

Infant History Form



Background Information

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

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No. Please specify why not: _____
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Have you seen any specialist, doctor or therapist for your baby's feeding difficulties?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify: _____
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Baby's Prenatal History

Is this your biological baby?

<input type="checkbox"/> Yes	<input type="checkbox"/> No. What is known about pregnancy history? _____ _____
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Were there any prenatal complications?

<input type="checkbox"/> Polyhydramnios	<input type="checkbox"/> Breech position	<input type="checkbox"/> HELLP syndrome	<input type="checkbox"/> IUGR
<input type="checkbox"/> Cervical cerclage	<input type="checkbox"/> Multiples. Please specify: _____		<input type="checkbox"/> Preeclampsia
<input type="checkbox"/> Atypical positioning	<input type="checkbox"/> LGA	<input type="checkbox"/> SGA	<input type="checkbox"/> Gastroschisis
<input type="checkbox"/> Other. Please specify: _____			

Were you (or your baby's birth mother) placed on bed rest?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. At what month and for how long? _____
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Did you (or your baby's birth mother) receive prenatal care?

<input type="checkbox"/> Yes	<input type="checkbox"/> No. Reason: _____
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Did your baby move positions frequently in-utero?

<input type="checkbox"/> Yes	<input type="checkbox"/> No. What position did they stay in most of the time? _____
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Was your baby exposed to controlled substances or alcohol in-utero?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify: _____
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Infant History Form

Additional information: _____

Baby's Birth History

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)

<input type="checkbox"/> Natural Delivery without Epidural	<input type="checkbox"/> Natural Delivery with Epidural	<input type="checkbox"/> Cesarean Section	<input type="checkbox"/> Assisted delivery (forceps or vacuum)
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Where was your baby's birth?

<input type="checkbox"/> Hospital	<input type="checkbox"/> Birthing center	<input type="checkbox"/> Home	<input type="checkbox"/> Other: _____
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Were there any birth complications? (please check all the apply)

<input type="checkbox"/> Jaundice	<input type="checkbox"/> Intubation	<input type="checkbox"/> Infection	<input type="checkbox"/> Hypoxia
<input type="checkbox"/> Nucal cord	<input type="checkbox"/> Prolonged labor	<input type="checkbox"/> Preeclampsia	<input type="checkbox"/> Delivery assistance
<input type="checkbox"/> Other: _____			

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

<input type="checkbox"/> Hemorrhaging	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Other. Please specify: _____		

Additional information: _____

Baby's Postnatal History

Did your baby spend time in the NICU?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Length of stay: _____
Treatments received: _____	

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



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<input type="checkbox"/> 1 day	<input type="checkbox"/> 2-3 days	<input type="checkbox"/> 3-4 days	<input type="checkbox"/> Other: _____
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Was your baby able to be placed on the mother's chest for skin-to-skin contact immediately after birth?

<input type="checkbox"/> Yes	<input type="checkbox"/> No. Please specify why: _____
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Did your baby have any problems after birth? (please check all that apply)

<input type="checkbox"/> Fracture	<input type="checkbox"/> RSV	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Other: _____
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What was your baby's first feeding from?

<input type="checkbox"/> Breast	<input type="checkbox"/> Bottle	<input type="checkbox"/> Tube	<input type="checkbox"/> Other: _____
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Additional information: _____

Baby's Feeding History

How is your baby typically fed?

<input type="checkbox"/> Bottle	<input type="checkbox"/> Breast	<input type="checkbox"/> Tube. Type: _____	<input type="checkbox"/> Other: _____
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Was breastfeeding attempted after birth?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Were there any complications with breastfeeding after birth?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify: _____ _____ _____
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Were there any complications with bottle feeding after birth?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify: _____ _____ _____
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Is your baby fed via tube?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify: _____ _____ _____
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Infant History Form

What is the average amount of feeds per day?

<input type="checkbox"/> 8-10 times	<input type="checkbox"/> 5-7 times	<input type="checkbox"/> 4-6 times	<input type="checkbox"/> On demand	<input type="checkbox"/> Other: _____
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What is the average length of feeds per day?

<input type="checkbox"/> 5-10 minutes	<input type="checkbox"/> 15-20 minutes	<input type="checkbox"/> 30-45 minutes	<input type="checkbox"/> Other: _____
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What is the average amount your baby is consuming each feeding?

<input type="checkbox"/> 1-2 ounces	<input type="checkbox"/> 3-4 ounces	<input type="checkbox"/> 5-6 ounces	<input type="checkbox"/> Other: _____
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Has your baby ever had a swallow study?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify results: _____
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Does your baby cough, sputter, or choke while feeding?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify: _____
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Does your baby use a pacifier?

<input type="checkbox"/> Yes	<input type="checkbox"/> No. Please specify why: _____
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About how many wet diapers does your baby have in 24 hours?

<input type="checkbox"/> 6 or more	<input type="checkbox"/> 4-6	<input type="checkbox"/> 2-4	<input type="checkbox"/> 0-2	<input type="checkbox"/> Not consistent
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About how many dirty diapers does your baby have in 24 hours?

<input type="checkbox"/> 3 or more	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> Not consistent
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What does your baby's stool typically look like?

<input type="checkbox"/> Yellow/curds	<input type="checkbox"/> Green/brown	<input type="checkbox"/> Tary/Black	<input type="checkbox"/> Bloody	<input type="checkbox"/> Not consistent
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Additional information: _____

Baby's Medical History

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

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify: _____
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Does your baby currently have any of the following? (please check all that apply)

<input type="checkbox"/> Acute infection	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Staph infection	<input type="checkbox"/> Tuberculosis
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Infant History Form

<input type="checkbox"/> Hemophilia	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Fractures	<input type="checkbox"/> Inflammation
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Contagious skin disorder	<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Abdominal lump
<input type="checkbox"/> Swollen joints	<input type="checkbox"/> Distention of abdomen	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Fever
<input type="checkbox"/> Malignant cyst	<input type="checkbox"/> Blood sugar disorder	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Recent surgery
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Broken or Dislocated bones	<input type="checkbox"/> Hydrocephalus	<input type="checkbox"/> Other: _____

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

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Specify type(s): <input type="checkbox"/> Tongue <input type="checkbox"/> Lip <input type="checkbox"/> Cheeks (<input type="checkbox"/> Right, <input type="checkbox"/> Left)
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Has your baby ever been treated for tongue, lip or cheek ties?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Method of release: <input type="checkbox"/> Scissors <input type="checkbox"/> Laser <input type="checkbox"/> Surgical with sutures
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Has your baby been diagnosed or have any suspected structural differences?

<input type="checkbox"/> Torticollis	<input type="checkbox"/> Plagiocephaly	<input type="checkbox"/> Other: _____
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Does your baby have any known allergies (latex, medications, etc.)?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify: _____
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Does your baby have reflux?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please time of day: _____
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Is your baby up-to-date on his/her vaccinations?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Is your baby currently taking any medications?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify type(s) of medication and what it is taken for: _____ _____
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Did your baby pass his/her newborn hearing screening?

<input type="checkbox"/> Yes	<input type="checkbox"/> No. Follow up appointment date: _____
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Does your baby have a history of ear infections?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify frequency: _____
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Infant History Form

Where does your baby sleep?

<input type="checkbox"/> Crib/bassinet in baby's room	<input type="checkbox"/> Crib/bassinet in parent's room	<input type="checkbox"/> Co-sleeper on parent's bed
<input type="checkbox"/> Parent's bed	<input type="checkbox"/> Other. Please specify: _____	

How is your baby's sleep at night?

<input type="checkbox"/> Good (sleeps through night)	<input type="checkbox"/> Fair (sleeps for 4-5 hours at a time)	<input type="checkbox"/> Poor (does not sleep for more than 4 hours)
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How is your baby's sleep for naps?

<input type="checkbox"/> Good (Takes 1.5-2 hour naps a few times per day)	<input type="checkbox"/> Fair (Takes 1-1.5 hour naps a few times per day)	<input type="checkbox"/> Poor (Takes short 30 minute naps a few times per day)
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In what position does your baby sleep?

<input type="checkbox"/> On his/her back	<input type="checkbox"/> On his/her tummy	<input type="checkbox"/> Other: _____
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Do you have your baby on a schedule and/or routine?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify: _____ _____
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Is your baby colicky and/or hard to console?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify: _____
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Does anyone in your baby's household smoke?

<input type="checkbox"/> No	<input type="checkbox"/> Yes. Please specify who and where it's done: _____
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How often does your baby get tummy time?

<input type="checkbox"/> 1 time per day	<input type="checkbox"/> 2-3 times per day	<input type="checkbox"/> 3-4 times per day	<input type="checkbox"/> None
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Additional information: _____





www.sunnyspeech.com
office@sunnyspeech.com

Office Phone: 407-486-2262 Fax: 850-391-4178

Sunny Speech Insurance Agreement

Client Name: _____

Date: _____

Primary Insurer: _____

Policy #: _____

Secondary Insurer: _____

Policy #: _____

I give consent for Sunny Speech Inc. 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 may 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 coverage

Please contact Sunny Speech Inc. immediately at 407-486-2262. 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 \$100	Re-Evaluation \$100	Travel Fee \$5-\$10
30-Min. Therapy Session \$50	45-Min. Therapy Session \$75	60-Min. Therapy Session \$100

Please send a clear picture of your current insurance card(s) to office@sunnyspeech.com

Print Name: _____ Relationship to Client: _____

Signature: _____ Date: _____



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

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 Speech Inc.

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 speech 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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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



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

COVID-19 Policy

Due to the consistent increase in COVID-19 cases and the vulnerable populations we work with, we have enacted a policy for keeping our patients and therapists safe during the pandemic. The following responsibilities of our therapists and the responsibilities expected of our patients' families are outlined below:

Therapist Responsibilities:

- Wear a mask in the client's home or daycare
- Wear gloves when working inside a child's mouth or on face
- Sanitize and/or wash hands upon arrival or before entry into each home or daycare
- Receive the COVID-19 vaccine
- Sanitize therapy toys, tools or equipment after each session
- If exposure or symptoms occur, notify all families and isolate for time recommended by CDC
- If exposure or symptoms occur, reschedule therapy sessions to teletherapy appointments if well enough to conduct sessions
- If notified of a patient and/or their family being exposed, reschedule therapy session for teletherapy (if family is well enough to participate)
- Resume in-person therapy sessions after isolation for recommended time and testing negative for COVID-19
- Continue teletherapy sessions if patient/family requests and/or the therapist has a preexisting condition which puts them at greater risk if exposed to COVID-19

Patient/Family Responsibilities:

- Notify your child's therapist if exposure or symptoms occur immediately
- If you or your child have been exposed or have symptoms, reschedule session(s) to teletherapy appointment(s) if well enough to participate in sessions
- Resume in-person sessions once recommended isolation time occurs
- If your therapist has been exposed or has symptoms, coordinate rescheduling the session(s) to teletherapy appointment(s) with them, if the therapist is well enough to conduct sessions

We appreciate your efforts in keeping everyone safe during these difficult times. Thank you!



Tallahassee, FL
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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



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

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