stmaryskids
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, Jamie Russell, at (718) 281-8541 or e-mail jrussell@stmaryskids.org.

Sincerely,

Program Coordinator

stmary'skids
The Cindy and Tod Johnson Center For Pediatric Feeding Disorders

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: _____

Home Telephone Number: _____ Cell Phone Number: _____

Email address: _____ Patient's Social Security: _____/_____/_____

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

Preferred Location of Services: ❑ Bayside, NY ❑ Roslyn, NY

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	☐ Milk Scan	☐ Modified Barium Swallow Study
☐ 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…)

_____

_____

_____

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	Type of Issue	Current	Previous	Type of issue
☐	☐	Autism, PDD or Asperger's	☐	☐	Gastroesophageal Reflux
☐	☐	Developmental or Speech Delay	☐	☐	Chronic constipation
☐	☐	ADHD/ADD	☐	☐	Chronic diarrhea
☐	☐	Learning Disability	☐	☐	Food Allergies
☐	☐	Mental Retardation	☐	☐	Lactose Intolerance
☐	☐	Traumatic Brain Injury	☐	☐	Seasonal Allergies
☐	☐	Depression or Bipolar Disorder	☐	☐	Blind or Severe Vision Impairment
☐	☐	Anxiety Disorder or OCD	☐	☐	Deaf or Severe Hearing Impairment
☐	☐	Cerebral Palsy	☐	☐	Delayed Gastric Emptying
☐	☐	Spina Bifida	☐	☐	G-tube or NG-tube Feeding
☐	☐	Seizure Disorder	☐	☐	Liver Disease
☐	☐	Diabetes, Type I or II	☐	☐	Endocrine Disorder or Growth Problems
☐	☐	Prematurity	☐	☐	Heart/Cardiac Problems
☐	☐	Kidney Disease	☐	☐	Asthma
☐	☐	Metabolic Disorder	☐	☐	Genetic Disorder (specify)
☐	☐	FTT			Dysphagia
☐	☐	Pneumonia			Pulmonary Disease
☐	☐	Neurological/Brain issues			Eosinophilic Esophagitis
☐	☐	Other:			

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? _____

Continuous feeding:
How much per hour _____ Length of feeding (start time/stop time) _____

Bolus feeds:
What is the bolus schedule? _____

Volume per bolus _____ How long does a bolus feed take? _____

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

How many times per day does your child vomit during or within one hour of tube feeding?

☐ 0 times ☐ 1-3 times ☐ 4-6 times ☐ 7-9 times ☐ 10 or more times

How many times per week does your child gag or retch during or within one hour of tube feeding?

☐ 0 times ☐ 1-3 times ☐ 4-6 times ☐ 7-9 times ☐ 10 or more times

How many times per week does your child cry during or within one hour of tube feeding?

☐ 0 times ☐ 1-3 times ☐ 4-6 times ☐ 7-9 times ☐ 10 or more times

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? _____

_____

_____

Other comments regarding tube feedings: _____

_____

_____

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. Goals

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

_____

_____

_____

X. 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:				
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:				
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. (OCA Official Form # 960).**

St. Mary's Healthcare System for Children
St. Mary's Hospital for Children, Inc.

NOTICE OF PRIVACY PRACTICES

Effective Date: April 2003; Revised September 24, 2013; Revised September 4, 2015; Revised August 5, 2016

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.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of St. Mary's health care professionals who provide treatment or care for St. Mary's patients, and affiliated health care providers that jointly perform payment activities and business operations with St. Mary's. A copy of our current notice will always be available in the reception area of all of our sites. You or your personal representative may also obtain a copy of this notice by requesting a copy from St. Mary's staff or **Martha Pellicano, Privacy Officer at (718) 281-8587***.*

Generally, when this notice uses the words, "you" or "your," it is referring to the patient 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 **Martha Pellicano, Privacy Officer at (718) 281-8587***.*

IMPORTANT SUMMARY INFORMATION

Requirement for Written Authorization. We will generally obtain your written authorization before using your health information or sharing it with others outside St. Mary's Healthcare System. You may also initiate the transfer of your records to another person by completing an authorization form. Your written authorization is required prior to the use or sharing of psychotherapy notes. We will not sell or receive anything of value in exchange for your medical information without your written authorization. Your information will not be used for marketing purposes without your written authorization. If you provide us with written authorization, you may revoke that authorization at any time, except to the extent that we have already relied upon it. To revoke an authorization, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587***.*

Exceptions to Requirement. There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

- **Exception for Treatment, Payment, and St. Mary's Operations.** For more information, see page 3-4 of this notice.

- **Exception for Disclosure to Friends and Family Involved in Your Care.** We will ask you whether you have any objection to sharing information about your health with your friends and family involved in your care. For more information, see page 4 of this notice.

- **Exception in Emergencies or Public Need.** We may use or disclose your health information in an emergency or for important public needs. For example, we may share your information with public health officials at the New York State or city health departments who are authorized to investigate and control the spread of diseases. For more examples, see pages 4-6 of this notice.

- **Exception if Information Does Not Identify You.** We may use or disclose your health information if we have removed any information that might reveal who you are.

How to Access Your Health Information. You generally have the right to inspect and to receive a copy your health information. For more information, please see page 6 of this notice.

How to Correct Your Health Information. You have the right to request that we amend your health information if you believe it is inaccurate or incomplete. For more information, please see page 7 of this notice.

How to Keep Track of the Ways Your Health Information Has Been Shared with Others. You have the right to receive a list from us, called an "accounting list," which provides information about when and how we have disclosed your health information to outside persons or organizations. Many routine disclosures we make will not be included on this list, but the list will identify non-routine disclosures of your information. For more information, please see page 7 of this notice.

How to Request Additional Privacy Protections. You have the right to request further restrictions on the way we use your health information or share it with others. We are not required to agree to the restriction you request, but if we do, we will be bound by our agreement. For more information, please see page 8 of this notice.

How to Request More Confidential Communications. You have the right to request that we contact you in a way that is more confidential for you. We will try to accommodate all reasonable requests. For more information, please see page 8 of this notice.

How Someone May Act on Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

How to Learn About Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information. 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. To request copies of these other notices now, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587***.*

How to Obtain a Copy of this Notice. You have the right to a paper copy of this notice. You may request a paper copy at any time. To do so, please ask a St. Mary's staff member or **Martha Pellicano, Privacy Officer at (718) 281-8587***.* You or your personal representative may also obtain a copy of this notice by requesting a copy from St. Mary's staff.

How to Obtain a Copy of Revised Notices. We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. The revised notice will apply to all of your health information, and we will be required by law to abide by its terms. We will post any revised notice in St. Mary's reception area. You or your personal representative will also be able to obtain your own copy of the revised notice by requesting a copy from a St. Mary's staff member or **Martha Pellicano, Privacy Officer at (718) 281-8587**. The effective date of the notice will always be located in the top right corner of the first page.

How to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587***. No one will retaliate or take action against you for filing a complaint.*

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information about your health condition (such as a disease you may have);
- information about health care services you have received or may receive in the future (such as an operation);

 information about your health care benefits under an insurance plan (such as whether a prescription is covered);
 geographic information (such as where you used to 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); and
 other types of information that may identify who you are.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

1. **Treatment, Payment and St. Mary's Business Operations**

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 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 to you. We may also share your health information with another company that performs 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.

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 for these fundraising efforts, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587**.

2. **Friends and Family**

We may share your information with friends and family involved in your care, without your written authorization or consent. We will always give you an opportunity to object. We will follow your wishes unless we are required by law to do otherwise.

Friends and Family Involved in Your Care. If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition here at the St. Mary's, or about the unfortunate event of your death. In some cases, we may need

to share your information with a disaster relief organization that will help us notify these persons. If you object to sharing your information with your family members, personal representative, or other person responsible for your care, please contact **Martha Pellicano, Privacy Officer (718) 281-8587**.

3. **Emergencies or Public Need**

We may use your health information, and share it with others, in order to treat you in an emergency or to meet important public needs. We will not be required to obtain your written authorization, consent or any other type of permission before using or disclosing your information for these reasons.

Emergencies. We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

Communication Barriers. We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

As Required by Law. We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury or disability. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so.

Victims of Abuse, Neglect or Domestic Violence. We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Product Monitoring, Repair and Recall. We may disclose your health information to a person or company that is required by the Food and Drug Administration to: (1) report or track product defects or problems; (2) repair, replace, or recall defective or dangerous products; or (3) monitor the performance of a product after it has been approved for use by the general public.

Lawsuits and Disputes. We may disclose your health information if we are ordered to do so by a court that is handling a lawsuit or other dispute.

Law Enforcement. We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws that we are required to follow;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your consent because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect that your death resulted from criminal conduct;
- If necessary to report a crime that occurred on our property;

To Avert a Serious Threat to Health or Safety. We may use your health information or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent 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).

National Security and Intelligence Activities or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Inmates and Correctional Institutions. If you later become incarcerated at a correctional institution or detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation. We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners and Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Organ and Tissue Donation. In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

Research. In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information without your authorization if we obtain approval through a special process to ensure that research without your authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters.

1. Right to Inspect and Obtain a Copy of Records

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 **Martha Pellicano, 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.

2. **Right to Amend Records**

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records. To request an amendment, please contact **Martha Pellicano, Privacy Officer (718) 281-8587**. Your request should include the reasons why you think we should make the amendment. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.
If we deny part or your entire request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

3. **Right to an Accounting of Disclosures**

After April 14, 2003, you have a right to request an "accounting of disclosures" which is a list with information about how we have shared your information with others. An accounting list, however, will not include:

- Disclosures we made to you;
- Disclosures we made in order to provide you with treatment or care, obtain payment for that treatment or care, or conduct our normal business operations;
- Disclosures made to your friends and family involved in your care;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures about inmates to correctional institutions or law enforcement officers; or
- Disclosures made before April 14, 2003.

To request this list, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587**. Your request must state a time 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 a 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.

4. **Right to be Notified in the Event of a Breach.**

We will notify you if your medical information has been "breached" which means that the privacy or security of your information has been compromised (used or shared in a way that violates the law).

5. **Right to Request Additional Privacy Protections**

You have the right to request that we further restrict the way we use and disclose your health information to provide you with treatment or care, collect payment for that treatment or care, or to conduct St. Mary's normal business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a surgery you had. If you pay for services or health care items out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We may agree unless a law requires us to share that information.

To request restrictions, please contact **Martha Pellicano, 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.

6. **Right to Request Confidential Communications**

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, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587***. 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.

FOR FURTHER INFORMATION, PLEASE CONTACT:
MARTHA PELLICANO, PRIVACY OFFICER
5 DAKOTA DRIVE, SUITE 200
NEW HYDE PARK, NY 11042
(718) 281-8587

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

NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

PATIENT NAME: _____ Date of Birth: _____

I have received this NOTICE OF PRIVACY PRACTICES for St. Mary's Healthcare System for Children. I understand that if I have any questions, I may contact Martha Pellicano, the St. Mary's Privacy Officer, by telephone at (718) 281-8587 or by mail at St. Mary's Healthcare System for Children, Inc., 5 Dakota Drive, Suite 200, New Hyde Park, NY 11042.

Signature _____ Date _____

Print Name _____

NOTE: Signed acknowledgement by a patient caretaker to be maintained in patient clinical record at St. Mary's Healthcare System for Children.

The Cindy and Tod Johnson Center For Pediatric Feeding Disorders

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 the Letter of Medical Necessity to Jamie Russell, Program Coordinator at 718-281-8541.

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,

Jamie Russell

Jamie Russell
Program Coordinator
Center for Pediatric Feeding Disorders
29-01 216th Street
Bayside, NY 11360
Tel: 718-281-8541
Fax: 718-281-8505

stmaryskids
The Cindy and Tod Johnson Center For Pediatric Feeding Disorders

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

stmaryskids
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 8am-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.
  Team members may include;
  - Dr. Edwin Simpser- Gastroenterologist, CEO
  - Patty Bashe – Behavior Analyst
  - JoKathleen Rodriguez- Pediatric Nurse Practitioner
  - Anselma Kuljanic- Registered Dietitian
  - Carla Villanella- Speech Language Pathologist
  - Stella Yusupova- Speech Language Pathologist, Supervisor

- 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.

<u>After the Appointment</u>

- 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