



**WILLIAM PATERSON**  
**UNIVERSITY**

**SPEECH AND HEARING CLINIC**

300 POMPTON ROAD  
WAYNE, NEW JERSEY 07470-2103  
Phone 973.720.2207 Fax 973.720.3357

Dear Prospective Client,

Thank you for inquiring about the Speech and Hearing Clinic at William Paterson University. The clinic offers assessment and treatment for children and adults with communication disorders or differences including, but not limited to, the following areas: articulation, expressive and receptive language, voice, stuttering, aphasia, traumatic brain injury and accent modification.

The Clinic is part of the training for students in the Master of Science program in speech/language pathology. Services are provided by students who are supervised by licensed and certified speech/language pathologists. Therapy is provided on a semester basis and begins at the onset of the semester in January, May and September. Therapy sessions are typically 50 minutes in duration. Individual and group therapy sessions are available and are determined based on a client's needs and availability within the Clinic. All services are available only in English.

Please complete the enclosed forms and return them to the Speech and Hearing Clinic promptly. In order to initiate therapy, a speech/language report or progress report must be attached to the application. If an evaluation has not been completed or is dated more than one year ago, you will be contacted to schedule an evaluation. Please attach any other pertinent information including medical/educational/therapy evaluations, progress notes from other therapists, and Individualized Educational Plans/Individual Family Service Plans.

We try to service as many clients as possible. Unfortunately, we are not always able to accommodate everyone who seeks services each semester. You will be contacted prior to the start of the semester for which you apply for services to determine your time availability. Flexibility in a client's schedule increases the likelihood of services being provided in a timely fashion. Clients remain on a waiting list until services are available.

If you have further questions please feel free to contact me at 973-720-3359.

Sincerely,

Eileen Fasanella, M.A., CCC-SLP  
Clinic Director



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Hours of Operation

Monday-Friday  
 8:30 AM-4:30 PM

*Evening appointments  
 available*

Speech Session Time

50 Minutes

(1 Hour Scheduled)

Speech Semesters

(11 or 12 weeks)

Fall

September-December

Spring

January-April

Summer TBA

Fees & Services

Speech & Language

Evaluation

\$225.00

Speech & Language

Therapy

\$450.00 per semester

(2 sessions per week)

\$225.00 per semester

(one session per week)

Group Therapy

*Group rates vary by*

*Semester*

*Please call for Rates*

Speech and Hearing

Clinic

Clinic Secretary

973-720-2207

Clinic Director

973-720-3359

Clinic Fax Number

973-720-3357

Clinic Email

*speechclinic@wpunj.edu*

The Speech and Hearing Clinic at William Paterson University is a clinical facility within the Department of Communication Disorders that is designed to provide assessment and treatment for all disorders of communication. An evaluation and/or treatment at the clinic will benefit any adult or child demonstrating communication difficulties.

**Children may have communication difficulties because of:**

- Developmental speech/language delay or disorder
- Neurogenic language disorders, aphasia
- Motor speech disorders, apraxia
- Stuttering
- Voice Disorders
- Accent Reduction

**Adults may have difficulties that result from:**

- Cerebrovascular accident (stroke)
- Traumatic Brain Injury
- Dementia
- Progressive neurogenic disease (i.e. Parkinson's disease)

**How to Apply to the Speech and Hearing Clinic**

Applications to the clinic are accepted on a continuing basis. However, new clients are only accepted into the program at the start of each semester (January, May and September). When your application is received, you will be placed on a waiting list and contacted when an opening at the clinic becomes available. Speech and Language evaluations are done by appointment throughout the year.

**Description of Fees and Services**

The clinical program at the Speech and hearing Clinic demonstrates a variety of innovative assessment and intervention modes. After completion of an intake interview, an evaluation plan is proposed, which may include the following:

*Speech and Language Evaluation...\$225.00 per evaluation*

To assess the status of language development, articulation, fluency, voice or neurogenic language impairment.

*Speech and Language Therapy.....\$450.00-2Xper semester/\$225.00-1Xper semester*

Preschool Group Therapy.....Please call for Group Rates



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### **PEDIATRIC APPLICATION**

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### **HOW TO APPLY**

Applications to the Clinic are accepted on a continuing basis. However, new clients are only accepted into the program at the start of each semester (January, May and September). **When your application is received, you will be placed on a waiting list and contacted when an opening at the center becomes available.** Speech and Language evaluations are done by appointment throughout the year.

### **DESCRIPTION OF FEES AND SERVICES**

The clinical program at the Speech and Hearing Clinic demonstrates a variety of innovative assessment and intervention modes. After completion of an intake interview, an evaluation plan is proposed, which may include the following:

**Consultation/Observation**.....\$120.00 per hour

**Speech and Language Evaluation**.....\$225.00 per evaluation

*To assess the status of language development, articulation, fluency, voice or neurogenic language impairment.*

**Speech and Language Therapy**.....\$450.00 per semester (2X/week) \$225.00 per semester (1X/week)

**Note:** *Financial assistance may be available to those who qualify. Please contact the clinic for more information. Individual or small group intervention for the remediation of communication disorders provided on a per semester basis. Fees subject to change.*

<u>SPEECH SESSION TIME</u>	<u>INDIVIDUAL THERAPY</u>	<u>GROUP THERAPY</u>	<u>HOURS OF OPERATION</u>
50 Minutes	\$450.00 (2 sessions/week)	Group Rates Vary	Monday-Friday
(1 hour schedule)	\$225.00 (1 session/week)	Please call for rates	8:30 AM-4:30 P Evening appts. available

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# PEDIATRIC APPLICATION

## GENERAL INFORMATION

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THE INFORMATION THAT YOU PROVIDE REGARDING YOUR CHILD'S MEDICAL, DEVELOPMENTAL AND ACADEMIC HISTORIES WILL HELP US PROVIDE APPROPRIATE SERVICES. PRIOR TO THE ONSET OF SERVICES, AN EVALUATION DATED WITHIN THE LAST 12 MONTHS MUST BE RECEIVED. EVALUATION MAY BE COMPLETED AT THE SPEECH AND HEARING CLINIC OR ELSEWHERE. APPLICANTS WHO DO NOT ATTACH A REPORT WILL BE CONTACTED TO ARRANGE AN EVALUATION.

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Application Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Gender:

- Male  
 Female

Street Address: \_\_\_\_\_ Apt/Unit: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent Name(s): \_\_\_\_\_ Referred By: \_\_\_\_\_

Describe any allergies of reactions: \_\_\_\_\_  
\_\_\_\_\_

Language(s) spoken in the home: \_\_\_\_\_  
\_\_\_\_\_

If parents are divorced, please indicate legal custodial status of child: \_\_\_\_\_  
\_\_\_\_\_

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**EDUCATION INFORMATION**

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**Current School:** \_\_\_\_\_ **Current Grade Level:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **Suite/Unit:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

<b>Name of Previous School(s)</b>	<b>Grade Level(s)</b>	<b>Date(s)</b>	<b>Reasons for Leaving</b>

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**SPEECH AND LANGUAGE COMMUNICATION**

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**Please describe the nature of your child's communication and the concerns that brought you to the Speech And Hearing Clinic:**

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**Please describe anything special or different about your child's motor, physical, academic, social or emotional development:**

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**Has your child received speech/language therapy in the past?**

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**If yes, where? What areas were addressed in therapy? Please provide the most updated evaluation/progress report as this will assist us in scheduling.**

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**Describe any hospitalizations, accidents, serious illness or medications:**

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If your child has been evaluated, please fill out the appropriate information below:

TYPE OF SCREENING	BY WHOM	DATE	RESULTS
HEARING			
PSYCHOLOGICAL			
NEUROLOGICAL			
EDUCATIONAL			
SPEECH & LANGUAGE			
OTHER (nutritional, allergy, occupational therapy)			

**PLEASE ATTACH ANY SPEECH/LANGUAGE DIAGNOSTIC REPORTS PREVIOUSLY COMPLETED.  
ALSO ATTACH RECENT IEP OR IFSP (IF APPLICABLE).**

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### SEMESTER INFORMATION

The information that you provide in this section is regarding your semester preferences for future scheduling upon acceptance into the program. New clients are only accepted into the program for therapy at the start of each semester (January, May, and September). We will do our best to meet all requests, but certain time slot availability is limited.

**PLEASE CHECK ANY TIME SECTION IN WHICH THE CLIENT IS GENERALLY AVAILABLE TO RECEIVE THERAPY**

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#### WHICH SEMESTER ARE YOU GENERALLY AVAILABLE:

FALL (September-December)       SPRING (January-April)

HOW MANY DAY(S)/TIMES(S) PER WEEK WOULD YOU LIKE SPEECH THERAPY:

- 1X/WEEK  
 2X/WEEK

ONE SESSION PER WEEK	
<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday
<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday
<input type="checkbox"/> Morning (9am -11:30am)	<input type="checkbox"/> Afterschool (2pm – 3:30pm)
<input type="checkbox"/> Afternoon (12pm -2pm)	<input type="checkbox"/> Evening (4pm – 7pm)
<input type="checkbox"/> Other: _____	

TWO SESSIONS PER WEEK	
<input type="checkbox"/> Monday/Wednesday	<input type="checkbox"/> Tuesday/Thursday
<input type="checkbox"/> Morning (9am -11:30am)	<input type="checkbox"/> Afterschool (2pm – 3:30pm)
<input type="checkbox"/> Afternoon (12pm -2pm)	<input type="checkbox"/> Evening (4pm – 7pm)
<input type="checkbox"/> Other: _____	

If you are sending the completed application, please mail, email or fax it to:  
**William Paterson University Speech and Hearing Clinic**  
**University Hall, Lower Level**  
**300 Pompton Road**  
**Wayne, NJ 07470**  
**[speechclinic@wpunj.edu](mailto:speechclinic@wpunj.edu)**  
**Fax 973-720-3357**

**PLEASE CONTINUE TO THE NEXT PAGE FOR THE STATEMENT OF UNDERSTANDING.**

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## STATEMENT OF UNDERSTANDING

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The Speech and Hearing Clinic is an integral part of the teaching and research programs of William Paterson University. Substantially, all services at the Clinic are performed by graduate students working under the supervision of qualified faculty and licensed and certified SLPs. Evaluations and tutorial sessions with children and conferences with their parents are, from time to time, observed by students through one-way mirrors, or recorded on video or audio tape for future discussions by groups of students and their instructors at the University. For this reason, the Clinic can accept, for service only, those clients who are willing to cooperate with the educational and research activities of the Clinic, as indicated above. Applicants may be assured that such activities will in no way interfere with the quality of services provided:

I have read the above statement and agree:

- a) These services may be rendered to me or my child by graduate students, faculty, and clinical associates.
- b) That the sessions in which I and/or my child participate may be viewed by students at the Center, or may be recorded on audio or video tape and used in connection with the teaching and research programs of the Center, including presentations at professional meetings.

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*Parent/Guardian*

*Date*

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*For Internal Use Only*

Date Received:	Faxed: _____ Emailed: _____ Mailed: _____ Client Delivered: _____	Notes:
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*Clinic Secretary Signature (If Applicable)*

*Director Signature (If Applicable)*

## USE OF STUDENT CLINICIANS

The Speech and Hearing Clinic is an integral part of the teaching and research programs of William Paterson University. Substantially all services at the Clinic are performed by graduate students working under the supervision of qualified faculty and licensed and certified SLPs. Evaluations and tutorial sessions with children and conferences with their parents are, from time to time, observed by students through one-way mirrors, or recorded on video or audio tape for future discussions by groups of students and their instructors at the University. In view of the foregoing, the Clinic *can accept for service only* those clients who are willing to cooperate with the educational and research activities of the Clinic, as indicated above. Applicants may be assured that such activities will in no way interfere with the quality of services provided:

I have read the above statement and agree:

- a) that services may be rendered to me or my child by both graduate students, faculty, and clinical associates.
- b) that sessions in which I and/or my child participate may be viewed by students at the Clinic, or may be recorded on audio or video tape and used in connection with the teaching and research programs of the Clinic, including presentations at professional meetings.

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Signature  
(Parent/Guardian must sign if applicant is a minor)

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Date

William Paterson University  
Department of Communication Disorders and Sciences  
SPEECH AND HEARING CLINIC

**ATTENDANCE AGREEMENT**

I understand that the William Paterson University Speech and Hearing Clinic's primary goal is to provide its students, under the supervision of ASHA certified personnel, with diagnostic and therapeutic experiences in preparation for professional practice as Speech-Language Pathologists. I understand that if the services I or my child require are beyond the scope of those provided at the Clinic, I will be referred to a more appropriate clinical setting.

Since the clinic is part of a training program, consistency of client attendance is essential for both the student-clinician and the client to obtain optimal benefits from the program. I understand that two absences are permitted per fall and spring semester and one absence is permitted during summer sessions. I further understand that absences in excess of that could result in termination from the program.

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Client (Parent) Signature

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Date