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 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 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 which will be pro-rated. 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 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:
464 Hillside Ave, Suite 202, Needham, MA 02494

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 ¾ of a mile. Turn right on West Street then left onto Hillside Avenue. The office is 464 Hillside Avenue. We are located on the second floor in Suite 202.

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 ¾ of a mile. Turn right on West Street then left onto Hillside Avenue. The office is 464 Hillside Avenue. We are located on the second floor in Suite 202.

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 ¾ of a mile. Turn right on West Street then left onto Hillside Avenue. The office is 464 Hillside Avenue. We are located on the second floor in Suite 202.

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 ¾ of a mile. Turn right on West Street then left onto Hillside Avenue. The office is 464 Hillside Avenue. We are located on the second floor in Suite 202.