Infant History Form

Background Information

Baby's Name: _____	Date of Birth: _____ Current age: _____
Baby's Address: _____	Baby's Gender: _____
Parent/Caregiver Name: _____	Parent/Caregiver Phone Number: _____
Baby's Primary Care Doctor: _____	Baby's Primary Care Doctor Phone Number: _____

Who does your baby live with? (please check all the apply)

___Mother	___Father	___Grandparent	___Twin Sibling	___Older Siblings	___Younger Siblings	___ Other: _____

Has your child been to his/her primary care doctor?

___ Yes	___ No. Please specify why not: _____

Have you seen any specialist, doctor or therapist for your baby's feeding difficulties?

___ No	___ Yes. Please specify: _____

Where does your baby sleep?

___ Crib/bassinet in baby's room	___ Crib/bassinet in parent's room	___ Co-sleeper on parent's bed
___ Parent's bed	____ Other. Please specify: _____	

In what position does your baby sleep?

___ On his/her back	___ On his/her tummy	___ Other: _____

Do you have your baby on a schedule and/or routine?

___ No	___ Yes. Please specify: _____ _____

Is your baby colicky and/or hard to console?

___ No	___ Yes. Please specify: _____

Does anyone in your baby's household smoke?

___ No	___ Yes. Please specify who and where it's done: _____

How often does your baby get tummy time?

___1 time per day	____ 2-3 times per day	___ 3-4 times per day	___ None

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Baby's Birth & Medical History

Is this your biological baby?

__ Yes	____ No. Age at adoption/foster: _____

How many weeks gestation was your baby born? _____ Weeks

What was your baby's birth weight? _____ lbs, _____ oz

How was your baby delivered? (please check all that apply)

___Natural Delivery without Epidural	____ Natural Delivery with Epidural	___ Cesarean Section	___ Assisted delivery (forceps or vacuum)

Were there any birth complications? (please check all the apply)

___ Jaundice	___ Intubation	___ Infection	___ Hypoxia	___ Preeclampsia
___ Other: _____				

Did your baby spend time in the NICU?

___ No	___ Yes. Length of stay: _____ Treatments received: _____

Did you (or the birth mother of your child) have any complications during the birth of your baby? (please check all the apply)

____ Hemorrhaging	___ Low blood pressure	___ High blood pressure	___ Preeclampsia
____ HELLP Syndrome	____ Other. Please specify: _____		

Did your baby have any problems after birth? (please check all that apply)

___Torticollis	____ RSV	___ Difficulty latching	___ Other: _____

What was your baby's length of stay in the hospital/birthing center after birth?

___1 day	____ 2-3 days	___ 3-4 days	___ Other: _____

Has your baby ever been diagnosed with a medical condition, syndrome or disorder?

___ No	___ Yes. Please specify: _____

Does your baby currently have any of the following? (please check all that apply)

____ Acute infection	____ Nausea/vomiting	____ Staph infection	____ Tuberculosis
____ Hemophilia	____ High blood pressure	____ Fractures	____ Inflammation

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____ Diarrhea	____ Contagious skin disorder	____ Tracheostomy	____ Abdominal lump
____ Swollen joints	____ Distention of abdomen	____ Seizure disorder	____ Fever
____ Malignant cyst	____ Blood sugar disorder	____ Jaundice	____ Recent surgery
____ Vericose Veins	____ Broken or Dislocated bones	____ Feeding tube	____ Hydrocephalus

Has your baby ever been diagnosed with tongue, lip or cheek ties?

___ No	___ Yes. Please specify type: _____ How it was revised: ___ scissors ____ laser ____ surgically

Does your baby have any known allergies (latex, medications, etc.)?

___ No	___ Yes. Please specify: _____

Does your baby have reflux?

___ No	___ Yes. Please time of day: _____

Is your baby up-to-date on his/her vaccinations?

___ Yes	___ No

Is your baby currently taking any medications?

___ No	___ Yes. Please specify type(s) of medication and what it is taken for: _____ _____ _____

Did your baby pass his/her newborn hearing screening?

___ Yes	___ No

Does your baby have a history of ear infections?

_____ No	_____ Yes. Please specify frequency: _____

Additional information about your baby's birth or medical history:

_____

_____

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Baby's Feeding History

How is your baby being fed currently?

___ **Breast Fed**	____ **Bottle**	____ **Tube fed**
Feeds per day: _____	Type of milk: _____	Reason: _____
Average length of feeding: _____	Feeds per day: _____	Feeds per day: _____
Is mother pumping? _____	Average length of feeding: _____	Type of feeds (continuous/ bolus): _____
Any complications: _____	Average OZ per feeding: _____	_____
_____	Any complications: _____	ML/OZ per bolus feeding: _____
_____	_____	Any complications: _____
____ **Other** _____		

Has your baby ever had a swallow study?

___ No	___ Yes. Please specify results: _____

Does your baby cough, sputter, or choke while feeding?

___ No	___ Yes. Please specify: _____

Does your baby use a pacifier?

___ Yes	___ No

About how many wet diapers does your baby have in 24 hours?

___ 6 or more	____ 4-6	___ 2-4	___ 0-2	___ Not consistent

About how many dirty diapers does your baby have in 24 hours?

___ 3 or more	____ 2	___ 1	___ 0	___ Not consistent

What does your baby's stool look like?

___ Yellow/curds	____ Green/brown	___ Tary/Black	___ Bloody	___ Not consistent

Additional information about your baby's feeding history:

_____

_____

Tallahassee, FL
www.sunnyspeech.com
office.sunnyspeechinc@gmail.com
Office Phone: 407-486-2262 Fax: 850-391-4178

Cancellation Policy

It is our policy that you notify your therapist (via phone call or text message) if you need to cancel or reschedule a therapy session. Cancellations and/or rescheduling of appointments must be given **at least 24 hours** before the scheduled session so that the therapist can make necessary arrangements to her schedule. If the therapist arrives to the agreed upon destination during the agreed upon therapy date/time (i.e., home, school, daycare) and your child is not there, this will count as a *no show*. If **two *no shows*** occur since the time services have begun, your child will no longer be able to receive services through Sunny Speech Inc. If **three cancellations occur without 24 hours notice**, your child my be at risk for losing services through Sunny Speech Inc. as well. Thank you for taking the time to read this and understand our policy. Please feel free to contact Samantha Bowers at 407-486-2262 or office.sunnyspeechinc@gmail.com with any questions or concerns about this policy.

_____ _____
Signature of parent/guardian Date

_____
Printed name of parent/guardian

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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

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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)

_____ 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)

_____

_____

_____

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