CHILDREN'S SPEECH & FEEDING THERAPY, INC.
PATIENT INFORMATION FORM

Today's Date: _____

PERSONAL

Name (Last, First): _____ Male___Female___

Parent or Guardian Name: _____

Street Address: _____

City, Zip: _____

Phone Number: _____Cell _____

Email Address: _____

Child's Birth Date: _____

I am paying privately for therapy _____Yes(please provide Credit Card # below) _____No (If no, please fill in insurance info below)

Primary Insurance or Credit Card:_____

Policy #: _____

Insured: _____

Insured DOB: _____ Relationship to Insured: _____

Co-Pay: _____ Is a referral on file for this visit?_____

Credit Card # (only if paying privately)_____

Exp Date:_____ CVV:_____

Child's Pediatrician's Name: _____

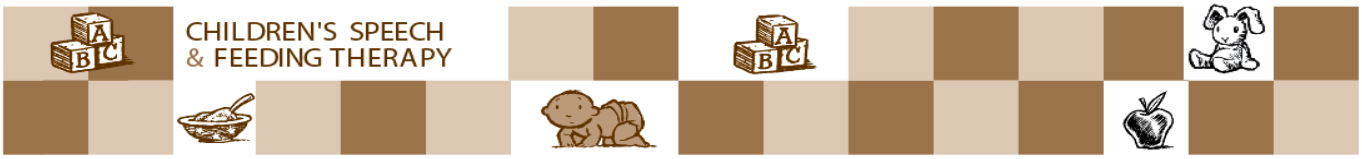
Pediatrician's Number: _____

Your Child's Medical Diagnostic Codes (e.g. prematurity, VSD, Autism, ADHD):

_____

I confirm all above information to be correct.

Parent or Guardian Signature: _____



OFFICE POLICIES and BILLING REQUIREMENTS

Thank you very much for choosing Children's Speech & Feeding Therapy, Inc. for your child's care. We look forward to providing quality evidence-based speech, language, and/or feeding therapy services to your child. We ask that you arrive on time for evaluation and therapy sessions as clinicians often have back-to-back therapy sessions and if you arrive late to your appointment we cannot extend your allocated time period. Additionally, if you are using insurance for your visit and arrive greater than 20 minutes late to a session, that session cannot be billed to insurance due to minimum minutes required for billing and you will therefore be charged the private pay rate of $150.00 for that visit.

Therapy sessions end five minutes prior to the scheduled end of a session in order to discuss the therapy session and explain and provide caregivers with homework assignments. Completing homework assignments will expedite the therapy process and remember you are the "secret weapon" to helping move your child's therapy along.

BILLING

We are Blue Cross Blue Shield (BCBS) and Harvard Pilgrim providers only; however, this is not a guarantee of payment. Families are responsible to inquire about their individual benefits and whether they will be reimbursed for any services received in our office. In the event that claims are not paid, you are responsible for payment in full. If your family has a deductible that must be reached in each calendar year, services will be applied to that deductible. Families with BCBS or HP will be billed any deductible, copayments or co-insurance that may apply. We will bill BCBS or HP for your child's assessment. Unfortunately, they will not reimburse for the required treatment plan which is $250.00, payable at the time of your child's initial evaluation and all subsequent re-evaluations.

Every insurance plan is unique and you are responsible for knowing how your plan works and what your speech, language and feeding coverage includes. It is not uncommon for some plans to require a written extension request if your child needs more visits beyond those initially approved. We will provide that documentation. That being said, some plans have a hard limit on how many visits your child can receive in a year and no extension request can change that. If you have a plan that is managed by your company, you may need to reach out to your human resources department for more information. In the event your visits are denied, you will be responsible for any non-covered services at private pay rates. Please provide our NPI number 1992862940 to process any needed referrals.

Families that do not carry BCBS or Harvard Pilgrim as their insurance are charged at a rate of $800.00 for a comprehensive speech and language evaluation or a feeding evaluation for children over 24 months. Speech screenings and infant feeding and swallowing evaluations are charged at a rate of $500.00. Payment in full is due on the day of your child's evaluation/consult.

A charge of $150.00 per session of individual speech, language, and feeding therapy will be billed monthly for families paying privately for services. Feeding group (two hours) is billed at $175.00 per group session. Phone consultations that exceed beyond 15 minutes in length will be pro-rated at $150.00 per hour. You will receive a monthly statement reflecting any payments owed for services received.

A family seeking reimbursement from an insurance company other than Blue Cross Blue Shield or Harvard Pilgrim must understand that we are not responsible for billing that Insurance Company nor do we accept payments from that insurance company. You are considered private pay and will be billed monthly for your visit(s). Any reimbursement from an insurance company must be received directly by you. Payments must be made to us in a timely manner while you are attempting reimbursement from any other Insurance company.

Please note that we will not release any report unless your account is current.

Payment is due at the end of each month. Every new patient will receive an invitation to set up their child's individual client portal. Electronic invoices will be sent to you through the portal known as Therabill and will include a link to your client portal to complete payment. You can find electronic invoices for your records through this portal as well. If you would prefer, payment may be made by check payable to Children's Speech & Feeding Therapy, Inc., and left in the check box on the front desk.

Following a period of 60 days after bills have been submitted to your insurance company, if payment has not been received, you will be billed in full for your child's visits. We are a small company who can't float bills beyond this time period. If payment is received from your insurance company after this time period, you will be reimbursed in full.

All accounts that go beyond 60 days past due will be transferred to Transworld Systems, a national collection agency, for accounts receivable assistance. You will first receive a letter stating a past due balance. If from then on a balance remains unpaid you will continue to see collection activity until resolved. We ask that you call the office immediately if you find yourself in a financial situation for other payment options.

Off-site conferences (such as a school IEP meeting) will be pro-rated and billed at $150.00/hour. If distance traveled exceeds fifteen minutes per leg, you will be billed the difference pro-rated at the $150.00 rate.

Credit cards are kept on file for cancelled appointments and uncollected billed balances. If your card is not already on file please request a credit card form to fill out in order to continue to receive services.

VACCINATION REQUIREMENT

We now require all eligible patients and their parents to receive their COVID-19 vaccine in order to receive services from Children's Speech & Feeding Therapy, Inc. All children five and older must have proof of their first vaccination by February 1st, 2022 to have an evaluation or continue to receive therapy services in our practice.

ATTENDANCE

Consistent attendance is essential to success in therapy. Therefore, we require a minimum ongoing attendance of 80%. If you miss greater than 20% of your scheduled sessions, we reserve the right to terminate therapy services and pass your slot onto another waiting family.

Our clinic operates throughout the calendar year. This schedule provides children with the maximal opportunity for progress in therapy. Therefore, we only allow families to take up to two weeks off during the summer months.

ILLNESS

Please do not bring your child to therapy when s/he is ill, has a fever, and/or a persistent cough. We ask that you assist us in minimizing exposure to other children and their families. We take children's temperatures at

the beginning of every therapy session and will cancel the session and send any child home with you if a fever is detected.

NO SHOWS, CANCELLATIONS, and RE-SCHEDULING

If you need to cancel an appointment, a twenty-four hour notice is required. All appointments missed without at least a twenty-four hour notice will be billed to you in full at the private pay rate of $150.00. Only illness, severe weather conditions, or true family or medical emergencies will be accepted as reasons for missing appointments with less than twenty-four hours notice.

We follow the Needham Public School closings for inclement weather conditions. If the Needham Public School is closed for inclement weather then our office will be closed too. Otherwise, assume we are open unless you have received a call or email directly from your child's clinician or another member of our staff. Your attendance will be expected if we are open. We are also open during school vacation weeks and all summer. Please check with your child's clinician for any change in schedule due to individual holidays.

No shows to visits will be billed to you at the private pay rate of $150.00. If you can reschedule your child's visit with their treating clinician within the same week of service this fee will be waived.

Please discuss re-scheduling options with your child's treating clinician.

I have read and accept the policies of Children's Speech & Feeding Therapy, Inc.

_____

Your Child's Name

_____

Parent/Guardian Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Child's name:_____

I give permission for Children's Speech & Feeding Therapy, Inc. to exchange information regarding my child with the following individual(s):

_____	_____
Name of person/facility	**Name of person/facility**
_____	_____
Street address	**Street address**
_____	_____
City/Town, State, Zip code	**City/Town, State, Zip code**
_____	_____
Telephone number	**Telephone number**

_____

Parent signature **Date**

This release of information will be valid for a twelve month period from the date of signing.

The following is a comprehensive questionnaire that we request you fill out prior to attending your feeding and swallowing assessment. Although we recognize it is lengthy, gathering this information ahead of time will allow more time for direct assessment of your child. Please be as detailed as possible. Not all questions will apply to all children. Please feel free to skip over all non-applicable questions.

Identifying Information:
Child's Name: _____DOB:_____
Parents:_____
Address:_____
Phone: (H): _____(W/C):_____
Referral Source:_____
Insurance: _____
Primary Pediatrician (including address):
_____
_____

What is your primary concern? (Check all that apply)

___ Not eating enough variety
___ Not eating enough volume
___ Eating too much
___ Food refusal
___ Poor growth
___ Transitioning from tube to oral feeding
___ Gagging
___ Vomiting
___ Avoiding whole food groups
___ Only eats purees
___ Only eats crunchy solids
___ Only drinks fluids
___ Aspiration
___ Constipation
___ Diarrhea
___ Toothbrushing intolerance

Birth History:
___ Full term ___ Premature (_____weeks)
___ Spontaneous Vaginal Delivery ___ C-Section ___ Induced
Reason for C-section or induction: _____
Please describe any complications during pregnancy: _____
_____
Did your child have a NICU stay? ____If so, for how long?_____
Did your child require oxygen? ____ If so, for how long? _____
Was your child intubated? ____ If so, for how long? _____
When did your child leave the hospital? (with mother, other time)
_____
_____

Feeding History:
When did you first notice your child had difficulty eating?_____

As a newborn, was your child bottle fed/breast fed/tube fed?

_____

How did that go? (i.e. refusal, gagging, vomiting, etc.)

_____

When did you introduce purees?_____
How did that go?_____
When did you transition to chewable solids?_____
How did that go?_____

Current Feeding:

How does your child currently receive liquids? _____
If tube fed, what type of tube does your child currently use?
___ ng-tube ___ g-tube ___ g-j-tube ___ j-tube
If tube fed, please list type of formula, times of feedings, rate of feedings, and total volume of feedings (i.e. 120cc bolus over one hour, five times per day)

_____

_____

If fed orally or orally with supplemental tube feeding, please fill out the attached one-day food intake sheet (see attached)

Please indicate which foods your child currently avoids. (Check all that apply)
___ fruits ___ vegetables ___ meats ___ starches
___ purees ___ lumpy ___ crunchy ___ solid
___ fluids ___ mixed textures ___ salty ___ sweet
___ spicy

Typical Mealtime:

Who does your child eat with?

_____

Where does your child eat?

_____

Do you use the television, toys, etc. as distractions during meals?

_____

What is the general feeling at your mealtimes? (pleasant, stressful, power struggle)

_____

Developmental History:

Does your child currently receive any therapy services?

Therapy	Frequency	Location	Treating Clinician
___ Speech/Language			
___ OT			
___ PT			
___ Feeding therapy			

___ Dev'l Educator
___ Other

At what age did your child…?
Babble: _____
Say first words: _____
Combine words: _____

How well do familiar and unfamiliar listeners understand your child?
_____
Do you have concerns regarding how your child understands language? (i.e. follow directions, comprehend concepts, etc.)
_____

At what age did your child…?
Sit up unsupported: _____
Crawl: _____
Walk: _____

Does your child feed him/herself? _____

Medical History:
Does your child currently have a diagnosis? ____
If so, what is it? _____
Does your child have any allergies? _____ If so, please list:
_____
Please list any foods we may NOT offer your child due to personal food diets, religious preferences, etc._____

Please list any medications your child takes:
Types: _____
Amounts: _____
Time given: _____

Has your child had a hearing test? ____ What were the results?_____
_____
Does your child currently or has your child ever had ear tubes?
_____

Has your child had any surgeries? ____ When did they occur and what were they for?
_____
_____

Has your child had any procedures? ____(i.e. pH probe, barium swallow) When did they occur and what were they for?

_____

Has your child ever had a videofluoroscopic swallow study? ____
When? _____ Results: _____
_____

Is your child followed by a dietician? _____
Recent weight: _____ When was this taken? _____
Recent length/height: _____ When was this taken? _____

*If possible, please bring copies of all pertinent reports.

ONE DAY FOOD INTAKE

Please fill out this one day food intake completely. List the time of day food or liquid is offered (by mouth or tube), what that food or liquid item is (if brand specific – include brand), and the volume your child ingested. Please use objective measurements such as 2oz of puree, ¼ cup of pasta, or ½ of a baby carrot, rather than subjective ones such as a handful of cereal, five spoonfuls of pasta, or six sips of milk.

TIME OF DAY	FOOD ITEM OFFERED	VOLUME INGESTED

Please circle: typical day less than average more than average

Please bring one preferred food item, one non-preferred food item and your child's formula, bottle or cup to the appointment.

Please fill out the following chart by listing all of your children's food items in the appropriate columns based on acceptance – always accepts, accepts intermittently, or used to eat, but doesn't now. Please also include a "wish list". While in an ideal world your child would eat everything without complaint, please list foods that would change your world if your child ate them (e.g. foods you eat as a family but s/he doesn't eat, foods for social occasions, etc.)

Always Accepts	**Accepts Intermittently**	**Used to eat but doesn't now**	**Wishlist**

DIRECTIONS TO CHILDREN'S SPEECH & FEEDING THERAPY:
145 Rosemary Street, Needham, MA 02494 (Rosemary Office Park)

FROM THE WEST:

Take the Massachusetts Turnpike to Exit 14 (Interstate 95/Route 128). After the tolls, follow the signs for Route 95/128 South. Exit Route 95/128 South at exit 19C (Highland Ave, Needham). This exit will bring you onto Highland Avenue traveling toward Needham. Continue on Highland Avenue for about a mile. Turn right on Rosemary Street. We are located in Building C of the Rosemary Office Park.

FROM THE EAST:

Take the Massachusetts Turnpike to Exit 14 (Interstate 95/Route 128). After the tolls, follow the signs for Route 95/128 South. Exit Route 95/128 South at exit 19C (Highland Ave, Needham). This exit will bring you onto Highland Avenue traveling toward Needham. Continue on Highland Avenue for about a mile. Turn right on Rosemary Street. We are located in Building C of the Rosemary Office Park.

FROM THE NORTH:

Take Route 95 South to exit 19C (Highland Ave, Needham). This exit will bring you onto Highland Avenue traveling toward Needham. Continue on Highland Avenue for about a mile. Turn right on Rosemary Street. We are located in Building C of the Rosemary Office Park.

FROM THE SOUTH:

Take Route 95 North to exit 19C (Highland Ave, Needham). This exit will bring you onto Highland Avenue traveling toward Needham. Continue on Highland Avenue for about a mile. Turn right on Rosemary Street. We are located in Building C of the Rosemary Office Park.