Carolina Pediatric Dysphagia

Patient Information Form

3714 Benson Drive, Raleigh 27609 www.feeding.com (919) 877-9800

Patient Name ______________________________ **Date** ______________

Address ______________________________ **DOB** ______________

City ______________ **State** ____ **Zip** ________ **E-mail** ______________

Parent/Guardian Name ______________________________

Home Phone ______________ **Work** ______________ **Cell** ______________

Pediatrician ______________________________ **Phone** ______________

PED's Practice Name ______________________________ **Fax #:** ______________

Who may we thank for this referral? ______________________________

Insurance Company ______________________________

I.D. # ______________________________ Group #: ______________

Policyholder: ______________________________ Employer ______________

Policyholder's DOB ______________________________

Has deductible been met? YES_______ NO_______ Authorization Required?______________

Copay Amount $__________ and/ or __________%

MEDICAID I.D. #______________________________ Expiration______________

BY SIGNING BELOW, I AGREE THAT:

- Payments for all professional services rendered are the responsibility of the patient regardless of insurance coverage. It is our policy for the patient to pay for services unless other arrangements have been made in advance.
- I have been informed of and will adhere to the CANCELLATION POLICY.
- I commit to scheduling a make- up session for all cancelled appointment. I understand that failing to schedule a makeup appointment will not only slow progress but may cause my insurance to refuse payment or authorization
- Insurance Authorization: I hereby authorize Carolina Pediatric Dysphagia to furnish information to the insurance carriers concerning my evaluations and therapy and I hereby assign payment to Carolina Pediatric Dysphagia for services rendered to my dependent. I understand that I am responsible for any amount not covered by my insurance.
- **I give my permission to allow CPD to email any pertinent forms pertaining to my child at the above email address or phone listed.**

Signature: ______________________________ Date______________
Relationship to patient: ______________________________
Witness signature______________________________ Date:______________

Feeding/Dysphagia Evaluation
Infant Questionnaire

3714 Benson Drive, Raleigh 27609 www.feeding.com (919) 877-9800

Please answer all questions that apply to your child

Patient Name ______________________________ Date of Birth _______________ Date of Evaluation __________

Parent/Guardian Names: ____

Pediatrician: ______________________________ Pediatric Group: ____

What, if any, diagnosis does your child have? ____

Please list any medications your child is currently taking and the dosage per day: ____________________________

____

Chief Feeding Concerns ____

What are your goals for this evaluation? ____

____

Prenatal/Birth History:

Was your child born full term? Yes ____ No ____; If no, how many weeks gestation? ______________________

Vaginal birth___ C-Section___ Was labor/delivery difficult? ____Birth Weight ______ Birth Height___ ____

Apgar Scores ________________ Did your child receive antibiotics at birth? _______

Was your child in the NICU? Yes ____ No ____; If yes, why and for how long? ___________________________

Check all that apply to your child prior to discharge: Intubation___ Oxygen___ OG tube feeds___ NG-tube feeds___

Surgery (Please describe) ____

Newborn hearing screening: Pass_____________Fail__________

Developmental/Sensory Processing History:

What is your child's current weight ________ weight percentile ________ height percentile ________

Is your child currently receiving any other therapies? ________ If yes, please list: ____________________________

____

Does your child have a visual impairment? Yes ____ No ____ auditory impairment? Yes ____ No ____

Does your child sleep through the night? Yes ____ No ____ Does your child take good naps? Yes___ No___

Does your child like to swing? Yes ____ No ____Is your child sensitive to certain fabric make? Yes ____ No ____

Is your child overly sensitive? Yes ____ No ____ Is your child irritable?____ What % of the day/night?__________

Is s/he able to maintain eye contact? Yes ____ No ____ Does your child track faces or objects? Yes___ No _____

General Medical History:

Has your child ever been hospitalized? _____; If yes, why? ____

Please list any specialists that your child has seen:____

Has your child had any of these procedures? EKG_________; EEG_________; MRI_______________________

Other:____

Bronchopulmonary and Otorhinolaryngeal History:

Is your child congested? Never____; Sometimes____; Always____; When eating____; When drinking ____.

Does your child do any of the following (please check all that apply): snore____; audibly breathe at rest____;

audibly breathe during activity___; audibly breathe while sleeping ___; have an open mouth posture___

Has your child had any of the following (please check all that apply): Colds___ Upper respiratory infections___

Bronchitis___ Ear infections___ Pneumonia___ Thrush___ Bad diaper rash?___ How often?__________

How many times has your child been treated with antibiotics? _______ Were they effective? Yes ____ No ____

Has your child had any problems with his/her tonsils or adenoids? ____ If yes, please explain: ________________

Gastrointestinal History:

Has your child been diagnosed with gastroesophageal reflux? Yes ____ No ____; if yes, please list any reflux

Is your child on reflux medications?(Please list)________________ Has any been discontinued?___________________

Has your child had any of these procedures? (please provide dates as possible): Modified Barium Swallow Study_____

Upper GI (Barium Swallow) ________ Gastric emptying scan________ Endoscopy___________ Ultrasound________

pH Probe________ other________________.

Does anyone in your family have a history of gastroesophageal reflux? Yes ____ No ____; if yes, please list

relationship to child: ____

Does your child spit up/vomit? Yes ____ No ____ Does it come out his/her nose? Yes ____ No ____

Do you feel like your child spits up more than most? Yes ____ No ____ How many times does your child typically

spit up/vomit? per day ____ times per week? ____ When does s/he usually spit up/vomit? ___________________

Can you predict when it will happen? Yes ____ No ____; If yes, how do you know? __________________________

Has your child had any of the following physical and/or behavioral symptoms (please check all that apply):

___ crying/fussing during or after feeds

___ reduced appetite/limited intake

___ grazing thoughout the day

___ gagging/retching/coughing

___ hiccupping/burping

___ seeming desire to eat and then refuses

___ eating small but frequent meals

___ requiring distractions in order to eat

___ arching

___ repeat swallows not associated with feeding

Do you feel like your child's bowel movements are normal? Yes ____ No ____ How many per day? ________

Does/Did your child suffer from constipation? Yes ____ No ____, diarrhea? Yes ____ No ____

Have you ever had to stimulate a bowel movement with medication? Yes ____ No ____; suppositories? Yes ___No ___, thermometer? Yes ____ No ____ Explain:____

Allergies and Food Intolerances:

Has your child ever had allergy testing? Yes ____ No ____; If yes, results: ______________________________

Does your child have a clinical diagnosis of any food or environmental allergies? Yes ____ No ____

If no, do you suspect any allergies? Yes ____ No ____; If yes, please list: ____________________________

Is your child allergic to latex? Yes ____ No ____ Has your child had eczema? Yes ___ No ___; rashes? Yes __ No __; yeast infections? Yes ____ No ____

Does anyone in your family have allergies or food intolerances? Yes ____ No ____; If yes, please list relationship to child and what they are allergic to: ____

____

Feeding History:

How is your child currently fed? Breast___; Bottle___; SNS____; NG Tube ___; G-Tube___; Puree; ___

Other____

Was your child breastfed? Yes ____ No ____; If yes, for how long? ___________________________________

If breast feeding was discontinued, please check why: Difficulty latching on ______ Personal preference ______

Weight gain issues (baby) ______ Return to work ______ Anatomical anomaly ______ Other ________

Is/was your child on formula? Yes ____ No ____ Current formula ____________________________________

Have you switched formulas? Yes ____ No ____ List all formulas tried and why they were changed: _________

____

Are you thickening the liquids? Yes ___ No___ Are you using rice cereal? Yes___ No ___ How much?_______

What is the name of the nipple/bottle you are using/used? ____

Have you switched bottle nipples? Yes ____ No ____; If yes, why? ___________________________________

Does your child choke____ ; cough____; gag ____; vomit _____ during feeding?_____ After feeding?________

Please describe: ____

Does your child indicate hunger? Yes ____ No ____   Does your child like to eat? Yes ____ No ____

Have you introduced spoon feeding? Yes___ No ___ Was it easy? Yes___ No____

Do you feel stressed regarding your child's feeding? Yes ____ No ____; If yes, why? _______________________

Have you ever forced your child to eat? Yes ___ No ___ , Has forcing ever resulted in vomiting? Yes___ No ___

Do you feel your child takes in adequate nutrition? Yes ___ No ___ Is your doctor concerned about your child's weight gain ? Yes ____ No ____ Are you worried about your child's weight gain? Yes ___ No ___

How many ounces does your child take per feeding?_______ per 24 hours?__________

How often does your child eat?_____________How long does feeding take?_______________________________

Consent To Release Information

3714 Benson Drive, Raleigh 27609 www.feeding.com (919) 877-9800

This Consent to Release Information is **HIPAA** compliant. It is intended for the person/persons it is addressed to. If you receive this in error, please shred all copies and discard or return to this office.

Patient Name____

Date of Birth_________________________

I __________________________ hereby give permission to Carolina Pediatric Dysphagia

to obtain and release any and all information about my child concerning his/her care,

treatment, evaluation, or billing, pertaining to his/her treatment for the purpose of continuity of

care.

To/From:

___________________________address__________________phone#_________
Physician or Healthcare Provider

___________________________address__________________phone#_________
Physician or Healthcare Provider

___________________________address__________________phone#_________
Physician or Healthcare Provider

___________________________address__________________phone#_________
Physician or Healthcare Provider

I give permission for my therapist at CPD to leave medical information or appointment reminders on my (please check all that apply):

Voicemail ______ Email_____ Text________

__________________________________ ______________
Parent/Guardian's Signature Date

__________________________________ ______________
Witness Date

Notice of Privacy Practices

3714 Benson Drive, Raleigh 27609 www.feeding.com (919) 877-9800

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: April 14, 2003

Our Pledge Regarding Your Child's Privacy:

We understand that medical information about your child and their health is personal. We are committed to protecting the confidentiality and privacy of your child's protected health information. We are required to abide by the terms of the notice currently in effect and when changes are made, a new Notice of Privacy Practice will be distributed.

How We Will Use or Disclose Your Child's Health Information:

Carolina Pediatric Dysphagia uses your child's protected health information for treatment, obtaining payment for treatment and conducting its healthcare operations. For example, Carolina Pediatric Dysphagia will use your child's medical information to perform requested consults or treatment services and provide your child's referring physicians with a report of our findings. We may share your child's protected health information (PHI) with your insurance company, our billing department and collection agencies. We will only use or disclose your child's private health information in accordance with applicable state and federal laws. Carolina Pediatric Dysphagia may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits.

Carolina Pediatric Dysphagia may use or disclose your child's protected health information without authorization for auditing purposes, public health purposes, and for emergency situations. For any other situation, Carolina Pediatric Dysphagia's policy is to obtain your written authorization before disclosing your protected health information. Once authorization is obtained, you may later revoke that authorization to stop any future disclosure.

Patient's Individual Rights:

You have the right to request to receive, inspect, amend and request restrictions on certain uses and disclosures of protected health information (PHI). You also have the right to request in writing, an accounting of disclosures of your child's protected health information for reasons other than treatment, payment, or other healthcare operations.

You also may request in writing that Carolina Pediatric Dysphagia not use or disclose your child's protected health information for treatment, payment and administrative purposes when required by law or in an emergency situation. Carolina Pediatric Dysphagia will review the request on an individual basis, but we are not legally required to accept it.

For More Information or to Report a Problem:

If you believe that Carolina Pediatric Dysphagia may have violated your child's privacy rights, you may file a complaint with us. These complaints must be filed in writing on a form provided by our practice. You may also file a written complaint with the Secretary of the Federal Department of Health and Human Services. There will be no retaliation for filing a complaint. For further information, you may contact our Privacy Officer at (919) 877-9800, ext. 111.

I acknowledge receipt of Carolina Pediatric Dysphagia's Notice of Private Practices.

____
Print Child's Name

____ ________________
Guardian's Signature Date

____ ________________
Witness Date

Carolina Pediatric Dysphagia

Business Policies

3714 Benson Drive, Raleigh 27609 www.feeding.com (919) 877-9800

Please read carefully. If you have questions or concerns, feel free to discuss them with us. We ask that you sign and date the enclosed agreement for services, which will become a permanent part of your file.

Office hours: 8:00AM to 5:00PM. **Evaluations: may take 45 minutes to 1 hour. Therapy sessions are 30 minutes.**

Payment: Payment is due at the time of service. Payment is accepted in cash, check or credit card.
To keep the office running smoothly have your payment ready and be prepared to exit the therapy room on time.

Deductibles: Many patients now have a high deductible. If you have not met your deductible, our evaluation and therapy fees will apply directly to your deductible and are due at the time of service. If you meet your deductible between the time of billing and the time insurance reimburses CPD, we will apply the credit towards your copay.

Medical Insurance: ***Services provided by our office are covered under most health insurance policies. As a courtesy to our patients, we will file insurance claims. We ask that you provide us with accurate and complete insurance information. We will help monitor authorizations and therapy visits. We will assist you in any way possible however; it is ultimately your responsibility to understand your healthcare policy, and its limitations, as your benefits are a contract between you and your insurance company****.* ***Please refer to our fee schedule, available upon request. Please verify with your insurance company any deductible, coinsurance, copay or authorization requirements. Authorizations do not guarantee payment by your insurer.***

All payments toward your deductible or copays are due at each visit. Please make sure that your account is paid in full. All account balances not paid within 30 days are subject to further collection efforts and reporting to a credit bureau.

Scheduling/Reminder calls: Scheduling is done in advance for your convenience. By signing this business policy, you give us permission to text, email or leave a voicemail reminder of your scheduled appointment. This is a courtesy that we offer. Please remember that by scheduling an appointment it is your commitment to attend your appointment. Weekly scheduled appointments will have scheduling priority over every other week appointments.

Progress in therapy: Research has repeatedly shown correlation between progress in therapy and therapist knowledge. Our therapists are expertly trained to enable the fastest progress towards your goals. This progress is only possible if therapy is attended consistently, on time, all homework is completed daily and recommendations are followed. Not attending therapy consistently, being late or not scheduling make-up sessions when needing to cancel, jeopardizes your child's progress and may result in insurance refusals. Please help us maximize progress gains.

Cancellations: Insurance companies are now strictly monitoring the number of therapy sessions attended vs scheduled and are refusing continued authorization or payment for patients that are not consistently attending therapy.

- **NON EMERGENCY: 48 HOURS NOTICE:** This includes vacations, doctor's appointments, family or school events, parties, sports events, lack of baby sitter etc. If the session is not canceled with 48 hours and a make-up session is not scheduled, a $25 missed session charge will be added to your bill. This charge is not reimbursable by insurance.

- **EMERGENCY: CANCEL BY 9 AM:** Emergency cancellations include illness, death in the family or illness of a family member. These sessions must be canceled before the scheduled session or by 9 am. A make-up session is required within 6 days of the cancelled appointment or a missed session charge of $25 will be added to your bill.

- **NO SHOW:** No show appointments are missed appointments without notice. If you no show your appointment, a $25 missed session fee will be added to your bill and your child will be taken off of the schedule.

OVERALL ATTENDANCE: Your scheduled appointment is our commitment to not overbook, to be on time, to prepare skilled therapy activities and to maximize progress.

It is your commitment to attend therapy and come prepared so that we can help you maximize progress. Attending therapy late, not keeping your appointment or not scheduling a make-up session in the event that you need to cancel will significantly impede your child's progress. Attendance is documented for insurance and business reasons. **If you miss more than 1 out of every 4 sessions or consistently miss 1 of 4 sessions, you will be contacted and asked to schedule on a day-of "call in" status.**

INCLEMENT WEATHER: We do NOT follow Wake County Public School cancellations. We independently decide before 7 am if the office will be closed due to inclement weather. For weather information: call 919-877-9800 x 111.

Observations and Homework: A PARENT OR CAREGIVER MUST BE IN THE OFFICE (OR IN THE HOME FOR HOME VISITS) AT THE TIME OF THERAPY.

Daily carryover is essential to your child's progress. It is critical that parents and caregivers observe therapy sessions and make every effort to work with the child at home. Activities learned in session should be practiced as recommended by your therapist. If carryover is not performed, progress will be significantly slowed.

CDSA: If your child is receiving services under the CDSA – Early Intervention Program, please provide that information to us at your first visit. We need to obtain the authorizations from CDSA for proper billing.

Email/Texting/Phone: We are happy to answer quick questions regarding your child outside of therapy. However, if you have frequent questions outside of therapy or question that requires a lengthy discussion, you will be encouraged to attend an additional therapy session to address your concerns. If you are unable to attend an additional therapy session, we can schedule a 30 minute phone consult at the fee of $50. Unfortunately, these consults are not reimbursed by insurance.

Medical Records: We will provide you a copy of your evaluations. If you need a copy of your entire chart, there is a medical record fee of $I0 or more depending on the size of the chart. There is no charge to send records to your medical doctors. To ensure HIPPA compliance, all records must be picked up from the office.

Confidentiality: We are HIPPA compliant and take confidentiality seriously. All written reports or progress notes are provided to parents and the referring physician. We require a Release of Information form to be signed prior to releasing any information to or obtaining any information from any party or agency. These forms can be obtained from our front office. We are HIPPA compliant.

Waiting Room /Bathroom: Due to our patient's high incidence of respiratory compromise and allergies, please refrain from wearing perfume or smoking directly before entering the office. There is no eating/drinking in the waiting area. The bathroom in the hallway is for all patients. Please do not flush sanitary products in the toilet. All diapers must be disposed of in the dumpster outside of the building.

I have read, understand and agree to adhere to the policies of Carolina Pediatric Dysphagia:

____ Date:______________________

Parent name

____ Date:______________________

Witness

Carolina Pediatric Dysphagia

Cancellation Policy

Patients that attend therapy consistently make the best progress!

We require that all missed/cancelled appointment be rescheduled.

Insurance companies are now strictly monitoring the number of therapy sessions attended vs scheduled and are refusing continued authorization or payment for patients that are not consistently attending therapy.

To Maximize Your Childs Progress:

CPD's COMMITMENT: Your scheduled appointment is our commitment to not overbook, to be on time, to prepare skilled therapy activities and to maximize progress.

YOUR COMMITMENT: to attend therapy on time, come prepared, complete your home work and schedule a make-up session in the event that you need to cancel.

Attending therapy late, not keeping your appointment or not scheduling a make-up session in the event that you need to cancel will significantly impede your child's progress.

OVERALL ATTENDANCE: Attendance is documented for insurance and business reasons.

If you miss more than 1 of 4 sessions or consistently miss 1 or more of 4 sessions, you will be asked to schedule on a day-of "call in" status.

- **NON EMERGENCY: 48 HOURS NOTICE:** This includes vacations, doctor's appointments, family or school events, parties, sports events, lack of baby sitter etc. If the session is not canceled with 48 hours and a make-up session is not scheduled, a $25 missed session charge will be added to your bill. This charge is not reimbursable by insurance.
- **EMERGENCY: CANCEL BY 9 AM:** Emergency cancellations include illness, death in the family or illness of a family member. These sessions must be canceled before the scheduled session or by 9 am. A make-up session is required within 6 days of the cancelled appointment or a missed session charge of $25 will be added to your bill. This charge is not reimbursable by insurance.
- **NO SHOW:** No show appointments are missed appointments without notice. If you no show your appointment, a $25 missed session fee will be added to your bill and your child will be taken off of the schedule.

I have read and understand the cancellation policy and agree to be bound by its terms.

____ Date: ____________________
Print Name (Parent / Legal Guardian) Relationship to Patient

____
Signature (Parent / Legal Guardian) Relationship to Patient

____ Date: ____________________
Wittness

Carolina Pediatric Dysphagia

Directions to Carolina Pediatric Dysphagia

3714 Benson Drive, Raleigh 27609 www.feeding.com (919) 877-9800

Please be on time for you appointment so that we can maximize your session.

Please read! Your GPS may take you the wrong way!

We are located at 3714 Benson Drive in the **Williamsburg Commons office complex.**
Please let us help you arrive on time. If you have any questions, please call our office at **(919) 877-9800 x 111.**

Directions from 440:

1. Exit Wake Forest Road.
2. Go North (pass Duke-Raleigh Hospital)
3. Turn left at the 3rd stop light which is DRESSER COURT
4. Turn right onto Benson Drive.
5. Turn right at the WILLIAMSBURG COMMONS sign on the right. (2nd driveway on the right)
6. Circle around to the right. 3714 Benson Drive is the last building on the left. Park in front of the building.
7. We are on the 1st floor. (We have a RED front door!)

Directions from Wake Forest Road: (coming from the north)

1. Turn right onto Dresser Court, and follow the same directions as above.