



Sensory Solutions, LLC

Physical, Speech and Occupational Therapy for Children

Policy & Procedures

- All co-pays are due at the time of service
- Balances on ALL accounts must be **PAID IN FULL** in order to continue therapy services. Please check your balance prior to the therapy session.
- Outstanding balances will be sent to collections and therapy will be discontinued.
- 24 hour **CANCELLATION NOTICE** is appreciated (see cancellation policy)
- 2 or more **NO CALL/NO SHOWS** will forfeit your standing appointment time
- Returned checks will result in a \$25 fee due at the time of notification
- We are a **teaching facility** therefore there may be times when a student observes or runs the therapy session. You will be notified before the session begins if a student will be involved in the therapy session.
- Due to insurance liabilities we ask that you be seated in the waiting area until a therapist can lead the patient to a treatment room for therapy.
- Please note that your therapist may advise you to step out of the therapy session or remain in the waiting room during the therapy session to assure your child's optimal performance, establish a trusting relationship, and good rapport with your child.
- We do our very best to begin and end treatment sessions on time. Please be prompt for appointments for they will end 40 minutes from the start of your scheduled appointment time. If you choose to drop off your child for therapy make certain you have filled out the Emergency Contact form and arrive 10 minutes prior to the end of your child's session
- Authorization is **not a guarantee of payment**. If your insurance company denies payment you will be responsible for the entire balance.
- We reserve the right to discontinue therapy services if we feel our staff, other patients, and/or your child are at risk for injury or physical harm, due to **aggressive behaviors** before, during, and/or after therapy sessions. When appropriate, we will offer a one time warning before discontinuing services. Aggressive behaviors include, but are not limited to, hitting, kicking, biting, punching, shoving, hair pulling, inappropriate language, and destruction of property.

By signing this document, I acknowledge that I have read and agree to everything listed in the above policy and procedures.

Signature _____ Date _____



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CLIENT FINANCIAL RESPONSIBILITY & CANCELLATION POLICY

It is important to discuss with our clients our financial policy so we may provide the best services for your child. Sensory Solutions, LLC is one of the only private therapy companies that allow families to bill services through their insurance. In taking on this additional responsibility, it is critical that families do their part to ensure that the services being provided for their child are being paid and therapists time being respected.

Deductibles need to be met at the beginning of each fiscal year by major insurance companies. Families are responsible for paying their deductible up front. Families need to pay all deductible payments and co/pays prior to the beginning of their child's therapy session. All bills must be paid prior to each therapy session. If bills become delinquent, therapy will be terminated immediately. If payment is not received, the case will be turned over to our company attorney for collections.

We allow "standing" appointments to our clients to assist with your schedule and ours. In doing this, we will respect your appointment time and will ensure that a therapist will be available if your particular therapist is sick or on vacation. To reciprocate that respect, we ask that you be 5 minutes early to your appointments. If you are late, it takes from your child's session. Each session is 40 minutes in duration so please try and arrive on time. We also ask that you respect our cancellation policy. We are here each and every day to provide a service and need your child here in order to treat him/her and make the most progress possible. It is our experience that children progress toward their therapy goals when there is consistent attendance.

CANCELLATION/ MAKE UP POLICY:

For clients being seen once per week, there will be TWO allowed cancellations per year. For clients being seen twice per week, there will be FOUR allowed. Any other cancellations are subject to our make-up policy. You will be billed (not insurance) for the cancelled session at the rate your insurance company reimburses. You will be allowed to make up this visit and will be credited the amount paid. You will not be reimbursed until the end of your make up session. If you know in advance you will be missing certain sessions (winter break, spring break, vacation) please try to schedule those make up sessions in advance. In case of long-term injury or illness, cases will be dealt with on an individual basis. Cancellations for days the clinic is closed will not be billed. This policy includes those that are scheduled for a group session as well.

NO SHOWS:

If you have not canceled a regularly scheduled appointment or scheduled a make-up session and still do not come, you are considered a "no show" and you will be billed for your session. "No show" sessions are not subject to our make-up policy

Name: _____ Date: _____



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CONFIDENTIALITY POLICY

At Sensory Solutions, LLC we are committed to maintaining client confidentiality. However, due to space constraints, we are unable to meet with each of our clients families in a private area at the end of each session. Therefore, we use the waiting area to provide you with information about your child's therapy session and home recommendations. We understand that you may prefer an alternative arrangement. If so, please let us know and we will accommodate you. If you prefer, you can schedule a meeting or phone consult with your child's therapist every 1-2 months in place of one of your child's sessions or in addition to his/ her session. Please understand that this visit will be billed privately to the family, not billed through insurance.

Child's name: _____

Parent's name: _____

_____ I DO GIVE permission for my child's therapist at Sensory Solutions, LLC to discuss and share verbal and/or written information about my child in the public waiting room at the end of each session.

_____ I DO NOT GIVE permission for my child's therapist at Sensory Solutions, LLC to discuss and share verbal and/ or written information about my child in the public waiting room at the end of each session. I will schedule a meeting or phone consult with my child's therapist every 1-2 months to discuss my child's therapy sessions. I understand that I will be billed for this meeting and that I may schedule this in lieu of a session. This will be billed as a private visit, not an insurance visit.

Corporate Office

10560 Old Olive St. Rd. Suite 100
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St. Peters Location

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www.sensorysolutions.org



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EMERGENCY CONTACT:

Child: _____ Birthdate: _____ Phone: (____) _____

Address: _____ Zip: _____ Email: _____

Parent Name (1) _____ Cell: _____

Parent Name (2) _____ Cell: _____

Caregiver's Name _____ Cell: _____

Two people we can reach in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Conditions that might require Immediate or Emergency Care (Diabetes, food allergies, epilepsy, etc.)

1. _____ Treatment _____

2. _____ Treatment _____

I accept responsibility for any necessary expense incurred in the medical treatment of my child which is not covered by the following:

Insurance co. _____ Policy No. _____

Parent's signature: _____ Date _____



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Patient History Form

***Please fill out the questionnaire as accurately and completely as possible.**

Child's Name: _____ Birthdate: _____

Referred by: _____

What are your concerns regarding your child? _____

Mother's Name: _____

Address: _____

Zip Code: _____ Cell Phone: _____ Home Phone: _____

Email: _____

Education: _____ Occupation: _____

Employer: _____ Work Phone: _____

Father's Name: _____

Address _____

Zip Code: _____ Cell Phone: _____ Home Phone: _____

Email: _____

Education: _____ Occupation: _____

Employer: _____ Work Phone: _____

Siblings (and ages): _____

Marital Status (Please check): Married Separated Divorced Widowed Single

Medical Insurance Company: _____

Whom will be responsible for payments: _____

Emergency contact information:

Name: _____ Relationship: _____

Phone Number: _____

Child's Pediatrician: _____

Address: _____

Zip Code: _____ Phone: _____ Fax: _____

How long has your child been under this physician's care?: _____



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MEDICAL HISTORY:

Pregnancy: Full Term Premature

Length of Pregnancy: _____

Mother's general health during pregnancy: Good Fair Poor

Problems encountered during pregnancy (e.g., illnesses, injuries, stress, bleeding, fainting spells, anemia, etc.): _____

Length of total labor: _____

Difficult labor: Yes No

Delivery Type:

Vaginal

C-section

Complications:

Induced Birth

Breech Presentation

Limpness

Stiffness

Other: _____

Elaborate on above delivery complications: _____

Length of hospitalization: _____ Child's birth weight: _____ lbs. _____ oz.

Complications:

Jaundice

Cyanosis

Congenital defects

Other: _____

Was there a need for:

Oxygen

Transfusions

Tube Feedings

If so, please explain: _____

Were there any feeding difficulties at birth: Yes No

Explain: _____



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Problems encountered during your child's first month: _____

List illnesses/diseases your child has experienced:

Illness: _____ Age: _____

Illness: _____ Age: _____

Illness: _____ Age: _____

List injuries/operations your child has had:

Injury/operation: _____ Age: _____

Injury/operation: _____ Age: _____

Injury/operation: _____ Age: _____

Has your child experienced high fevers: Yes No

Age: _____ Temp: _____ Frequency: _____

Has your child experienced convulsions/seizures: Yes No

Age: _____ Type: _____ Frequency: _____ Medication: _____

Has your child experienced ear infections: Yes No Frequency: _____

Has your child had tubes placed: Yes No When: _____

Date of last hearing evaluation: _____ Results: _____

Where was the hearing evaluation completed: _____

Date of last vision evaluation: _____ Results: _____

Where was the vision evaluation completed: _____

Allergies:

None

Seasonal

Food

Other

Please list all allergies: _____

History of acid reflux: Yes No

If yes, when and how was it treated: _____

Child's general health at present:

Good

Fair

Poor



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Is your child currently taking any medications: __Yes __No

If yes, type(s): _____

SPECIALTY CONTACTS:

Specialty	Name of Agency/Specialist	Address	Phone
Audiologist	_____	_____	_____
Behavior Therapist	_____	_____	_____
Cardiologist	_____	_____	_____
Chiropractor	_____	_____	_____
ENT	_____	_____	_____
Occupational Therapist	_____	_____	_____
Ophthalmologist/ Optometrist	_____	_____	_____
Orthopedist	_____	_____	_____
Physical Therapist	_____	_____	_____
Psychologist/ Psychiatrist	_____	_____	_____
Speech Pathologist	_____	_____	_____
GI	_____	_____	_____
Other	_____	_____	_____



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DEVELOPMENTAL HISTORY:

Check which of the following describes/described your child as an infant:

- Fussy
- Irritable
- Good
- Quiet
- Passive
- Active
- Liked being held
- Resisted being held
- Floppy when held
- Tense muscles when held
- Good sleep patterns
- Irregular sleep patterns

Check which of the following describes your child at present:

- | | |
|--|--|
| <input type="checkbox"/> Usually happy | <input type="checkbox"/> Poor attention span |
| <input type="checkbox"/> Mostly quiet | <input type="checkbox"/> Easily frustrated |
| <input type="checkbox"/> Overly active | <input type="checkbox"/> Cries often |
| <input type="checkbox"/> Tires easily | <input type="checkbox"/> Cries infrequently |
| <input type="checkbox"/> Talks constantly | <input type="checkbox"/> Rocks self frequently |
| <input type="checkbox"/> Too impulsive | <input type="checkbox"/> Has difficulty learning new tasks |
| <input type="checkbox"/> Restless | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Resistant to changes | <input type="checkbox"/> Overreacts |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Wets bed |
| <input type="checkbox"/> Fights frequently | <input type="checkbox"/> Frequent temper tantrums |
| <input type="checkbox"/> Difficulty separating from primary caretakers | <input type="checkbox"/> Nervous habits or tics |
| <input type="checkbox"/> Falls often | |

Approximate ages in which your child completed the following routinely:

Held up head (while on stomach): _____

Rolled over: _____

Belly crawled: _____

Crawled on hands and knees: _____

Sat independently: _____

Pulled to standing: _____

Standing independently: _____

Walking independently: _____

Babbling: _____ Were there a variety of sounds: _____

Producing single words: _____

Combining 2-words: _____

Obeying simple commands: _____



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Does your child wear orthotics: Yes No Type: _____

Does your child require/use medical equipment: _____

Does your child use assistive devices for walking: Yes No Type: _____

General impressions of your child's motor development:

Gross Motor: Slow Normal Advanced

Fine Motor: Slow Normal Advanced

Handwriting: Poor Fair Good

Does your child show a hand preference with:

Feeding Which hand: _____

Writing/Drawing Which hand: _____

Throwing Which hand: _____

Pointing Which hand: _____

Cutting Which hand: _____

Has your child achieved skills and then lost them: Yes No

Explain (what and when): _____

Has your child received prior therapy? (Please check all that apply):

First Steps School Outpatient facility similar to Sensory Solutions

FEEDING:

Bottle fed: Yes No Type of formula: _____

Nursed: Yes No

Currently eats:

Breast milk

Formula

Baby food

Junior foods

Mashed table foods

Table foods

Feeds self: All Most Some Rare

If feeds self, uses: Bottle Fingers Spoon Fork

Drinks from:

Bottle Sippy cup Soft straw Hard straw Open cup

List most preferred foods: _____



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List avoided foods: _____

SELF-CARE:

Bathes self: All Most Some None
Undresses self: All Most Some None
Dresses self: All Most Some None

Is your child toilet trained: Yes No
If yes, at what age: _____
 Bladder (daytime) Bladder (day and nighttime) Bowel

SENSORY HISTORY:

VESTIBULAR (Movement and gravity information). Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Rocks while sitting | <input type="checkbox"/> Jumps a lot |
| <input type="checkbox"/> Likes being tossed in the air | <input type="checkbox"/> Good balance |
| <input type="checkbox"/> Fearful of heights | <input type="checkbox"/> Fearful of movement |
| <input type="checkbox"/> Likes Merry-Go-Rounds | <input type="checkbox"/> Spins and Whirls more than others |
| <input type="checkbox"/> Gets car sick | <input type="checkbox"/> Prefers quiet play as opposed to active |
| <input type="checkbox"/> Enjoys being rocked: <input type="checkbox"/> Now <input type="checkbox"/> As an infant | |
| <input type="checkbox"/> No fear of movement or falling | |

Comments: _____

TACTILE (Touch information). Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Avoids messy things (mud, finger paints, etc.) | <input type="checkbox"/> Dislikes face or hands washed |
| <input type="checkbox"/> Irritated by cloth of certain textures | <input type="checkbox"/> Objects to being touched |
| <input type="checkbox"/> Dislikes unexpected touch | <input type="checkbox"/> Avoids using hands for extended periods |
| <input type="checkbox"/> Bangs head on purpose (now or in past) | <input type="checkbox"/> Pinches, bites, hurts self |
| <input type="checkbox"/> Mouths non-food objects | <input type="checkbox"/> Feels pain less than others |
| <input type="checkbox"/> Isolates self from others | <input type="checkbox"/> Strong like/dislike toward food textures |
| <input type="checkbox"/> Excessively ticklish | <input type="checkbox"/> Dislikes hair washing |
| <input type="checkbox"/> Dislikes nail cutting | <input type="checkbox"/> Wants to handle everything |
| <input type="checkbox"/> Seeks a lot of touch | |

Comments: _____



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PROPRIOCEPTIVE (Muscle and joint information). Check all that apply:

- Holds hands in strange positions
- Holds body in strange positions
- Good coordination with small items
- Walks on toes (or did when younger)
- Went from sitting to standing with little to no crawling
- Crept on tummy rather than hands and knees
- Leaps from one position to the next, unable to move slowly from one place to another

Comments: _____

AUDITORY: (Check all that apply)

- Responds negatively to unexpected or loud noise
- Has difficulty paying attention when there are other noises nearby
- Misses hearing some sounds
- Seems confused as to the direction of sounds
- Seems to enjoy strange noises and/or makes loud noises
- Appears to be hard of hearing
- Enjoys music
- Has a diagnosed hearing loss
- Wears a hearing aid

Comments: _____

VISUAL: (Check all that apply)

- Reversals in copying
- Happier in the dark
- Looks very closely at pictures/objects
- Difficulty discriminating shapes or colors
- Resists having eyes covered
- Squints often
- Becomes excited when there is a variety of visual objects
- Difficulty focusing on objects far away
- Difficulty focusing on close objects
- Wears glasses
- Difficulty maintaining eye contact
- Difficulty following objects across the room
- Sometimes shakes head awkwardly
- Difficulty following object tossed to him/her
- Shifts head to one side in order to look at an object

Comments: _____

GUSTATORY-OLFACTORY (Taste and smell information). Check all that apply:

- Acts as though all food tastes the same
- Chews on non-food objects
- Has unusual cravings for certain foods
- Dislikes food of certain textures
- Explores by smelling
- Discriminates odor
- Reacts negatively to smell
- Ignores unpleasant odors

Comments: _____



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SPEECH-LANGUAGE HISTORY:

SPOKEN LANGUAGE (Expressive Language). Check all that apply:

- Makes no sounds or makes sounds on a limited basis
- Uses gestures more than words to communicate
- Babbles only
- No true words
- Uses sign language. If yes, what signs: _____
- Produces only single words or short phrases
- Produces simple sentences
- Produces long sentences
- Produces long sentences which are disorganized or hard to understand what the child means
- Repeats words often or hesitates frequently
- Words are difficult to understand (articulation)
- Voice quality is unusual (e.g., hoarse, nasal, abnormally high pitched)
- Has difficulty recalling recent events
- Has trouble remembering the correct names of items or people
- Has no apparent problems expressing himself/herself
- Seems frustrated when attempting to relate events
- Stutters frequently

Approximately how many words does your child produce spontaneously: _____

Comments on any of the above: _____

COMPREHENSION (Receptive Language). Check all that apply:

- Does not understand spoken language
- Understands a few words
- Understands most words
- Understands simple conversations
- Understands everything said to him/her
- Follows simple commands
- Requires directions to be broken down in steps in order to follow
- Follows all directions easily

Comment on any of the above: _____

PRAGMATIC LANGUAGE (Social Skills). Check all that apply:

- Difficulty interacting with peers and/or adults
- Difficulty greeting/saying goodbye to others



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- Difficulty with turn-taking
- Difficulty with maintaining conversations
- Makes frequent inappropriate remarks
- Difficulty making/maintaining eye contact

Comment on any of the above: _____

ARTICULATION (Check all that apply):

- Speech sounds are not understood by others
- Speech sounds are understood by others some of the time
- Speech sounds are understood by others most of the time
- Speech sounds are understood by others all of the time

Comment on any of the above: _____

If applicable, how severe do you think your child's language and/or articulation is:

- Severe
- Moderate
- Mild

Is your child aware of the problem: Yes No

How does he/she react: _____

Is any language other than English used in the home: Yes No

If yes, what language(s): _____

What percent of the time: _____

SCHOOL INFORMATION:

School: _____ Grade: _____

School Days: Part day (AM/PM) All day

Teacher: _____

Grades Repeated: _____ Grades Skipped: _____

Has your child been in a special classroom and/or attended any remedial classes: Yes No

If yes, describe what type, when, and when: _____

Does your child have an IEP/IFSP: Yes No

If yes, please provide a copy to your therapist

Have you or the teacher observed that you child is (Check all that apply):

- Noticeably distracted in class
- Functions better in a one-to-one relationship rather than in classroom situations
- Has to be reminded how to hold pencil/paper when writing
- Needs to prop his/her head in hand while reading or writing at the desk



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__ Confused in right-left discrimination tasks (describe): _____

__ A poor speller

Which academic skills are the hardest: _____

If there are other concerns not covered in this form, please share: _____

Person completing this form: _____

Date: _____

V-05-216

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Consent for Release of Information

Date: _____

Patient Name: _____

Date of Birth: _____

I, _____, authorize the mutual exchange of information and/or medical records between Sensory Solutions and _____.

Signed: _____

Relationship to child: _____

*****By signing this release of information, I affirm that I am the parent or legal guardian of the name child and have been informed of the reason and need for this exchange of information. I understand that all information exchanged by these persons and/or agencies is confidential and will not be disclosed to any other party without the prior consent of the parent or legal guardian except as permitted by law. Information exchanged by these persons or agencies may be used for the purpose for which it was released. This information can be revoked at any time by submitting a written notice.**