Easterseals Central Alabama • 2185 Normandie Drive, Montgomery, AL 36111
334-288-0240 • www.eastersealsca.org

Dear Parent:

Having a child who does not feed well is a worrisome, frustrating, confusing and at times, medically concerning problem. We, at SOS Food School at Easterseals Central Alabama, 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 all the possible contributing factors in a feeding problem through the use of a Multidisciplinary/Transdisciplinary Evaluation Team. Our Team is made up of one Occupational Therapist and one Speech Pathologist. 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.

In order to best help us prepare for your child's evaluation, we would like you to carefully read over the following information and to complete the enclosed forms. Please make sure that you have received and completed EACH of these forms

1. **Family and Medical History Form**
2. **Feeding History Form**
3. **3 Day Diet History**
4. **Sensory History**
5. **Release(s) of Information**
6. **Patient Rights/Consent to Treat Form**
7. **HIPPA Policy (2 forms)**
8. **Billing/Payment Policy**
9. **Financial Agreement**

Please complete the forms in as much detail and as readable as possible. Many items on the forms can be simply answered by checking YES or NO in the appropriate space. If you give a YES response, please explain this answer thoroughly in the space provided or on the back of the page. If you cannot, or wish to not answer a question, leave it blank. If a question does not apply to your child, you may write in NA for "not applicable".

Please return your completed forms by mailing them AT LEAST 1 WEEK in advance of your scheduled appointment date so our staff can review the paperwork. If your child gets sick or there is an emergency over the weekend and you are unable to attend your evaluation on Tuesday, please call us as soon as possible at 334-288-0240.

Our mailing address is:

Easterseals Central Alabama Food School

2185 Normadie Drive

Montgomery, AL 36111

Thank you for allowing us to serve you and your family.

Sincerely,

Mary Elizabeth Johns, MS, OTR/L and Hannah Tremlett, MS, CCC-SLP

DEMOGRAPHICS

Information About Your Child

Full Name: _____

Date of Birth: _____ Age: _____

School: _____ Grade Level: _____

Home Address: _____

City: _____ State: _____

Race: _____

Current Medications: _____

Allergies: _____

Diagnoses (Autism, Down Syndrome, Speech Delay, etc.):

_____

Parent/Guardian Information

Name	Relationship	Phone		Email
			_ H _ W _ C	
			_ H _ W _ C	
			_ H _ W _ C	

❑ **Check here if it's ok to call all parties listed above**

I have the legal right to give permission for therapy services because my relationship to the child is:

__ Birth Parent __ Adoptive Parent __ Legal Guardian __ DHS Caseworker

Emergency Contact

Name	Relationship	Phone

CONFIDENTIAL PERSONAL HISTORY: Children

Please answer as completely and accurately as possible.

Child's Physician or Health Care Providers (including Primary Care Physician):

Name: _____ Profession: _____
Phone: _____
Address: _____

Name: _____ Profession: _____
Phone: _____
Address: _____

Date of Child's Last Medical Checkup: _____ Height: _____ Weight: _____

Is your child in good health at the present time? _____

Are there any medical precautions the therapist should be aware of when working with your child?
_____

Family Members: Detailed Information

	Name	**Age**	**Sex** (circle one)	**Adopted** (circle one)	**Occupation**	**Education** (circle one)
Parent A			M F	Yes No		High school or GED AA BA/BS
Parent B			M F	Yes No		High school or GED AA BA/BS
Stepparent			M F	Yes No		High school or GED AA BA/BS
Stepparent			M F	Yes No		High school or GED AA BA/BS
Sibling			M F	Yes No		
Sibling			M F	Yes No		
Sibling			M F	Yes No		

Other persons living in this Child's household:

Name	**Age**	**Sex** (circle one)	**Relationship to Child**
		M F	
		M F	

Married Status of Parents:

Married Date: _____ Separated Date: _____

If both primary caregivers work, who cares for the child?

Name: _____ Phone #: _____

Address:_____

When is the child in this childcare? _____

What language(s) is/are spoken at home**?**_____

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

NO	**YES**	**EVENT**	**EXPLANATION**
		Marital Separations/Divorce	
		Death in the Family	
		Financial Crisis	
		Job Changes/Difficulties	
		School Problems	
		Legal Problems	
		Medical Problems	
		Household Move	
		Extended Separation from Parents	
		Other Stressful Events	

Family Annual Income:

<$50,000 $50,000-$100,000>$200,000 $100,000-$200,000

Family Adaptation:

How would you describe your child's general adjustment at home? (Circle) Poor/ Fair/ Good/ Excellent

How does your child get along with each member of the family?

Parent A: _____

_____

Parent B: _____

_____

Siblings: _____

Have there been any traumatic family events in the course of this child's development? Explain.

Have there been any specific events or traumas linked with the onset of your child's difficulties?

Have there been any major moves? (City to city, country to country)

PREGNANCY AND BIRTH HISTORY

(If this child is adopted, skip to Adoption Section of paperwork)

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

Pregnancy Number	Birth Weight	Any Delivery, Health, or Developmental Problems	Father's Name
1			
2			
3			
4			
5			
6			

PRENATAL HISTORY

Was the pregnancy for this child planned? YES/NO

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

Were any fertility treatments used for this pregnancy? _____

Was a sperm or egg donor used for this pregnancy? _____

In what month did you begin prenatal care? _____

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

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

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

What kind of experience was the pregnancy for both parents?

Parent A: _____
Parent B: _____

Did Mother talk and sing much throughout the pregnancy? _____
Was Mother physically active throughout the pregnancy? _____

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

NO	YES	DESCRIPTION	EXPLANATION/COMMENT
		Allergy/Asthma	
		Anemia	
		Diabetes/Blood Sugar Problems	
		Edema (swelling, water retention)	
		Excessive vomiting	
		Fatigue	
		Headaches/Migraines	
		Heart Disease	
		Kidney Disease	
		Pre-eclampsia	
		Rh-negative	
		Toxemia	
		Toxin exposure	
		Accidents	
		Bleeding/Spotting	
		Blood pressure issues	
		Blood transfusion	
		Cervical incompetence	
		Infections (bladder or genital)	
		Infections (Other)	
		Pre-term labor	
		Uterine or uterine fluid problems	
		Other physical injury	
		Shock	
		Severe stress	
		Loss of a loved one	
		Commitment to bed	
		Exposure to loud noises	
		Consumption of alcohol	
		Consumption of caffeine	
		Consumption of street drugs	
		Other non-specified problems	

BIRTH HISTORY

Please describe your/the mother's experience during labor and delivery:

_____

_____

Hospital where born, including city and state: _____

Delivery Physician's or midwives Name: _____

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

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

Any type of labor stimulation and what was used?_____

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

Pain Relief: _____

Anti-vomiting:_____

Anesthesia:_____ Sedation:_____

What type of delivery (please circle)?

Vaginal Cesarean Section: elective or emergency

Reason for C-section:_____

Presentation: Head Face Breech Transverse

Assistance: Forceps High Forceps Vacuum Suction or Other

Did the baby cry immediately? _____

How soon after the delivery did you see your baby?_____

Was there immediate physical contact between Mother and newborn at birth? _____

Was there positive bonding between Mother and newborn at birth?_____

What were the baby's APGAR scores? 1 minute_____5 minute__

What was the baby's Birth Weight?_____Lbs._____oz. Birth Length_____

Number of days spent in the nursery? _____ NICU or Newborn Nursery?_____

Were there any separations from Mother during the first days of life, please describe? _____

_____

Did Mother experience any post-partum depression? ___No_Yes

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

NO	YES	Description	Explanation
		Maternal infection	
		Low/high red/white blood cell count	
		Pelvis or cervical problems	
		Placenta problems	
		Dysfunctional labor	
		Cord wrapped around baby's neck	
		Cord problems (knots, prolapses, compression)	
		Baby have a very low/high heart rate	
		Baby have heart rate decelerations	
		Fetal distress was noted	
		Meconium was noted	

What was the condition of your infant <u>following birth</u>? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, how treated, etc.):

NO	YES	Description	Explanation
		Was blue/cyanotic at birth	
		Required stimulation to breathe	
		Required oxygen at birth	How much/What type?
		Required resuscitation	
		Was considered small for gestational age	
		Had tremoring or seizures	Which/For how long?
		Very low tone	
		Brain hemorrhage	
		Anemia and/or transfusions	Which/How many times?
		Jaundice (yellow)	How much/How treated?
		Had bruising	
		RH incompatibility problems	
		Infections	
		Congenital birth defects	
		Aspiration (meconium or fluid)	Which/How treated?
		Respiratory distress signs of syndrome	
		Needed ventilation	What type/how long?
		Choking or vomiting episodes	
		Tube feedings	
		Needed medications	

Adoption History

Please describe the circumstances surrounding the adoption:

At what age was the child adopted? _____

In what year did the adoption take place? _____

What was their physical appearance at the time of adoption? _____
_____

Was the child previously in a foster home?_____

What was the child's response to the new home? _____
_____

Has there been positive bonding and engagement between the child and adoptive parents? _____

Does the child accept physical contact (i.e. cuddling) from adoptive parents? _____

Is your child aware of his/her adoption? ___Yes ___No

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 questions answered "yes". In your explanation, please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

NO	YES	DESCRIPTION	EXPLANATION [WHEN & WHAT AGE(S)]
		Frequent colds/respiratory illness	
		Frequent strep throat/sore throat (Tonsils or adenoid problems?)	
		Frequent ear infections? (PE Tubes placed?)	None/A Couple/Many
		Birth defect/genetic disorder	
		Lung condition/respiratory disorder	
		Allergies or asthma	Environmental or Food?
		Heart Condition	
		Anemia/blood disorder	
		Kidney/renal disorder	

		Urinary problems/infections	
		Hormonal problem	
		Muscle disorder/muscle problem	
		Joint or bone problems	
		Fractured bones	
		Skin disorder/skin problems (eczema)	
		Visual disorder/vision problems	
		Eye infections	
		Neurological disorder	
		Seizures or convulsions (Epilepsy?)	
		Stomach disorder/stomach pain	
		Vomiting/digestion problems	
		Failure to gain weight/feeding problems	
		Constipation/diarrhea problems	
		Dehydration episodes	
		Hearing loss/ear disorder	
		Significant accidents/injury	
		Head injuries or concussions	
		Ingestion of toxins, poisons, foreign objects	
		Chronic medications (for what? When?)	
		Any major childhood illness (pox, croup, measles, mumps, meningitis, etc)	
		Major medical procedures (detail below)	

HOSPITALIZATIONS AND/OR SURGERIES:

Please 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 reason.

1. _____

2._____

3._____

4._____

Has your child been diagnosed with (PLEASE CHECK ALL THAT APPLY):

_____ADD
_____ADHD
_____Anxiety Disorder or Mood Disorder (specify): _____
_____Autism Spectrum Disorder
_____Cognitive Delay
_____Down Syndrome
_____Dyslexia
_____Emotional disorder (specify): _____
_____Fragile X Syndrome
_____Learning Disabilities (specify if possible): _____
_____Sensory Processing Disorder or Sensory Integration Dysfunction
_____Tourette's Syndrome
_____Other (specify): _____

Please note, who provided the diagnosis and based on what criteria i.e. test scores, comprehensive clinical evaluation, genetic study, etc.): _____

MEDICATIONS

List any medications your child has consistently used **in the past:**

Medication:_____Purpose:_____When Taken:_____

Medication:_____Purpose:_____When Taken:_____

Medication:_____Purpose:_____When Taken:_____

List any medications your child is **currently** taking:

Medication: _____Purpose:_____Frequency of dosage:_____

Medication:_____Purpose: _____Frequency of dosage:_____

Medication:_____Purpose: _____Frequency of dosage:_____

Please note any illnesses for which your child is currently being treated:_____
_____

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 of 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.

NO	YES	DESCRIPTION	MOTHER OR FATHER'S SIDE?	WHO (as related to your child)	EXPLANATION
		Birth defects/Congenital disorder	Mother's Father's		
		Neurological disorder or seizures (eg. Alzheimer's, Parkinson's)	Mother's Father's		
		Respiratory disease or tuberculosis (eg. Asthma, COPD)	Mother's Father's		
		Hormonal or Gland disorder (eg. Hypothyroidism, pituitary tumor)	Mother's Father's		
		Allergies- food or environmental (specify which type and for whom)	Mother's Father's		
		Diabetes (Type 1 or 2)	Mother's		
		Stomach disease/disorder/problems (eg. Reflux, Colitis, Chron's, Celiac)	Mother's Father's		
		Senses problems- vision, hearing, touch, taste, smell, balance	Mother's Father's		
		Swallowing or feeding problems (eg. Described as a picky eater as child esophageal strictures)	Mother's Father's		

NO	YES	DESCRIPTION	MOTHER OR FATHER'S SIDE?	WHO (as related to your child)	EXPLANATION
		Attentional/learning problems	Mother's Father's		
		Hyperactivity	Mother's Father's		
		Developmental therapy (eg. Speech therapy, Physical therapy)	Mother's Father's		
		Alcohol/drug problems	Mother's Father's		
		Psychological/nervous issues	Mother's Father's		

Developmental History

PERSONALITY PROFILE

What are your child's gifts/strengths?_____

What do you enjoy most about your child and family?_____

What kind of interest and activities does your child have (hobbies, sports, clubs)?
Please list them in order of preference beginning with the favorite activity.

EARLY HISTORY

Going back to the first two years of the child's life, what type of baby was he/she? (i.e. feeding, sleeping, activity level):_____

Please describe your child's toddler stage:_____

DEVELOPMENTAL MILESTONES

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**. Or, if you cannot 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 N/A in the age column. Please also check the column that best describes your opinion of the quality of your child's skills.

Age Achieved	Milestone	Early	On-time	Late	Skill Quality Good/Fair	Skill Quality 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 word phrases					
	Ate unaided (spoon/fork)					
	Dressed self					
	Chewed solid food					
	Drank from open cup					
	Rode bicycle without training wheels					
	Caught a thrown object					
	Demonstrated handedness (which hand)					
	Recognized colors					
	Counted to 5					
	Knew alphabet					
	Bladder trained- days					
	Bladder trained- nights					
	Bowel trained					

Was your child's crawling phase brief? _____No _____Yes

Please describe the position your child crawled in (i.e. four point, army crawl, scooted on bottom):_____

_____

Did your child use a walker (rolling plastic seat)? _____No _____Yes If yes, how often?_____

Did your child experience hesitancy or delays in learning to go down stairs? _____No_____Yes

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

_____

VISUAL DEVELOPMENT

Has your child experienced any problems with his/her eyesight or vision? _____

Are there any current problems of which you are aware? _____

When was the last time your child had their eyesight tested?_____

AUDITORY DEVELOPMENT

Has your child experienced any problems with his/her hearing? (i.e. operations, infections, tubes placed)

_____

How often and to what severity has your child had ear infections (please check all that apply)?

_____Seldom	____Mild
_____Sometimes	____Moderate
_____Often	____Severe

When was your child's hearing last tested? : _____

SPEECH AND LANGUAGE DEVELOPMENT

How would you describe your child's speech and language development?

_____Normal _____Delayed _____Advanced

Did your child begin speaking in single words, then two words, then a sentence?___No ___Yes

Did your child not talk for a long while, then all of a sudden speak in complete sentences?__No __Yes

Do you or others have difficulty understanding what your child says? ___No ____Yes

First word he/she said was_____at the age of_____.

Please describe any speech related problems:_____

_____

SENSORY AND MOTOR DEVELOPMENT

Please check all that apply:

_____My child seems to be overly sensitive to sensory experiences more so than most people:
_____Auditory ____Tactile____Visual _____Movement ___Taste ___Smell

_____My child doesn't seem to react to sensory experience as readily as most people:
_____Auditory ____Tactile____Visual _____Movement ___Taste ___Smell

_____My child actively seeks out sensory experiences more so than most people:
_____Auditory ____Tactile____Visual _____Movement ___Taste ___Smell

_____My child has difficulty differentiating sensory experiences. (e.g. confuses sounds, can't find objects in drawer or bag without looking, bumps into things) Please describe: _____

_____My child has trouble learning new movements.

_____My child tends to be clumsy and has balance and coordination problems.

Do any of the following behaviors describe your child currently or in the past? Please indicate by placing a checkmark in the "no" or "yes" column and if yes, please explain.

NO	YES	Description	Explanation
		Extended separations during first two years	
		Thumb sucking/pacifier	
		Sleeping problems	
		Colic or "fussy baby"	
		Were they able to self soothe?	
		Were they on a regular schedule?	
		Preferred certain positions as an infant	
		Disliked lying on back	
		Did they enjoy bouncing?	
		Were they calmed by car rides as an infant	
		Become nauseated by car rides as infant	
		Toe walker	
		Excessive drooling	
		Did they go through "terrible twos"	
		Temper tantrums	
		Head banging	
		Breath holding	

NO	YES	Description	Explanation
		Bedwetting	
		Nightmares	
		Nervous habits (i.e. nail biting)	
		Any unusual fears?	
		Major mood swings	
		Aggression/destructiveness	
		Fire play or cruelty to animals	
		Masturbation	

Previous Testing and Treatments

Has your child had any previous ASSESSMENTS or TREATMENTS? **Please attach any relevant reports.**

ASSESSMENTS

	NO	YES	DATE	PLACE
Medical				
Audiological				
Speech				
Educational				
Psychological				
Occupational Therapy				
Physical Therapy				
Feeding				

TREATMENTS

	NO	YES	START/END	PLACE	PROVIDER & CONTACT INFO
Medical					
Audiological					
Speech					
Educational					
Psychological					

Occupational Therapy					
Physical Therapy					
Feeding					

EDUCATION

In general, how would you describe your child's experience/learning at school from kindergarten to the present time?_____

Please give us more detailed information about any difficulties your child encountered in school beginning with the earliest experience:

Initial school adjustment

_____

Pre-school/Daycare

_____

Primary (K-3rd Grade)

_____

Junior (4th-6th Grade)

_____

Intermediate (7th-8th Grade)

_____

High School (9th-12th Grade)

_____

Name of current school: _____Grade: _____ Address: _____

_____ Phone: _____

Teacher: _____

Describe any concerns shared by the teacher: _____

_____

Has there been remedial help given **inside** the school system?_____No _____Yes

If yes, please describe: _____

_____

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, obtaining 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/before September 1, 2009.

Acknowledgment of Receipt of Privacy Practices & HIPAA Acknowledgment

I, _____have received a copy of Easterseals Central Alabama's Notice of Privacy Practices with an effective date of February 28, 2019.

I, _____ understand that all personal health information that I am privy to during my observation time at Easterseals Central Alabama is confidential according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Under the HIPAA federal law all individually identifiable health information (name, birth date, diagnosis, etc) and all health care records used or disclosed in any form, whether electronically, on paper, or orally, must be keep confidential. HIPAA provides penalties for covered entities that misuse protected personal health information.

If we are unable to speak with you directly by phone, is it okay for us to leave detailed/Clinical information on your voice mail, if available or e-mail?

Phone: ☐ Yes ☐ No
E-mail: ☐ Yes ☐ No

Are there any restrictions on releasing information: _____

Name of Client: _____

Address of Client: _____

Signature of Client/ Parent or Guardian: _____ **Date:** _____

PHI Policy

Authorization Form Policy

Effective date of policy: _____

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include:

Public health activities; information regarding victims of abuse, neglect, or domestic violence, health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.

Easterseals Central Alabama will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

You may revoke this authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Name of Client: _____

Signature of Parent/Guardian: _____ Date: _____

Expiration date of Authorization: _____

CONSENT AND PHOTO/VIDEO RELEASE

_____

Printed Name

I hereby grant consent, authority, and permission to Easterseals Central Alabama and to those acting with the authority of Easterseals Central Alabama, to use, reuse, publish, republish the name, statements or comments, likeliness, picture, photographic image, or videotape or electronic image of the adult or minor (under the age of 19) below, in whole or in part, or composited or distorted, without any restriction as to changes or alterations, without prior approval, in conjunction with the original or reproductions in color or otherwise in printed or electronic form, made through any medium or media, of or illustration, promotion, advertising, trade, or any other purpose whatsoever.

I understand and agree that I will not receive any compensation for the use consented to herein. I hereby release and discharge all persons acting under the consent granted above from all liability, cause of action or claim civil or criminal, by virtue of any distorted or use, intentional or otherwise that may occur or produced in the taking of subsequent processing or publication of my name, statements, comments, or the images covered herein.

I hereby warrant that I am of legal age and have the right to contract, consent, or grant the release prior to its execution and that I am fully familiar with the contents hereof. This consent and release shall be binding upon me, my heirs, legal representatives and assigns.

This release will be in effect for a period of time to not exceed five years.

☐ I do.

☐ I do not.

Signature: _____ Date: _____

Minor Name (if applicable): _____

Parent/Guardian: _____

Witness Signature: _____

CONSENT TO RELEASE OF CONFIDENTIAL INFORMATION
Dual Release

I, _____(Parent/Guardian if minor), do hereby authorize Easterseals Central Alabama to release and share any and all information pertinent to:

_____
(Client's name)
To the following provider and/or facility: _____

_____
(Name of provider/facility)

_____
_____ (Address of facility)

_____(Fax #/ Telephone #)

Dates of Service: _____

I hereby authorize Easterseals Central Alabama to share and obtain information regarding the evaluation and treatment of my child (named patient above) for the purposes of treatment, planning and coordination. I authorize the release of such information as the treating therapist deems relavant and pertinent to the professional listed below. I authorize the provider to release complete information from the medical school, social service and/ or psychological record of my child as relevant to their therapy sessions.

I do understand that this release and sharing of information will include, but not be limited to conversations, therapy sessions, records, reports, determinations, evaluations and factual information regarding myself and/or family member(s) who are minors. I understand that this action is taken to assist Easterseals Central Alabama in working with me and/or my family.

Please Check what records you are releasing to the above facility/Provider

☐ OT Eval and TX notes ☐Speech Eval and TX notes
☐ Feeding Eval

This authorization is voluntary and remains in effect until _____, unless specifically revoked by written notice to the agency or person. A photocopy of this release is as effective as the original.

_____ _____
Date Signature of Parent/Guardian

Financial Agreement

Payment for Services

Payment is due at the time service is rendered. We accept cash, checks and major credit cards. Returned checks will be subject to a $25.00 returned check fee.

Billable Services

While there is no ordinary charge for a brief telephone consultation, more lengthy or complex situations may result in charges. Some reports and consultations may also result in charges.

Insurance Coverage

Our services are not guaranteed to be covered by your insurance. We will submit your insurance claim electronically if possible to your Insurance Company.

If your Insurance Company denies a claim, we will attempt to assist. We will submit Appeal letters as appropriate if requested, and we will immediately correct any billing errors made on our part to assist you in the process of making sure your Insurance Company is paying their portion of the bill. However, you are ultimately responsible for payment.

I acknowledge that I have read and understand my responsibility to pay for services. By signing this agreement, I agree to the terms of this document.

_____ _____

Client/Parent/Guardian Signature Date

CANCELLATION / NO SHOW / TARDINESS POLICIES

Dear Parents,

Thank you for choosing **SOS Food School at Easterseals Central Alabama** for your child's care. The policies written below are designed to improve our ability to see all of our clients, and to provide complete, consistent treatment for your child. We hope that these policies will improve our overall service to our clients. Since continuity of care is important to maximize the outcomes of your child's therapy, we use the following guidelines for your appointments:

1. Therapists often are not able to wait more than 15 minutes for a late appointment. Please notify your therapist as soon as you know you will be late. Because of scheduling constraints, late arrivals may not be able to be seen, and if seen, **the session will end at the regularly scheduled time**.
   If you are late and your therapist needs to see your child for a shorter amount of time, you will be charged for the entire scheduled session.

2. If you need to cancel your child's appointment, our Easterseals Central Alabama requires that you cancel 24 hours in advance of the scheduled appointment time. **You will be charged $35.00**, except in emergency situations, if we have not received the 24-hour notification. Please note that this cancellation fee cannot be billed to your Insurance; it will need to be paid for by you.

3. If you have three consecutive cancellations of your child's appointments or you miss more than ½ of your scheduled appointments, your child will lose their slot in Food School and be discharged from feeding therapy.

4. If your child does not attend their scheduled appointment, and you have not called to give any type of notification that the session was going to be missed **prior to the start time of the session**, you will be considered to be a "No Show" for treatment. Additionally, you will be charged $35.00 for the scheduled therapy appointment which was missed. If you have two "No Shows" for scheduled Food School appointments, your child will be discharged from feeding therapy for poor attendance without exceptions.

5. Any client who is discharged from therapy due to poor attendance cannot be put on our waiting list for 1 year. You and your child's primary care physician will be notified by phone or letter of such circumstances.

Please feel free to speak with your therapist about any concerns you may have about these policies, or to discuss changing your regularly scheduled appointment time if you know that your current scheduled time is not optimal. We will do everything possible to provide you with a time that is consistently available for both you and your therapist. Thank you for your cooperation.

Patient's Name: _____

Parent/Guardian Signature: _____ Date: _____

CONSENT FOR PARTICIPATION IN TREATMENT AND EMERGENCY CARE

The consents on this page are mandatory prior to beginning therapy at Easterseals Central Alabama

Child's name: _____

Parent/Guardian's name: _____

CONSENT FOR PARTICIPATION WITH THERAPEUTIC EQUIPMENT

Intervention programs at Easterseals Central Alabama usually involve the use of specialized equipment such as suspended equipment and various swings, bolsters, inflated therapy balls and inner tubes, climbing structures, hanging bars and trapezes, scooter boards, tactile media (such as soap foam, playdoh, lotion and foods), and a variety of other activities that involve fine, gross and oral motor coordination. Therapy activities often involve encouraging the child to try new things in ways that are challenging in order to foster increased skills and abilities. While Easterseals Central Alabama staff make great efforts to ensure each child's safety, the nature of the therapeutic intervention includes the risk of falling, bumping into other people/equipment, pulling/straining muscles and/or gagging. I verify that I have seen the type of equipment that will be used in my child's therapy program that I am aware of the inherent risk of this type of activity and I give permission for my child to participate in therapy as described.

Signature of Parent/Guardian: _____ Date: _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In case of emergency and if I am not present and cannot be contacted at the telephone numbers on my child's parent information form, I understand that in the event of a medical emergency, Easterseals Central Alabama will call 911 or other appropriate medical personnel. If an ambulance must transport my child, I understand that it will take my child to the closest medical facility available. I give permission to the personnel of Easterseals Central Alabama to consent to any x-ray examination, anesthesia, medical or surgical treatment and/or other emergency medical care advised by a licensed physician or dentist and rendered under the provisions of the Medical or Dental Practice Act. I understand that Easterseals Central Alabama will not be liable for any first aid treatment, medical or hospital care, medications, or surgical procedures rendered pursuant to this consent.

Signature of Parent/Guardian: _____ Date: _____

PATIENT RIGHTS AND CONSENT TO EVALUATE/TREAT

As a part of any Evaluation or Treatment received at Easterseals Central Alabama, you and your child will be working with at least one, and possibly up to 6 trained professionals from a number of different disciplines. Because we believe children are best served through the use of a multi-disciplinary approach, professional consultation within the Team members may occur requiring information be shared about your child. 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. In any professional relationship, sexual intimacy is not appropriate and should be reported to a Professional Grievance Board. There are state regulatory agencies which govern the practice of licensed and unlicensed therapists in the State of Alabama. You have the right to contact these agencies or the appropriate Grievance Board if you have questions or complaints about the services you receive.

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 EASTERSEALS CENTRAL ALABAMA LIABLE FOR THESE RESULTS.

I FURTHER ACKNOWLEDGE THAT EASTERSEALS CENTRAL ALABAMA WILL CHARGE THE APPROPRIATE AGENCY, INSURANCE COMPANY OR RESPONSIBLE PARTY FOR THE SERVICES RENDERED FOR ME, BUT 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 EASTERSEALS CENTRAL ALABAMA

Patient's Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(If patient is a minor)

Relationship to Patient: _____

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 Easterseals Central Alabama with the rest of your forms.

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, orange, 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 + tbsp. margarine). Be sure to include any 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
1/1/20	4 pm	Gerber apple sauce	1 oz.			X	
		White bread (Wonder)	¼ slice			X	
		Ham lunch meat (Hormel)	½ oz.			X	
		Mayonnaise	1 tsp.			X	
		White grape juice	1 oz.		X	X	
	6:30 PM	Veggie straws (Whole foods 365)	5			X	
	7:00 pm	Similac Advance Formula	4 oz.	X		X	
	9:00 pm	Pediasure with fiber	8 oz.				X

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

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

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PEDIATRIC FEEDING HISTORY FORM

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

1. Please explain, is 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:

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?)

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):

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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

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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Sensory History

For each question, place a check in the column that best describes your child. (Please compare with other children you know of the same age.)

QUESTIONS		Often	Sometimes	Rarely
	Does your child:			
TACTILE SENSATION	1. Object to being touched?	1		
	2. Seem irritable when held?	2		
	3. Isolate self from other children?	3		
	4. Avoid/dislike getting hands messy?	4		
	5. Become upset when face is being washed?	5		
	6. Become upset when having hair combed, fingernails clipped or teeth brushed?	6		
	7. Prefer long sleeve clothing, sweaters or jackets even when it's warm?	7		
	8. Seem sensitive to certain fabrics and avoid wearing clothes made of them?	8		
	9. Have trouble changing to new types of clothing when seasons change? (i.e. From long pants to shorts)	9		
	10. Avoid going barefoot? (i.e. In sand or grass)	10		
	11. Become irritated by tags on clothing?	11		
	12. Seem to crave being held or cuddled?	12		
	13. Express discomfort when touched by other people, even as in a friendly hug or pat?	13		
	14. Tend to bump or push others?	14		
	15. Seem overly sensitive to pain? (i.e. Especially bothered by small cuts)	15		
	16. Seem less sensitive to pain than others? (i.e. To falls and bruises)	16		
	17. Mouth objects or clothing often?	17		
	18. Have difficulty judging how much strength to use? (i.e. when petting animals may use too much force)	18		
	Does your child:			
AUDITORY SENSATION	19. Seem overly sensitive to sound?	19		
	20. Seem confused about the direction of sounds?	20		
	21. Like to make loud noises?	21		
	22. Become distracted or have trouble if there is a lot of noises around?	22		
	23. Respond negatively to unexpected or loud noises?	23		
	Does your child:			
GUSTATORY SENSATION	24. Act as though all food tastes the same?	24		
	25. Explore by tasting?	25		
	26. Dislike foods of a certain texture?	26		
	27. Chew or lick non-food items?	27		
	Does your child:			
OLFACTORY SENSATION	28. Explore objects by smelling them?	28		
	29. Discriminate odors?	29		
	30. React defensively to smell?	30		
	31. Seem bothered by smells that most other people don't notice?	31		

QUESTIONS		Often	Sometimes	Rarely
	Does your child:			
VISUAL SENSATION	32. Become easily distracted by visual stimulation?	32		
	33. Express discomfort at bright lights?	33		
	34. Avoid or have difficulty with eye contact?	34		
	35. Have a hard time picking out a single object from many? (i.e. Finding a specific toy in the toy box)	35		
	36. Have difficulty with a camera flash, seems irritated by it?	36		
	Does your child:			
VESTIBULAR SENSATION	37. Chew or lick non-food items?	37		
	38. Seem fearful in space (i.e. Going up & down stairs, riding a tricycle?)	38		
	39. Appear clumsy, often bumping into things &/or falling down?	39		
	40. Prefer fast-moving, spinning carnival rides?	40		
	41. Have poor balance?	41		
	42. Become anxious or distressed when his/her feet leave the ground?	42		
	43. Avoid climbing or jumping?	43		
	44. Dislike elevators or escalators?	44		
	45. Dislike riding in a car?	45		
	46. Dislike activities where head is upside down or when lifted overhead? (such as with hair washing or somersaults)	46		
	47. Loved to be tipped upside down or lifted overhead?	47		
	48. Seek out all kinds of movement activities?	48		
	49. Jump a lot on beds or other surfaces?	49		
	50. Like to spin him/herself?	50		
	51. Bang his/her head on purpose?	51		
	52. Throw him/herself against the floor, wall or other people for enjoyment? (likes to "crash")	52		
	53. Take unusual risks during play?	53		
	Does your child:			
COORDINATION	54. Manipulate small objects easily?	54		
	55. Seem accident prone (i.e. Have frequent scrapes and bruises)?	55		
	56. Neglect one side of the body or seem unaware of it?	56		
	57. Use one hand more than the other?	57		
	Does your child:			
FEEDING	58. Need assistance to feed him/herself?	58		
	59. Tend to eat in a sloppy manner?	59		
	60. Frequently spill liquids?	60		
	61. Drool?	61		
	62. Have trouble chewing?	62		
	63. Have trouble swallowing?	63		
	64. Have difficulty eating foods with lumps?	64		
	65. Stuff or put too much food in his/her mouth?	65		

**Adapted from Pat Wilbarger, OTR, Special Education Workshop. St. Paul Public Schools, St. Paul, Minnesota, August 1973.*
Sensorimotor Integration for Developmentally Disabled Children: A Handbook Montgomery, P., Richter.

Easterseals Central Alabama

Feeding Evaluation

What to Bring:

Our team asks that you come into the clinic and re-create a meal to be as close to a meal your child will eat at home. This means bringing in any preferred cups, bowls, plates, spoons, forks, bottles, etc. You do not need to bring in a chair unless your child uses a special chair for feeding. We also ask that you bring the following items on the day of the evaluation:

- At least 2 different foods of different textures that you are sure that your child will eat. This is so we can see your child at their best and can evaluate what his/her skills are with foods they prefer.

- At least 2 different foods of different textures that you are sure your child will **not** eat. This is so we can see how your child reacts when they are challenged with foods that are difficult for them.

- A preferred drink and the cup/bottle your child typically uses.