# Infant Intake Form

## 1. Demographic Information

**Gender:** ☐Male ☐Female

**Client's Name:**_____ **Birth Date:**____/____/____

**First** **Last** **MI** **Month** **Day** **Year**

Home Address:_____ Daycare:_____

Primary Caregiver's Name: _____ Relationship to client:_____

Phone Number:_____ Email Address: _____

**Are text messages OK at this #: ☐Yes ☐No**

Secondary Caregiver's Name: _____ Relationship to client:_____

Phone Number:_____ Email Address: _____

**Are text messages OK at this #: ☐Yes ☐No**

Client's Pediatrician Name: _____ Pediatrician's Phone: _____

Primary Insurance: _____ Policy Number: _____

Primary Language: _____ Secondary Language: _____

**Who does the client live with?**

- ☐ Mother
- ☐ Father
- ☐ Grandparent(s)
- ☐ Older Sibling(s)
- ☐ Younger Sibling(s)
- ☐ Twin Sibling(s)
- ☐ Aunt/Uncle(s)
- ☐ Other:

**Does the client attend daycare?**

☐No ☐Yes If yes, where do they attend? _____ Class:_____

Days/Hours they attend:_____

**Has the client been to his/her pediatrician?**

☐Yes ☐ No. When is the appointment scheduled?_____

**Has the client been seen by any specialist, doctor, or therapist for feeding concerns?**

☐No ☐Yes. If yes, please specify: _____

## 2. Prenatal History

**Were there any prenatal complications?**

- ☐ Polyhydramnios (high amniotic fluid)
- ☐ Oligohydramnios (low amniotic fluid)
- ☐ Cervical Cerclage
- ☐ Atypical positioning
- ☐ Breech position
- ☐ HELLP syndrome
- ☐ Preeclampsia
- ☐ Controlled substance/alcohol abuse
- ☐ Intrauterine growth restriction
- ☐ Large for gestational age
- ☐ Small for gestational age
- ☐ Gastroschisis
- ☐ Gestational diabetes
- ☐ Multiples: _____
- ☐ Other: _____
- ☐ Unknown

**Did the client's mother receive prenatal care?**

☐Yes ☐No. Reason: _____ ☐Unknown

**Was the client's mother placed on bed rest?**

☐No ☐Yes. Please specify: _____ ☐Unknown

**Did the client move positions frequently in-utero?**

☐No ☐Yes. Please specify: _____ ☐Unknown

## 3. Birth History

**How many weeks gestation was the client born?**_____weeks ☐Unknown

**What was the client's birth weight?** _____,_____ ☐Unknown
**Pounds** **Ounces**

**How was the client delivered?** ☐ Vaginal Delivery ☐Cesarean Section ☐Unknown

**Were there any birth complications?**

- ☐ Assisted delivery
- ☐ Jaundice
- ☐ Intubation
- ☐ Prolonged labor
- ☐ Low APGAR score
- ☐ Hypoxia
- ☐ Nuchal Cord
- ☐ Other: _____

**Did the mother experience any complications during or after birth?**

- ☐ Hemorrhaging
- ☐ Low blood pressure
- ☐ Infection
- ☐ Preeclampsia
- ☐ High blood pressure
- ☐ Other: _____

## 4. Postnatal History

**Did the client spend any time in the NICU?**

☐No ☐Yes. Please specify: _____ ☐Unknown

**Did the client receive any treatments after birth?**

☐No ☐Yes. Please specify: _____ ☐Unknown

**Did the client experience any of the following after birth?**

- ☐ Fracture
- ☐ RSV
- ☐ Infection
- ☐ Difficulty breathing
- ☐ Low glucose levels
- ☐ Other: _____

## 5. Medical History

**Has the client ever been diagnosed with a medical condition, syndrome, or disorder?**

☐No ☐Yes. Please specify: _____ ☐Unknown

**Has the client ever been diagnosed with tongue, lip or cheek ties?**

☐No ☐Yes. Please specify type and if released: _____

**Does the client have any allergies (specifically to food or latex)?**

☐No ☐Yes. Please specify: _____ ☐Unknown

**Is the client up-to-date on their vaccines?**

☐No ☐Yes ☐Unknown

**Is the client currently taking any medications?**

☐No ☐Yes. Please specify the type(s) and what it is taken for: _____

_____

**Did the client pass the newborn hearing screening?**

☐Yes ☐No. When is follow-up test? _____☐Unknown

**Does the client have reflux?**

☐No ☐Yes. Please specify how it is currently being treated: _____

**Does the client currently have any of the following?**

- ☐ Ear infection
- ☐ Nausea/vomiting
- ☐ Recent surgery
- ☐ Staph infection
- ☐ Hemophilia
- ☐ Swollen joints
- ☐ Diarrhea
- ☐ Malignant cysts
- ☐ Tracheostomy
- ☐ Jaundice
- ☐ Torticollis
- ☐ Plagiocephaly
- ☐ Reflux
- ☐ Distention of abdomen
- ☐ Caput succedaneum

## 6. Developmental History

**Does the client have any delays with the following skills?**

- ☐ Turning head to both sides
- ☐ Rolling
- ☐ Pushing up on all fours
- ☐ Cooing
- ☐ Grabbing toys
- ☐ Holding bottle/breast
- ☐ Mouthing toys/objects
- ☐ Babbling
- ☐ Lifting head while on tummy
- ☐ Smiling at people
- ☐ Looking at someone speaking
- ☐ Other: _____

**How often does the client spend time on their tummy?**

- ☐ None
- ☐ Several hours per day
- ☐ Every few days
- ☐ A few minutes per day
- ☐ Always when awake
- ☐ Unknown
- ☐ A few hours per day
- ☐ Sleeps on tummy
- ☐ Other: _____

**Where the client sleep?**

- ☐ Crib/Bassinet in own room
- ☐ Co-sleeper on parent's bed
- ☐ Swing or MamaRoo
- ☐ Car seat
- ☐ Crib/bassinet in parent's room
- ☐ Co-sleep with parent in bed
- ☐ SNOO
- ☐ Other: _____

**Is the client colicky or difficult to console?**

☐No ☐Yes. Please specify: _____

## 7. Feeding History

**How was the client first fed?**

- ☐ Breastfed
- ☐ Bottle fed
- ☐ NG tube fed
- ☐ Syringe fed
- ☐ Cup fed
- ☐ Other: _____

**Was breastfeeding attempted after birth?**

☐No ☐Yes. Please specify: _____ ☐Unknown

**How is the client currently fed? (check all that apply)**

- ☐ Breastfed
- ☐ Bottle fed
- ☐ Tube fed. Type: _____
- ☐ Syringe fed
- ☐ Cup fed
- ☐ Other: _____

**What is the client currently experiencing with feeding?**

- ☐ Coughing/choking when feeding
- ☐ Difficulty latching to the breast
- ☐ Difficulty removing milk from the breast
- ☐ Difficulty accepting breast (prefers bottle)
- ☐ Difficulty latching to bottle
- ☐ Difficulty removing milk from the bottle
- ☐ Difficulty accepting bottle (prefers breast)
- ☐ Maternal pain during breastfeeding
- ☐ Risk of aspiration
- ☐ Unable to accept feedings by mouth
- ☐ Vomiting during/after feeding
- ☐ Reflux symptoms
- ☐ Difficulty coordinating suck-swallow-breathe
- ☐ Aversive to feedings
- ☐ Crying before/during feeding
- ☐ Other: _____

**What is the average amount of times the client is fed per day?**

☐ On demand ☐ 4-6 times ☐ 7-9 times
☐ 10-12 times ☐ 9-12 times ☐ Other: _____

**What is the average length of time per feeding?**

☐ 5-10 minutes ☐ 10-15 minutes ☐ 15-20 minutes
☐ 20-30 minutes ☐ 30-45 minutes ☐ Other: _____

**What is the average amount the client consumes during each feeding?**

☐ Less than 1 ounce ☐ 1-2 ounces ☐ 3-4 ounces
☐ 5-6 ounces ☐ More than 6 ounces ☐ Other: _____

**Has the client ever received a swallow study?**

☐ No ☐Yes. Please specify results: _____

**Does the client use a pacifier?**

☐ No ☐Yes. Please specify type: _____

**About how many wet diapers does the client have in 24 hours?**

☐ 6 or more ☐ 4-6 ☐ 2-4
☐ 0-2 ☐ Iconsistent ☐ Other: _____

**About how many stooled diapers does the client have in 24 hours?**

☐ 3 or more ☐ 2 ☐ 1
☐ Less than 1 ☐ Inconsistent ☐ Other: _____

**What does the client's stool typically look like?**

☐ Yellow curds ☐ Green/brown slimy ☐ Tar Black
☐ Bloody/Dark ☐ Inconsistent ☐ Other: _____

**Please write below anything else you would like to share with us about the client:**

Thank you for taking the time to fill out this intake form. All personal information collected by Sunny Speech Inc. (DBA Sunny Pediatric Services) for the purposes of providing services, assessing client needs and referring to services. Contact the (850) 909-5521 or office@sunnyspeech.com if you have questions about the use of your personal information.

**www.SunnyPediatricServices.com**
office@sunnyspeech.com
Office Phone: (850) 909-5521  Fax: (850) 391-4178

# Sunny Pediatric Services Insurance Agreement

Client Name: _____ Date: _____

Primary Insurer: _____ Policy #: _____

Secondary Insurer: _____ Policy #: _____

I give consent for Sunny Speech Inc. (DBA Sunny Pediatric Services) to bill Medicaid / Private Insurance for covered services for my child's evaluation and therapy sessions. My signature also authorizes Sunny Speech Inc. to release health records and educational services to Medicaid / Private Insurance as necessary for eligibility verification, billing and auditing. I agree to pay all amounts that are *not* covered by my insurer(s) and for which I am responsible under state and federal law. I understand that these amounts my include, but are not limited to co-payments, deductibles and amounts denied by Medicaid / Private Insurance. It is understood that the above explanation of benefits is not a guarantee of payment as it remains subject to benefit limits, exclusions and eligibility.

Sunny Speech Inc. will bill Medicaid / Private Insurance for evaluation and therapy services rendered. However, if your child has any changes in coverage including:

- Change in Medicaid provider
- Loss of Medicaid coverage
- New private insurance policy
- Change in private insurance policy
- Loss of private insurance
- Other changes in insurance overage

Please contact Sunny Speech Inc. immediately at (850) 909-5521. If we are not informed of these changes, it may be impossible for us to bill your insurance or Medicaid carrier and you may be held responsible to pay our private rate fees.

Private Pay Rates:

| | | |
|---|---|---|
| Initial Evaluation $200 | Re-Evaluation $100 | Travel Fee $10 per 15 min of travel |
| 30-Min. Therapy Session $50 | 45-Min. Therapy Session $75 | 60-Min.Therapy Session $100 |

Print Name: _____ Relationship to Client: _____

Signature: _____ Date: _____

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# Cancellation/No-Show Policy

Regular attendance is imperative for our services to be effective and beneficial for our clients. For goals to be accomplished, presence and engagement in therapy is necessary. Our therapists make every effort to accommodate client's schedules when making appointments. Irregular attendance costs both the therapist and the company time and money. It is therefore the responsibility of the parent/guardian of the client to attend all appointments. Please communicate with your therapist to create a realistic scheduling system that will be effective for you and your family. If you find a cancellation or rescheduling necessary, please contact your child's therapist directly as soon as possible.

**Cancellation Policy:**

We request that if you must cancel your appointment, that you give your therapist 24 hours' notice to allow for rescheduling of sessions. If you contact your therapist within 24 hours from the scheduled appointment time it is considered a cancellation. We understand circumstances arise, however, communicating with your therapist as soon as possible is extremely important. After the first cancellation, the therapist will contact you to reschedule. If **3 appointments** are cancelled within 24 hours notice, the therapist reserves the right to remove the client from her schedule. The 3 appointments cancelled also include "No-Shows" (see below for further explanation of a "No-Show"). This means that the client will no longer receive services from Sunny Pediatric Services.

**No-Show Policy:**

If you do not call to cancel at least 2 hours prior to your scheduled appointment or if the therapist arrives to the client's home/daycare and the client is not present, it is considered a "No-Show"

- After the first No-Show, the therapist will call/text to reschedule and our office manager will contact you to remind you of our policy
- After **2 No-Shows**, therapy will be discontinued and the client will no longer be able to receive therapy services with Sunny Speech Inc.
- If the client is more than 10 minutes late to the scheduled therapy session, it is considered a No-Show as well

If you are going on vacation or will be out for an extended period of time, please let your therapist know more than 48 hours from your scheduled appointment time. If you will be out more than 2 weeks, your scheduled therapy times are subject to change according to the therapist's availability.

I acknowledge the receipt of this cancellation policy:

Parent/Guardian Signature: _____ Date: _____

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office@sunnyspeech.com

# NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices is given to you as a requirement of the Health Insurance Portability and Accountability Act (HIPPA). This notice communicates to you how we may use or disclose your protected health information (PHI), with whom we may share the information with, and about the safeguards we have in place to protect it. It also explains your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our practice except when the release is required or authorized by law or regulation. Our policy has always been to keep the patient's records safe. Records are stored in a computer or secured data software. Records can also be kept by your child's therapists in a folder of papers with the patient's name and identification number on it. Records tell what treatments and tests a patient has had and medical information the doctors have provided. Files are kept for at least 6 years from the date of termination of services.
ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE: You will be asked to provide a signed acknowledgment of receipt of this notice on the patient form. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of therapy services will in no way be conditioned upon our signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment and health care operations when necessary.
OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION: "Protected health information" (PHI) is individually identifiable health information. This information includes demographics (for example, age, address), and relates to your past, present, or future physical or mental health or condition and related health care services. Our practice is required by law to do the following: • Keep your PHI private • Give you this notice of our legal duties and privacy practices related to the use and disclosure of PHI • Follow the terms of the notice currently in effect • Communicate to you any changes we may make in the notice.
HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION: Following are examples of permitted uses and disclosures of your PHI. These examples are not exhaustive.
1. Treatment- We will use and disclose your PHI to provide, coordinate, or manage your therapy and/or related services. This includes the coordination or management of your treatment with a third party. For example, we may disclose your PHI from time-to-time to another physician (for example, your ordering physician, pediatric dentist, neurologist) who becomes involved in your care for diagnosis or treatment.
2. Payment- Your PHI will be used, as needed, to obtain payment for therapy services provided. This may include certain activities we may need to undertake before your health care insurer approves or pays for the therapy services recommended for you, such as determining eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for speech therapy might require that your relevant PHI to be disclosed to obtain approval of therapy.
3. Practice Operations- We may use or disclose, as needed, your PHI to support our daily activities related to therapy services. These activities include, but are not limited to billing, collections, oversight or staff performance reviews, licensing, communications about a product or service, and conducting or arranging for other health care related activities. For example, we may disclose your PHI to a billing agency in order to prepare claims for reimbursement for the services we provide to you. We may disclose your PHI to college level students, that see patients for training/educational purposes. We may call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment via phone, email, or mail. These business associates at our practice will also be required to protect your health information.
4. Required by Law- We may use or disclose your PHI if law or regulation requires the use or disclosure.
5. Public Health- We may disclose your PHI to a public health authority that is permitted by law to collect or receive the information. For example, disclosure may be necessary to report child abuse or neglect •
6. Legal Proceedings- We may disclose PHI during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.
USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSION: In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your PHI. These circumstances will require you to give consent on our authorization for release of information form. Following are examples in which your agreement or objection is required. A member of your family that brings your child to therapy, a teacher or therapist and the child's school, or a relative, a close friend, or any other person you identify that has involvement in your child's therapy, or to someone who helps pay for the services provided. You can notify us of your agreement via text, verbal communication, written communication (email).
YOUR RIGHT REGARDING YOU PROTECTED HEALTH INFORMATION: You may exercise the following rights by submitting a written request to our office manager.
Right to Request Restrictions- You may ask us not to use or disclose any part of your PHI for treatment, payment or health care operations. In your request, you must tell us (1) what information you want restricted; (2) whether you want to restrict our use or disclosure, or both; (3) to whom you want the restriction to apply; and (4) an expiration date. If we believe that the restriction is not in the best interest of either party, or that we cannot reasonably accommodate the request, we are not required to agree to your request. If the restriction is mutually agreed upon, we will not use or disclose your PHI in violation of that restriction. You may revoke a previously agreed upon restriction, at any time, in writing.
Right to Request Confidential Communications- You may request that we communicate with you using alternative means or at an alternative location not originally indicated on the initial patient forms. We will accommodate reasonable requests, when possible.
Right to Request Amendment- If you believe that the information, we have about you is incorrect or incomplete, you may request an amendment to your PHI as long as we maintain this information.
Right to Obtain a Copy of this Notice -You may obtain a paper copy of this notice from us by requesting one or view it or download it electronically at our web site.
Complaints- If you believe these privacy rights have been violated, you may file a written complaint with our Office Manager. No retaliation will occur against you for filing a complaint.
You may request by written notice an accounting of the disclosures we have made of the patient's PHI. The disclosure must have been made after July 1, 2021, and no more than 6 years prior to the date of request.
RIGHTS TO CHANGE TERMS OF THIS NOTICE
We reserve the right to modify and change the terms in this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. You may request and receive a copy of this Notice of Privacy Practices in writing or by accessing our web site at www.sunnyspeech.com.

By signing below, I agree that I have received a copy of the Privacy Policy

_____ _____

Signature of parent/guardian Date

_____ _____

Printed name of parent/guardian Name of client

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# AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Child's Name: _____  Child's Date of Birth: _____

I, _____, authorize the Sunny Speech Inc. to:
(printed name of parent/caregiver)

Please place your initials in the blank in order to give consent to any statement that may apply to your child.

_____ release records to, obtain records from and exchange information with **any and all** healthcare professionals whom my child is currently or has previously been seen by

_____ release records to, obtain records from and exchange information with **only specific** healthcare professionals whom my child is currently or has previously been seen by (indicated below)

Name: _____ Phone Number:_____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

_____ exchange information pertaining to the care and progress my child with any person/s listed below:

Name:_____ Phone number:_____

Name:_____ Phone number: _____

Name:_____ Phone number: _____

_____ communicate information regarding my child and their care through the following:

____ text messages  ____ email

____ phone call  ____ message left on voicemail

____ all of the above

In order to best serve your child in evaluation/assessment and coordinating treatment, we ask for your permission to exchange information with your child's current and/or previous healthcare providers. Our notice of privacy practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our patient consent form. On occasion, the patient and the practice may want to use (PHI) for the reason other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and the Health Information Technology for Economic and Clinical Health Act of 2009 among other laws. The below mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules. We assume no liability for disclosure by the receiving party.

_____  _____
Signature of parent/guardian  Date

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# Consent for Clinical Student Diagnostic and Treatment Services

_____ _____
Client name  Date of Birth

As part of the training of future professionals, clinical speech-language pathology students are required to complete practicum hours under the direct supervision of a certified speech-language pathologist.

____ I **authorize** observation, evaluation and/or treatment services to be conducted by clinical practicum students under the direct supervision of a certified speech-language pathologist.

____ I **decline** observation, evaluation and/or treatment services to be conducted by clinical practicum students under the direct supervision of a certified speech-language pathologist.

By signing, I understand that services provided by clinical practicum students are for training purposes and that the certified speech-language pathologist is responsible for all services provided.

_____ _____
Signature of parent/guardian  Date

_____
Printed name of parent/guardian