



Sensory Solutions, LLC

Physical, Speech, Occupational, and Nutritional Health for Children

Policies & Procedures

- All co-pays and balances are due at the time of service and must be paid in full before your child will be seen by his/her therapist
- Authorization is not a guarantee of payment. If your insurance company denies payment you will be responsible for the entire balance.
- Outstanding balances will be sent to collections and therapy will be discontinued
- If you are scheduled for an evaluation for one discipline, the cancellation/no call no show fee is \$75
- If you are scheduled for a team evaluation (Feeding Team, AAC, ADOS), the fee will be \$50 per discipline. The team evaluation fee will be \$100 if cancellations/no call no shows occur
- 2 NO CALL/NO SHOWS will forfeit your standing appointment time
- 2 CANCELLATIONS must be made up within the following 2 weeks; otherwise, this will result in a forfeiture of your standing appointment time
- Returned checks will result in a \$30 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 under the supervision of the treating therapist. 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 your child to a treatment room for therapy
- If you choose to bring siblings with you, please bring activities to keep them occupied as excessive volume may interrupt treatment sessions. Siblings are not allowed on therapy equipment at any time
- 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 ensure your child's optimal performance and to 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 as they end 25 minutes from the start of your scheduled appointment time.
- If you choose to drop off your child for therapy, please leave an emergency contact number at the front desk and return to the waiting room before your child's session is over.
- If your child is potty training or was recently potty trained, please bring extra diapers and a change of clothes
- 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.



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- Unless we are provided with legal documents stating otherwise, we are required by law to provide both parents with information regarding the child's therapy services, progress, etc.

Release and Assumption of Risk

- In Consideration of the services of Sensory Solutions, LLC, their agents, owners, officers, affiliates, volunteers, interns, participants, therapists, therapeutic assistants, employees and all other persons or entities acting in any capacity on their behalf, (hereinafter collectively referred to as "SSL"), I hereby agree to release, indemnify, and discharge SSL on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representative and estate as follows:
- I acknowledge that my participation in Sensory Solutions, LLC, programs, therapies, camps, retraining techniques, rehabilitation programs, games or activities entails known and unanticipated risks that could result in physical or emotional injury, paralysis, death, or damage to the patient, to property, or potentially to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the therapy and/or activity.
- If you or your child is injured, you or your child may require medical assistance, at your own expense.
- Furthermore, SSL therapists and employees have difficult jobs to perform. They seek safety, but they are not infallible. They might be completely unaware of a participant's health or abilities. They may give incomplete warnings or instructions, and the equipment being used might malfunction.
- The undersigned expressly agrees and promises to accept and assume all of the risks existing in these therapies and activities. My or my child's participation in the program is purely voluntary, and I elect to participate or allow my child to participate in spite of the risks.
- I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless SSL from any and all claims, demands, or causes of action, which are in any way connected with my participation in SSL activities or my use of SSL equipment or facilities, including any such claims which allege negligent acts or omissions of SSL.
- Should SSL or anyone acting on their behalf, be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.
- I certify that I have adequate insurance to cover any injury or damage my child may cause or suffer while participating, or else I agree to bear the costs of such injury or physical conditions I may have.
- Any disagreements under this agreement shall be resolved in the County of St. Louis, State of Missouri. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.
- By signing this document, I acknowledge that if anyone is hurt or property is damaged



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during my or my child's participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against SSL on the basis of my claim from which I have released them herein.

Parent's or Guardian's Additional Identification

(For participants under the age of 18)

- In consideration of my child ("Minor") being permitted by SSL to participate in its therapies and activities and to use its equipment and facilities, I further agree to indemnify and hold harmless SSL from any and all claims which are brought by, or on behalf of Minor, and which are in any way connected with such use or participation by Minor.

Acknowledgement of Receipt of Notice of Privacy Practices

- This form is being provided to acknowledge your receipt of our Notice of Privacy Practices.
- The Notice of Privacy Practices explains how your patient health information may be used or disclosed by us. In addition, it explains your rights with regard to your patient health information, as well as our legal responsibilities.

Patient Agreement

- I authorize and direct that any insurance (major medical, Medicaid, Medicare or any other) proceeds payable for products or services provided to patient by Sensory Solutions, LLC be paid directly to Sensory Solutions, and hereby assign to Sensory Solutions, without recourse, all interest and rights to claim, collect, and receive, said proceeds from any insurance company providing coverage for these products and services. I authorize any and all insurance companies to furnish to Sensory Solutions, or its agent, any and all information pertaining to the patient's insurance benefits and the status of claims submitted by Sensory Solutions.

Financial Responsibility

- Some or all of the services or products provided to patients by Sensory Solutions may be covered by insurance. Sensory Solutions has no responsibility for but at my request will attempt to assist in determining whether such coverage exists. If patient's insurance does not cover the products or services, or if patient's insurance carrier shall for any reason fail to pay, I acknowledge that patient is financially responsible for, and I agree to timely pay Sensory Solutions all charges for products and services provided to patient, plus attorney's fees and expenses incurred by Sensory Solutions in the collection of such charges. This obligation is binding upon my estate and my executors and administrators.



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Agreement and Consent for Sensory Solutions Products and Services

- I certify that I am duly authorized by Patient to act as Patient's personal representative and agent to execute this Agreement form on behalf of the Patient, and that my signature will bind the undersigned as parent or guardian of the Patient to the above-stated terms. I recognize that Sensory Solutions will provide products and services to Patient in reliance upon this statement.

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 the visit will be billed privately to the family, not billed through insurance.

Media Release Form

- At times, Sensory Solutions, LLC uses various forms of media for advertising purposes allowing members of the community to be made aware of the services Sensory Solutions, LLC provide. We also use photographs and videos to assist with public relations. We request your permission to use pictures/videos of your child in any form of media we deem necessary to promote Sensory Solutions, LLC. We assure you that any form of media used in reference to your child will be in good taste while maintaining the respect and dignity of your child and their relationship with Sensory Solutions, LLC.

Custody/Release of Information

- Please provide Sensory Solutions, LLC with a copy of legal documentation regarding custody arrangements.

Attendance and Scheduling Policy

- At Sensory Solutions, LLC regular attendance is essential for your child's progress and to help your child thrive. Therapy works best when sessions happen consistently. We understand that families are busy and that things come up; this policy is designed to be fair, flexible, and supportive while helping us serve all families well.

Appointments and Reminders

- Appointments are scheduled in advance and reserved just for your child. Having



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“standing” weekly appointments help families to be able to schedule other activities around these times.

- You'll receive appointment reminders via email 24 hours in advance.

Cancellations

- We ask for at least 24 hours' notice if you need to cancel or reschedule. You can call or text the office when you need to cancel. Please do not contact your/ your child's therapist to cancel or reschedule.
- Cancellations with proper notice help us offer the spot to another child from a waitlist.

Late Cancellations and No-Shows

- Late cancellations (less than 24 hours' notice) and no-shows will result in a fee of \$50 per visit.
- If you are scheduled for an evaluation for one discipline, the cancellation/no-show fee is \$75.
- If you are scheduled for a team evaluation (Feeding Team, AAC, ADOS), the fee will be \$50 per discipline (\$100 total).
- 2 no-shows will forfeit your standing appointment time.
- Insurance companies do not reimburse missed visits, so this fee is the family's responsibility.

Attendance Expectations

- Families are expected to attend at least 80% of scheduled sessions.
- Frequent missed visits can interrupt progress and may lead to placement on a same-day or call-ahead schedule only or a temporary discharge with the option to return when scheduling allows.

Late Arrivals

- If you arrive late, the session will still need to end at the scheduled time unless otherwise stated by the office.
- Sessions shortened due to late arrival are considered attended and billed accordingly.

How We Support Success

- Make-up sessions when possible; this is highly encouraged
- Open communication with your therapy team; we are partners in this!
- Help problem-solve barriers like transportation, timing, or feelings of overwhelm.
- If attendance becomes difficult, please talk to us.

Thank you for valuing your child's therapy time and for helping us provide high-quality care to all families we serve. Consistency makes a difference and we're grateful to be part of your child's journey!



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Policies and Procedures Signature Pages (Return to the Front Desk)

Media Release Form

Please sign and date this form to allow or reject your consent for Sensory Solutions, LLC to use all forms of media of your child for advertising purposes.

I, _____ (parent/guardian name) DO GIVE permission to Sensory Solutions, LLC to use photographs and other media involving my child for public relations and advertising activities.

I, _____ (parent/guardian name) DO NOT give permission to Sensory Solutions, LLC to use photographs and other media involving my child for public relations and advertising activities.

Insurance

I understand that I am responsible for any amount not covered by my insurance.

Upon notification that my insurance will not cover all or part of the fees, I hereby authorize Sensory Solutions to charge the following credit card the total fees due:

VISA/MASTERCARD/DISCOVER/AMEX (Circle one)

Card# _____ Expiration date _____ CVV _____

Cardholder name _____

Signature _____

Name of patient _____

Address: _____

Home #: _____ Cell#: _____

Attendance and Scheduling Policy

By signing this form, I acknowledge that I have received, read, and understand the Attendance & Scheduling Policy for Sensory Solutions, LLC.

Confidentiality Policy

___ 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 as an insurance visit.



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Custody/Release of Information

The following individual(s) have **current custody** of the above child and I authorize Sensory Solutions, LLC permission to disclose any and all information to the following parties regarding patient care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Toileting Permission Form

I give permission for the staff of Sensory Solutions, LLC to assist my child with their toileting needs if they are not self-reliant and/or an accident occurs. Toileting supplies such as diapers and wipes may be provided to my child in an emergency. I will provide supplies if my child has any special supplies.

___ I DO understand the consent form above and give my permission for my child to be assisted in the bathroom if necessary. In the event the necessary supplies are not available, I will be called to bring supplies and/or pick up my child.

___ I DO NOT give permission for Sensory Solutions staff to assist my child in toileting. I understand if my child soils themselves, I will be called, and it will be my responsibility to come to the clinic immediately to tend to my child.

Activities of Daily Living (ADLs) Parent Authorization

I give permission for the staff of Sensory Solutions, LLC to assist my child with dressing/undressing if this is a goal of my child's. Dressing and undressing may pertain to, but are not limited to, taking off shirts and/or pants as well as putting on shirts and/or pants. Please note that underwear will not be removed, unless working on toileting and the "Toileting Permission Form" has authorized the therapist to aid in changing my child's underwear.

___ I DO give my permission for my child to work on dressing and undressing in any manner related to the goals my child's therapist has developed for my child

___ I DO NOT give permission for Sensory Solutions' staff to work on dressing and undressing in any manner related to the goals my child's therapist has developed for my child (**Please note, this may limit the goals your child's therapist is allowed to address)

I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.

Participant Name: _____

Parent/Guardian Signature (if child is minor) _____

Date: _____