Speech Processing in Stuttering

NCT04929184

07/11/2025

CONSENT TO BE PART OF A RESEARCH STUDY

PART 2 OF 2: SITE INFORMATION

INFORMATION ABOUT THIS DOCUMENT:

This part of the consent form includes additional information about being a research participant at your enrolling site. Before making your decision to join the study, review both the General study information and this Site information.

Study title: Speech Processing in Stuttering

Site Name: University of Michigan

8(A) FINANCIAL INFORMATION (CONTINUED)

8.1 Who will pay for the costs of the study? Will I or my health plan be billed for any costs of the study?

There are no costs or billing for this study.

See the Part 1 *General Information* section 8.1 for additional information on this topic.

8.2 Will I be paid or given anything for taking part in this study?

You will receive $50 for each visit. If you discontinue the study before the end of the visit, you will be paid a pro-rated amount at $10/hour.

8.3 Who could profit or financially benefit from the study results?

See the Part 1 *General Information* section 8.3 for additional information on this topic.

9(A) CONFIDENTIALITY OF SUBJECT RECORDS AND AUTHORIZATION TO RELEASE YOUR PROTECTED HEALTH INFORMATION (CONTINUED)

9.1 How will the researchers protect my information?

See the Part 1 *General Information* section 9.1 for additional information on this topic.

9.2 What protected health information (PHI) about me could be seen by the researchers or by other people? Why? Who might see it?

See the Part 1 *General Information* section 9.2 for additional information on this topic.

Signing this form gives the researchers your permission to obtain, use, and share information about you for this study, and is required in order for you to take part in the study.

Medical information and billing records are protected by the privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This type of information is called protected health information (PHI).

Please note that we will not contact any medical provider for information about you. All PHI collected as part of this study will come directly from questionnaires you complete for the purposes of this study only. We do not have access to any of your health information other than what you provide directly to us. Your participation in this study will not be linked to any of your health records.

If you receive any payments for taking part in this study, the University of Michigan accounting department may need your name, address, Social Security number, payment amount, and related information for tax reporting purposes.

Adult Abuse - Michigan law requires the reporting by certain persons of actual or suspected adult abuse, neglect, or exploitation. Required reporters include physicians, nurses, therapists, and other persons employed by healthcare institutions. More information about required reporting is available at

http://legislature.mi.gov/doc.aspx?mcl-400-11a. If you tell us or we learn something that makes us believe that you or others have been or may be harmed, we may be required to report that information to the appropriate agencies.

Child Abuse - Michigan law requires the reporting of actual or suspected child abuse or neglect by certain persons (called mandated reporters). Mandated reporters include physicians, nurses, therapists, and other medical professionals. A complete list may be found at https://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_44443-157836--,00.html. If you tell us or we learn something that makes us believe that you or others have been or may be physically harmed, we may be required to report that information to the appropriate agencies.

9.3 What happens to information about me after the study is over or if I leave the study before it is finished?

As a rule, the researchers will not continue to use or disclose information about you, but will keep it secure until it is destroyed. Sometimes, it may be necessary for information about you to continue to be used or disclosed, even after you have canceled your permission or the study is over.

Examples of reasons for this include:

- To avoid losing study results that have already included your information
- To provide limited information for research, education, or other activities. (This information would not include your name, social security number, or anything else that could let others know who you are.)
- To help University and government officials make sure that the study was conducted properly

As long as your information is kept within the University of Michigan Health System, it is protected by the Health System's privacy policies. For more information about these policies, ask for a copy of the University of Michigan "Notice of Privacy Practices". This information is also available on the web at http://www.uofmhealth.org/patient+and+visitor+guide/hipaa. Note that once your information has been shared with others as described under Question 9.2, it may no longer be protected by the privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

10 CONTACT INFORMATION

Who can I contact about this study?

Please contact the researchers listed below to:

- Obtain more information about the study
- Ask a question about the study procedures or treatments
- Talk about study-related costs to you or your health plan
- Report an illness, injury, or other problem (you may also need to tell your regular doctors)
- Leave the study before it is finished
- Express a concern about the study

Site Principal Investigator:	Emily O. Garnett, Ph.D., CCC-SLP
Site Principal Investigator Contact:	4250 Plymouth Road, Ann Arbor Michigan 48109 734-232-3371
Site Study Coordinator:	Research study coordinator
Site Study Coordinator Contact:	4250 Plymouth Road, Ann Arbor Michigan 48109 734-926-8775

You may also express a question or concern about a study by contacting the Institutional Review Board responsible for the review of the study:

University of Michigan Medical School Institutional Review Board (IRBMED)
2800 Plymouth Road
Building 520, Room 3214
Ann Arbor, MI 48109-2800
Telephone: 734-763-4768
Fax: 734-763-1234
e-mail: irbmed@umich.edu

When you call or write about a concern, please provide as much information as possible, including the name of the researcher, the IRBMED number (at the top of this form), and details about the problem. This will help University officials to look into your concern. When reporting a concern, you do not have to give your name unless you want to.

11. RECORD OF INFORMATION PROVIDED

11.1 What documents will be given to me?

Your signature in the next section means that you have received copies of all of the following documents:

- This "Consent to be Part of a Research Study" document. (*Note: In addition to the copy you receive, copies of this document will be stored in a separate confidential research file)*

12. SIGNATURES

Consent to Participate in the Research Study

I understand the information printed on this form. I have discussed this study, its risks and potential benefits, and my other choices with _____.

My questions so far have been answered. I understand that if I have more questions or concerns about the study or my participation as a research subject, I may contact one of the people listed in Section 10 (above). I understand that I will receive a copy of this form at the time I sign it and later upon request. I understand that if my ability to consent or assent for myself changes, either I or my legal representative may be asked to re-consent prior to my continued participation in this study.

Print Legal Name: _____

Signature: _____

Date of Signature (mm/dd/yy): _____

Consent to video/audio recording/photography solely for purposes of this research

This study involves video and/or audio recording and/or photography. If you do not agree to at minimum audio recording for the experimental tasks, you cannot participate in the study.

Please initial your response:

_____ Yes, I agree to be video/audio recorded/photographed.

_____ Yes, I agree to be audio recorded for the experimental tasks **only**

_____ No, I do not agree to be video/audio recorded/photographed.

Consent to Collect for Unspecified Future Research

This project involves the option to allow the study team to keep your identifiable data for use in future research. I understand that it is my choice whether or not to allow future use of my data. I understand that if my ability to consent or assent for myself changes, either I or my legal representative may be asked to re-consent prior to my continued participation in this study.

Please initial your choice:

_____ Yes, I agree to let the study team keep my data for future research.

_____ No, I do not agree to let the study team keep my data for future research.

Legally Authorized Representative or Parent Permission

Subject Name: _____

Parent/Legally Authorized Representative:

Printed Legal Name: _____

Signature: _____

Address: _____

Date of Signature (mm/dd/yy): _____

Relationship to subject: Parent Spouse Child Sibling Legal guardian Other

If "Other," explain: _____

Reason subject is unable to consent: _____

If this consent is for a child who is a ward of the state (for example, a foster child), please tell the study team immediately. The researchers may need to contact University of Michigan IRBMED.

Principal Investigator or Designee

I have provided this participant and/or his/her legally authorized representative(s) with information about this study that I believe to be accurate and complete. The participant and/or his/her legally authorized representative(s) indicated that he or she understands the nature of the study, including risks and benefits of participating.

Printed Legal Name: _____

Title: _____

Signature: _____

Date of Signature (mm/dd/yy): _____