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_____No

Primary Insurance:_____

Policy #: _____

Insured: _____

Insured DOB: _____ Relationship to Insured: _____

We request a Credit Card on file to process co-pays/deductibles/private pay (MC,Visa or Discover)

Credit Card # _____

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

1. We are only Blue Cross Blue Shield (BCBS) and Harvard Pilgrim 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 the Treatment Plan 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. 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 referrals.

4. Families that do not carry an insurance we take are charged at a rate of $800.00 for a comprehensive speech and language evaluation or a feeding evaluation. 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. 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, filing an appeal for denied coverage, 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.

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 report unless your account is current.

9. Payment in full is to be made monthly, upon receipt of bill. Checks should be made out to Children's Speech & Feeding Therapy, Inc., and mailed to 464 Hillside Ave, Suite 2, 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 fifteen 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 a fee 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 a school IEP meeting) will be billed at the consultative rate of $150 an hour in 15 minute increments. If distance traveled exceeds fifteen minutes per leg, you will be billed the difference at the regular hourly 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 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			