Pediatric Feeding and Swallowing Associates

Address: 11300 4th St N, Suite 210
St. Petersburg, FL 33716
Phone: 727-217-5023
Fax: 727-279-4977

PATIENT INFORMATION

INFORMATION

PATIENT NAME:			DATE:
ADDRESS:			
DOB:		E-MAIL:	
CITY:		STATE:	ZIP:
PARENT/GUARDIAN NAME:			
HOME PHONE:		WORK:	CELL:
PEDIATRICIAN:			PHONE:
PED's PRACTICE NAME:			FAX #:
WHO MAY WE THANK FOR THIS REFERRAL?			

Insurance

INSURANCE COMPANY:			
I.D.#			GROUP #:
POLICY HOLDER:			EMPLOYER:
POLICYHOLDER's DOB:			
HAS DEDUCTIBLE BEEN MET? ☐ YES ☐ NO	COPAY AMOUNT $	and/or	%
☐ I DO NOT PARTICIPATE IN MEDICAID OR MEDICARE_(SIGN)			
☐ I DO NOT HAVE SECONDARY INSURANCE (SIGN)			

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Feeding/Dysphagia Evaluation

INFANT QUESTIONNAIRE

Please answer all questions that apply to your child

Patient Name:		Date of Birth:	Date of Evaluation:
Parent/Guardia 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:			
What are your goals for this evaluation?			
Does your child have a tongue or lip tie?	Was it released?	When?	By whom?

Please check all concerns:

☐ Coughing/choking	☐ Breastfeeding difficulty	☐ Nipple pain
☐ Congestion during feeding	☐ Milk coming out of nose	☐ Feeding refusals
☐ Reduce bottle dependence, transition to breast	☐ Feeding stress	☐ Stressed feedings
☐ Short frequent feeding	☐ Constipation	☐ Weight gain
☐ Uncoordinated suck swallow breathe	☐ Decrease tube feedings	☐ Tongue and/or Lip Tie
☐ Reflux or other GI issues	☐ Biting instead of sucking	☐ Suck training
☐ Better breastfeeding	☐ Other:	

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?		
Circle 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			

General Medical History:

Current medication:	
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

My child: Please check all that apply

☐ Has a visual impairment	☐ Maintains eye contact	☐ Tracks faces or objects
☐ Has an auditory impairment	☐ Holds own bottle	☐ Irritable
☐ Sleeps through the night	☐ Sensitive to touch	☐ Likes to swing
☐ Takes good naps	☐ Overly senstive	☐ Irritable (% of day)

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Other:

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

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

Developmental/Sensory Processing History:

My Child:

Bronchopulmonary and Otorhinolaryngeal History:

Is your child congested? ☐ Never ☐ Sometimes ☐ Always ☐ When drinking

My child:

☐ Snores ☐ Audibly breathes at rest ☐ Audibly breathes while sleeping ☐ Audibly breathes during activity ☐ Has an open mouth posture ☐ Drools

My child has/had: ☐ Cold ☐ Bronchitis ☐ Pneumonia ☐ Respiratory infection ☐ Ear infection ☐ Diaper rash ☐ Thrush

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

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

My child completed these procedures (include when and where): (Please provide dates as possible):

☐ Upper GI-Barium Swallow ☐ Gastric emptying scan ☐ ph Probe ☐ Ultrasound ☐ MBS

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 Did it come out his/her nose? ☐ Yes ☐ No

Do you feel like your child spits up more than most? ☐ Yes ☐ No

How many times your child typically spit up/vomit? | times per week? | When did s/he usually spit up/vomit?

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

☐	Crying / fussing during or after feeds	☐	Seeming desire to eat and then refuses
☐	Reduced appetite/limited intake	☐	Eating small but frequent meals
☐	Grazing thoughout the day	☐	Requirement distractions in order to eat
☐	Gagging/retching/coughing	☐	Repeat swallows not associated with feeding
☐	Hiccupping/burping	☐	Arching

Are bowel movements are normal? ☐ Yes ☐ No | How many per day? | What color?

Does/Did your child suffer from constipation? ☐ Yes ☐ No Diarrhea? ☐ Yes ☐ No

Have you or do you stimulate a bowel movement with: ☐ Diet ☐ Medication ☐ Suppositories ☐ Thermometer

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:

Is your child allergic to latex? ☐ Yes ☐ No Has your child had eczema? ☐ Yes ☐ No Rashes? ☐ Yes ☐ No Yeast infections? ☐ Yes ☐ No

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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:

Is 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, names and 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?

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CONSENT TO RELEASE INFORMATION

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.

Print Name:	Date of Birth:

I hereby give permission to Pediatric Feeding & Swallowing Associates 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:

Physician or Healthcare Provider

Address:	Phone#:

Physician or Healthcare Provider

Address:	Phone#:

Physician or Healthcare Provider

Address:	Phone#:

Physician or Healthcare Provider

Address:	Phone#:

I give permission for my therapist at Pediatric Feeding & Swallowing Associates to leave medical information or appointment reminders on my (please check all that apply):

Voicemail (best #):	Text (best #):

Email (best address):

Parent/Guardian's Signature	Date:
Witness:	Date:

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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:

Pediatric Feeding & Swallowing, Inc. uses your child's protected health information for treatment, obtaining payment for treatment and conducting its healthcare operations. For example, Pediatric Feeding & Swallowing, Inc. 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. Pediatric Feeding & Swallowing, Inc. may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits.

Pediatric Feeding & Swallowing, Inc. 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, Pediatric Feeding & Swallowing, Inc. 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 Pediatric Feeding & Swallowing, Inc. 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. Pediatric Feeding & Swallowing, Inc. 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 Pediatric Feeding & Swallowing, Inc. 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 727-217-5023.

I acknowledge receipt of Pediatric Feeding & Swallowing, Inc. Notice of Private Practices.

Print Child's Name:	
Guardian's Signature:	Date:

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Legal Guardian Consent/Release Form To Use Video Recording

Pediatric Feeding & Swallowing (PFS) is a teaching organization for professionals and students. We provide courses that teach other professionals about pediatric dysphagia. Occassionally, we use video material of patients to show the proper diagnosis and treatment of pediatric dysphagia.

I give my permission to PFS to record my child during evaluation and treatment sessions. I agree that PFS may use the recordings as needed, in whole or in part. These may be distributed electronically, in classrooms, or other methods. This Consent/Release Form shall be governed by the laws of Flordia.

Print Child's Name:	
Guardian's Signature:	Date:

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Our Policies:
Thank you for choosing Pediatric Feeding & Swallowing. Your clear understanding of our financial policies is important to our professional relationship. Carefully Review the following information and please ask if you have questions about our fees, our policies, or your responsibilities.

General:

- Payments for all professional services rendered are the responsibility of the patient regardless of insurance coverage.
- Payment is due at the time of service via cash, check, or credit card. There is a $35 charge for returned checks.
- We accept cash, check, or visa/Mastercard. There is an additional 3 percent fee to cover credit card charges.
- All balances need to be paid at discharge. If not payed, I give Pediatric Feeding & Swallowing, Inc. permission to charge my credit card the remaining balance regardless of in-network or out-of-network status.
- I give my permission to allow Pediatric Feeding & Swallowing, Inc. to email any pertinent forms pertaining to my child via regular email.
- 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 $10 or more depending on the size of the chart. There is no charge to send records to your pediatrician. To ensure HIPPA compliance, all records must be picked up in person from the office.
- Waiting Room: 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.

Patient Progress Policy:

- Given the medical and behavioral nature of pediatric dysphagia, it is your responsibility for your child to be seen per the treatment plan. Together, we cannot make progress without this, and insurers will not approve additional visits without documented progress.

Credit Card Authorization:

- Even though you may not intend to pay by credit card, our policies require a valid credit card authorization. This remains on file if you do not pay your bill, do not give a 24 hour cancellation notice, or have a consult via phone or internet.

Cancellation Policy:

- Cancellations: Insurance companies are now strictly monitoring the number of therapy sessions attended vs scheduled and are refusing continued authorization or payment for patients with inconsistent attendance.
- Your appointment time is reserved exclusively for you because we do not double-book. If you miss or do not cancel your appointment without 24 hour notice, we will be unable to care for another patient in your place and we have no method of recovering lost revenue due to last minute cancellations.
- 24 HOUR CANCELLATION NOTICE: All cancellations must be made at least 24 hours in advance to allow us to accommodate other patients. Regretfully, failure to do so, will result in a charge to you of $150. This charge is not reimbursable by insurance and is automatically charged to your credit card. I agree to adhere to the cancellation policy.
- I agree that this authorization is valid for the length of therapy and authorize Pediatric Feeding & Swallowing, Inc. to use this credit card per the policies stated herein.

Cardholders name:	Card #:	CCV#:
Signature:	Exp. Date:	Zip Code:

Patients Paying with Insurance:

- We will assist you in any way possible with your insurance. However, it is ultimately your responsibility to understand your healthcare policy and its limitations. Your insurance is a contract between you and your insurance company. Authorization from your insurer does not guarantee payment by your insurer. You are ultimately responsible for tracking your visits and enduring that you stay within your allowed amount of visits. Dysphagia is complex and you may require more visits than what your insurance provides.
- If payment has not been received from your insurer within 60 days, the patient or guardian will need to pay the full amount and work through any issues directly with the insurer. PFS will only file your insurance if we are in network or have explicitly agreed to do so.
- Insurance Authorization: If Pediatric Feeding & Swallowing is filing my insurance, I hereby authorize Pediatric Feeding & Swallowing, Inc. to furnish information to the insurance carriers concerning any evaluations and therapy and I hereby assign payment to Pediatric
- Feeding & Swallowing, Inc. For services rendered to my dependent. I understand that I am responsible for any amount not covered by my insurance.

BY SIGNING BELOW, I AGREE TO THE ABOVE POLICIES:

Guardian or Caregiver Signature:	Date: