The Cindy and Tod Johnson Center For Pediatric Feeding Disorders

The Cindy and Tod Johnson Center for Pediatric Feeding Disorders
29-01 216th Street
Bayside, NY 11360
Phone: 718 281-8541
Fax: 718 281-8505

Dear Caregiver(s),

Thank you for your recent inquiry about the Cindy and Tod Johnson Center for Pediatric Feeding Disorders. Enclosed is an application that must be completed and returned in order to receive a feeding evaluation appointment. Please complete the application and return it to the feeding center along with the growth chart and any pertinent medical records. In addition, a letter of medical necessity must be obtained from your pediatrician or GI doctor. Once we have received all the necessary paperwork we will call you to schedule the feeding evaluation.

All of the following documentation must be received by the center before the appointment can be scheduled:

- Completed application packet
- Growth Chart with measurements:
  - For 12mo-24mo: (Weight-for-Age; Length-for-Age; Weight-for-Length; Head Circumference-for-Age)
  - For 24mo+: (Weight-for-Age; Height-for-Age; BMI-for-Age)
- Three day food diary (2 typical weekdays & 1 weekend day)
- Letter of Medical Necessity
- Immunization record
- Notice of Privacy Practices (signed last page)
- HIPAA
- Photo Consent
- Short recording of your child's mealtime

If applicable:

- Gastroenterology reports: Upper GI, Endoscopy, Swallow study, Esophagram
- Blood and/or biopsy results
- Allergist report
- Pulmonologist report
- Record of Hospitalizations or any other medical procedures
- Early Intervention
  - IFSP (Individual Family Service Plan)
  - Early Intervention Therapist Evaluations (speech, OT, PT, counseling, special education, ABA)
  - Early Intervention Quarterly Reports
- For preschool and school age: IEP (Individualized Education Plan)
  - Special Education Therapist Evaluations (speech, OT, PT, counseling, special education, ABA)
  - IEP Quarterly Reports (these come with report cards)
  - Behavior Intervention Plan (BIP) and related progress reports
- MRI or CAT scans

All information can be faxed, e-mailed or mailed to the center. If you have any questions about the application process, please call Program Coordinator at (718) 281-8541 or e-mail feedingadmin@stmaryskids.org.

Sincerely,

Program Coordinator

The Cindy & Tod Johnson Center for Pediatric Feeding Disorders
ST. MARY'S HOSPITAL FOR CHILDREN
29-01 216th Street
Bayside, NY 11360
718-281-8541

PATIENT APPLICATION (for children 12 months & older)

Please complete the following intake form. Mark N/A if the question does not apply to your child

INTAKE INFORMATION: Today's date: ________________

Patient (Last): ______________________ (First): __________________ Date of Birth: ________________

Gender: ❑ Male ❑ Female Caregiver Name: _______________________ Relationship:_______________

Home Address: ____

City, State, Zip: ____

Cell Phone Number: ________________________ Secondary Phone Number: ___________________________

Email address: ________________________________ Patient's Social Security: _______/______/__________

Preferred Method of Communication: ❑ Home Phone ❑Cell Phone ❑ E-mail

Preferred Type of Service: ❑ Live Therapy - Bayside, NY ❑ TeleHealth

Referred By: _______________________________________ Preferred Language:__________________________

Does your child currently receive or previously received services from St. Mary's Healthcare System?
❑ YES ❑ NO If Yes, explain:____

Ethnicity origin (or Race): Please specify your child's ethnicity.
❑ White ❑ African American ❑ Latino or Hispanic ❑ American Indian or Alaskan Native
❑ Native Hawaiian or Pacific Islander ❑ Asian ❑ Other

Family Members

Please list all the people that live in your household:

Name	Age	Relationship to Child	Occupation	Education

Insurance Information

Primary Insurance Name: __________________________________ Policy Number: _____________________

Name of Policy Holder: ___________________________________ Policy Holder DOB: ___________________

Policy Type: ______________________________

Secondary Insurance Name: _______________________________ Policy Number: _____________________

Name of Policy Holder: ___________________________________ Policy Holder DOB: ___________________

Policy Type: ______________________________

Therapeutic Service Information:

Contact Person at education institution: (EI coordinator, CPSE/CSE administrator) ______________________________

Contact Phone Number: ___________________________ Contact Fax Number: ________________________________

Contact Address: ____

List therapeutic services and mandates: ____

____

Therapist names and numbers: ____

____

____

____

____

School Information:

Name of school: ____

Contact Person at education institution: ____

Contact phone Number: __________________ Contact Fax Number: _____________________________

Contact Address: ____

Physician's Information

Primary Care Physician: ____

PCP Address: ____

City, State, Zip: ____

PCP Telephone Number: ______________________ PCP Fax Number: _____________________________

Gastroenterologist:: ____

Address: ____

City, State, Zip: ____

GI Telephone Number: ____________________________GI Fax Number: ____________________________

Specialist: ____

Specialist Address: ____

City, State, Zip: ____

Specialist Telephone Number: _____________________ Specialist Fax Number: _____________________

Specialist: ____

Specialist Address: ____

City, State, Zip: ____

Specialist Telephone Number: ____________________ Specialist Fax Number: ______________________

I. Birth History:

At how many weeks was the baby born? (i.e., 40 weeks is full term) ____________________

At which hospital? ____________________

How much did your baby weigh at birth?____________________Height: ____________________

Born via: ☐ Vaginal Delivery ☐ Caesarian Section

Did you have any of the following problems with: pregnancy, labor, or delivery?

☐ Gestational Diabetes ☐ Preterm Labor ☐ Eclampsia/Pre-eclampsia
☐ Abnormal Ultrasound ☐ Infection
☐ Other (specify)

Was your baby admitted to the NICU?__________If yes, how long was he/she there? ____________________

Did your baby have any of the following problems in the nursery?

☐ Gastroesophageal Reflux (GER) ☐ Mechanical Ventilation ☐ Bronchopulmonary Dysplasia (BPD)
☐ Apnea ☐ CPAP Therapy ☐ Necrotizing Enterocolitis (NEC)
☐ Feeding and Growth Issues ☐ Tube Feedings ☐ Intraventricular Hemorrhage (bleeding in brain)
☐ Other (specify) __________

Please describe: ____________________

____

II. General History

Feeding History:

Was your child breast-fed, bottle-fed or other? (Note any problems) ____________________

____

As an infant did your child switch to different formula? ☐ Yes ☐ No
If yes please list which ones and how they were tolerated ____________________

____

As your child grew did he/she tolerate larger volumes of formula/breast milk? ____________________

At what age did your child eat baby cereal or baby food? (Note any problems) ____________________

____

At what age did your child start eating solid/chewable food? (Note any problems) ____________________

____

____

At what age did your child transition from baby formula to milk or equivalent? (Note any problems) __________

____

____

Has your child received feeding therapy? If yes who was the treating therapist? Did the child make progress? _______

____

____

Developmental Milestones:

At what age did your child:
Sit_____ Crawl________Stand__________Cruise__________ Walk_________Babble_________

Say single words________Sentences_____________Follow directions _______________

III. Medical History

List any major hospitalization or illnesses: (include dates) ______________________________

____

____

____

List any surgeries or outpatient procedures: ______________________________

____

____

____

Have any of the following medical tests been done?

☐ Upper GI Series ☐ Gastric Emptying study ☐ Swallow Study (MBS or FEES)
☐ Endoscopy ☐ pH Probe ☐ Genetic (Chromosome) Testing
☐ Head CT Scan ☐ Head MRI Scan ☐ Bone Age Film/X-ray
☐ Allergy Testing ☐ Other (specify) ______________________________

List medical tests completed in the last year: (i.e., Upper GI, MBS, FEES, X-rays, MRI, vision, hearing…)

____

____

____

***** Please submit ALL test results prior to your appointment with us.**

IV. Pediatric Care:

Is your child up to date with immunizations? ☐ Yes ☐ No

If No, please explain______________________________

Diagnosis: Please check any of your child's medical, developmental and/or mental health diagnosis:

Current	Previous	Family History (specify)	Type of Issue	Current	Previous	Family History (specify)	Type of Issue
			Autism, PDD or Asperger's				Gastroesophageal Reflux
			Developmental or Speech Delay				Chronic constipation
			ADHD/ADD				Chronic diarrhea
			Learning Disability				Food Allergies
			Seizure Disorder				Lactose Intolerance
			Traumatic Brain Injury				Seasonal Allergies
			Depression or Bipolar Disorder				Vision Impairment
			Anxiety Disorder or OCD				Hearing Impairment
			Cerebral Palsy				Delayed Gastric Emptying
			Spina Bifida				Tube Feeding (NG, G, J tube)
			Tracheomalacia or Layngomalacia				Liver Disease
			Diabetes, Type I or II				Endocrine Disorder or Growth Problems
			Prematurity				Cardiac Condition
			Metabolic Disorder				Genetic Disorder (specify)
			Failure To Thrive				Dysphagia
			Pneumonia				Chronic Lung Disease
			Cleft Palate or Lip				Eosinophilic Esophagitis
			Other:				Other:

List all current medications and dosages: ____________________

____

____

List all known allergies/intolerance (i.e. food, drugs, material): ____________________

____

Does your child currently have any GI issues? ☐ Yes ☐ No

If your child vomits, on average what is the volume of vomit per episode? ____________________

When does vomiting occur? (i.e. at meals, after meals, when upset) ____________________

How many bowel movements a day does your child have? ____________________

Are the stools runny, soft, formed, hard, pebbles? (specify) ____________________

Does your child complain of abdominal pain? ☐ Yes ☐ No If yes, how frequently, associated to what?

____

How often does your child experience problems with diarrhea or constipation? ____________________

If he/she has vomiting, diarrhea or constipation, what treatments have the doctors recommended? ____________________

____

V. Nutritional Information

Does your child currently see a dietician/nutritionist? ☐ Yes ☐ No If yes, name: ____________________

Child's most recent Height:________'_______" Weight:______lbs. When were they taken:________________

Does your child take vitamins or supplements: ☐ Yes ☐ No

If yes, please list: ____________________

Your child's appetite is best described as (choose one):

☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Eats too much

VI. Tube Feeds

Has your child ever had?

☐ G-tube ☐ J-tube ☐ NG-tube ☐ NJ-tube ☐ GJ-tube

Dates of use: from:______________to: _____________

Does your child currently have?

☐ G-tube ☐ J-tube ☐ NG-tube ☐ NJ-tube ☐ GJ-tube

Formula:______________________How many calories per ounce is the formula? ____________________

If receiving **Continuous** feeding:
How much per hour______________ Length of feeding (start time/stop time) ____________________

If receiving **Bolus** feeds:
What is the bolus schedule? ____________________

Volume per bolus_______________________ How long does a bolus feed take to complete? __________________

Has your child had difficulty gaining weight on the current tube-feeding schedule? ☐ Yes ☐ No

How long has your child been on this regimen? ____

How often does your child need to be vented during the day and at what times? ______________________________

Have you ever increased the rate of tube in the last 3-6 months and what happened? ___________________________

____

____

VII. Current Feeding/Drinking Skills:

Which of these does your child consume? (Check all that apply):

☐ Breast Milk	☐ Baby cereal	☐ Blenderized Foods
☐ Formula	☐ Ground meats	☐ Strained Baby Food
☐ Milk	☐ Liquids/Soup	☐ Table Foods
☐ Juice	☐ Creamy Foods	☐ Crisp Foods (crackers)
☐ Water	☐ Chewy Food (meat)	☐ Crunchy Food (celery)

List the liquids your child will consistently drink: ____

____

____

List the food your child will consistently eat: ____

____

____

How does your child indicate he/she is hungry? ____

____

Does your child eat on a schedule? ☐ Yes ☐ No

Where does your child eat? (i.e., at the table, in a high chair) ____________________________________

What feeding problems does your child currently have?

☐ Food Refusal (i.e. refuses all or most foods)

☐ Food Selectivity by Texture (i.e. refuses puree, crunchy, smooth)

☐ Food Selectivity by Type (i.e. only eats a limited number of foods)

☐ Abnormal preferences (i.e., must be a certain temp., brands, cup…)

☐ Other feeding problems

Does your child have any problems with? (Check all that apply)

☐ Drooling	☐ Poor Sucking
☐ Poor Tongue control	☐ Hypersensitivity to textures
☐ Gagging during meals	☐ Hypersensitivity to temperatures
☐ Poor Lip control	☐ Difficulty with Chewing
☐ Swallowing Problems	☐ Coughing during or after meals
☐ Vomiting during or after meals	☐ Other:

1. What feeding issues do you want addressed by the Feeding Program (circle each)?

Increase the volume of food my child eats	Reduce/eliminate diarrhea or constipation	Improve mealtime behaviors
Increase the variety of foods my child eats	Increase weight gain	Decrease vomiting related to eating
Improve oral motor skills	Resolve reflux or other GI issues	Decrease tube feedings
Decrease gagging during eating	Increase the texture of food my child eats	Other:
Improve cup drinking	Self-feeding	

VIII. Sensory

Does your child have defensiveness towards? (Check if applicable)

- ☐ Keeping shoes or socks on
- ☐ Labels on clothes
- ☐ Touching hands to different textures
- ☐ Sitting in chair
- ☐ Washing hair
- ☐ Touching feet to different textures
- ☐ Brushing teeth
- ☐ Other:

IX. Behavior

When very agitated, my child sometimes displays the following behaviors: (check all that apply)

- ☐ Complaining
- ☐ Whining
- ☐ Threats
- ☐ Spitting
- ☐ Screaming
- Other: _________
- ☐ Running away
- ☐ Throwing things
- ☐ Pinching
- ☐ Hitting
- ☐ Kicking
- ☐ Scratching
- ☐ Biting
- ☐ Tantrums
- ☐ Vomiting
- ☐ Self-injury (specify):___

How long does it generally take your child to calm down? ____________________________________

Does your child have difficulty separating from you or other family members? Yes _____ No ______

X. Goals

List the goals you would like your child to achieve during admission: ____

____

____

____

XI. Other

Please indicate any other concerns or information that you would like to share about your child: __________________

____

____

____

Name of Child:_______________________________ **Date:**___________________

Food Diary: (Please document below what your child consumed per feed in a 24 hour period for 2 weekdays and 1 weekend. List all food and liquid that was consumed, how much and indicate if it was given in a bottle, tube, cup or via spoon and if it was self-fed).

Time & Place of Meal:	***List the food/drink your child consumed for that meal/snack & estimate how much was consumed.***	**Method** Tube or by mouth	**Length of Meal:**	**Comments or feeding problems: (i.e. refusal, gag, vomit, holding food, coughing)**
Time: 7:20am Place/ Position: Kitchen /Highchair	**EXAMPLE** ½ cup oatmeal made with whole milk 3oz orange juice	By mouth via sippy cup	45 minutes	Gagging on oatmeal, refusal on initial bites
Time: Place/ Position:				
Time: Place/ Position:				
Time: Place/ Position:				
Time: Place/ Position:				
Time: Place/ Position:				
Time: Place/ Position:				

Name of Child:_______________________________ **Date:**___________________

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Name of Child:______________________________ **Date:**___________________

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Time: Place/ Position:				
Time: Place/ Position:				

stmaryskids
The Cindy and Tod Johnson Center For Pediatric Feeding Disorders

RELEASE FOR TAKING & UTILIZING PHOTOGRAPHS, PHOTOCOPIES, TAPE RECORDINGS, FILMS

I am the parent/legal representative of ________________________________ and hereby grant permission to St. Mary's, it's agents, employees, and any person, firm or organization that St. Mary's may designate or authorize, to take photographs, tape recordings, video tapes and films (collectively, the "materials") of me, other members of my family, and/or the above named minor.

This consent includes the use of the materials with or without my name, other family members' names or my son's/daughter's name and biographical data by St. Mary's or anyone else on its behalf, without limitations as to time or frequency of use, for any or all of the following purposes: newspaper, website, publicity, release of communication to other media, educational/teaching purposes, and use in St. Mary's materials. Other:

____

I grant this consent voluntarily and hereby waive any and all rights I may have to royalties or other compensation in connection with publication or other use of the materials.

Relationship: ☐ Parent ☐ Guardian ☐ Legal Representative ☐ Other: ____________________

Signed: ____________________________________ Date: ______________________

☐ I do not consent to the taking of photographs, tape recordings, videotapes or films of the above named resident/patient.

AUTORIZACIÓN PARA TOMAR Y UTILIZAR FOTOGRAFÍAS, FOTOCOPIAS, GRABACIONES MAGNETOFÓNICAS Y PELÍCULAS

Yo estoy padre o representante legal de ____, y autorizo a St. Mary's, sus agentes, empleados y cualquier otra persona, empresa u organización que St. Mary's pueda designar o autorizar, a que tome fotografías, realice grabaciones magnetofónicas o de video y filme películas (en adelante, los "materiales") de mí, otros miembros de mi familia y/o el residente antedicho.

Esta autorización incluye el uso por parte del St. Mary's o cualquier otro en su nombre, de los materiales, con o sin mi nombre, el nombre de otros miembros de mi familia o el nombre de mi hijo e información biográfica, sin limitación en cuanto a tiempo o frecuencia de uso, para cualquiera de estos fines o todos ellos: periódicos, publicidad, autorización de comunicación a otros medios, propósitos educativos, pedagógicos o docentes. ________________________

Concedo esta autorización voluntariamente y, por consiguiente, renuncio a cualquiera y todos los derechos que pudiera tener en cuanto a regalías u otras compensaciones relacionadas con la publicación o cualquier otro uso de los materiales.

Parentesco: ☐ Padre ☐Tutor ☐ Representante legal ☐ Otro: ______________________

Firma: ____________________________________ Fecha: ______________________

☐ No autorizo la toma de fotografías, ni la realización de grabaciones magnetofónicas o de video ni la filmación de películas del residente antes mencionado.

ST. MARY'S HEALTHCARE SYSTEM FOR CHILDREN
St. Mary's Hospital for Children, Inc.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name:	Date of Birth:	Social Security Number
Patient Address:		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL**, and **DRUG ABUSE, MENTAL HEALTH TREATMENT**,
except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line of the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9. (a) Specific information to be released:
□ Medical Record from (insert date) ________________ to (insert date)____________________
□ Entire Medical Record, including resident histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
□ Other: _________________________
____

Include: (Indicate by Initialing)
________**Alcohol/Drug Treatment**
________**Mental Health Information**
________**HIV-Related Information**

Authorization to Discuss Health Information
(b) □ By initialing here ______________I authorize____
Initials — Name of Individual health care provider
To discuss my health information with my attorney, or a governmental agency, listed here:
____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information □ At request of individual □ Other:	11. Date or event on which this authorization will expire:
12. If not the resident, name of person signing form:	13. Authority to sign on behalf of resident:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Name of Representative Authorized by Law (Parent): _______________________________________

____ Date: _____________________

Signature of Representative Authorized by Law (Parent)

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

ST. MARY'S HEALTHCARE SYSTEM FOR CHILDREN
St. Mary's Hospital for Children, Inc.
St. Mary's Community Care Professionals, Inc.
Extraordinary Home Care, Inc.
SMH Case Management, Inc.
SMH Administrative Services, Inc.

NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: ______________________________ ID#: ____________________
______

I have received a copy of this NOTICE OF PRIVACY PRACTICES for St. Mary's Healthcare System for Children, Inc. I understand that if I have any questions, I may contact:

Christine Hutton, St. Mary's Privacy Officer
Telephone: (718) 281-8587
Mail: St. Mary's Healthcare System for Children, Inc
333 Earle Ovington Boulevard
Suite 600
Uniondale, New York, 11553

______________________________ ____________________
Patient/Agent/Relative/Guardian* (Signature) Date

____
Print Name Relationship if other than patient

______________________________ ____________________ ____________________
Telephonic Interpreter's ID # Date Time

______________________________ ____________________
Interpreter (Signature) Date

____
Print: Interpreter's Name and Relationship to Patient

______________________________ ____________________
Witness to Signature (Signature) Date

____
Print Witness Name

St. Mary's Healthcare System for Children, Inc.
St. Mary's Hospital for Children, Inc.
Extraordinary Home Care, Inc.
SMH Case Management, Inc.
SMH Administrative Services, Inc.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice explains how we fulfill our commitment to respect the privacy and confidentiality of your Protected Health Information. This Notice explains how we may use and share your Protected Health Information, as well as the legal obligations we have regarding your Protected Health Information and about your rights under federal and state laws. The Notice applies to all records held by St. Mary's Healthcare System for Children entities listed on this Notice, regardless of whether the record is written, computerized or in any other form. We are required by law to make sure the information that identifies you is kept private and make this Notice available to you. In this Notice, the term "Protected Health Information" refers to individually identifiable information about you, which may include:

- Information about your health (such as medication conditions and test results you may have)
- Information about healthcare services you have received or may receive in the future (such as operation)
- Information about your healthcare benefits under an insurance plan (such as whether a prescription is covered
- Geographical information (such as where you live or work)
- Demographic information (such as your race, gender, ethnicity, or marital status)
- Unique numbers that may identify you (such as social security number, phone number, or driver's license number)
- Other types of information that may identify who you are

Generally, when this noticed uses the words, "you" or "your," it is referring to the patient, employee, or beneficiary (covered under St. Mary's Healthcare System's benefits plans) which is the subject of patient information. However, when this Notice discusses rights regarding patient information, including rights to access or authorize the disclosure of patient information, "you" and 'your" may refer to a minor-patient's parent(s), legal guardian or other personal representative, or, as applicable, an adult patient's personal representative.

If you have any questions about this notice or would like further information, please contact **Christine Hutton, Privacy Officer, at (718) 281-8587.**

OVERVIEW

The following is a summary of the key provisions in our Notice. This summary is not a complete list of how we use and disclose your Protected Health Information. If you have any questions about any of the information contained in this summary, please read this full Notice of Privacy Practices or contact St. Mary's Privacy Officer for more information.
St. Mary's Healthcare System for Children may use and disclose your protected health information without your consent to:

- Provide you with medical treatment and other services

- Carry out certain operations necessary to the operation of our programs, such as quality improvement studies, medical education, and verifying qualifications of doctors
- Coordinate your care, which may include such things as giving your appointment reminders with affiliated healthcare providers
- Talk to family or friends involved in your care, unless otherwise indicated by you
- Ensure that we follow the rules of regulatory agencies regarding the quality of care that we provide
- Comply with all legal requirements, subpoenas and court orders
- Engage in certain preapproved research activities
- Request payments from you, your insurance company, or some other third-party payer
- May include information in our hospital directory, such as name and room number, for the benefit of visitors or members of the clergy
- Contact you for fundraising activities unless otherwise indicated by you
- Meet special situations as described in this Notice, such as public health and safety

YOU HAVE THE RIGHT TO

- See and obtain a copy of your medical record in the format of your choosing, with certain restrictions
- Ask us to amend the protected health information we have about you if you feel the information we have is wrong or incomplete
- Ask us to restrict or limit the protected health information we use and share about you
- Ask us to communicate with you about medical matters in a certain way or at a specific location
- Obtain a list of individuals or entities that have received your protected health information from St. Mary's, subject to limited permitted by law
- Be notified if your protected health information is improperly disclosed or accessed
- Obtain a paper copy of this Notice
- Submit a complaint (*No one will retaliate or take action against you for filing a complaint)*

How we may use and share your protected health information with others:

St. Mary's staff and other health care professionals in the St. Mary's Healthcare System may use your health information or share it with others for the purposes of your treatment or care, obtaining payment for treatment or care, and conducting St. Mary's normal business operations. Your health information may also be shared with affiliated health care facilities and providers so that they may jointly perform certain payment activities and business operations along with St. Mary's. Below are further examples of how your information may be used with your consent.

Treatment: We may share your health information with health care providers at St. Mary's who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A health care provider at St. Mary's may share your health information with another health care provider inside St. Mary's, or at another health care facility, to determine how to diagnose or treat you. A health care provider may also share your health information with another health care provider to whom you have been referred to for further health care.

Payment: We may use your health information or share it with others so that we obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement for treatment or care we have provided to you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your future treatment or care.

Business Operations: We may use your health information or share it with others in order to conduct our normal business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you. We may also share your health information with another company that provides business services for us, such as a billing company. If so, we will have a written contract to ensure that this company also protects the privacy of your health information.

Appointment Reminders: We may use and share your protected health information to remind you of your appointment for treatment or medical care with affiliated healthcare provider(s).

Hospital Directory: If you are admitted to St. Mary's Hospital, your name and room location may be listed in the hospital's patient directory. This is so your family, friends, and outside clergy can visit you in the hospital and generally know how you are doing. Unless you object to being included in the hospital directory, we will not disclose your information to anyone who asks for you unless required by law. If you do not want your information listed in the hospital directory, you must notify personnel during admissions.

Business Associates: We may share your protected health information with a business associate that we engage with to help us, such as a billing or computer company. Business associates will have assured us in writing they will safeguard your protected health information as required by law.

Treatment Alternatives, Benefits and Services: We may use your health information when we contact you in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

Fundraising: We may use your information when deciding whether to contact you or your personal representative to raise money to help us operate. We may also share this information with a charitable foundation that will contact you or your personal representative to raise money on our behalf. If you do not want to be contacted about these fundraising efforts, please contact **Christine Hutton, Privacy Officer, at (718) 281-8587** and we will no longer reach out to you. Please give your name and address so that we may suppress your name from all future fundraising.

Friends and Family: Unless you decline, we may release protected health information to people such as family members, relatives, or close personal friends who are helping to care for you or payment for that care. Additionally, we may disclose information to a patient representative. If a person has the authority under the law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your protected health information. Parents and legal guardians are generally patient representatives for minors unless the minors are permitted by law to act on their own behalf and make their own medical decisions in certain circumstances. If you do not want protected health information about you released to those involved in your care, please notify us.

Disaster Relief Efforts: We may disclose your protected health information to an organization such as American Red Cross so that your family can be notified about your condition, status and location in the event of a disaster. If we can reasonably do so while trying to respond to the emergency, we will try to obtain your permission to share this information first.

Research: All research projects conducted by St. Mary must be approved through a special review process to protect patient safety, welfare and confidentiality. Your protected health information may be important to research efforts and may be used for research purposes in accordance with state and federal law.

Researchers may contact you regarding your interest in participating in certain research studies after receiving your authorization or approval from a special review board called an Institutional Review Board (IRB). An IRB is a special committee that protects the rights and welfare of people who participate in research studies. These studies will not affect your treatment or welfare, and your private health information will continue to be protected. Federal law also allows researchers to look at your protected health information when preparing future research studies, so long as any information identifying you does not leave St. Mary's. If you have any questions about how your medical record information could be used in a research protocol, please call the Chief Medical Officer at (718) 281-8863.

As required by law: We will share your protected health information when federal, state or local law requires us to do so. This includes to the Secretary of the U.S. Department of Health and Human Services for HIPAA rules compliance and enforcement purposes.

SPECIAL SITUATIONS

Legal proceedings, lawsuits and other legal actions: We may share your protected health information with courts, attorneys and court employees when we get a court order, subpoena, discovery request, warrant, summons, or other lawful instructions from those courts or public bodies, and in the course of certain other lawful, judicial or administrative proceedings, or to defend ourselves against a lawsuit brought against us.

Law enforcement: If asked to do so by law enforcement, and as authorized or required by law, we may release protected health information:

- To identify or locate a suspect, fugitive, material witness or missing person
- About a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death suspected to be result of a criminal conduct
- About criminal conduct at St. Mary's Healthcare System for Children, Inc.

To avert a serious threat to health and safety: We may use and disclose your protected health information when necessary to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help stop or reduce the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

Public health risks: As required by law, we may disclose your protected health information to public health authorities for purposes related to: preventing or controlling disease, injuries or disability; reporting vital events, such as deaths; reporting child abuse or neglect; reporting domestic violence; reporting reactions to medications or problems with products; notifying people of recalls; repairs or replacements of products they may be using; notifying a person who many have been exposed to a disease or may be at risk for contracting or spreading a disease and reporting to your employer findings concerning work-related illness or injury so that your workplace may be monitored for safety.

Workers' compensation: We may share your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Specialized government functions: If you are a member of the armed forces (of either the United States or of a foreign government), we may share your protected health information with military authorities so they may carry out their duties under the law. We may also disclose your protected health information if it relates to national security and intelligence activities, or to providing protective services for the President or for other important officials, such as foreign heads of state.

Health oversight activities: We may disclose your protected health information to local, state or federal governmental authorities responsible for the oversight of medical matters as authorized by law. This includes licensing, auditing and accrediting agencies and agencies that administer public health programs such as Medicare and Medicaid.

Coroners, medical examiners and funeral directors: We may release your protected health information to a coroner or medical examiner as necessary to identify a deceased person or to determine the cause of death. We also may release protected health information to funeral directors so they can carry out their duties.

Organ, eye and tissue donation: If you are an organ donor, we may release your protected health information to organizations that obtain organs or handle organ, eye or tissue transplantation. We also may release your information to an organ donation bank as necessary to facilitate organ, eye or tissue donation and transplantation.

Inmates: If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law officer as authorized or required by law.

This includes sharing information that is necessary to protect the health and safety of other inmates or people involved in supervising or transporting inmates.

Incidental disclosures: While we will take reasonable steps to safeguard the privacy of your protected health information, certain disclosures of your information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your information. For example, during the course of a treatment session, other patients in the treatment area may see or overhear discussion of your information. These "incidental disclosures" are permissible.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Uses and disclosures not covered in this Notice: Other uses and disclosures of your protected health information not described above in this Notice or permitted by law will be made only with your written authorization. In addition, we will obtain your authorization for most uses and disclosures of psychotherapy notes. When consent for disclosure is required by law, your consent will be obtained prior to the disclosure. If you give us authorization to use or share protected health information about you, you may revoke the authorization in writing at any time. Please understand that we are unable to retract any disclosures already made with your authorization.

Under the regulations known as Part 2, certain substance use disorder patient records have greater privacy protections. If we have any of these patient records, we cannot use them to investigate or prosecute a patient without your written or pursuant to a court order after you are presented with notice and an opportunity to be heard. You can provide a single consent for all future uses and disclosures of such records for purposes of treatment, payment and health care operations that does not permit use for civil, criminal, administrative or legislative proceedings.

Special privacy protections apply to HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you will be provided with separate notices explaining how the information will be protected.

YOUR RIGHTS CONCERNING YOUR PROTECTED HEALTH INFORMATION

Right to ask to see and obtain a copy: You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request to **Christine Hutton, Privacy Officer (718) 281-8587**. Upon your request, we will provide you with a copy of your record in the format you request, if it is available. This includes a paper copy or electronic copy of your record, if it is available. If you request a copy of your record, we may charge a fee for the cost of copying, mailing or other supplies we use to fulfill your request. The standard fee is $0.75 per page for paper and $10.00 for an electronic copy. The fee must generally be paid before or at the time we give the copies to you. For St. Mary's Hospital for Children residents, we will respond to your request for inspection of records within twenty-four hours and we ordinarily will respond to requests for copies within two working days. For patients and clients of all other St. Mary's programs, access to your records will be made within ten days of your request.
Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy. You may be charged a fee for the cost of preparing the summary of your record.

Right to ask for an accounting of disclosures: You have the right to ask us for a listing of those individuals or entities who have received your protected health information from St. Mary's in the six years prior to your request. This list will not cover disclosures made:

- To you or your personal representative
- To carry out treatment, payment or healthcare operations
- To parties you authorize to receive your protected health information
- To your family member, relatives, or friends who are involved in your care
- To correctional institutions or law enforcement officials
- To provide or arrange for your care
- Incident to a permitted use or disclosure
- To those who request your information through the hospital directory
- For national security or intelligence services
- As part of a limited data set for research purposes

To request this list, please contact **Christine Hutton, Privacy Officer at (718) 281-8587**. Your request must state a period for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between January 1, 2004, and January 1, 2005. You have the right to one list within every twelve-month period for free. However, we may charge you for the cost of providing any additional lists in that same twelve-month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily we will respond to your request for an accounting list within 60 days. If we need additional time to prepare the accounting list you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting list. In rare cases, we may have to delay providing you with the accounting list without notifying you because a law enforcement official or government agency has asked us to do so.

Right to request restrictions: You have the right to ask us to restrict or limit the protected health information we use or disclose about you for treatment, payment or healthcare operations. In most cases, we must consider your request, but we are not required to agree to it. However, we must agree to limit disclosures made to your health insurer or other third-party payer about services we provided to you if, prior to receiving the medical services, you pay for the services in full, unless the disclosure of that information is required by law.

To request restrictions, please contact **Christine Hutton, Privacy Officer at (718) 281-8587**. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply.

We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. *However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law.* Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

Right to request confidential communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask when we contact you only at home, only by mail/email or by text. If you want us to communicate with you in a special way, you will need to give us details about how to contact you, including a valid alternate address. You will also need to give us information about where your bills may be sent. However, if we are unable to contact you using the requested means or location, we may contact you using whatever information we have

You have the right to request that we communicate with you or your personal representative about your medical matters in a more confidential way. To request more confidential communications, ***we will not ask you the reason for your request, and we will try to accommodate all reasonable requests***. Please specify in your request how you or your personal representative wishes to be contacted, and how payment for your health care will be handled if we communicate with your personal representative through this alternative method or location. As indicated in this Notice, this request must be sent to **Christine Hutton, Privacy Officer** at St. Mary's

Healthcare System for Children, Inc 333 Earle Ovington Blvd, Suite 600, Uniondale, NY 11552.

Right to receive notice of a breach: You have the right to be notified in the event of a breach of a privacy of your unsecured protected health information by St. Mary's or its business associates. The notice will provide you with the date we discovered the breach, a brief description of the type of information that was involved and the steps we are taking to investigate and mitigate the situation, as well as contact information for you to ask questions and obtain additional information.

Right to a paper copy of this Notice: Upon request, you may at any time obtain a paper copy of this Notice, even if you previously agreed to receive this Notice electronically. To request a copy, please contact **Christine Hutton, Privacy Officer, at (718) 281-8587** or ask admissions for one at the time of your next visit.

How to file a privacy complaint: If you believe that your privacy rights have not been followed as directed by federal regulations and state law or as explained in this Notice, you may contact us by telephone, submit a written complaint through our web-based reporting, or file a written complaint with us at: **Christine Hutton, Privacy Officer** at St. Mary's Healthcare System for Children, Inc 333 Earle Ovington Blvd, Suite 600, Uniondale, NY 11552.
Compliance Hotline: (888) 343-2581 or web-based reporting: https://www.integrity-helpline.com/stmaryskids.jsp.

You will not be retaliated against or denied any health services if you file a complaint: If you are not satisfied with our response to your privacy complaint or wish to file a complaint, you may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. The complaint must be in writing; it must describe the subject matter of the complaint and the individuals or organization that you believe violated your privacy and it must be filed within 180 days of when you knew or should have known that the violation occurred. The complaint should then be sent to: Long Island Region Office at info.longisland@dhr.ny.gov or Telephone: (516) 539-6848 or U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C 20201, calling 1-877-696-6775 or visiting https://www.hhs.gov/ocr/complaints/index.html

Future changes to St. Mary's Healthcare System for Children, Inc's privacy practices and this Notice: We reserve the right to change this Notice and the privacy practices of the organizations covered by this Notice without first notifying you. We reserve the right to make the revised or changed Notice effective for protected health information we already have about you as well as any information we receive in the future. To request a copy of the most recent Notice, please contact **Christine Hutton, Privacy Officer, at (718) 281-8587** or ask admissions for one at the time of your next visit.
The current Notice will also be posted to the St. Mary's website, www.stmaryskids.org. At any time, you may request a copy of the Notice currently in effect.

LETTER OF MEDICAL NECESSITY

Date:
RE:
DOB:

To Dr.

The above patient is awaiting an appointment for a clinic evaluation at the Center for Pediatric Feeding Disorders. In order for us to contact insurance to obtain coverage, we are in need of a Letter of Medical Necessity from the patient's physician. Below is an example of what should be mentioned in the letter. Please fax or e-mail the Letter of Medical Necessity to Program Coordinator.

Please include in your letter the following information.

- Patient Name:
- Diagnosis: (with DX codes)
  - Stating any underlying medical conditions and medical issues due to feeding.
- Brief statement about how severity of problem and/or failure to make sufficient gains with other interventions (medical treatments, outpatient or school-based feeding therapy, etc.) warrants more intensive treatment.
- Medical History
- Recent Height, Weight, BMI
- Referral for intensive feeding services at the Center for Pediatric Feeding Disorders

Sincerely,

Program Coordinator
Center for Pediatric Feeding Disorders
29-01 216th Street
Bayside, NY 11360
Tel: 718-281-8541
Fax: 718-281-8505
feedingadmin@stmaryskids.org

DAY PATIENT ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to St. Mary's Hospital for Children for services rendered in connection with this admission.

I authorize the release of any medical or other information necessary to process my medical claims. I also request payment of government benefits (if any) either to myself or to the party who accepts assignment as above.

I severally accept responsibility for payment of the full amount due to ST. MARY'S. This includes co-insurance, co-payments or deductibles as well as for payment of non-covered services. Should the parties be successful in obtaining insurance coverage for services rendered to patient by the Feeding Program, I shall remain responsible for the difference between any amounts collected from patient's plan and ST. MARY'S charges for services rendered.

______________________________ ____________________
Print Name: Parent/Legal Guardian Date

______________________________ ____________________
Signature: Parent/ Legal Guardian Date

stmary'skids

The Cindy and Tod Johnson Center For Pediatric Feeding Disorders

EVALUATIONS AND SERVICES

CLINIC (Initial Evaluation visit)

Preparing for the visit

- The average wait time from date of referral to initial assessment can take a few weeks.
- All relevant reports and documents including the child's growth chart have to be on file before an evaluation can be scheduled.
- The 3-day food diary should have been sent to the team or presented on the day of the evaluation.

Fees and Payment

- The Managed Care department will process insurance for authorization and detail any charges to the family prior to the evaluation. These charges are based on your child's needs and the level of evaluation service to be conducted.
- Payment is expected on the day of the evaluation. It can be made in check, money order or credit card.

What to Bring

- Families should bring to clinic 2-3 foods the child will consume (preferred) and 2-3 foods the child can but does not consume (non-preferred). These items will be used for the feeding observation portion of the evaluation.
- Families are expected to bring with them all necessary foods (variety, texture), utensils (specialized spoons, oral motor tools) and equipment (special seats, etc.).
- Families are encouraged to bring items that will engage their child and occupy their child's attention during that waiting period.
- If you are bringing children who are not part of the evaluation and/or your child requires a level of supervision that will prevent you from interviewing with team members, please attend the appointment with another adult who can assist in supervision.

The Day of the Appointment

- Free parking is available on premises. Valet parking is available 8:30am-4pm.
- The evaluation can take up to 2-3 hours. You will be kept informed about any unforeseen delays and every effort will be made to provide you with service in a timely way.
- A comprehensive evaluation will be conducted by St. Mary's interdisciplinary team.
- Your child will be weighed and height will be taken during the clinic evaluation.
- One or more specialists from Nutrition, Gastroenterology, Nursing, Behavior and Speech/Feeding may join in the evaluation at different periods of the evaluation.
- Besides a detailed interview and document review, observation of a feeding session will also be conducted. Caregivers will feed the child as they would at home and specialists will document observations in order to provide you with specific feedback and treatment options.
- An oral motor assessment will be conducted and clinician probe with non-preferred foods may be implemented.
- After conducting the evaluation, the interdisciplinary team members will meet by themselves to discuss the findings and develop appropriate recommendations for the child and family. Following that meeting, the team members will meet with the family to explain the findings and recommendations.

After the Appointment

- A written report with findings and recommendations will follow in approximately 2 weeks from the date of the evaluation. Where indicated, community providers will be contacted for consultation on recommended changes to the child's feeding status.
- There is currently a wait list for Day Patient Program and outpatient services. However, there will be times when an opening may come sooner than expected. At that time an offer will be made to families to take up the available slot. If a family is unable to accept the offer the child will be put back on the waiting list.
- Following clinic evaluation St. Mary's staff will consult with your current SLP/ feeding therapist.
- While you are on wait list and during your admission we will consult with your current GI/Pediatrician. Decisions concerning admission (timing, tube feeds, supplements, medications, etc.) will be made with their input.
- Caregivers and community providers are expected to continue to work on the child's feeding difficulties while waiting on the child's admission. In addition, medical tests and changes to the child's feeding regimen may be recommended to assure that the child is ready to benefit from the program. Failure to complete these recommendations may delay the child's admission. It is the caregiver's responsibility to contact relevant program staff with updates on recommendations and/or obstacles to following recommendations. This should be a collaborative process between caregivers and the evaluation team.

Follow up clinics (while waiting for admission to the Day Patient Program)

- The schedule for follow up clinics is based on each child's needs. The clinic team will arrange follow up appointments as needed. Our recommendations and admission guidelines may change based on our findings during follow-up evaluations.
- Only specialists deemed essential will see the child during the follow up visits. Caregivers may request to meet with other specialists if they need additional consultation. Caregivers are encouraged to make such requests through our Program Coordinator in advance of the clinic appointment.
- Follow up evaluations will last approximately 1 hour. Updates on the child's progress and any new concerns will be addressed. A feeding observation will be conducted. Caregivers need to bring with them all necessary food, utensils, equipment used during meal times.
- Caregivers should also bring with them tests/reports if completed since the last clinic visit.
- A written report will follow in approximately 2 weeks.

PLEASE DO NOT HESITATE TO ASK IF YOU HAVE QUESTIONS AND/OR CONCERNS REGARDING ANY OF THE INFORMATION CONTAINED IN THIS PACKET