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: _______________________SS#: __________________________

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

Primary Insurance: ____

Policy #: ____

Insured: ____

Insured DOB: __________________ Relationship to Insured: ___________________

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

OTHER

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

1. We are Blue Cross Blue Shield (BCBS), Harvard Pilgrim, and Allways insurance providers; 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 written documentation.

2. The fee for treatment plans is $250. 00 payable the day of your child's initial evaluation and all subsequent re-evaluations.

3. If your insurance plan requires a referral, you are responsible to contact your child's pediatrician's office to request this. In the event your visits are denied, you will be responsible for any non-covered services at our private pay rates. Please provide our NPI number 1992862940 to process referrals.

4. Families that do not carry insurance we take are charged at a rate of $800.00 for a comprehensive speech and language evaluation or a feeding evaluation for children over 24 months of age. Infant feeding and swallowing evaluations and speech screenings are charged at a rate of $500.00. Payment in full is due on the day of your child's evaluation/consult.

5. 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 groups (one and a half to two hours) are billed at $175.00 per group session. Phone consultations that exceed beyond 15 minutes in length will be pro-rated. You will receive a monthly statement reflecting any payments owed for services received.

6. A family seeking reimbursement from an insurance company other than insurances we take 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. We are not responsible for appealing a denied claim from an insurer with which we are not contracted.

7. Payments must be made to us in a timely manner while you are attempting reimbursement from any other insurance company.

8. Please note that we will not release any written documentation unless your account is current.

9. Payment in full is to be made monthly, upon receipt of a bill. Checks should be made out to Children's Speech & Feeding Therapy, Inc., and mailed to 145 Rosemary Street, Suite C Needham, MA 02492. In addition we take Visa, Mastercard, and Discover. Bills that remain unpaid will be subject to collections and possibly legal action.

10. An adult must accompany children at all times in the waiting area. In addition we ask that you monitor their behavior. Running down the hall or destructive behavior in the waiting area is not permitted for safety concerns.

11. If you are twenty or more minutes late for your appointment we cannot bill insurance, in which case you will be billed privately for that day's session.

12. If you must cancel a scheduled appointment, please do so at least twenty-four hours in advance. If you cancel a therapy session fewer than twenty-four hours in advance, you will be charged the full private pay rate of $150.00. If you no show to an appointment a fee of $150.00 will be billed to you. This will only be excused in cases of emergency or sudden illness.

13. Please do not bring your child to therapy when s/he is ill, has a fever, or a persistent cough. Children do not benefit from therapy when they don't feel well. We ask that you assist us in minimizing exposure to other children and their families.

14. Consistent attendance is essential to success in therapy. If you miss greater than 20% of your scheduled sessions, we reserve the right to terminate therapy services.

15. Off-site conferences (such as an IEP meeting) will be billed at the consultative rate. Please note, this will vary based on the clinician's years of experience and areas of expertise. If distance traveled exceeds fifteen minutes per leg, you will be billed the difference at the regular private pay rate.

16. All accounts that go beyond 30 days past due may 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.

17. 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.

18. Please see your clinician when planning spring, fall and winter vacations as certain terms may apply. Let your clinician know as soon as possible when planning time away from therapy

I have read and accept the policies of Children's Speech & Feeding Therapy, Inc. I understand that I am legally responsible for timely payment of this account.

____

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.

<u>Identifying Information:</u>

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.

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.