196 E. Nine Mile Road
Suite D
Pensacola Florida 32534
Phone: (850) 972-8823
Fax: (844) 848-7557
Email: admin@tubes2tables.com
Web: www.tubes2tables.com

Feeding and Swallowing Therapy

Dear Parent,

Having a child who does not feed well is a worrisome, frustrating, confusing and at times, medically concerning. We, at ***Tubes 2 Tables, Inc.***, understand how complex feeding difficulties can be. Because of these complexities, we believe it is important to look at the "whole" child and to assess as many of the contributing factors as possible in a feeding problem. We approach your child's care from a positive feeding approach. We are committed to helping you and your child identify what is interfering with your child's eating and how to improve their growth and interactions with food.

Our mission is to improve the lives of families by helping caregivers understand the power of positive feeding experiences. To understand your child's feeding challenges, we feel it best to evaluate him in his/your home where he is most comfortable. Our evaluation process usually takes about 2 hours and consists of three steps.

- First, you will be asked to complete pre-assessment history documents and complete a sensory profile where you will answer questions about your child.
- Second, we schedule an appoint to be completed either in your home or in our office. During the evaluation, the therapist will want to observe your child eating with both preferred foods and non-preferred foods. Please plan to feed him exactly as you try to feed him every day.
- Third, the therapist will discuss her recommendations, educate you on how children learn to eat through positive experiences, provide you immediate suggestions to begin making feeding fun again, and answer your questions.

If treatment is indicated, your therapist will discuss treatment options with you. What sets **Tubes 2 Tables** apart from other feeding therapy programs is our commitment to going the extra mile to train you to be your child's best teacher for learning to eat. We want you to be comfortable being his/her best food teacher.

We are looking forward to beginning a journey toward better feeding experiences for you and your child. Please know that you are not alone. Research indicates that 68% of parents are stressed out during meal time because their child will not eat. Our goal is to decrease that percentage one child at a time. We know how to make feeding fun and swallowing safe for your child. Please visit our website for more information. www. tubes2tables.com.

Warmly,

Neina F. Ferguson

Neina F. Ferguson, Ph.D., CCC-SLP
Pediatric Feeding Specialist
Speech-Language Pathologist

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Feeding & Swallowing Therapies

Neina F. Ferguson, Ph.D., CCC-SLP
Owner/Speech-Language Pathologist
Feeding and Swallowing Specialist
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FAMILY AND MEDICAL HISTORY FORM

PART 1 - GENERAL INFORMATION

CHILD'S FULL NAME: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____

HOME PHONE: _____

PHYSICIAN'S NAME: _____
PHONE #:_____

COMPOSITION OF FAMILY IN WHICH CHILD CURRENTLY RESIDES (Primary Caregivers)

FATHER'S NAME: _____ OCCUPATION: _____

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

MOTHER'S NAME: _____OCCUPATION: _____

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

BIOLOGICAL PARENT INFORMATION (if not current caregiver or different from above):

FATHER'S/MOTHER'S NAME_____

ADDRESS:

PHONE #: _____

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IF BOTH PRIMARY CAREGIVERS WORK, WHO CARES FOR THE CHILD?

Name_____

ADDRESS: _____

PHONE#: _____ WHEN IS CHILD IN THIS CHILDCARE? _____

_____

OTHER PERSONS LIVING IN THIS CHILD'S HOUSEHOLD:

NAME SEX AGE RELATIONSHIP TO CHILD

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY STRESSORS (please note/explain if any of the following stressful events happened in the last 12 months):

ITEM	NO	YES	EVENT	EXPLANATION
1			Marital separations/divorce	
2			Death in the family	
3			Financial crisis	
4			Job change/difficulties	
5			School problems	
6			Legal problems	
7			Medical problems	
8			Household move	
9			Extended separation from parents	
10			Other stressful event	

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PART 2: PREGNANCY AND BIRTH HISTORY

Please list all pregnancies in order (including this child, miscarriages, terminations or deceased):

PREGNANCY #	BIRTH WEIGHT	ANY DELVIERY, HEALTH OR DEVELOPMENTAL PROBLEMS	FATHER
1			
2			
3			
4			
5			
6			

PRENATAL HISTORY:

1. Did you have any problems getting pregnant? Please describe: _____

_____

2. In what month did you begin prenatal care? _____

3. Please list all over the counter medications taken during this pregnancy and when (eg. vitamins, antacids, cold medications, aspirin etc): _____

4. Please list any cigarettes, caffeine, street drugs taken (how much a day and when in pregnancy): _____

_____

5. Please list all prescription medications taken (name, dosage and from when to when): _____

_____

_____

6. Please give in pounds, the amount of total weight lost and/or gained during this pregnancy:_____

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7. Did you have any of the following events occur during this pregnancy? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Allergies or asthma	
2			Anemia	
3			Diabetes/blood sugar problems	
4			Edema (swelling, water retention)	
5			Excessive vomiting	
6			Headaches/migraines	
7			Heart disease	
8			Kidney disease	
9			Pre-eclampsia	
10			Rh negative	
11			Toxemia	
12			Toxin exposure	
13			Accidents	
14			Bleeding/spotting	
15			Blood transfusions	
16			Cervical incompetence	
17			Infections (bladder or genital)	
18			Infections (other)	
19			Pre-term labor	
20			Uterine or uterine fluid problems	
21			Other physical injury	
22			Other not specified problem	

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BIRTH HISTORY (for the child being evaluated):

1. Hospital where born + city + state: _____

2. Physician's Name: _____

3. Gestational Age at time of delivery (or # weeks early or late): _____

4. Length of Labor (in hours)? _____ Length of membrane rupture? _____

5. Any type of labor stimulation and what was used? _____

6. Any type of pain medication or anesthesia used during delivery (name, type, amount if known)?

Pain relief _____ Anti-vomiting _____

Sedation _____ Anesthesia _____

_____

7. What type of delivery (please circle)? Vaginal Cesarean Section = elective or emergency

Presentation: Head, Face, Breech, Transverse Reason for C-section _____

Assistance: Forceps, Vacuum, other _____

8. Did you experience any of the following problems during the labor/delivery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (why, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			MATERNAL infection	
2			Low/high red/white blood cell count	
3			Pelvis or cervical problems	
4			Placenta problems	
5			Dysfunctional labor	
6			BABY had the cord around the neck	
7			Cord problems (knots, prolapsed, compression)	
8			Baby had very low or high heart rate	
9			Baby had heart rate decelerations	
10			Fetal distress was noted	
11			Meconium was noted	

9. How soon after the delivery did you see your baby _____

10. What was the baby's APGAR scores? 1 minute _____ 5 minute _____

11. What was the baby's Birth Weight? _____ Birth Length _____

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12. Number of Days spent in the nursery? _____NICU or Newborn Nursery? _____

13. What was the condition of your infant while in the nursery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Was blue/cyanotic at birth	
2			Required stimulation to breathe	
3			Required oxygen at birth	How much/what type?
4			Required resuscitation	
5			Was considered small for gestational age	
6			Had tremoring or seizures	Which/for how long?
7			Very low tone	
8			Brain hemorrhage	
9			Anemia and/or transfusions	Which/how many times?
10			Jaundice (yellow)	How much/how treated?
11			Had bruising	
12			Rh incompatibility problems	
13			Infections	
14			Congenital birth defects	
15			Aspiration (meconium or fluid)	Which/how treated?
16			Respiratory distress signs or syndrome	
17			Needed ventilation	What type/how long?
18			Choking or vomiting episodes	
19			Tube feedings	
20			Needed medications	

HOSPITALIZATIONS AND/OR SURGERIES:
List the dates of any hospitalizations your child has had and the reason. List the dates of any surgeries your child has had and the reasons.

1. _____

2._____

3._____

4._____

PRESENT HEALTH STATUS: Most recent Height = _____ Weight = _____Date: _____

Please note any illnesses for which your child is currently being treated, including their Current Medications:

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PART 3: MEDICAL HISTORY OF CHILD

It is very important to have as complete a medical history for your child as possible. Please fill out the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	
3			Frequent Ear Infections (?tubes)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Anemia/blood disorder	
9			Kidney/Renal disorder	
10			Urinary problems/infections	
11			Hormonal problem	
12			Muscle disorder/muscle problem	
13			Joint or bone problems	
14			Fractured bones	
15			Skin disorder/skin problems (eczema)	
16			Visual disorder/vision problems	
17			Eye infections	
18			Neurological disorder	
19			Seizures or convulsions	
20			Stomach disorder/stomach pain	
21			Vomiting/digestion problems	
22			Failure to gain weight/feeding problems	
23			Constipation/diarrhea problems	
24			Dehydration episodes	
25			Hearing Loss/Ear disorder	
26			Significant accidents	
27			Head injuries or concussions	
28			Ingestion of toxins, poisons, foreign objects	
29			Major medical procedures (detail below)	
30			Chronic medications (for what? when?)	
31			Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	

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PART 4: DEVELOPMENTAL HISTORY

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you can not recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If your child has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

MILESTONE	AGE	EARLY	ON TIME	LATE		GOOD/FAIR	POOR
Smiled							
Held head up							
Rolled over							
Reached for an object actively							
Transferred object between hands							
Sat unsupported							
Crawled							
Stood alone							
Walked by self							
Said first words							
Threw objects actively							
Ran by self							
Followed simple 1 step directions							
Said 2-3 phrases							
Ate unaided with a spoon/fork							
Dressed self							
Rode bicycle without training wheels							
Caught a thrown object							
Demonstrated handedness (which?)							
Knew colors							
Counted to 5							
Knew alphabet							
Bladder trained - days							
Bladder trained - nights							
Bowel trained							

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Part 4: Developmental History (continued)

1. Do you feel your child was "faster" or "slower" than his/her peers in any other way? Please explain ___

2. If your child is in school, please describe any difficulties or strengths in reading, writing or spelling: ____

3. Name of previously attended school(s):_____ Grades(s): _____

4. Name of current school: _____ Grade: _____

   Address: _____ Phone: _____

   Any special educations services (which, when)?_____

   Teacher:_____

   Describe any other concerns shared by the teacher: _____

5. Has your Child ever been in therapy (eg. Occupational Therapy, Speech Therapy, psychotherapy, Physical Therapy)? Please indicate what type and when, and who the provider was.

Start date – End date	Type of Therapy	Provider Name	Provider contact information

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6. Has your child had problems with any of the following (beyond expected for child's age):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Sleeping problems	
2			Bed wetting	
3			Drooling	
4			Thumb sucking	
5			Temper tantrums	
6			Head banging	
7			Breath holding	
ITEM	NO	YES	DESCRIPTION	EXPLANATION
8			Aggression/destructiveness	
9			Nervous habits (nail biting etc)	
10			Masturbation	
11			Fire play or cruelty to animals	
12			Major mood swings	
13			Under or over reactive to sounds	
14			Under or over reactive to clothing	
15			Under or over reactive to taste	
16			Under or over reactive to smell	
17			Any unusual fears?	

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PART 5: FAMILY MEDICAL HISTORY

Are there any of the following medical problems on either side of the child's BIOLOGICAL parents' families? If YES, please indicate on which side of the family, MOTHER or FATHER and explain WHO this is in relation to the CHILD. Please also explain if medications, surgery or hospitalizations were needed.

ITEM	NO	YES	DESCRIPTION	MOTHER Or FATHER'S SIDE ?	WHO? (as related to your child)	EXPLANATION
1			Birth defects/Congenital disorder			
2			Neurological disorder or seizures (eg. Alzheimer's, Parkinson's)			
3			Respiratory disease or tuberculosis (eg. Asthma, COPD)			
4			Hormonal or Gland disorder (eg. Hypothyroidism, pituitary tumor)			
5			Allergies - food or environmental (specify which type and for whom)			
6			Diabetes (Type 1 or 2)			
7			Stomach disease/disorder/problems (eg. Reflux, Colitis, Chron's, Celiac)			
8			Senses problems - vision, hearing, touch, taste, smell, balance			
9			Swallowing or feeding problems (eg. described as picky eater as child, esophageal strictures)			
10			Attentional/learning problems			
11			Hyperactivity			
12			Developmental therapy (eg. Speech therapy, Physical therapy)			
13			Alcohol/drug problems			
14			Psychological/nervous issues			

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PEDIATRIC FEEDING HISTORY FORM

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

1. Please explain, in your own words, what your child's current feeding problem is:

2. Was your child breast fed? From when to when _____

   Was your child bottle fed? From when to when _____

Please describe your child's initial skill on the breast and/or bottle:

3. During these early feedings, did your child frequently arch, cry, spit up, gag, cough, vomit or pull off the nipple?
   Circle the behaviors shown and describe when they would happen, and why, and for how long:

4. Describe how the weaning process off the breast and/or bottle went and why the child was weaned:

5. At what age was your child introduced to Baby cereal? _____ Baby food? _____

   Finger foods? _____ Table food? _____

When did they Transition fully to table food? _____

Please describe how these transitions were handled by your child, especially if any difficulties happened:

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IF YOUR CHILD EATS BY MOUTH, PLEASE ANSWER THE FOLLOWING QUESTIONS:

6a. List the foods that your child currently will eat and drink (put a star next to their favorites):

6b. List the foods your child refuses:

6c. List the foods your child is allergic to:

6d. Describe your child's mealtime:

Who typically feeds your child? _____

Who typically eats with your child? _____

What type of chair is used? _____

How long are meals typically? _____

Does your child use utensils or any type of special cups/bowls (describe)? _____

Are there any other activities going on at meals? What activities (describe)? _____

6e. What times does your child typically eat and what type (bottle, breast, solids)?

Time	Breast	Bottle	Solids (baby food; table?)

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IF YOUR CHILD IS *TUBE FED*, PLEASE ANSWER THE FOLLOWING QUESTIONS:

7a. What type of formula is used and exactly how do you mix it?

7b. Describe where your child is tube fed and what activities are occurring at the same time:

7c. Describe your child's reactions to the tube feedings (connecting, during, disconnecting):

7d. Please detail your child's feeding schedule below.

Time of feeding (start time)	NG, G or Continuous	Amount	Gravity or Pump	Over what time period or what rate

*PLEASE ANSWER FOR ALL CHILDREN

8. Has your child ever been on any type of special diet other than what you just described (circle 1)? **YES NO**
   If yes, please describe type of diet, at what ages, why and what was your child's response:

9. How do you know your child is hungry or full?
   Hungry?

   Full?

10. Has your child lost or gained any weight in the last 6 months, and how much?

11. Would you describe your child's weight as (circle one): Ideal Underweight Overweight

12. Does your child have/had any of the following problems (circle which ones)? Please describe:
    Dental, frequent constipation, frequent diarrhea, vomiting, choking, gagging, coughing

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13. Does your child take a vitamin supplement? Which one?

14. Describe how you, and your child feel after a feeding:
    You:

    Your child:

15. What other evaluations have been completed regarding your child's feeding difficulties and what were the results/what were you told?

16. What treatments have been tried for this problem, and what were the results?

17. How can we be most helpful to you and your child?

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3 Day Diet History Form

Instructions:

You are being asked to record **ALL foods and drinks** eaten/ drank by your child for 3 days in a row. The following directions will guide you in filling out the form. You need to complete this history and send the information to *Tubes 2 Tables, Inc.* with the rest of your forms, OR you will need to bring it with you to your appointment.

1. Please fill out ALL the information at the top of the first page.
2. Please record the DATE and DAY of the week for each day. Record ALL food and drinks eaten along with the TIME your child ate or drank them. It is best to carry the history form with you and to record items immediately so that nothing is missed.
3. Include an EXACT description of the item and your best guess of the portion size of the amount eaten. Write the brand name of formula your child is on (i.e. Enfamil, Prosobee, etc.), what type of juice he/ she drank (i.e. apple, grape, etc.), any special recipes for drink mixtures your child uses (i.e. 24 calorie Isomil + 1 tsp Polycose), and any additions to foods (i.e. ¼ cup mashed potatoes + 1 Tbsp margarine). Be sure to include dressings, sauces, gravies, or anything extra.
4. It is suggested that you may wish to use measuring spoons and cups when serving your child for these 3 days to report the amounts eaten/ drank better.

Example:

Date	Time	Food/ Drink Item	Amount	Bottle	Cup	Mouth	G-tube
1/1/02	4 pm	Gerber applesauce #2	1 ounce			✔	
		White Bread (Wonder)	¼ slice			✔	
		Ham lunch meat (Hormel)	½ ounce			✔	
		Mayonnaise	1 tsp			✔	
		White grape juice	1 ounce		✔	✔	
	6:30pm	Veggie Straws (Whole Foods 365)	5			✔	
		Diced pears (Del Monte)	1 plastic container			✔	
	7 pm	Similac Advance Formula	4 ounces	✔		✔	
	9 pm	Pediasure with fiber	8 ounces				✔

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OFFICE USE ONLY

Ht: _____ Wt: _____ Date: _____

Estimated Needs: _____ Calories

_____ Protein

_____ Fluid

_____ Eval _____ Individual _____ Group

Parent/ Guardian Name: _____ Daytime Phone #: _____

Child's Name: _____ Date of Birth: _____

Vitamin or Mineral Supplement: ____ NO ____ YES Name & Amount: _____

Formula Mixing: Number of scoops: _____

Amount of Water: _____

_____ I put water in the bottle first then the formula powder.

_____ I put the formula powder in the bottle first then the water.

_____ The formula is liquid in a can and I do not add anything.

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Date	Time	Food/ Drink Item	Amount	Bottle	Cup	Mouth	G-tube

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Child's Name:_____

Date	Time	Food/ Drink Item	Amount	Bottle	Cup	Mouth	G-tube

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Feeding & Swallowing Therapies

RELEASE OF INFORMATION REQUEST

Dear Parent:

Please sign and send one copy of this release form to your pediatrician, and any other therapist or health care provider treating your child. Please feel free to make as many copies of this form as you need. We need at least one form completed for your primary care physician and one for the professional who referred your child to us, so that we may share information regarding our assessment and treatment. Thank you.

Dear Health Care Professional:

The patient named below is going to be seen at ***Tubes 2 Table, Inc.*** for an evaluation and/or treatment. We would appreciate receiving a copy of your records regarding your client to assist in our comprehensive review and assessment. If the child is going to be seen for a feeding problem, we would especially appreciate a copy of the growth curve or any other relevant reports be included with your records. Below is a release to be signed by the child's guardian. If you have already sent this information as a part of your referral, please disregard this request. Please return a xerox copy of this request with your records and keep the original. Thank you.

Patient's Name: _____ **Date of Birth:** _____

Guardian's Name: _____ **Relationship:** _____

I HEARBY AUTHORIZE THE FOLLOWING HEALTH CARE PROFESSIONAL TO RELEASE COMPLETE INFORMATION FROM THE MEDICAL, SCHOOL, SOCIAL SERVICE AND/OR PSYCHOLOGICAL RECORD OF THE ABOVE NAMED CLIENT/PATIENT TO:

Tubes 2 Tables, Inc.
196 E Nine Mile Road Suite D
Pensacola, Florida 32534
Fax: 850-807-5499

I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that treatment, payment, or eligibility of benefits can not be conditioned on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Name of Health Care Professional: _____

Address: _____

Phone Number: _____

GUARDIAN/CLIENT SIGNATURE: _____ **DATE:** _____

WITNESSED BY: _____ **DATE**: _____

Feeding & Swallowing Therapies

Neina F. Ferguson, Ph.D., CCC-SLP
Owner/Speech-Language Pathologist
Feeding and Swallowing Specialist
Phone: (850) 972-Tube (8823)
Fax: (850) 807-5499
Email: Neina.ferguson@tubes2tables.com

PATIENT RIGHTS AND CONSENT TO EVALUATE/TREAT

As a part of any Evaluation or Treatment received at *Tubes 2 Tables, Inc.*, you and your child will be working with trained professionals. Each professional is ethically and legally responsible to keep all information gathered in the evaluation or treatment process confidential. Your permission is required to release any information to any other person, except in cases of imminent danger, neglect or abuse as is required by law. You have the right to seek a second opinion or to end the evaluation/treatment at any time. You are entitled to information about the methods and techniques used in the evaluation/treatment, an estimate of the duration of the therapy and the cost to you and your family. You may also ask any of the professionals for information about their training and credentials.

I VERIFY THAT I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED ME ABOUT MY RIGHTS AND THE EVALUATION OR THERAPY TO BE COMPLETED. I UNDERSTAND THAT **NO GUARANTEE CAN BE MADE TO ME REGARDING THE RESULTS OF THE EVALUATION AND/OR TREATMENT**, AND WILL NOT HOLD THE TUBES 2 TABLES, INC OR ANY INDIVIDUAL THERAPIST LIABLE FOR THESE RESULTS.

I FURTHER ACKNOWLEDGE THAT **TUBES 2 TABELS, INC.** WILL PROVIDE DOCUMENTATION NEEDED FOR ME TO SUBMIT TO INSURANCE FOR REIMBURSMENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING IN FULL FOR ALL SERVICES RENDERED AT THE TIME OF SERVICE. I ALSO UNDERSTAND THAT THIS BILLING PROCESS WILL INCLUDE PROVIDING INFORMATION REQUESTED BY THE AGENCY, INSURANCE COMPANY OR RESPONSIBLE PARTY TO PROPERLY PAY THE CLAIM TO ME.

Please note that we will assist in any reasonable way to facilitate payment being made by the responsible agency, insurance company or responsible party in a timely fashion.

I HEREBY CONSENT AND GIVE PERMISSION FOR EVALUATION/TREATMENT AT **TUBES 2 TABLES, INC.**

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____
(If patient is a minor)

Relationship to Patient: _____

Witnessed by: _____ Date: _____

Feeding & Swallowing Specialists

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AND/OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW ALL POINTS BELOW CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operations of the practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, assisting you to obtain approval/ payment for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval/ payment for the treatment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your treating provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Disease Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your Consent, Authorization or Opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician, provider, or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS – Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician/ provider is NOT required to agree to a restriction that you may request. If the physician/ provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. 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 alternatively (i.e. electronically).

You may have the right to have your physician/ provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you via mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying your provider of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before September 15, 2016.

196 E Nine Mile Road Suite D Pensacoal, Floirda 32634; Phone: 850 972 8823
Neina.ferguson@tubes2tables.com

Feeding & Swallowing Specialists

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT FORM

By signing this form, I acknowledge that I have received a copy of *Tubes 2 Tables, Inc.* Notice of Privacy Practices.

Client's name: _____ DOB: _____

Guardian's name: _____ (printed)

Relationship to patient: _____

Guardian's Signature: _____

Date: _____

If we are unable to speak with you directly by phone, is it okay for us to leave detailed/ clinical information on your answering machine, if available?

☐ YES ☐ NO

OFFICE USE

Witness: _____ Date: _____

Comments/Restrictions: _____

_____

_____

_____

_____

196 E Nine Mile Road Suite D Pensacola, Florida 32534
Phone: 850-384-0132 Fax: 850-807-5499

Feeding & Swallowing Specialists

Payment Policy: Self-Pay

Thank you for choosing **Tubes 2 Tables, Inc.** as your feeding and swallowing specialist. This is an agreement between **Tubes 2 Tables, Inc**. and you for payment of services provided. By signing this agreement, you are agreeing to pay for all services provided to you or your family member.

Please read the following information carefully.

Tubes 2 Tables, Inc. does not bill insurance for evaluations and treatment. We will provide you with the information you need to submit a bill to your insurance company.

If you plan to submit bills to your insurance company, you should:

- Check with your insurance company before your first visit to find out what speech and language services they will pay for.
- Find out what information the insurance company needs.
    - You may need a note from your doctor, called a referral. You may need permission from the insurance company, called pre-authorization.
    - Referrals and pre-authorizations do not guarantee that insurance will pay for services.

Payment Options:

- Payment is due at the time of service. We accept cash, checks, or major credit cards. An additional processing fee of 2.5% will be added to credit card payments.

Returned checks:

- You will be charged a $45.00 fee for each returned check.
- You will be asked to bring cash to the office to cover the amount of the returned check and the fee. Services will be suspended until your account is brought current.

_____
Patient's Name

I agree to the payment policies outlined above.

_____ _____
Patient or Parent/Guardian Signature Date

_____
Relationship to Patient

196 E Nine Mile Road Suite D Pensacola, Florida 32534
Phone: 850-972-8823 / Fax: 850-807-5499