, or exploitation of a child, elderly adult, or incapacitated adult. Finally, if you file a complaint or legal proceedings against SJC, we may disclose relevant information regarding your treatment in order to defend against such an action.

The **HIPAA Provider Notice of Privacy Practices** describes in detail how personally identifiable health information about you may be used and disclosed and how you can get access to this information. Please review this information (provided in a separate document) carefully.

Scheduling Appointments
The staff at SJC sees clients by appointment only. Please contact us at 434-924-7034 if you are unable to keep your appointment. If you need to cancel, please notify SJC as soon as possible. Please refer to your payment agreement for SJC policies regarding canceled or no-show appointments.

Emergency Communications
SJC's regular operating hours are Monday through Friday, 8 AM to 5 PM; there is no provision of services or on-call availability after hours. In the case of an emergency or a life-threatening matter, contact 911 or go to your nearest emergency room. For urgent, non life-threatening matters after hours, you may contact Region 10 Community Services Board at 434-972-1800.

Use of Records for Archival Research
SJC periodically conducts archival research to determine clinical trends and the effectiveness of care. In order to accomplish this, approved personnel review records in order to gain specific needed information. Any data used in such research or program evaluation efforts are de-identified to ensure confidentiality, removing all identifiable information. The UVA Institutional Review Board has determined that Center data collected and stored in the clinic record for service purposes can be used for de-identified research purposes without IRB review, exemption, consent, waiver of consent, or notification.

Future Research Participation
You may be contacted in the future to receive information regarding potential participation in clinical or educational research related to your (or your dependent family member's) clinic use or a more general research topic. This consent extends to contact via email, phone, text and postal services. These instances are rare and you can opt out at any point. Your personal information will never be shared with any external entity as this consent applies only to opportunities for research participation conducted at the University of Virginia.

Acknowledgment of Consent for Services
By signing below, I acknowledge that I have been informed about the above policies, have had the opportunity to ask questions about them, and understand my rights and responsibilities when receiving services at the Sheila C. Johnson Center (SJC). I accept these policies as a condition of receiving services at SJC and consent to receive treatment through SJC.

* _____ * _____
Client's Name Date

Check Box to Sign ☐

* _____ * _____
Signature of Client or Client's Representative Relationship to Client

If you do not have access to a digital signature, please check the box as an indication that you have read and understand this document.

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Electronic Communications

SJC offers clients convenient messaging with providers through the secure Onpatient portal. Onpatient can be accessed by a web browser or on a mobile device through the Onpatient app.

By consenting to Onpatient, you consent to receive an email invitation from the SJC with instructions on creating an account (please note that email communications cannot be guaranteed to be secure). You may decline this invitation. Please note that while Onpatient is compatible with Federal and State privacy laws, including HIPAA, it is **your** responsibility to secure access to passwords and protected health information (PHI) on your own device(s).

If your provider activates Onpatient then they will respond to Onpatient messages within 1-2 business days. If you do not receive a response to a message within 2 business days, please contact the front desk at 924-7034. Please be aware that Onpatient messages become a part of your clinical record. Though intended to facilitate communication with providers regarding scheduling and ongoing care, Onpatient is not intended to replace clinical services. Thus, providers may request that you schedule an office visit to address matters communicated over Onpatient. SJC reserves the right to revoke client access to Onpatient at any time if clinically indicated.

Please note that Onpatient is not intended for urgent matters, including life-threatening emergencies. In an emergency or after hours, please call 911 or go to the nearest emergency room.

Telehealth:
My provider may ask me to engage in telehealth services. The Sheila Johnson Center uses HIPAA-compatible Zoom software to facilitate services via secure video conferencing. Although this encrypted platform is compatible with Federal and State privacy laws, including HIPAA, there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

Text Reminders:
SJC sends clients appointment reminders through text messages. If you wish to opt out of text message reminders, please alert our front desk staff at 924-7034.

I consent to the terms and conditions for Onpatient access and electronic communications. I request access to the Onpatient portal and consent to receiving an invitation from the SJC at the email address below:

* _____ E-mail

* _____ Mobile Number (for Onpatient activation)

* _____ Printed Name of Client

* _____ Client's Date of Birth

* _____ Signature of Client or Legal Representative

* _____ Date

* ☐ Please check this box if you **do not** wish to participate with electronic communication with the Sheila C. Johnson Center.

☐ Please check this box if you **do not** wish to participate with text messaging.

Revised: 6/20/2024

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Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Provider 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.

This notice describes the privacy practices of the University of Virginia Sheila C. Johnson Center, including discipline-specific services. The following categories describe different ways that we may 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.

Treatment: With your consent, we may use and disclose your protected health information (PHI) to provide, coordinate or manage your health care and any related services. For example, your PHI may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

Payment: We may use and disclose medical information about you so that the treatment and services received may be billed to and payment may be collected from you, an insurance company or another 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 treatment. If you **do not** want your health plan to receive information about treatment for which you have paid in advance, see "Right to Request Restrictions" in this notice.

Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to 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 provide information in the aggregate to teachers and students in our graduate training programs for review and learning purposes.

Individuals Involved in Your Care or Payment for Your Care: With your consent, we may release information about you, such as appointment times or billing information, to a family member or friend who is involved in your care, or the payment for your care.

Other Care Providers: With your consent, we may disclose medical information to other health care professionals who have cared or currently are caring for you, for them to use in treating you, seeking payment for treatment, and certain health care operations, such as evaluating the quality of their care and the performance of their staff, providing training, and licensing and accreditation reviews.

Business Associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. Similarly, there are departments of the University that provide services to us, and may need access to your health information to do their jobs. Examples of these services include information technology specialists servicing our HIPAA compliant electronic medical records. We require business associates and other UVA departments to appropriately safeguard your information.

As Required By Law: We may 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 an immediate, serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans: We may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: With your consent, we may release medical information about you for workers' compensation or similar programs.

Public Health Risks: We may disclose medical information about you for public health activities, such as to report abuse or neglect of children, the elderly and incompetent patients, or reactions to medications or problems with products.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensures. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: We may disclose medical information about you in response to a court order, search warrant, or a subpoena but only if efforts have been made to tell you about the subpoena.

Research: We may use and disclose medical information about you for research. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. In most cases, your authorization would be required. In other cases where the review process determines that the project creates minimal risk to privacy, it would not. We may disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Center. And if a research project can be done using medical data from which all the information that identifies you has been removed, we may use or release the data without special approval. We may use or release data for research with a few identifiers retained—such as age, gender, and treatment. However, in this case we will have those who receive the data sign an agreement to appropriately protect it.

Social Security Numbers: We may collect your social security number. We use social security numbers for identification and verifications (for example, to provide the right medical record when two patients have the same name). We also are required to collect social security numbers by Virginia law (VA. Code 58.1-521) for use if needed in the administrative offset program. Some other government programs, such as Medicaid, require social security numbers. Providing a social security number is voluntary, except for applicants to governmental programs that require it. The privacy practices in this notice apply to your social security number.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

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

Right to Inspect and Copy: In most cases, you have the right to inspect and copy your medical and billing records. To inspect and copy your medical or billing records, you must submit your request in writing to Sheila C. Johnson Center for Clinical Services, 417 Emmet Street S, Box 400270, Charlottesville, VA 22904. If you request a copy of the information, we may charge a fee for costs for copying and mailing. You may request copies of records in an electronic format, and if the records are available in that format, they will be provided accordingly. If they are not, we will provide an alternate.

We may deny your request to inspect and copy in some circumstances: We may deny your request to inspect and copy in certain very limited circumstances. If we do, you may request that the denial be reviewed. Another licensed health care professional chosen by the Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

For Psychotherapy Services: Psychotherapy Notes are specifically defined in the HIPAA regulations as "notes recorded in any medium by a mental health provider documenting or analyzing the contents of a conversation during a private, group, joint or family counseling session, and that they are separated from the rest of the individual's medical record" and are treated differently than other medical records. Psychotherapy Notes must be kept in a separate file and are considered the private self-communication of the mental health provider. HIPAA does not allow patients specific access to Psychotherapy Notes. In contrast, mental health records are available to clients and include the following types of information: counseling session dates, diagnoses, functional status, treatment plan, symptoms, prognosis, progress to date, termination summary, and psychological testing reports. These are usually more accessible to you.

Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment your request must be made in writing and submitted to the Sheila C. Johnson Center for Clinical Services, 417 Emmet Street S, Box 400270, Charlottesville, VA 22904. In addition, you must provide a reason that supports your request. We may deny your request if you ask us to amend information that:

- Was not created by us; we will add your request to the information record;
- Is not part of the medical information kept by the Center;
- 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 disclosures of medical information about you that were not for treatment, payment or health care operations and of which you were not previously aware. To request this list of accounting of disclosures, you must submit your request in writing to the Sheila C. Johnson Center for Clinical Services, 417 Emmet Street S, Box 400270, Charlottesville, VA 22904. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions: You have the right to restrict disclosure of health information to your health plan for services paid out of pocket in full prior to the service being provided. This right applies only if the disclosure is to a health plan for purposes of payment or health care operations and the health information relates to a health care item or service for which you have paid in full prior to the service. You have the right to request other restrictions on the information we use or disclose about you for treatment, payment of 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. We are not required to agree to your request for these other restrictions. To request restrictions, you must make your request in writing to the Sheila C. Johnson Center for Clinical Services, 417 Emmet Street S, Box 400270, Charlottesville, VA 22904. 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 Receive Notice of Any Breach: You have the right to receive written notice from us if there has been a breach of your identifiable health information.

Right to Request Alternative 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 at work or by mail. To request alternative communications, you must make your request in writing to the Sheila C. Johnson Center for Clinical Services, 417 Emmet Street S, Box 400270, Charlottesville, VA 22904. Your request must specify how or where you wish to be contacted.

Right to a 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.

CHANGES TO THIS NOTICE

We have the right to change this notice and make the changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain on the first page, in the bottom right-hand corner, the effective date. In addition, each time you register we will have copies of the current notice available on request.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Sheila C. Johnson Center for Clinical Services. To file a complaint, you must make your request in writing to the Sheila C. Johnson Center for Clinical Services, 417 Emmet Street S, Box 400270, Charlottesville, VA 22904. You may also send a written complaint to the U.S. Department of Health and Human Services. 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 (an "authorization"). In particular, most uses and disclosures of medical information for marketing purposes, most disclosures in return for payment, and most uses and disclosures of psychotherapy notices would require your authorization. If you request the transmission of any PHI to a third party you will need to complete a written authorization for each recipient. Authorization forms and instructions are available on the Center's website at education.virginia.edu/research-initiatives/sheila-c-johnson-center-clinical-services/forms-and-resources. Call (434) 924-7034 with any questions, you may revoke authorization, in writing, at any time by contacting the Sheila C. Johnson Center for Clinical Services, 417 Emmet Street S, Box 400270, Charlottesville, VA 22904. 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.

MORE INFORMATION

If you have any questions you may contact:

Sheila C. Johnson Center for Clinical Services
417 Emmet Street S, Box 400270
Charlottesville, VA 22904-4270
Phone: (434) 924-7034

Acknowledgment of Receipt of HIPAA Provider Notice to Privacy Practices

Please sign and print your name and date on this acknowledgment form. Then return your signed acknowledgment to the Front Desk Staff or to the following address:

Sheila C. Johnson Center for Clinical Services
417 Emmet Street S, Box 400270
Charlottesville, VA 22904-4260

CLIENT'S NAME: _____

Check Box to Sign

Signature of Client: _____ ☐

Or

Signature of Parent/Guardian (if applicable): _____ ☐

Printed Name of Individual Signing: _____

Date: _____

If you do not have access to a digital signature, please check the box as an indication that you have read and understand this document.

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3. Save form after filling in the fields.
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AGREEMENT TO PAY FOR SERVICES

Assignment of Benefits/Release of Information: In the event I am entitled to insurance benefits, Medicare or any recovery, I hereby assign the benefits of my insurance policy, Medicare or other recovery to the University of Virginia, to pay for the care provided at the Sheila C. Johnson Center. If applicable, I certify that the information given by me in applying the payment under Title XVIII of the Social Security Act is correct.

I authorize the Sheila C. Johnson Center for Clinical Services to release to the Centers of Medicare and Medicaid Services and/or to my health insurance company all information needed in order to consider payment of my claim for services rendered or as otherwise requested by them.

Note: Insurance Companies **DO NOT** provide coverage or payment for the following services: Educational Testing, Diagnostic Educational Evaluation, Diagnostic Literacy Evaluation, Special Education Observation/Assessments, Reading Services and Tutoring, and Career Counseling or Consultation. **These services are the financial responsibility of the client.**

Financial Statement: In consideration of services furnished or to be furnished, I guarantee payment to The University of Virginia Sheila C. Johnson Center of all outstanding balances incurred or to be incurred including those paid by any third party source. I understand that I am responsible for all charges not covered by my insurance company. If payment is not made when due, I agree to pay all reasonable costs and expenses related to collection of any outstanding balances, including but not limited to, reasonable attorney's fees.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Name of Client (please print): _____

Name of Person Agreeing to Pay (please print): _____

SSN of Person Agreeing to Pay: _____ Relationship to Client: _____

Signature of Person Agreeing to Pay: _____ ☐ Date: _____

Check Box to Sign

If you do not have access to a digital signature, please check the box as an indication that you have read and understand this document.

Mailing Information:

My monthly billing statements are to be mailed to the following address:

_____

_____

To protect your privacy, the Center will only address and send invoices to the person(s) listed above. However, for your convenience, payment will be accepted from other family members or persons presenting payment on your behalf.

(OPTIONAL): Please list persons, if any, who you **do not** authorize to make payments.

_____

_____

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CLINICAL SERVICES PAYMENT POLICY NOTICE

The University of Virginia does not discriminate on the basis of age, color, disability, gender identity, marital status, national or ethnic origin, political affiliation, race, religion, sex (including pregnancy), sexual orientation, veteran status, and family medical or genetic information, in its programs and activities. Complaints of discrimination, harassment, and retaliation may be directed to the University of Virginia Office for Equal Opportunity and Civil Rights at UVaEOCR@virginia.edu.

- Copays are due at the beginning of each session. If you intend to pay out of pocket, full fee is due at the time of services.

- Payments may be made by credit card or checks. Checks should be payable to Rector and Visitors of the University of Virginia. We no longer accept cash payments.

- It is the clients' responsibility to provide the most up to date insurance information. If the client is in default with this practice, it may result in the client being financially responsible for services rendered.

- Sheila C. Johnson Center (SJC) does not assume responsibility for resolving disputes with your insurance company, nor for notifying you when your benefits are about to run out.

- University financial policy does not allow for the accrual of/or unpaid debt; therefore, the continued provision of services is dependent on satisfactory periodic payment towards any account balance greater than 30 days.

- If you have a balance due on your account, you will receive monthly statements reflecting the payment and charges. Any outstanding balance is due upon receipt of the statement and past due after 30 days. We are required to submit unpaid accounts to the Office of the University Comptroller. If we have not received payment and/or a portion of payment based on a documented payment plan for more than 120 days, the account will be transferred to a collection agency.

- If you have any portion of your balance that is 120 days past due, you are responsible for paying the total balance on the account to prevent the account from going into the collections process.

- If cost is an undue burden, there may be options, such as access to grants to assist with costs. However, the SJC cannot promise that any such options will be available. We also offer payment plans. For more information regarding payment plans please contact our billing specialist at 434-924-1406.

- If SJC purchased custom equipment on behalf of a client and the equipment is non-refundable and cannot be returned to the manufacturer, the client is responsible for reimbursing SJC the total cost of procuring the equipment if the client is non-compliant attending appointments.

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CLIENT HISTORY

Client's Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Ethnicity: _____

Gender: ☐ Female ☐ Male ☐ Non-Binary/third gender ☐ Prefer not to say ☐ Self-Describe _____

Gender as it is related to your insurance policy: ☐ Female ☐ Male

Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parent/Guardian (if client is child): _____ Age: _____

Address (if different): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Highest Level of Education: _____

Relationship to client: _____

Parent/Guardian (if client is child): _____ Age: _____

Address (if different): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Highest Level of Education: _____

Relationship to client: _____

Additional individuals living in household:

Name	Relationship	Age	Name	Relationship	Age

REASON FOR VISIT

What services are you seeking? ☐ Clinical Psychology Services ☐ Counseling Services ☐ Audiology Services ☐ McGuffey Reading Services ☐ Speech-Language Services

Briefly state your reason(s) for seeking services:

_____

_____

By whom were you referred: _____

Have you had services like this before? ☐ Yes ☐ No

When? _____

Where? _____

HISTORY

Client currently attends: ☐ daycare ☐ elementary school ☐ middle school ☐ high school ☐ college/university ☐ none

Where: _____

Has the client ever in the past received special help or accommodations at school or work? ☐ Yes ☐ No

If so, please explain: _____

_____

Has client received any diagnoses related to learning, mental health, communication, etc.? ☐ Yes ☐ No

If so, please explain: _____

_____

*** If the client has received any previous evaluations for learning, mental health or communication concerns please provide copies**

MEDICAL

Primary Physician or Pediatrician: _____ Phone: _____

Date of last visit: _____

Does the client have any chronic illnesses, current health problems and/or medical diagnoses? ☐ Yes ☐ No

If yes, please describe: _____

Is the client currently taking prescription or non-prescription medications? ☐ Yes ☐ No

If yes, please list medication(s), problem(s) being treated, and prescribing physician(s): _____

_____

Does the client have any known allergies? ☐ Yes ☐ No

If yes, please indicate): _____

Is there any family history of significant health problems? ☐ Yes ☐ No

If yes, please describe: _____

_____

Name of person completing this form: Signature: ☐ Check Box to Sign

Relationship to client (if applicable): Date:

If you do not have access to a digital signature, please check the box as an indication that you have read and understand this document.

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____ Phone number: _____

The University will not tolerate discrimination or harassment in the workplace, academic setting or in its programs or activities based on age, color, disability, marital status, national or ethnic origin, political affiliation, race, religion, sex (including pregnancy), sexual orientation, veteran status, or family medical or genetic information. This policy is intended to be consistent with applicable federal and state laws and state and University policies. The Office of Equal Opportunity Programs is responsible for enforcing this policy on behalf of the University and has compliant procedures available to do so.

UNIVERSITY of VIRGINIA

SCHOOL of EDUCATION
and HUMAN DEVELOPMENT
Sheila C. Johnson Center

Sheila C. Johnson Center
417 Emmet Street South
Box 400270
Charlottesville, VA 22904-4270
Phone: 434-924-7034 • Fax: 434-924-4621
education.virginia.edu/research-initiatives/sheila-c-johnson-center

1. Download form to your computer desktop.
2. Open form with Adobe Reader, available at https://acrobat.adobe.com/us/en/acrobat/pdf-reader.html
3. Save form after filling in the fields.
4. Return form via OnPatient

CLIENT AND INSURED (POLICY/ CARD HOLDER) INFORMATION

PLEASE FILL OUT THIS FORM COMPLETELY IN ORDER THAT WE MAY BILL YOUR INSURANCE COMPANY FOR YOUR SERVICES

CLIENT	POLICY/CARDHOLDER
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Date of Birth: _____	Date of Birth: _____

Client's relationship to policy/cardholder: ☐ Child ☐ Spouse ☐ Self ☐ Other: _____

Policy/Cardholder ID #: _____ Group #: _____

Medicaid/ Medicaid Managed Care #_____

POLICY/CARDHOLDER SIGNATURE: _____ **DATE:** _____
(If Medicaid Guarantor Must Sign)

I request that payment of authorized Medicare and/or other health insurance benefits be made on my behalf to the University Of Virginia, Sheila C. Johnson Center for Clinical Services/Speech-Language Hearing, for services furnished to me by their clinicians. I authorize the Sheila C. Johnson Center to release any information needed to determine these benefits or the benefits payable for related services to insurance carriers.

DO NOT COMPLETE IF WE HAVE A COPY (Front & Back) OF YOUR INSURANCE CARD

Insurance Company: _____

Insurance Company Provider Telephone Number (on back of insurance card): _____

Insurance Company Provider Address: _____

_____

*****PLEASE ALLOW US TO COPY YOUR INSURANCE CARD FOR OUR RECORDS*****

Revised 6/20/2024