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:_____

Carolina Pediatric Dysphagia

Feeding/Dysphagia Evaluation
Child 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? _____

Chief Feeding Concerns _____

What are your goals for this evaluation? _____

Has your child received previous services for this problem?_____ Where:_____

Prenatal/Birth History:

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

Birth Weight and Percentile _____ Birth Height and Percentile _____ Apgar Scores _____

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) _____

Other _____

Did your child pass the newborn hearing screening? ____

Developmental/Sensory Processing History:

Does your child attend day care or school? _____

When did your child sit unassisted _____ crawl _____ walk _____?

What is your child's main form of communication? Words____; Gestures ____; Signs ____; Body Language ____

What is your child's current weight _____ weight percentile _____ height percentile _____Is weight gain a concern? Yes___ No____ 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 ____ Where tested?

Does your child sleep through the night? Yes ____ No ____ Is s/he able to maintain eye contact? Yes ____ No ____

Does/Did your child hold her/his bottle? Yes ____ No ____ Does your child feed her/himself? Yes ____ No ____

Does your child like to swing? Yes ____ No ____ Does your child seek rough play? Yes ____ No ____

Does your child enjoy playing in a sandbox? Yes ___ No ___ Is your child sensitive to certain fabric make? Yes ____ No ____ Will your child tolerate being messy or having their hands messy? Yes ____ No ____

Will your child play, crawl, walk, or sit in grass? Yes ____ No ___

General Medical History:

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

Check all procedures your child has had and fill in the approximate dates: _____ _____EKG; ____

EEG; _____ MRI; _____ Other _____

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

_____

Bronchopulmonary and Otorhinolaryngeal History:

Is your child congested? Never ____; Sometimes ____; Always ____; When eating ____; When drinking ____

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 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: _____

_____

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

audibly breathe during activity ___; audibly breathe while sleeping ___; have an open mouth posture ___

Gastrointestinal History:

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

Medications your child is currently taking and the dosage per day: _____

Has your child ever completed any of these procedures (include when and where)? Upper GI (Barium Swallow)____

Endoscopy_____ Gastric emptying scan _____ pH Probe_____

Does anyone in your family have a history of gastroesophageal reflux or other GI issues? Yes ____ No ____; if yes,

please list relationship to child: _____

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

Did or Do you feel like your child spits up more than most? Yes ____ No ____ How many times per day did or does

your child typically spit up/vomit? ____ times per week? ____ When did s/he usually spit up/vomit? _____

Could you predict when it would happen? Yes ____ No ____; If yes, how did you know? _____

_____Could you identify food in vomit? Yes ____ No ____

Physical and/or behavioral symptoms observed currently (C) or as an infant (I) (please indicate C or I for each):

___ (C I) crying/fussing during or after feeds

___(C I) seeming desire to eat and then refuses

___ (C I) reduced appetite/limited intake

___ (C I) eating small but frequent meals

___ (C I) grazing thoughout the day

___ (C I) requiring distractions in order to eat

___(C I) limiting textures

___ (C I) not progressing to age-appropriate foods

___ (C I) gagging/retching/coughing

___ (C I) arching

___ (C I) hiccupping/burping

___(C I) repeat swallows not associated with feeding

___ preference for crunchy foods and/or strong spicy or sour flavors

Do you feel like your child's bowel movements are normal? Yes ____ No ____ Explain_____

Does your child suffer from constipation? Yes ____ No ____, diarrhea? Yes ____ No ____ Stomach ache? Yes___ No___ How many bowel movements does your child have per day? _____ Is the bowel movement typical? Yes___ No____ Do you stimulate a bowel movement with diet? Yes____ No___ , medication Yes ___ No___, suppositories Yes___ No___, or a thermometer Yes___ No ___? Describe_____

Have there been past issues with constipation or diarrhea? Please describe_____

_____

Have you ever identified food in a bowel movement? Yes ____ No ____

Allergies and Food Intolerances:

Does your child have a diagnosis of food or environmental allergies? Yes ____ No ____Has your child ever had allergy testing? Yes ____ No ____; If yes, type of test and results: _____

_____

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

Has your child had eczema? Yes ___ No ___; other 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___; NG Tube___; G-Tube___; Puree___; Solids ___

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: _____

_____

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

Have you switched bottle nipples? Yes ____ No ____; If yes, names and why? _____

Does your child currently drink from a bottle____; sippy cup____; cup with straw____; open cup____?

Does your child choke____; cough____; gag____; vomit during feeding____? Please describe: _____

_____

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

Has your child ever completed a Modified Barium Swallow Study? Yes___ No___ Where/When? _____

Results_____

	Child's Age	Was it Easy? (Y/N)	If no, please describe	Has it gotten easier?
Spoon-feeding first introduced				
Chunky Stage 3 foods introduced				
Finger foods first introduced (i.e., Cheerios, biter biscuits, etc.)				
Table foods first introduced				

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 refusal to eat? Yes___ No___

Has forcing ever resulted in vomiting? Yes___ No___ Have you ever bribed your child to eat? Yes ___ No ___ Has it worked? Desribe_____

Where does your child eat best?_____ When does your child eat best? _____Do you have a meal when your child is eating? Yes___ No___. Does your child sit during mealtime? Yes___ No ___. Do you need to distract your child so he/she will eat? Yes___ No___ If yes please explain _____Do you feel your child takes in adequate nutrition from food? Yes ___ No ___, from formula/liquid? Yes ____ No ____How many ounces of liquid does your child take a day? Formula _____ounces, Milk_____ounces, Water_____ounces. Do you feel like your child is a "picky eater"? Yes ____ No ____ Name your child's favorite foods and liquids:_____What is your biggest frustration about mealtime? _____ Do you and your significant other(s) agree on your child's difficulty with feeding and ways to manage mealtime behaviors? _____

Food Diary: Please include a 3 day food log. Be as specific as possible regarding variety and amount

Day 1: Breakfast_____

_____

Lunch_____

_____

Dinner_____

_____

Snacks (time of day) _____

Approximate amount of solids per day _____, fluids per day _____

Day 2: Breakfast_____

_____

Lunch_____

_____

Dinner_____

_____

Snacks (time of day) _____

Approximate amount of solids per day _____, fluids per day _____

Day 3: Breakfast_____

_____

Lunch_____

_____

Dinner_____

_____

Snacks (time of day) _____

Approximate amount of solids per day _____, fluids per day _____

_____

Oral Motor History:

How many teeth does your child have?_____ Is tooth brushing stressful? Yes ____ No ____

Does___Did ___ Mouth objects

Does___Did ___ Suck thumb

Does___Did ___ Take a pacifier

Does___Did ___ Have difficulty weaning from pacifier/bottle

Does___Did___ Drool or wet shirts/bibs

Does___Did___ Suck or chew shirt

Does___Did___ Have open mouth resting position

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

Carolina Pediatric Dysphagia
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

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.