Phone: 865-579-2293
Fax: 865-579-2295
MoserSpeech.com

MOSERSPEECH
Speech Therapy Services
Claire Moser MA, CCC-SLP

10721 Chapman Hwy
Suite #22
Seymour, TN 37865

PEDIATRIC FEEDING INTAKE – CONTACT INFORMATION

(PLEASE FILL IN ALL BLANKS TO THE BEST OF YOUR KNOWLEDGE.)

PATIENT'S NAME: _____ **TODAY'S DATE:** _____
BIRTHDATE: _____ **SOCIAL SECURITY NUMBER:** _____ **GENDER:** _____

NATURE OF PARENT CONCERN: _____

_____

_____

CONTACT INFORMATION

ADDRESS: _____ **HOME PHONE:** _____
_____ **CELL PHONE:** _____
EMAIL: _____ **WORK PHONE:** _____

PARENT/GUARDIAN'S CONTACT INFORMATION

MOTHER'S NAME: _____ **BIRTHDATE:** _____ **SOCIAL SECURITY #:** _____
ADDRESS (if different from child): _____ **HOME PHONE:** _____
_____ **CELL PHONE:** _____
EMAIL: _____ **WORK PHONE:** _____

FATHER'S NAME: _____ **BIRTHDATE:** _____ **SOCIAL SECURITY #:** _____
ADDRESS (if different from child): _____ **HOME PHONE:** _____
_____ **CELL PHONE:** _____
EMAIL: _____ **WORK PHONE:** _____

EMERGENCY CONTACT INFORMATION

NAME: _____ **PHONE NUMBER:** _____
RELATIONSHIP TO THE PATIENT: _____

PRIMARY CARE PHYSICIAN INFORMATION

REFERRING PHYSICIAN NAME: _____ **PHONE NUMBER:** _____
GROUP NAME: _____ **FAX NUMBER:** _____

INSURANCE INFORMATION

INSURANCE COMPANY: _____ **PHONE NUMBER:** _____
MEMBER ID#: _____ **GROUP #:** _____

PEDIATRIC INTAKE – HISTORY INFORMATION

(PLEASE FILL IN ALL BLANKS TO THE BEST OF YOUR KNOWLEDGE.)

BIRTH HISTORY

___ FULL TERM PREGNANCY ___ UNCOMPLICATED ___ C-SECTION

BIRTH WEIGHT: ____pounds, ____ounces

Was there anything unusual about the pregnancy or birth? ___ YES ___ NO

If yes, please describe. _____

_____

_____

How old was the mother when the child was born? _____ How many months was the pregnancy? _____

Was the mother sick during the pregnancy? ___ YES ___ NO

If yes, please describe. _____

_____

Did the child go home with his/her mother from the hospital? ___ YES ___ NO

If child stayed at the hospital, please describe why and how long. _____

_____

MEDICAL HISTORY

Has your child had any of the following?

___ adenoidectomy
___ allergies
___ breathing difficulties
___ chicken pox
___ colds
___ frequent ear infections
___ ear tubes
___ hearing problems
___ encephalitis
___ flu
___ head injury
___ high fevers
___ measles
___ meningitis
___ mumps
___ scarlet fever
___ seizures
___ sinusitis
___ sleeping difficulties
___ thumb/finger sucking habit
___ tonsillectomy
___ tonsillitis
___ vision problems
___ feeding problems
___ Other: _____

Has your child had any serious injuries or surgeries? ___ YES ___ NO

If yes, please describe. _____

_____

_____

Is your child currently (or recently) under a physician's care? ___ YES ___ NO

If yes, why, and who is the physician? _____

_____

Please list any medications your child takes regularly: _____

Please list any known allergies: _____

DEVELOPMENTAL HISTORY

Please tell the approximate age your child achieved the following developmental milestones:

_____ sat alone	_____ grasped crayon/pencil
_____ babbled	_____ said first words
_____ put two words together	_____ spoke in short sentences
_____ walked	_____ toilet trained

Does your child… (Check all that apply)

___ choke on foods or liquids? ___ currently put toys/objects in his/her mouth? ___ brush his/her teeth and/or allow brushing?

SPEECH-LANGUAGE-HEARING

Does your child… (Check all that apply)

___ repeat sounds, words or phrases over and over?
___ retrieve/point to common objects upon request (ball, cup, shoe)?
___ follow simple directions ("Shut the door" or "Get your shoes")?
___ respond correctly to who/what/where/when/why questions?
___ understand what you are saying?
___ respond correctly to yes/no questions?
___ become frustrated by speech/language difficulties

Your child currently communicates using… (Check all that apply)

___ body language.
___ words (shoe, doggy, up).
___ sentences longer than four words
___ sounds (vowels, grunting).
___ 2 to 4 word sentences.
___ other: _____

Did siblings have any speech and/or language delay? _____

What do you see as your child's most difficult communication problem at home? _____

_____

BEHAVIORAL CHARACTERISTICS (Check all that apply)

___ cooperative
___ attentive
___ willing to try new activities
___ plays alone for reasonable length of time
___ separation difficulties
___ easily frustrated/impulsive
___ stubborn
___ restless
___ poor eye contact
___ easily distracted/short attention
___ destructive/aggressive
___ withdrawn
___ inappropriate behavior
___ self-abusive behavior

SCHOOL HISTORY (If your child is in school, please answer the following):

NAME OF SCHOOL _____ **GRADE:** _____ **TEACHER:** _____

What are your child's strengths and/or best subjects? _____

Is your child having difficulty in any subjects or skills? _____

Is your receiving help in any subjects? _____

*** Is there a current IEP in place? _____

THERAPEUTIC HISTORY

Has your child ever received an evaluation or therapy before? (Check all that apply):

___ Speech Therapy ___ Occupational Therapy ___ Physical Therapy
___ Hearing ___ Vision ___ Other

Feeding/Eating History Form

Patient Name:	DOB:	Today's Date:
Name of person completing form:	Relationship to Patient:	

Instructions: Place a check beside any area that applies to your child

What is the purpose of the evaluation:

- ❑ Does not like putting things in or near mouth
- ❑ Refusing food
- ❑ Difficulty transitioning to solids
- ❑ Choking and/or coughing when eating
- ❑ Gagging or vomiting when eating
- ❑ Difficulty accepting liquids by mouth
- ❑ Difficulty accepting solids by mouth
- ❑ Reduced variety of foods
- ❑ Reduced volume of foods
- ❑ Follow up to a swallow study (MBS or FEES)
- ❑ Nutrition concerns
- ❑ Poor weight gain
- ❑ Failure to thrive
- ❑ Other _____

Allergies/Intolerances to any food, environmental, any other?

- ❑ None
- ❑ Yes, _____

Medical History related to feeding/eating:

- ❑ Esophageal Reflux
- ❑ Nasal Reflux
- ❑ Upper GI Testing Done –results_____ _____
- ❑ Modified Barium Swallow Study (MBS)
  Date of most recent MBS ___/___/____
  Results_____
- ❑ Fiberoptic Endoscopic Evaluation of Swallowing, (FEES)
  Date of most recent FEES___/___/____
  Results _____
- ❑ Constipation _____
- ❑ Diarrhea/Loose Stools _____
- ❑ Asthma _____
- ❑ Respiratory Status:_____
- ❑ Cardiac Status: _____
- ❑ See additional history _____
- ❑ Related/Previous therapy services_____

IN THE PAST

How has your child taken food in the PAST?

- ❑ By mouth
- ❑ By mouth and tube (NG, NJ, GJ, GT, OG, OJ),
- ❑ By tube (NG, NJ, GJ, GT, OG, OJ),
- ❑ Other _____

Has your child had any feeding difficulties in the PAST?

- ❑ Difficulties with Breast feeding?
- ❑ With transitions to foods?
- ❑ Controlling liquids in the mouth?
- ❑ Managing or accepting solids?
- ❑ **Family History of feeding problems, intolerances or allergies:** Please list:_____

CURRENTLY

How does your child take in food NOW?

- ❑ By mouth
- ❑ By mouth and tube (NG, NJ, GJ, GT, OG, OJ),
- ❑ By tube (NG, NJ, GJ, GT, OG, OJ),
- ❑ Other _____

Is your child having any difficulties with the following?

- ❑ Difficulties with Breast feeding? ❑ With transitions to foods?
- ❑ Controlling liquids in the mouth?
- ❑ Managing or accepting solids?

When is your child fed/ or eat by MOUTH?

- ❑ Ad lib
- ❑ _____times a day
- ❑ Every _____ hours
- ❑ Other

_____

How long does it take to eat a meal? _____

When is your child fed by TUBE:

- ❑ Ad lib
- ❑ Continuous (rate_____ for how long_____)
- ❑ Bolus (every ___ hours, volume_____, Frequency _____, Length of Feeding _____, Pump or syringe (gravity)
- ❑ Other

_____.

How long does it take to deliver each feeding? _____

PATIENT NAME:	DOB:	Today's Date:

Current diet:

Liquids

- ❑ Formula (type) _____ ❑ Breast milk ❑ Cow's milk
- ❑ Soy Milk
- ❑ Other liquids_____
- ❑ Quantity of liquid per day _____ounces

Solids: Types/quantities of food eaten for meals: ❑Not developmentally appropriate.

Breakfast:_____

_____

Lunch:_____

_____

Snacks:_____

_____

Dinner:_____

_____.

Other foods your child has tried 1-2 times before but does not regularly eat:_____

Eating Routine:

- ❑ Does your child eat in a High Chair?
- ❑ Does your child eat in a Car Seat?
- ❑ Does your child eat at the Table?
- ❑ Does your child eat at the counter/bar?
- ❑ Does your child eat with other family members present?
- ❑ Do you use distraction? List types_____

Reported Self Feeding Skills:

- ❑ Bottle (6+ months)
- ❑ Fingers (14-16 months)
- ❑ Spoon(14-30 months)
- ❑ Fork (14-36 months)
- ❑ Sippy Cup
- ❑ Open Cup
- ❑ Straw

Other _____

Comments:

FAMILY HISTORY OF ALLERGIES:

_____

_____

CHILD'S ALLERGIES:

_____

_____

EATING CONCERN'S:

_____

_____

Please list the foods your child **will eat** from each category:

Meats/Eggs/Cheese	Carbohydrates: Cereal/bread/cookies/cracker Chips/rice/potatoes	Fruits	Vegetables

Please list the foods your child **AVOIDS** from each category:

Meats/Eggs/Cheese	Carbohydrates: Cereal/bread/cookies/cracker Chips/rice/potatoes	Fruits	Vegetables

High Allergy Foods Y/N	Avoided Textures:	Snacks:	Foods you DO NOT want your child to have:
Honey Y N			
Peanut Butter Y N			
Tree Nuts Y N			
Citrus Fruits Y N			
Acidic Foods Y N			
Corn Y N			
Eggs Y N			
Whole Milk Y N			
Wheat Y N			
Hot Dogs Y N			

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NOTICE OF PRIVACY PRACTICES

Moser Speech Therapy Services provides this Consent to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

This summary of and consent for the privacy practices and patient care at Moser Speech Therapy Services and services as a condensed version of our Notice of Privacy Practices. You have the right to review our Notice before signing this Consent upon request. The terms of our Notice may change and you may obtain a revised copy by contacting our office.

If you ever believe your privacy rights have been violated, you may file a complaint with the Compliance Officer of Moser Speech Therapy Services or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

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.

How will we use or disclose your information? Here are a few examples:

* For speech, language & feeding treatment and referral
* To obtain payment and file insurance
* In emergency situations
* For appointment and patient recall reminders
* To run our Practice more efficiently and ensure all our patients receive quality care
* For research and education
* Prevent serious threats to health safety
* For workers' compensation programs
* In response to certain requests arising out of lawsuits or other disputes

You have certain rights regarding the information we maintain about you. These rights include:

* The right to inspect and copy
* The right to amend
* The right to an accounting of disclosures
* The right to request restrictions
* The right to a paper copy of this notice
* The right to request confidential communications

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Moser Speech Therapy Services may condition treatment upon the execution of this Consent. *This information and Notice of Privacy Practices is made available on request.*

PATIENT NAME: _____ **SOCIAL SECURITY:** _____

Signed by: _____ **DATE:** _____

Relationship (if other than patient): _____

WITNESS: _____ **TITLE:** _____

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CONSENT FORM

As a service to our patients, we routinely phone you the day before your appointment as a reminder to you. It may also be necessary for the secretary or Speech Therapist to contact you regarding you or your child's progress.

Confidentiality regulations require that we obtain your written consent to be contacted. Please indicate your preferences below:

1. **YOU MAY LEAVE A MESSAGE ON MY ANSWERING MACHINE.** **YES** **NO**
2. **YOU MAY LEAVE A MESSAGE WITH A FAMILY MEMBER.** **YES** **NO**
3. **YOU MAY TEXT WITH APPT CHANGES/REMINDERS** **YES** **NO**

Is there anyone that we MAY NOT leave any information with? **YES** **NO**

If yes, please list the name(s), phone number and relationship to the patient. _____

_____

_____

_____

Will there be anyone else bringing your child to the facility? **YES** **NO**

If yes, please list the name(s), phone number and relationship to the patient. _____

_____

_____

_____

_____ _____

Signature **Date**

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ASSIGNMENT OF BENEFITS

I hereby authorize and assign payment directly to Moser Speech Therapy Services all insurance benefits due and otherwise payable to me for services provided by Moser Speech Therapy Services. I further authorize and direct my insurance company to provide Moser Speech Therapy Services with all information regarding my benefits, status of claims, reason or reasons for non-payment and any other information deemed necessary or appropriate. I hereby appoint Moser Speech Therapy Services and its authorized agents and representatives as my attorney-in-fact for the purpose of executing all claims, authorizations, and instructions relating to payment for services provided by Moser Speech Therapy Services.

_____

PATIENT NAME

_____ _____

INSURED/RESPONSIBLE PARTY **DATE**

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PATIENT CANCELLATION / NO-SHOW POLICY

We understand that sometimes things will come up that will prevent a patient from keeping his/her speech therapy appointment. Due to a limited amount of available appointment slots, patients are requested to cancel or reschedule appointments at least eight hours in advance when possible. Failure to cancel or reschedule appointments will result in a No-Call-No-Show fee that will be billed to your insurance company, and may affect your benefits and eligibility. This means you could lose all of your benefits and be dropped from your insurance provider.

I have read and understand the above policy.

_____

PATIENT NAME

_____ _____

PARENT SIGNATURE **DATE**

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ROUTINE VERBAL SESSION PROGRESS DISCUSSIONS

The clinical and administrative teams at Moser Speech value our relationship with the families we serve. Much of that relationship is reinforced by regular communication about your child's progress and needs. As our time with each patient is typically limited to thirty minutes, we strive to make the most of this time by providing skilled therapy in the therapy room, followed by informative routine verbal progress reports with the parent in the lobby.

Given your signed authorization below, the clinician will share session-specific information with you verbally in the lobby at the close of each session. These discussions will be routine in nature. (example: a report of how the session went, what they worked on, what to try at home, etc.)

In the case of more sensitive issues, such as diagnosis, medical or behavioral concerns or any other personal subject, the clinician will not address these in the lobby. Depending on the available time, the clinician may invite you into the therapy room or another private conference area, or schedule an appointment time for a more formal conference.

At Moser Speech, we recognize that not everyone will feel comfortable with ANY discussion in a public setting, which is why we would like for you to share with us your preference regarding the session-specific routine verbal progress discussions. We will accommodate each family's discussion preference as listed below:

REGARDING PATIENT, _____,
(PRINT PATIENT NAME)

_____ **I authorize the staff at Moser Speech to provide session-specific routine progress reports verbally in the lobby after each session, with the understanding that these discussions will be kept general in nature and will be communicated at a reasonably low volume and will not include sensitive topics such as diagnosis, medical or behavioral concerns, or any other personal subject matter.**

_____ **I prefer that all discussions regarding my child's progress, including general verbal progress reports take place either in the therapy room or in a private conference setting. Please do not discuss anything about the session in the lobby or any public space.**

_____ _____
Parent/Legal Guardian's Signature Printed Name of Parent/Guardian

_____ _____
Witness Date Signed

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PHOTO RELEASE / PERMISSION STATEMENT

PATIENT NAME: _____ **BIRTHDATE:** _____

___ I GIVE MY PERMISSION FOR THIS PATIENT TO BE PHOTOGRAPHED AND FOR THE PHOTOGRAPH(S) TO BE USED IN INFORMATION BROCHURES AND PRINTED LITERATURE FOR **MOSER SPEECH THERAPY SERVICES.**

___ I GIVE MY PERMISSION FOR THIS PATIENT TO BE PHOTOGRAPHED AND FOR THE PHOTOGRAPH(S) TO BE USED ONLINE ON THE WEBSITE(S) AND SOCIAL MEDIA PAGES FOR **MOSER SPEECH THERAPY SERVICES.**

___ I GIVE MY PERMISSION FOR THIS PATIENT TO BE PHOTOGRAPHED AND FOR THE PHOTOGRAPH(S) TO BE USED FOR EDUCATIONAL PURPOSES SUCH AS SEMINAR PRESENTATIONS, DISPLAYS, ETC.

NOTES and/or RESTRICTIONS TO THE ABOVE INITIALED PERMISSION STATEMENTS:

_____

_____

_____

_____

_____	_____	_____
Authorized Signature	Printed Name	Date Signed
_____	_____	_____
Staff / Witness Signature	Title	Date Signed

******* THANK YOU SO MUCH FOR SUPPORTING MOSER SPEECH THERAPY SERVICES! *******

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PARENT/GUARDIAN COMMITMENT TO PATIENT'S PLAN OF CARE

PATIENT NAME: _____ **PAN:** _____ **TODAY'S DATE:** _____

Based on the results of your formal evaluation at Moser Speech Therapy, your SLP has recommended that you attend therapy _____ / week to address the goals which have been explained to you. Consistent attendance has been shown to greatly impact the amount of progress that our patients make, and as such, we ask that you make every effort to commit to the plan of care that your SLP has established.

For the convenience of our patients and their families, Moser Speech Therapy offers a "regular recurring" schedule to all patients as they enter into a Plan of Care, based on the recommended frequency, established by the SLP. **A "regular" schedule means that our facility has a recurring day and time RESERVED for a patient**, which allows a family to plan ahead in order to commit to the patient's plan of care.

While Moser Speech Therapy understands that things come up from time to time, creating the need for cancellations and/or rescheduling a regular appointment, Moser Speech Therapy requests the commitment of all patients/families who accept a RESERVED SCHEDULE, to adhere to their treatment plan with a minimum of 75% attendance, recognizing that RESERVED recurring appointments are offered as part of Moser Speech Therapy's practice of MUTUAL ACCOUNTABILITY, as discussed in the CORE VALUES provided to each patient on their first visit to our clinic.

If a patient is unable to commit to a "regular" (RESERVED) schedule, our Patient Service Coordinator will be happy to provide appointments as available, on a weekly basis; however, we cannot guarantee that a set day/time will be available. This may affect the frequency of sessions that a patient will receive. Moser Speech Therapy is committed to working with patients to the extent that we are able, but it is anticipated that patients will work with us to ensure that the patient is being brought regularly to the clinic.

As RESERVED appointments are limited, Patients who do commit to a "regular" (RESERVED) schedule must maintain a minimum of 75% attendance. If monthly attendance falls below 75%, their "reservation" (regular recurring appointment day/time slot) may be forfeited, at which time that patient will need to begin scheduling individual appointments on a weekly basis.

Thank you for your understanding of Moser Speech Therapy's position on this requirement. We are so privileged to be working with you and look forward to celebrating PROGRESS with each and every one of you!!

PARENT/GUARDIAN COMMITMENT TO PATIENT'S PLAN OF CARE

Patient Name: _____ **Today's Date:** _____

___ I am able to commit to a **RESERVED** schedule: _____

I understand that by accepting this regular recurring schedule, I must commit to a minimum of 75% compliance with this schedule, and that if my attendance falls below 75%, my appointment times may be forfeited, at which time I will need to schedule individual appointments as they are available.

___ I am unable to commit to a **RESERVED** schedule at this time; however, I am committed to supporting the patient's plan of care by scheduling individual appointments at the recommended frequency.

I understand that I must contact MOSER SPEECH THERAPY at (865) 579-2293 each week to schedule these individual appointments.

___ I am unable to commit to the frequency of sessions that has been recommended by the SLP, but I am able to commit to _____ sessions per week, and will schedule individual appointments each week.

I understand that I must contact MOSER SPEECH THERAPY at (865) 579-2293 each week to schedule these individual appointments.

_____ _____

PARENT/GUARDIAN SIGNATURE **PRINTED NAME**

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Notice of Possible Alternate SLP:

Moser Speech is committed to providing exceptional services for you and your child. Each child will primarily see the same Speech Language Pathologist (SLP), but please know that on occasion (in cases of illness, unexpected meetings, emergencies, or vacations) your child may be seen by an assistant or a different SLP. We will always try to accommodate you and your requests. NOTE: In the event that you cancel an appointment due to your child seeing a substitute SLP, the cancellation **will** count against your attendance.

Thank you for your understanding!

Parent/Guardian Initials:_____