Consent Form/Feeding Background Information

Patient Name:_____ Gender: male female DOB:_____
Address:_____

Parent/Guardian 1 Name:_____ DOB:_____ SS#:_____ Cell #:_____ Home #:_____ Work:_____
Employer:_____ Email:_____

Parent/ Guardian 2 Name:_____ DOB:_____ SS#:_____
Cell #:_____ Home #:_____ Work:_____
Employer:_____ Email:_____

Primary Care Physician

Name of Practice/Doctor:_____ Phone#:_____
Fax:_____ Address:_____
Diagnosis or reason for referral:_____

Primary Insurance

Patient Name:_____ DOB:_____
Insured's Name:_____ Relationship:_____ DOB:_____
Insurance Company:_____
Customer Service/Provider #:_____
Claims Address:_____
Member/Subscriber ID #:_____ Group ID:_____

Secondary Insurance

Patient Name:_____ DOB:_____
Insured's Name:_____ Relationship:_____ DOB:_____
Insurance Company:_____
Customer Service/Provider #:_____
Claims Address:_____
Member/Subscriber ID #:_____ Group ID:_____

☐ I do not have insurance or I do not wish to bill my insurance for services rendered. I understand that **Kidspeech, Inc.** requires that all payments for services rendered be paid in full at the time of service. It is the responsibility of the parent/guardian to notify **Kidspeech, Inc.** of any changes.

I hereby consent that all information provided on this form is true to the best of my knowledge.

_____ _____ _____
Parent/Guardian (print name) Parent/Guardian Signature Date

It is important for authorization and billing purposes that you provide **Kidspeech, Inc**. with all information about the services your child has received or is currently receiving.

Does your child receive Speech-Language, Occupational or Physical Therapy services with the Public School System? **Yes** **No** If yes, what county:_____ Frequency:_____

To ensure accurate services are provided and that your child receives the best care, **Kidspeech Inc. MUST** have a copy of your child's current IEP before services are provided.

Most insurance companies require pre-certification or authorization to be in place prior to services being rendered. If there is another authorization in place with a different provider, your insurance company will not approve services with Kidspeech, Inc. Therefore, you will be responsible for any charges denied by your insurance company for this reason.

Other than the school system; is your child receiving Speech-Language, Occupational, or Physical Therapy services with any other company? **Yes** **No** If Yes, which company:_____

_____ I understand that **Kidspeech, Inc**. will verify my benefits with my insurance company as a courtesy . However, the verification of benefits **is not** a guarantee of payment. Claim payment is determined at the time services are rendered and eligibility, exclusions, or provisions on your plan may effect payment. It is also recommended that you call your insurance company to be aware of your benefits.

_____ I understand that each Medicaid program has different authorization requirements. It is very important that you notify our office of any changes. This will ensure that your child receives continuation of care and that we obtain authorizations as required by your policy, so that you will not be responsible for these charges.

_____ I understand that insured/parent/guardian listed above is fully responsible for any balance due, non-covered services, and/or denied claims for any reason.

_____ I authorize **Kidspeech, Inc**. to release any medical records or other information necessary to process claims pertaining to my treatment.

_____ I authorize payment of medical benefits to **Kidspeech, Inc.** I also understand that it is my responsibility to inform this office of any insurance or address changes immediately.

_____ I have been notified of all HIPPA regulations and I have received and read a copy of the Privacy Practices regulations implemented by **Kidspeech, Inc.**

_____ I understand that I am making a commitment based on recommendations made by my clinician for my child. It is my responsibility to make sure that my child is at each scheduled appointment and implement the home program provided by my child's clinician.

_____My clinician will share information regarding progress at the end of the session; typically a five minute time slot during the regular scheduled therapy session.

_____I understand that if I am late for a scheduled session that my clinician will only see my child for the remaining time and will not run into the next scheduled appointment.

I hereby consent that all the information provided on this form is true to the best of my knowledge. I also understand that services will be provided as recommended by my physician and the Speech-Language Pathologist.

_____ _____ _____

Parent/Guardian (print name) Parent/Guardian Signature Date

Background Information

Patient Name:_____ Parent/Guardian:_____

DOB:_____ Gender male female Home Phone#:_____

PCP (referring physician):_____

Birth History

Pregnancy: _____Full-Term _____ Premature (_____ weeks gestation)

Birth History: _____Unremarkable _____Complications Please explain:_____

_____

_____

NICU Stay: _____Yes _____No If yes, please explain:_____

Did your child require oxygen? _____ Yes _____No How Long?:_____

Was your child intubated? _____Yes _____No How long?:_____

Did your child leave the hospital with his/her mother? _____Yes _____No

Medical History

Does your child currently have a diagnosis? ___ Yes ___ No Specify please:_____

Any food/medical allergies?_____

Please list any foods we may NOT offer your child due to diet, religious preference, etc._____

_____

Please list any surgical procedures your child has had and when they occurred_____

_____

Has your child ever been diagnosed with any of the following? (Check all that apply)

Yes	No		Yes	No		Yes	No	
		GE Reflux			Neurologic Issues (brain)			Hearing Loss
		Failure to Thrive			Renal Issues (kidney)			Autism/PDD
		Developmental Delay			Delayed Emptying			Genetic Disorder
		Esophagitis			Constipation			Chromosome Abnormality
		Pulmonary Issues (lungs)			Chronic Diarrhea			
		Cardiac Issues (heart)			Dental Concerns			
		Craniofacial History			Vision Problems			

If yes, please specify:_____

Has your child ever had any swallow or gastrointestinal studies? _____Yes _____No

If yes, please specify:_____

Developmental History

Does your child currently receive therapy services (OT, PT, ABA, ST, etc.)

Therapy	**Frequency**	**Location**	**Treating Clinician**

At what age did your child: Sit Unsupported_____ Crawl_____ Walk_____ Self Feed_____

Does your child have impaired or delayed FINE motor skills? _____Yes _____No
If yes, please explain:_____
Does your child have impaired or delayed GROSS motor skills? _____Yes _____No
If yes, please explain:_____
Does your child have impaired or delayed SENSORY motor skills? _____Yes _____No
If yes, please explain:_____

FEEDING HISTORY

When did you first notice your child had difficulty eating? _____
As a newborn, how was your child fed (bottle, breast, tube)? _____
When were the following introduced? _____ cereal _____ purees _____ solids
Any difficulty with specific textures? _____

Current Feeding

Does your child have any of the following symptoms when eating or drinking? (check all that apply)

Yes	No		Yes	No		Yes	No	
		Gagging/Coughing during or after meals			Tooth brushing intolerance			Difficulty progressing to table food
		Vomiting			Choking			Refusal to eat
		Limited variety of foods			Difficulty swallowing			Self-feeding
		Slow weight gain			Limited volume intake			Holding food in mouth
		Difficulty chewing						

How does your child receive liquids (bottle, sippy cup, open cup, straw)? _____
If tube fed, what type of tube does your child use? _____
If fed orally, please fill out the attached one-day food intake sheet (SEE ATTACHED)

Please indicate which foods your child currently AVOIDS. (Check all that pply)

	Fruits		Purees		Crunchy
	Vegetables		Solids		Lumpy
	Meats		Mixed Textures		Salty
	Starches		Fluids		Sweet

Does your child self-feed? _____ Yes _____No If yes, with fingers, utensils, or both? _____
Where does your child typically eat? _____
What does your child sit in during meal time? _____
Who primarily feeds your child? _____
What temperature does your child prefer foods (hot, cold, room temp)? _____

Does your child do any of the following during meal times? (check all that apply)

	Refusing to eat		Tries to get out of seat
	Spits out food		Falls asleep
	Cries/screams		Gags/Coughs
	Vomits		Throws food/utensils
	Holds food in mouth		Gurgly voice after eating

What strategies have you tried to accomidate your child's feeding difficulties?

	Distractions during mealtime (games, TV, etc.)		Giving preferred foods only
	Skipping meals		Punishment
	Rewards		Supplements
	Feeding child on demand/ following request		Allowing child to drink high calorie drinks
	Coaxing		
	Forcing		

Does your child complain of physical pain while eating or drinking? _____Yes _____No

What do you hope to gain from feeding therapy?_____
_____
_____
_____

_____ _____ _____

Informant Relationship to Client Date

ONE-DAY FOOD INTAKE

Please fill out this intake form completely. List the time the food or liquid is offered (by mouth or tube), type of food or liquid offered (if brand specific-include brand), and the volume your child ingested. Please use objective measurements (e.g. 2 oz of puree, ¼ cup pasta or ½ of a baby carrot) rather than subjective measurements (e.g. handful of cereal, 5 spoonfuls of pasta, or six sips of milk).

TIME OF DAY	FOOD ITEM OFFERED	VOLUME INGESTED

*******PLEASE BRING ONE PREFERRED FOOD ITEM, ONE NON-PREFERRED FOOD ITEM, AND YOUR CHILD'S FORMULA, BOTTLE OR CUP TO THE APPOINTMENT*******