Pediatric Feeding & Swallowing Therapy Intake

The information you provide will help our staff determine the care you need and the tests administered during your child's evaluation. A child's individual background, cultural experience, and family support are important factors in determining a treatment plan for your child.

Service Location Preference

☐Edmond Clinic ☐Midwest City Clinic ☐Northwest OKC Clinic

General Information

Child's Name:_____ Sex: ☐ Male ☐ Female
Birthday: _____ / _____ / _____
Home Address:_____
City:_____ Zip:_____

Guardian Name:_____
Phone Number:_____
Email:_____
Occupation:_____
Secondary Caregiver/Guardian Name:_____
Phone Number:_____

Siblings (name & age):_____

Medical Team

Primary Care Physician Name:_____
Phone Number:_____ Fax Number:_____

Gastroenterologist Name:_____
Phone Number:_____ Fax Number:_____

Please list any other specialist who are treating your child:
Name:_____
Phone Number:_____ Fax Number:_____

Name:_____
Phone Number:_____ Fax Number:_____

Is your child participating in an Early Intervention program? ☐ Yes ☐ No

If yes, please list therapists involved (i.e. SLP, OT, PT, Nutritionist, etc):
Name: _____ Title:_____
Name: _____ Title:_____
Name: _____ Title:_____

Medical Information

Medical Diagnoses:
_____
_____
_____

Pregnancy details:

☐ Full term ☐ Premature, born at _____ weeks

☐ Vaginal birth ☐ C-Section Apgar scores (if known): _____

Assisted Birth: ☐ Yes ☐ No If yes, what intervention was used? _____
Complications during pregnancy or during/following delivery: _____
_____
_____

Respiratory/ Nutritional support: ☐ Yes ☐ No If yes, please explain? _____
Feeding Tube? ☐ Yes ☐ No If yes, what age and how long?
_____

Overall development: ☐ Normal ☐ Delayed If delayed, what areas? _____

Hospitalizations (month/year & reason: _____
_____
_____

Current Health (please check all that apply):

☐ Frequent Illness	☐ Eczema	☐ Irritability	☐ Seizures
☐ Rotavirus	☐ Upper Respiratory Infections		☐ Pneumonia
☐ Aspiration	☐ Ear Infections	☐ Other_____	

Current weight: _____
Current length/height: _____

Current Medications (including supplements):

Name	Dosage	Frequency

Please provide the dates of any procedures below:

Swallow Study (MBSS) Date: _____ Results:_____
Endoscopy Date: _____ Results:_____
Gastric Emptying Date: _____ Results:_____
pH Probe Date: _____ Results:_____
Upper GI Date: _____ Results:_____
Allergy Testing Skin Test Date: _____ Results:_____
Blood Test Date: _____ Results:_____

Describe any special diet or food intolerance: _____
_____
_____

Bowel Habits:
Frequency of bowel movements: _____ times per ☐ day ☐ week.
Consistency: _____

Feeding History

Breast fed? ☐ Yes ☐ No
If yes, what age was the child weaned? _____
If currently breastfeeding, please describe schedule _____
Bottle fed? ☐ Yes ☐ No
If yes, ☐ Breastmilk ☐ Formula Current Formula: _____

Please indicate your child's typical meal schedule:
Number is meals/snacks: _____
Timing of meals/snacks:_____

Liquids

Describe sequence in which food/liquids are offered (i.e. liquids first): _____

_____

_____

Formula type: ☐ Powder ☐ Concentrate ☐ Ready-to-feed

Please describe how you prepare (i.e. 4 oz water, 2 scoops powder:_____

List any previous formulas & describe tolerance: _____

Other fluids presented in bottle: _____

Solids

At what age were solids introduced? _____

Any problems at introductions? ☐ Yes ☐ No If yes, please explain?

_____

Please check all stages of baby food that your child ate/eats:

☐ 1st ☐ 2nd ☐ 3rd ☐ Toddler If problems, please explain?

_____

Does your child have any of the following?

Food refusal (refusing all or most foods)

☐ Yes ☐ No If yes, age started? _____

Food selectivity by texture (eating only certain textures)

☐ Yes ☐ No If yes, please explain? _____

Food selectivity by type (eating a limited variety of foods)

☐ Yes ☐ No If yes, please explain? _____

Oral motor delays (problems with chewing, etc.)

☐ Yes ☐ No If yes, please explain? _____

Dysphagia (problems with swallowing)

☐ Yes ☐ No If yes, please explain? _____

Abnormal preferences (temperature sensitive, color specific, particular brands)

☐ Yes ☐ No If yes, please explain? _____

Other feeding problems: _____

_____

_____

What is your major feeding concern? Please describe feeding problems. _____

_____
_____
_____

What is your feeding goal(s) for your child? _____
_____
_____
_____

Current Meal Pattern

Which meal is your child's best? _____

Which meal is your child's worst? _____

How long does a 'typical' meal take? _____

Please list preferred foods: _____
_____
_____
_____
_____

Please list non-preferred foods: _____
_____
_____
_____
_____

Feeding Behavior

Does your child experience any of the following with feeding?

Choking	☐ Yes ☐ No	Difficulty chewing	☐ Yes ☐ No
Gagging	☐ Yes ☐ No	Coughing	☐ Yes ☐ No
Vomiting	☐ Yes ☐ No	Over fills mouth	☐ Yes ☐ No
Drooling	☐ Yes ☐ No	Teeth grinding	☐ Yes ☐ No
Hypersensitive	☐ Yes ☐ No	Penetration/Aspiration	☐ Yes ☐ No
Sweating	☐ Yes ☐ No	Problem with biting	☐ Yes ☐ No

Does your child exhibit any of these behaviors at mealtimes? Check all that apply.

☐ Cries or screams	☐ Messy	☐ Refuses to self-feed
☐ Spits out food	☐ Throws food	☐ Eats too fast/slow
☐ Plays with food	☐ Picky eater	☐ Pushes food away

☐ Does not suck ☐ Induces vomiting ☐ Refuses to swallow
☐ Leaves table ☐ Wants 'down' ☐ Refuses to open mouth
☐ Eats non-food items ☐ Clenches lips shut ☐ Turns away from spoon
☐ Other: _____

Feeding Practices

Who feeds your child? _____

Does your child eat better for a particular feeder ☐ Yes ☐ No If yes, who? _____

Where does your child currently eat (check all that apply):

☐ Adult's lap ☐ Infant seat ☐ High chair ☐ Booster seat
☐ Table/chair ☐ Sofa ☐ Crib/Bed ☐ Car seat
☐ Modified chair ☐ Wheel chair ☐ Tumble form ☐ Roaming (other rooms)
☐ Other: _____

What feeding techniques do you use with your child to get them to eat (check all that apply):

☐ Coax ☐ Distract with toys ☐ Provide 'favorite' foods ☐ Threaten
☐ Ignore ☐ Send to room/time out ☐ Provide 'mini-meals' ☐ Offer reward
☐ Force feed ☐ Allow grazing/roaming ☐ Change meal schedule ☐ Threaten
☐ Punish ☐ Change foods
☐ Other: _____

What do you do if your child refuses to eat/drink?

_____
_____
_____

What does your child drink from (check all that apply):

☐ Bottle ☐ Sippy Cup ☐ Open Cup ☐ Straw

Is your child able to self-feed? ☐ Yes ☐ No
Do you think your child feels hunger? ☐ Yes ☐ No

How does your child indicate hunger? _____

Is there something we forgot to ask, that you think would be helpful for us to know:

_____
_____
_____
_____

Parent/Guardian Signature: _____ Date: _____

Consent to Screen, Evaluate And/Or Treatment of Services

Patient Name: _____ Date of Birth: _____

Address: _____

Patient's Primary Care Doctor: _____

Primary Care Doctor Phone Number: _____

Patient Diagnosis Code (office use only): _____

- ❑ Speech Therapy
- ❑ Occupational Therapy
- ❑ ABA Therapy

Insurance Information

Primary Insurance: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Phone Number:_____

Secondary Insurance: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Phone Number:_____

I authorize Cornerstone Behavioral Health and Pediatric Therapies to screen, evaluate, and provide any subsequent treatment needed based on the evaluation results for the above named child.

Guardian Signature: _____ Date:_____

Guardian Printed Name: _____ Date: _____

Relationship to Patient : ☐ Parent ☐ Legal Guardian ☐ Other: _____

Signature of Cornerstone Representative:_____ Date:_____

Patient Attendance Policy

In order for us to ensure the best possible results from therapy, you must actively participate in the program developed for you by attending all scheduled sessions. Please be respectful to your therapist and to other patients who are waiting to be scheduled.

Please contact our office at 405-455-6868 if your child is unable to attend his regularly scheduled therapy appointment. Canceled appointment notifications must be made 24 hours in advance, except for emergencies and unforeseen illnesses. All requests for changes in your child's therapy schedule will need to be discussed with your child's therapist and front office staff. The following definitions and procedures apply to all attendance topics.
Please notify us of upcoming pre-planned trips as soon as possible. Families who are planning to be absent for greater than 2 weeks will be removed from their treatment schedule, unless previously arranged with your therapist and the office.

No Show Appointment Definition: A no show is any missed appointment without a phone call to cancel the appointment(s) **a minimum of 24 hours in advance**. This does not apply to appointments that are rescheduled by your provider.

Cancellation Definition: Any appointment canceled by phone or in person **at least 24 hours in advance**. An appointment that is rescheduled does NOT count as a cancellation.

Late Arrival Definition: A late arrival occurs any time the child is more than 10 minutes late for their scheduled appointment. If the appointment is scheduled for 3 p.m., and you arrive at 3:11 p.m., you are considered late. If your arrival or availability time is 15 minutes or more after your scheduled appointment time, your appointment may be canceled.

If you are unsure about whether you can arrive within 10 minutes of your appointment time, call the clinic to inform them you are running late. Your therapist will determine whether you should reschedule the appointment.

Late Pick-up Definition:

It is also necessary that you pick your child up on time**,** as to not interfere with another child's therapy appointment. **A late pick-up occurs any time the parent is 5 minutes late for their scheduled pick up time. If you are scheduled to pick up at 3 p.m., and you arrive at 3:05 p.m., you are considered late.**

A consistent pattern of late arrivals and/or pick-ups will result in a review of your services and possible cancellation of services from Cornerstone Behavioral Health & Pediatric Therapies. We feel the allotted time for your child's treatment is necessary for adequate rehabilitation of their condition.

Please Note: *Therapists are only paid when the child is present. Due to limited scheduling availability, we ask that all patients attend their scheduled treatments. When an appointment is applied to our schedule, that time is reserved to meet your child's needs. We work hard to accommodate each of our patients. Continuous neglect to follow the regulations stated in this policy could lead to termination and/or change of status to your remaining treatments and/or sessions. Thank you in advance for your understanding and cooperation in this matter.*

In the following instances, your child will be taken off the therapy schedule and placed on a waiting list:

1. **After 2 No-Show Appointments.**
2. **After 3 Cancellations in a 9-week period. Cancellations that are rescheduled and attended will not count against you.**

<u>Late and No Show Fees:</u>

Late Arrivals Fee: A late arrival occurs any time the child is more than 15 minutes late for their scheduled appointment. If the appointment is scheduled for 3 p.m., and you arrive at 3:16 p.m., you are considered late and there will be a $15 charge every 15 minutes that you are late.

Late Pick-up Fee

A late pick-up occurs any time the parent is 5 minutes late for their scheduled pick up time so as not to interfere with another client's scheduled appointment time. If you are scheduled to pick up at 3 p.m., and you arrive at 3:05 p.m., you are considered late and there will be a $5 charge every 5 minutes that you are late.:

Failure to Cancel / No Show Fee

It is our policy that **if you fail to cancel, or no show, a scheduled appointment a minimum of 24 hours in advance, you will be charged a $25.00 fee for the missed appointment.*** **If your child misses more than one therapy, you will be charged this fee for each hour.** This balance on your account will not be covered by insurance and will need to be paid before scheduling any additional appointments.

**Medicaid clients will not be charged the fee*

ILLNESS

For the safety of other children and our staff, please do not bring your child to therapy if your child is ill. When your child is sick, please call the clinic to cancel your appointment as soon as possible. Below are guidelines to assist you in deciding whether your child should attend the appointment.

If a child arrives and/or is brought to Cornerstone Behavioral Health & Pediatric Therapies and is believed to be ill or contagious, the guardian will be contacted immediately and will be responsible for picking up, or making arrangements for picking up, the child as soon as possible.

Children should be kept at home when they meet the following criteria:

- Temperature of 99.9°, or higher, in the past 24 hours.
- Conjunctivitis ("pink eye"), pink/redness of the eye and/or lids, usually with yellow discharge and crusting.
- Bronchitis, COVID-19*, virus/flu with hoarseness, cough, and fever.
- A rash you cannot identify which has not been diagnosed.
- Impetigo: red pimples, which become small vesicles surrounded by a reddened area. When blisters break, the surface is raw and weeping. Look for signs in neck creases, groin, underarms, face, hands, or edge of diaper.
- Diarrhea three or more times within 24 hours (watery or greenish BM's that look different and are more frequent than usual).
- Vomiting within 24 hours (more than usual "spitting up").
- A severe cold with fever, sneezing, and nose drainage.
- An unknown illness without obvious symptoms other than unusual paleness, irritability, tiredness, or lack of interest.
- A contagious disease, including measles, chicken pox, mumps, roseola, strep throat, etc.
- Hair lice (same as public school policy).

While we regret the inconvenience caused by strict adherence to these guidelines, our concern for all the children dictates a very conservative approach when dealing with health matters.

Safe Return After an Illness:

Usually a child can return to the clinic under these circumstances except for cases of COVID-19:

- The child has been fever free for 24 hours.
- The child has been diagnosed as having a bacterial infection and has been on an antibiotic for 24 hours.
- It has been 24 hours since the last episode of vomiting or diarrhea.
- The nasal discharge is not thick, yellow, or green.
- Eyes are no longer discharging, or the condition has been treated with an antibiotic for 24 hours.
- The rash has subsided, or a physician has determined that the rash is not contagious.

*__Physician documentation is required.__

Individuals who have tested positive for COVID-19 should not return until the following criteria have been met:

- 10 days since symptoms first appeared (the time it takes to shed the virus) **and**
- At least 36 hours of no fever without fever-reducing medication **and**

- Absence of respiratory symptoms **or**
- Two consecutive negative COVID-19 tests 24 hours apart **or**
- A release from a physician stating the individual may return to school or work

Inclement Weather

In the event of inclement weather, Cornerstone will cancel sessions when local schools close (Edmond PS & Mid-Del PS, or local district of home or community services). Office will attempt to notify parents by text or phone call. If you are unable to keep an appointment due to weather conditions, please notify the clinic at Ext.1, as soon as possible. Occasionally, we may reopen the office it is determined that streets are clear and safe for travel.

**Please be informed that if your insurance requires a prior-authorization for therapy and you only attend a portion of your sessions, your insurance company will likely reduce the number of visits in future authorizations or completely deny future requests.*

Acknowledgment- I have read the attendance policy and acknowledge my understanding as well as agree to the terms.

_____

Patient Name

_____ _____

Signature of Parent or Guardian Date

Cornerstone Behavioral Health and Pediatric Therapies, Inc.

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

If you have any questions about this notice please contact Carolyn Donaghey at Cornerstone Behavioral Health and Pediatric Therapies, Inc. at (405) 455-6868 or by email at office@cornerstoneok.org

This Notice of Privacy Practices describes how Cornerstone Behavioral Health and Pediatric Therapies may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Cornerstone Behavioral Health and Pediatric Therapies is required to abide by the terms of this Notice of Privacy Practices. Cornerstone Behavioral Health and Pediatric Therapies may change the terms of this notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF HEALTH INFORMATION: Treatment: Information about you may be used by the personnel (including students in the field of speech- language pathology who are completing extern placements) associated with Cornerstone Behavioral Health and Pediatric Therapies for diagnosis, treatment planning, and treatment. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian or personal representative. It is the policy of Cornerstone Behavioral Health and Pediatric Therapies to release private health information only to clients or the parents/guardians of clients if clients are minors. In some cases, should Cornerstone Behavioral Health and Pediatric Therapies need to send information to another professional, a signed Release of Information form is required.

Payment: Cornerstone Behavioral Health and Pediatric Therapies bills directly to insurance companies. You will be given a Notification of Benefits and Financial Responsibility form. You will be responsible for all services rendered that are not covered by your insurance in addition to any co-payments and/or co-insurance amounts required.

Cornerstone Behavioral Health and Pediatric Therapies will communicate with you only in ways you have provided on the Contact Information form you completed prior to starting therapy. It is the client's responsibility to update contact information with Cornerstone Behavioral Health and Pediatric Therapies.

OTHER DISCLOSURES: Cornerstone Behavioral Health and Pediatric Therapies may use or disclose your protected health information in some situations without your authorization or providing you the

opportunity to agree or object. Some of these situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification

and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

YOUR RIGHTS:

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. Copies can be obtained for $.25 a page.

Under federal law, however, you may not inspect or copy records related to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. Depending on the circumstances, a decision to deny access may be reviewable.

You have the right to revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You have the right to request that information about you be communicated by other means or to another location.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

COMPLAINTS: If you believe your rights have been violated by Cornerstone Behavioral Health and Pediatric Therapies please bring the problem to our attention first. Your concerns will be addressed in a timely manner. If you are not satisfied with the manner in which the Clinical Director, Dr. Gotcher, PhD (ngotcher@cornerstoneok.org or 405-455-6868) handles a complaint, you may submit a formal complaint to:

Attn: Director Office for Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201

This notice was published and becomes effective on signed date below. It will remain in effect for two years from this date.

_____ _____

Legal Guardian Signature Date

_____ _____

Cornerstone Representative Signature Date

Authorization for Release of Information

Patient Name: _____ Date of Birth: ____/____/____

I authorize Cornerstone to release information TO:

1. Name of Provider/ Facility:_____

Address:_____

Phone number:_____

Fax number:_____

Information requested/authorized: ⬜ Evaluation ⬜ Records ⬜ Other: _____

2. Name of Provider/ Facility:_____

Address:_____

Phone number:_____

Fax number:_____

Information requested/authorized: ⬜ Evaluation ⬜ Records ⬜ Other: _____

I authorize Cornerstone to obtain information FROM:

1. Name of Provider/Facility:_____

Address:_____

Phone number:_____

Fax number:_____

Information requested/authorized: ⬜ Evaluation ⬜ Records ⬜ Other: _____

_____ _____

Signature of Parent or Guardian Date

_____ _____

Cornerstone Representative Date

Financial Responsibility Statement

Patient full name: _____

Patient's DOB: ____/____/_____

Primary Insurance: _____

Policy Holder Name: _____ Date of birth: _____

Member ID Number: _____ Group Number: _____

Phone Number: _____

Secondary Insurance: _____

Policy Holder Name: _____ Date of birth: _____

Member ID Number: _____ Group Number: _____

Phone Number: _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Cornerstone Behavioral Pediatrics, and authorize Cornerstone Behavioral Pediatrics to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

By signing this form I am stating that I understand and agree to the following:
Fees for services were reviewed with me and agreed upon prior to the commencement of services. Payment is due at the time services are rendered unless other arrangements have been made. All returned checks will result in a $25.00 return fee. Failure to meet financial obligations will result in termination of services.

I, _____, (print name) assume all financial responsibility for charges related to all services provided by Cornerstone BH&PT for _____ (print child's name).

_____ _____

Signature of Parent or Legal Guardian Date