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: ____

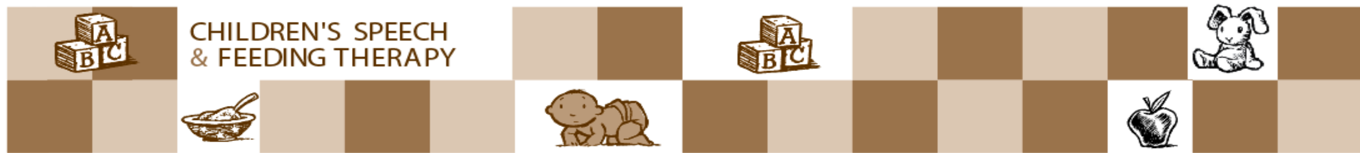
Pediatrician's Number: ____

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

<u>**AUTHORIZATION FOR RELEASE OF INFORMATION**</u>

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.

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.

The following is a comprehensive questionnaire that we request you fill out prior to attending your speech and language 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: ____

Diagnoses: ____

Primary Pediatrician (including address):

____

What is your primary concern? ____

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? _____________

Did your child pass their newborn hearing screening? __________

Was your child intubated? ____ If so, for how long? ________________

When did your child leave the hospital? (with mother, other time)

____

Feeding History:

Does your child have a history of feeding issues?____________

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?____

How does your child receive liquids? (e.g., straw cup, open cup, bottle, etc.) ______________________________

Medical History:
Does your child have any medical diagnoses? ________________________________
    If so, what are they? ________________________________
Has your child had a hearing assessment with an audiologist? _______
    If so, what were the results? ________________________________
    Did your child wear headphones during testing?________________
    Does your child currently or has your child ever had ear tubes? ____________
    If so, where was this surgery performed and when? ____
    Does your child have a history of ear infections? _______
    If so, how many? What was the course of treatment?
    ____
Has your child had any major accidents, surgeries, or hospitalizations? ________
    If so, when did they occur and what were the circumstances?
    ____
Does your child have any allergies? _______
    If so, please list: ________________________________
Does your child have trouble sleeping? _______
    If so, please describe (e.g., snoring, tossing and turning, etc.) ________________
Please list any medications your child takes:
    Types: ________________________________
    Amounts: ________________________________
    Time given: ________________________________
Is your child followed by any medical professionals? _______
    If yes, who and why? ____

Family history:
Does anyone in your family have a history of speech and language impairment? ______
    If yes, who? ______________________________
Does your child have any siblings? ________________________________
    If yes, do they have speech and language needs? _______________________
Is there a history of stuttering in your family? __________
    If yes, who? _____________________
Developmental History:

At what age did your child produce…?
    Reduplicated babble (e.g., bababa, mamama) _____________________
    Variegated babble (e.g., bamabama, mameemamee) _____________________
    Jargon ______________
    Their first word(s) _____________________
    Word combinations _____________________
    A point _____________________

How well do familiar and unfamiliar listeners understand your child?
____

Do you have concerns about how your child understands language? (i.e., understands concepts, follows directions, and/or understands stories, etc.)
____

At what age did your child…?

Sit unsupported ____________________

Crawl ____________________

Walk ____________________

Current Communication Skills:

How does your child communicate (e.g., vocalizations, signs, word approximations, words, phrases, sentences, etc.) and in what language(s), if any, other than English?
____
____

If your child is exposed to another language:

Who speaks to your child and in what language? ____________________

Are you concerned about your child's language comprehension and expression in both languages or just one? ____________________

What do you think your child does well with regards to communication?
____

What is most challenging with regards to communication?
____

Education:

What grade is your child in? ____________________________________

Where do they go to school? ____________________________________

How are they doing academically? ____________________________________ Socially? ____________________________________

Assessment & Treatment History:

When did you first become concerned about your child's speech or language skills?_________

What aspect/s of communication were you concerned about?____________________________

How did you address these concerns? _________________

Has your child had one or more of the following in the past twelve months:

(A) Speech and/or Language Evaluation,

(B) Developmental or Neuropsychological Evaluation,

(C) Academic Testing.

If yes, please attach these to this document.

Does your child currently receive any therapy services? ___________

If your child has received services, but doesn't now, please specify which as well as the course of treatment____

Are they currently on an IFSP, IEP, 504 plan or does he/she receive informal support at school? _________

Do they also receive services privately?__________

If yes to any of the above, please provide the frequency, type, and service delivery (e.g., group or individual)? ______________________

If your child has a 504 plan or receives informal academic support, please provide information regarding the amount & type of supports in place:

____
____
____

Please use the table below to provide information regarding your child's IFSP or IEP:
What is the date range of your child's current IEP?

Therapy	Frequency	Location	Treating Clinician
Speech & Language			
OT			
PT			
Feeding therapy			
Developmental educator or ABA			
Other			