610-455-4040
855-251-8777
info@ebschildrenstherapy.com
www.ebschildrenstherapy.com
200 Skiles Blvd. | West Chester, PA 19382

Dear Parent:

Having a child who does not eat well is a stressful, frustrating, confusing and at times, medically concerning problem. We, at EBS Children's Therapy, 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 an Interdisciplinary Evaluation Team. Our Team is made up of a Speech-Language Pathologist, Occupational Therapist, and Behavioral Therapist, that consults with other psychologists, physical therapists, dietitians and pediatricians. We are all 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 complete and return EACH of these documents

- ☐ Referral for Feeding Therapy from Pediatrician
- ☐ 3 day diet history
- ☐ Release/Obtain Information Form
- ☐ Cancellation, Illness, and HIPAA Policies
- ☐ Photograph/Video Permission Form
- ☐ Informed Consent
- ☐ Financial Policy
- ☐ Copy of Insurance Card

Please complete the forms in as much detail as possible. Many items on the forms can be answered by a simple YES or NO. If you answer YES, please **explain your answer thoroughly** in the space provided. If you cannot or wish not to answer a question, you can leave it blank. If a question does not apply to your child, you can write NA for "not applicable".

Please return your completed forms by scanning and emailing them to nora.murphy@ebschildrenstherapy.com or dropping them off at the front desk in person AT LEAST 1 WEEK prior to your child's scheduled evaluation.

THE FEEDING APPOINTMENT:

On the day of your appointment, the Evaluation Team will be observing your child, yourself and preferably all other major caretakers having a snack together. The Team will

observe from behind a one-way mirror so as to not disturb your child with a large number of strangers.

The full Feeding evaluation is made up of 3 parts:

1. Face-to-Face feeding assessment (1 hour)- Parents and child
2. Team meeting and Report write-up (1 hour) +returning your child to school, day care or a baby sitter
3. Parent "Interpretive" session (30 minutes) to review report and recommendations-Parents only

Face-to-Face Feeding Assessment with you and your child:

For the feeding evaluation portion, we would like you **to bring at least 2-3 foods of different textures and 1 drink that your child will most likely eat, and at least 1-2 food(s) your child will most likely refuse.** We want to be able to assess your child's current skill level with foods that they do well with, as well as determining how they handle more challenging foods.

Please also **pack your child's preferred utensils, cup, bottles, and dishes** to make the assessment situation as "home-like" as possible. If you have an older child, you can explain that you are packing a "picnic" to eat together at the food school, and that the food school teachers help children and families learn to eat better together.

Please also give your child only a light breakfast on the day of their appointment and that you **NOT** feed them for at least 1 ½ hours before their scheduled appointment time.

Report Writing/Team Meeting and Child Transport:

After the face-to-face portion of the Feeding Evaluation has been completed, we would like to have you bring your child to daycare, a babysitter for the remainder of the evaluation. Please make arrangements in advance so that you can be fully focused in the interpretive session on hearing the results and what can be done to help your child's issues. If you cannot arrange for anyone to watch your child, please call 610-455-4040 to discuss other options that may be available.

Parent Interpretive Session:

This portion of the assessment is to review all of the Team's findings and treatment recommendations with you. In addition, you will have time to ask any questions that you may have not yet been able to get answered. This session is approximately 30 minutes, depending on the number of questions you have. The "interpretive" session begins with a summary of the therapists' findings during the assessment. Then, the therapists' recommendations and next steps are explained. You should receive a Draft copy of the report at the end of your meeting. A final copy of the report will be sent to you and your child's physician, sometime during the following 4 weeks.

On the day of the appointment, please **bring your insurance card**

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Payment and Insurance:

EBS Children's Therapy will bill your insurance for 3 different evaluations, as 3 different disciplines are evaluating your child. If you have a co-pay for each discipline, the total of all will be collected on the initial evaluation only. As a complimentary service, EBS Children's Therapy will verify your insurance benefits. However, it is your responsibility to know your child's insurance benefits.

For further information, please give us a call at 610-455-4040 or email us at nora.murphy@ebschildrenstherapy.com

Sincerely,
EBS Children's Therapy

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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 EBS Children's Therapy with the rest of your forms, OR you will need to bring it with you to your appointment.

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, 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 + 1 Tbsp margarine). Be sure to include 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
1/1/02	4 pm	Gerber applesauce #2	1 ounce			☐	
		White Bread (Wonder)	¼ slice			☐	
		Ham lunch meat (Hormel)	½ ounce			☐	
		Mayonnaise	1 tsp			☐	
		White grape juice	1 ounce		☐	☐	
	6:30pm	Veggie Straws (Whole Foods 365)	5			☐	
		Diced pears (Del Monte)	1 plastic container			☐	
	7 pm	Similac Advance Formula	4 ounces	☐		☐	
	9 pm	Pediasure with fiber	8 ounces				☐

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

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

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

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Feeding Client Consent to Release/Obtain Information

I, the parent/guardian, ______________________________, do hereby authorize EBS Children's Therapy to RELEASE TO and OBTAIN INFORMATION AND DOCUMENTATION FROM the record of the individual identified below for therapeutic purposes including collaboration, planning and treatment:

Child's Name ______________________ Child's DOB ______________

I authorize information and documentation to be shared with:
(i.e. pediatrician, school staff, outside therapists, etc.)

Pediatrician ______________________ Practice ______________________

Phone Number ______________________ Fax Number ______________________

Name of Other Specialist ______________________ Practice ______________________

Phone Number ______________________ Fax Number ______________________

Parent/Guardian Signature ______________________ Relationship ______________________ Date ______________

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Cancellation and Tardiness Policy 2019- 2020

Consistency is vital to the therapy process. The more regular your child's attendance, the more likely he/she will make therapeutic progress. Your therapist's plan can only be effective when attendance is regular and consistent with the scheduled therapy time.

In the event that your family becomes unable to attend sessions regularly, we will make every effort to accommodate your family's needs. **If your child's attendance becomes inconsistent and is no longer therapeutically appropriate, your child's therapy may be placed on hold until consistency can be improved.**

Please review the guidelines below regarding the cancellation and tardiness procedures:

Cancellation Policy: Your child's therapist has reserved valuable time for your child's treatment. Your therapist has prepared for the session and blocked out all other activity during this time. In the event that a therapy session is missed with less than 24 hour notice, a fee of $35 will be given to the family. If you leave a voice message, we suggest that a follow up call and email be made during regular business hours to assure that the message has been received to the CLINIC.

If there are more than three absences without proper notice, in a period of six months, your appointments will be at the risk of permanent suspension.

If you fail to attend a session with no form of communication such as a phone call or email to the clinic, this is considered a "NO SHOW". In this event, a fee of $35 will be given to the family.

Tardiness: Please call the clinic to notify if you will be running **late to your appointment** or **picking up after your appointment** scheduled end time. If you are more than 15 minutes late there will be a $25 late fee assessed to the family. If there are more than three instances of tardiness (15 minutes or more) in a period of six months, your appointments will be at the risk of permanent suspension.

Vacation: Please inform the clinic at least two weeks prior to absence due to vacation.

Illness: Please call the clinic as soon as you know that your child may miss your scheduled session. Please refer to the Illness Policy for details.

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Other: Routine Dr.'s visits, meetings and other flexible appointments should be scheduled so they _do not conflict with the existing therapy appointment._ Therapy is an important part of your child's schedule, and should be treated as such.

Illness Policy

Please understand that, while attendance is vital, it is also important to protect your child, as well as the health of the therapist and other children. Please also understand a child must be in good health to have a successful and productive therapy session. We require children to be symptom and fever-free for at least 24 hours prior to returning for a session. If a child is on an antibiotic for an illness, the medication must be administered for at least 24 hours before returning to the clinic. Please call the clinic as soon as you know that your child may miss your scheduled session due to illness.

The following circumstances warrant cancellation (with possible rescheduling) of the therapy session:

- The child is unusually lethargic or irritable
- Presence of yellow or green mucus secretion
- Vomiting/diarrhea
- Fever (within 24 hours of session)
- Seizures
- Open skin sores
- Head lice or nits present
- The child is in a contiguous state of a communicable disease including by not limited to:
    - Pink Eye
    - Explained rash
    - Strep Throat
    - Chickenpox
    - Ringworm - must be 24-48 hours on treatment and completely covered if rash is still present.

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I have received a copy of the Cancellation/ Tardiness and Illness Policy.

____
Child's Name

____ __________
Signature of Parent or Guardian Date

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HIPAA Notification Policy 2020

Please review our Notice of Privacy Practices carefully.
The privacy of your health information is important to us. This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities,

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reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities. If we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

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National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as e-mail and voicemail messages, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.35 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

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Electronic Notice: If you receive this Notice on our Web site or by electronic mail (email), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions, please contact us.
Cody Carraro, Clinical Director of EBS Children's Therapy
200 Skiles Boulevard
West Chester, PA 19382
Phone: 610-455-4040
Email: cody.carraro@ebsunited.com

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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I have *received a copy* and agree to abide by the terms of EBS Children's Therapy:

- **HIPAA Notification Policy**

o I acknowledge that I have received the Notice of Privacy Practices (Notice). The Notice describes, in accordance with the HIPAA Privacy Regulations, how EBSCI may use and disclose my child's protected health information to carry out treatment, payment or health care operations and for the other specific purposes that are permitted or required by law. The Notice also describes my rights and EBSCT's duties with respect to protected health information about my child.

____
Child's Name

____________________________________ ______________
Signature of Parent or Guardian Date

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Notice of Privacy Practices

Section A: To the Patient – *Please read the following statements carefully.*

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations (TPO).

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

With my permission the office of ***EBS CHILDREN'S THERAPY*** may call my home or other designated location and leave messages on voicemail that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my permission the office of ***EBS CHILDREN'S THERAPY*** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient invoices and statements.

With my permission, the office of ***EBS CHILDREN'S THERAPY*** may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient invoices and statements.

I have the right to request that ***EBS CHILDREN'S THERAPY*** restrict how it uses or discloses my protected health information to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

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You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer: Cody Carraro, M.S., BCBA
Telephone: 610-455-4040 | Email: Cody.carraro@ebsunited.com
Address: 200 Skiles Boulevard| West Chester, PA. 19382

Section B: Parent or Guardian Giving Consent (if Patient is not 18 years of age and their own guardian)

Name: ____ Date: ____________

Relationship to Patient:_______________________

Right to Revoke: You will have the right to revoke this Consent at any time by giving written notice of your revocation submitted to ***EBS CHILDREN'S THERAPY attn.: Cody Carraro***. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may *decline* to treat you or to continue treating you if you revoke this Consent.

I, ____, have had full opportunity to read and consider the contents of this Consent and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Child's Name: ____

Signature:____

Date:________________________

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I understand that the information that is released between the treatment providers is confidential and is for the well -being of my child.

_______________________________________ _______________
Signature of Parent or Guardian Date

CONSENT FOR VIDEOTAPING & PHOTOGRAPHING FOR THERAPEUTIC PURPOSES

Therapists often videotape or photograph children who receive therapy services at EBS to help monitor and document a child's areas of concern, as well as progress. Videotapes and photos are used and reviewed only by EBS staff. Parents are welcome to view their child's videotape at EBS.

I do____ do not____ give consent for my child to be videotaped and/or photographed as part of his/her therapy program for use by EBSCT staff only.

_______________________________________ _______________
Signature of Parent or Guardian Date

CONSENT FOR VIDEOTAPING & PHOTOGRAPHING FOR EDUCATIONAL & PUBLIC AWARENESS PURPOSES

Staff at EBS are frequently asked to teach at courses, seminars or workshops. We often like to include videotape, slides or photos during our presentations. Additionally, we may occasionally use photographs to share on Social Media and for promotional purposes

I do___ do not___ give permission for my child to be videotaped/photographed for educational and public relations purposes. I understand that my child's name and any identifying information, will not be used in association with these images.

_______________________________________ _______________
Signature of Parent or Guardian Date

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Informed Consent

Child's Name: ____

CONSENT FOR THERAPEUTIC TREATMENT

I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at EBS Children's Therapy. I understand that I may terminate these services at any time.

____ ____________________

Signature of Parent or Guardian Date

INVOLVEMENT IN CARE AND SERVICES

EBS encourages all clients and families to be an active member of the therapy session. Parent training and home generalization programs are critical for success and progress. I agree to be an active member of my child's treatment plan.

____ ____________________

Signature of Parent or Guardian Date

IF SHARED CUSTODY- both parties must sign this consent prior to treatment

I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at EBS Children's Therapy. I understand that I may terminate these services at any time.

____ ____________________

Signature of Parent or Guardian Date

CONSENT FOR PARTICIPATION WITH THERAPEUTIC EQUIPMENT

Intervention programs at EBS Children's Therapy usually involve the use of specialized equipment such as various swings, bolsters, inflated therapy balls, climbing structures, tactile media (such as soap foam, Play-Doh and lotion), and a variety of other activities that involve fine, gross and oral motor coordination. Therapy activities often involve encouraging the child to try new in order to foster increased skills and abilities. While EBS 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. 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.

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Financial Policy 2020

As a courtesy to all of our patients, we will call to verify benefits and will make reasonable effort to collect from your insurance company, should you choose to utilize insurance. Please understand, however, primary responsibility for understanding coverage limits belongs to the parent. There are instances when insurance may deny benefits (deductible not met, services not covered under the plan, etc.) and you will then be responsible for payment. In the event that insurance denies payment, the family may wish to appeal the matter to their insurance company, and we will support the parent in their effort. Any payment which is deemed to be due from the parent (**private pay/co-pays**) is due at the time of the service.

If a payment plan is required, those terms will be provided to you in writing and agreed upon by both EBS Children's Therapy and the person responsible for patient's bills. Please inquire with our office administration regarding rates for services.

Notification of Insurance Changes/Renewal Policy

EBS Children's Therapy (EBS) must have **current** information on file regarding Insurance at **all** times. It is the responsibility of the parent/guardian to know of any and all changes that may occur in your insurance policy. It is also the responsibility of the parent/guardian to be sure that EBS CI is aware of any and all changes to the policy at or before the time that they go into effect.

Please note that many insurance policies change on January each year, however they can change at any time.

IMPORTANT: *Notification of Change: All changes must be directed to the Clinic Administration Staff and appropriate insurance card and identification provided

All **Co-Pays Must be PAID AT TIME OF SERVICE**. We can offer to have a credit card on file for your Co-Pays if you prefer.

We thank you in advance for your cooperation, and invite you to call the Clinical at 610-455-4040 with any questions that you may have about billing.

I have read and agree to my financial responsibility for the services provided to me by EBS Children's Therapy. This also certifies that the information I have provided to EBS Children's Therapy, to the best of my knowledge, is true and accurate. I authorize my insurance carrier to pay EBS Children's Therapy the full and entire amount of the bill incurred by my child.

____
Child's Name

______________________________ ____________
Signature of Parent or Guardian Date

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TALKING TO YOUR INSURANCE COMPANY ABOUT FEEDING PROBLEMS

Calling about a Feeding Evaluation at EBS Children's Therapy

Step 1 – Call your main Insurance Company information phone # and ask for the BENEFITS line.

Step 2 – TELL THE BENEFITS technician that:
Your child will be assessed by a multidisciplinary team. I need to know my in/out-of-network benefits for the evaluation.

Step 2a – ONLY IF THE TECH ASKS FOR MORE INFORMATION, would you volunteer the following information.

A. Team first reviews the assessment forms packet completed by the family prior to the first visit = Medical and Family History form, Feeding History form, Sensory History form, 3 Day Diet History, Rights and Releases.
B. Child is observed eating preferred and non-preferred foods with parents. A Team member then works with the child directly to determine extent of the feeding problem
C. Team writes the report as the family is on break
D. Team shares the assessment directly with the parents, explains in detail what the feeding problem is and how to treat it, and answers any questions the family may have.

Step 3 – you may be asked what **ICD10 Diagnostic Code(s)** will be used for the evaluation = F98.29 (**Failure to Gain Weight**)- if your child is underweight or R63.3 (**Feeding Disturbance**) – if your child's weight is okay), unless your child carries another known medical diagnosis (give any known diagnoses names as well, such as, Reflux, Down Syndrome, Allergy, Autism) or R13.11 **(Dysphagia, oral phase)**– if your child has difficulty chewing foods. .

EMPHASIZE THAT YOUR CHILD HAS A MEDICAL FEEDING PROBLEM, NOT AN EATING DISORDER. AVOID USING THE WORD "EAT" AND DON'T TALK ABOUT YOUR CHILD NOT EATING. Tell them your child has a physical problem that interferes with their ability to feed and gain weight.

i. If they try to send you to a Mental Health benefits technician or to the psychology department/division of your insurance company, tell them "NO. This is NOT a mental health issue."

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Step 4 – you may be asked what BILLING CODES will be used, or what CODES THIS EVALUATION WILL BE BILLED UNDER

CPT Billing Codes for the evaluation = one unit 92610 OR one unit 92523, one unit 97167, and four units of 96150.

Step 5 – Hopefully, the Technician will tell you the following information about your in/out-of-network benefits without you prompting them. However, **you may need to ask directly for any of this information which they haven't told you**

Out of Network Deductible = ___________ How much have I already paid on this __________

% Insurance covers after the deductible = _________ % Client pays after deductible _________

Out of Pocket Maximum = _______________
(amount client has to pay each year before Insurance Company pays at 100%)

Lifetime Maximum = ______________
(your plan may have a restriction for this particular diagnosis)

ANY SPECIAL CLAUSES< RESTRICTIONS OR PRE-AUTHORIZATIONS NEEDED? ________________

Step 6 – Typically, it will be easier to ask DURING this phone call, about your child's therapy benefits, as well as the Evaluation benefits. Please also ask for the information below, in Step 3

Depending on the scheduling needs of your child and the therapists' schedules, you may be assigned a feeding therapist from the disciplines of either speech-language pathology, occupational therapy, or behavioral therapy. It is important that you know your benefits for each code listed below, as coverage for services may influence who your child is scheduled with.
Discipline:
Speech-language Therapy codes: 92526, 92508, 92507
Occupational Therapy: 97110, 97112, 97150
Behavioral Therapy: 90837, 90834