tubes 2 tables
Feeding & Swallowing Therapies

196 E Nile Mile Rd. Ste D
Pensacola, FL 32534
Phone: (850) 972-Tube (8823)
Fax: (850) 807-5499
Email: admin@tubes2tables.com

SPEECH AND LANGUAGE QUESTIONAIRE

Identifying Information:
Child's Name: _____ Date of Birth: _____
Parent/Guardian Name: _____Relationship:_____

Primary speech and language concerns:
_____
_____
_____

Hearing:
Has your child's hearing been assessed? ☐ Yes ☐ No
Type of assessment: ☐ Screening ☐ Evaluation
If yes, where was the assessment completed? _____ Date completed? _____
Results indicated your child's hearing was: Within Normal Limits ☐ Impaired ☐
If impaired, explain: _____
_____
If no, do you have any concerns regarding your child's vision? _____
_____

Vision:
Has your child's vision been assessed? ☐ Yes ☐ No
If yes, where was the assessment completed? _____ Date completed? _____
Results indicated your child's vision was: Within Normal Limits ☐ Impaired ☐
If impaired, explain: _____
_____
If no, do you have any concerns regarding your child's vision? _____
_____

Speech and Language:
Primary language spoken in the home: _____
Are there other languages spoken in the home? If yes, please list _____

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Developmental History:

Please provide the approximate age at which your child acquired the following skills if applicable.

Activity	Age
Sit	
Crawl	
Roll Over	
Walk	
Feed self	
Dress Self	
Use Toilet	
First Word	

Check all that apply:
How does your child usually communicate (check all that apply)?
☐ gestures (body language) ☐ sign language ☐ single words
☐short phrases ☐ sentences other: _____

Does your child…..
☐repeat sounds, words or phrases?
☐appear to understand what you are saying?
☐retrieve/point to common objects when named?
☐follow simple directions (ex. “get the ball”)?
☐respond correctly to yes/no questions?
☐respond correctly to who/what/where/when/why questions?
Additional Information :_____
_____
_____

If verbal, approximately how much of your child’s speech do you understand?
☐ less than 10% ☐ 25%☐ 50%☐75%

Behavior Characteristics:

Does your child:

	Yes	No
Seem unusually quiet?		
Seem restless or fidgety?		
Get upset easily?		
Rock his/her body?		
Enjoy “messy” play?		
Bump or push others?		

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	Yes	No
Pinch, bite, or hurt oneself?		
Understand personal safety?		
Have difficulty with change?		
Become easily distracted?		
Enjoy the company of other children?		
Enjoy reading or listening to books?		

Additional Information :_____
_____
_____

What would you like to see in your child's development in the next 6 months?
_____
_____

What do you see as your child's strengths?
_____
_____

What does your child enjoy playing with or enjoy doing?
_____
_____

If there is anything else you would like us to know about your child, please report below.
_____
_____
_____
_____

Thank you for completing this questionnaire, we look forward to working with you and your child!

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

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