Sensory Solutions, LLC
Physical, Speech and Occupational Therapy for Children

Feeding Team History Form

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

Child's Name:_____ Birth Date:_____
Person Completing this Form and relationship:_____
Referred by:_____
Diagnosis(es) (i.e., Autism, Down syndrome, ADHD, etc.)_____
_____
What are your concerns regarding your child?_____
_____
_____

Parent/Guardian Name:_____
Relationship to Child:☐Biological ☐Foster ☐Adoptive ☐Other:_____
Address:_____
Zip Code:_____ Cell Phone:_____ Home Phone:_____
Email:_____
Education:_____ Occupation:_____
Employer:_____ Work Phone:_____

Parent/Guardian Name:_____
Relationship to Child: ☐Biological ☐Foster ☐Adoptive ☐Other:_____
Address_____
Zip Code:_____ Cell Phone:_____ Home Phone:_____
Email:_____
Education:_____ Occupation:_____
Employer:_____ Work Phone:_____

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

Emergency contact information:
Name:_____ Relationship:_____
Phone Number:_____

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

Is any language other than English used in the home:☐Yes ☐No
If yes, what language(s):_____

Corporate Office
10332 Old Olive St. Rd.
Creve Coeur, MO 63141
314.567.4707
fax 314.567.4505

St. Peters Location
4200 N Cloverleaf Drive, Suite J
St. Peters, MO 63376
636.922.4700
fax 636.922.4505

Florissant Location
235 Dunn Rd
Florissant, MO 63031
314.912.4704
fax 314.866.5849

sensorysolutions.com

Sensory Solutions, LLC
Physical, Speech and Occupational Therapy for Children

MEDICAL HISTORY:

Pregnancy: ☐ Full Term ☐ Premature
Length of Pregnancy:_____(weeks or months)

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

Length of total labor:_____

Labor/Delivery Complications:
☐ Induced Birth
☐ Breech Presentation
☐ Limpness
☐ Stiffness
☐ Other:_____
Elaborate on above labor/delivery complications:_____
_____
_____
_____

Delivery Type:
☐ Vaginal
☐ C-section

Complications following birth regarding child:
☐ Jaundice
☐ Cyanosis
☐ Congenital defects
☐ Other (please specify):_____

Length of hospitalization:_____ Child's birth weight: _____lbs. _____oz

Did your baby require any of the following:
☐ Oxygen How long:_____
☐ Transfusions Type(s):_____
☐ Tube Feedings Type(s) and how long:_____
Other (please specify):_____
_____

Were there any feeding difficulties at birth: ☐ Yes ☐ No

Sensory Solutions, LLC

Physical, Speech and Occupational Therapy for Children

Please specify feeding difficulties at birth:_____

_____

List illnesses/diseases/injuries/operations your child has experienced:

Illness:_____ Age:_____
Illness:_____ Age:_____
Illness:_____ Age:_____
Injury/operation:_____ Age:_____
Injury/operation:_____ Age:_____
Injury/operation:_____ Age:_____

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:_____

Is your child currently taking any medications/vitamins/supplements: ☐ Yes ☐ No
If yes, type(s):_____

_____

SPECIALTY SERVICES YOUR CHILD RECEIVES:

☐ Audiologist ☐ Behavior Therapist ☐ Cardiologist ☐ Chiropractor
☐ Dietitian ☐ ENT ☐ Neurologist ☐ Occupational Therapist

Corporate Office
10332 Old Olive St. Rd.
Creve Coeur, MO 63141
314.567.4707
fax 314.567.4505

St. Peters Location
4200 N Cloverleaf Drive, Suite J
St. Peters, MO 63376
636.922.4700
fax 636.922.4505

Florissant Location
235 Dunn Rd
Florissant, MO 63031
314.912.4704
fax 314.866.5849

sensorysolutions.com

☐ Ophthalmologist ☐ Optometrist ☐ Orthopedist ☐ Physical Therapist
☐ Psychologist ☐ Psychiatrist ☐ Speech Pathologist ☐ GI
☐ Other (please specify):_____

DEVELOPMENTAL HISTORY:

Developmental Milestones:
Approximate ages in which your child completed the following routinely:
Held up head (while on stomach):_____
Rolled over:_____
Sat independently:_____
Belly crawled:_____
Crawled on hands and knees:_____
Pulled to standing:_____
Standing independently:_____
Walking independently:_____
Babbling:_____ Were there a variety of sounds:_____
Producing single words:_____
Combining two words:_____
Obeying simple commands:_____

FEEDING:

History of Feeding Method	Age Introduced/Duration	Difficulties Noted
Feeding tube		
Breast-fed		
Bottle-fed		
Stage 1 baby food		
Stage 2 baby food		
Stage 3 baby food		
Table foods		
Cup with Spout		
Soft straw drinking		
Hard straw drinking		
Open cup drinking		
Spoon		
Fork		
Knife		

Comments on above: _____
_____
_____

_____

_____

TUBE FEEDINGS:

Type of tube currently using:_____

Feedings per day:_____ Length of Feedings:_____

Volume per Feeding:_____

Comments on above:_____

_____

BREAST/BOTTLE FEEDING:

Bottle nipple brand and level:_____

Nipple shield required during breastfeeding? ☐ Yes ☐ No

Has your child been diagnosed with a tongue or lip tie? ☐ Yes ☐ No

*If yes, at what age and who provided the diagnosis?_____

If your child was diagnosed with a tongue or lip tie, was a release completed?

☐ Yes ☐ No

*If yes, who performed the release?_____

Position during feeding:_____

_____

CURRENT BABY FOOD/TABLE FOOD FEEDING:

History of Sensory Preferences	Preferred	Non-preferred
Sweet		
Sour		
Bitter		
Bland		
Salty		
Spicy		
Smooth purees		
Chunky purees		
Soft Solids		
Hard Solids		
Hot Foods		
Warm foods		
Room Temperature Foods		
Cold Foods		

Comments on above:_____

_____

Feeds self: ☐ All ☐ Most ☐ Some ☐ Rare

Food Category	Current Foods Consumed
Protein	
Dairy	
Vegetables	
Fruits	
Grains	
Other	

Comments on above:_____
_____
_____
_____
_____

List avoided foods:_____
_____
_____

CURRENT RESPONSE TO FEEDING:

Behavior	Always/Often/ Sometimes/Never	Additional Comments
Acid Reflux		
Arching Back		
Choking		
Coughing		
Crying		
Difficulty Chewing		
Drooling		
Eating Too Fast		
Eating Too Slow		
Fails To Chew Food		

Frequently Changes Nipple		
Gagging		
Getting Down from Table		
Hiccupping		
Holding Food in Mouth		
Nasal Regurgitation		
Pockets Food		
Poor Intake		
Refuses to Open Mouth		
Refuses to Eat		
Spillage of Food/Liquid		
Spits Out Food		
Stuffs Mouth		
Throws Food		
Turns Head Away		
Vomiting		

NUTRITION:

Usual Food, Beverage, and Feeding Schedule: *Please record the time, food/formula/ beverages/human milk/tube feedings consumed, amount/volume, duration of ingestion time, and location feedings take place. Please include any nutritional supplements, vitamins, and other supplements. The first entry is an example of how to complete. Please continue onto next page.*

Time	Solids/Liquids	Amount	Duration	Location
9 AM	Scrambled egg Wheat toast Butter Whole milk Flintstone V/M	1 egg with fork 1 piece w/o crust 1 teaspoon 4 oz in cup 1 vitamin	25 minutes	Highchair in Kitchen
11 AM	Pediasure	4 oz. in bottle	10 minutes	Crib before nap

Child's appetite:
☐ Child does not recognize hunger
☐ Child does not recognize satiety/fullness
☐ Child's appetite is consistent from day-to-day

Family Meals:
How many meals per week does your family eat together?_____
Where are your family meals eaten most often?_____
How many meals per week are eaten away from home?_____
Who is the primary person in the household who prepares most meals?_____

Growth Assessment:
Current weight:_____
Percentile for Weight:_____
Current Height:_____
Percentile for Height:_____
Please list any concerns you have with your child's growth:_____
_____
Has your child been following their own growth curve or has their growth percentile changed in the last few months? Please explain_____
_____
Bowel Movements: ☐ Regular ☐ Irregular How Often:_____
Type: ☐ Pebble-like ☐ Formed ☐ Loose
Number of wet diapers per day:_____
Sleep schedule (Wake, naps, bedtime):_____

SELF-CARE:
Bathes self: ☐ Independently ☐ Needs Assistance
Undresses self: ☐ Independently ☐ Needs Assistance
Dresses self: ☐ Independently ☐ Needs Assistance

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:

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

Comments:_____
_____

TACTILE (Touch information). Check all that apply:

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

Comments:_____
_____

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

☐Holds hands in strange positions
☐Good coordination with small items
☐Holds body in strange positions
☐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
☐ Looks very closely at pictures/objects
☐ Resists having eyes covered
☐ Becomes excited when there is a variety of visual objects
☐ Difficulty focusing on objects far away
☐ Wears glasses
☐ Difficulty following objects across the room
☐ Difficulty following object tossed to him/her
☐ Shifts head to one side in order to look at an object
☐ Happier in the dark
☐ Difficulty discriminating shapes or colors
☐ Squints often
☐ Difficulty focusing on close objects
☐ Difficulty maintaining eye contact
☐ Sometimes shakes head awkwardly
Comments:_____
_____

GUSTATORY-OLFACTORY (Taste and smell information). Check all that apply:
☐ Acts as though all food tastes the same
☐ Has unusual cravings for certain foods
☐ Explores by smelling
☐ Reacts negatively to smell
☐ Chews on non-food objects
☐ Dislikes food of certain textures
☐ Discriminates odor
☐ Ignores unpleasant odors
Comments:_____
_____

SPEECH-LANGUAGE HISTORYCONCERNS (CHECK ALL THAT APPLY):
☐ Spoken Language/Expressive Language
☐ Comprehension/Receptive Language
☐ Articulation/Speech Sound Production
☐ Stuttering
☐ Social Skills
Other (please specify):_____
_____

SCHOOL/DAYCARE/THERAPY INFORMATION:
Does your child attend school/daycare: ☐ Yes ☐ No
School/Daycare:_____ Grade:_____
School/Daycare Days: ☐ Part day (AM/PM) ☐ All day
Teacher:_____

Sensory Solutions, LLC

Physical, Speech and Occupational Therapy for Children

Has the teacher expressed any concerns ☐ Yes ☐ No
(If yes, please specify):_____
_____

Has your child received prior therapy? (Please check all that apply):
☐ First Steps ☐ School ☐ Outpatient facility similar to Sensory Solutions

Does your child have an IEP/IFSP/504 Plan: ☐ Yes ☐ No
If yes, please provide a copy to your therapist
If there are other concerns not covered in this form, please share:_____
_____
_____

Person completing this form:_____
Date:_____

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
- 24 hour **CANCELLATION NOTICE** is appreciated; otherwise, there will be a $50 charge per service your child receives
- 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 Feeding Team fee will be $150 and the AAC and ADOS team evaluations 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 $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 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.
- 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.

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

Signature_____Date_____

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

Participant Name:_____
Parent/Guardian Signature (if child is minor)_____
Date:_____

Sensory Solutions, LLC
Physical, Speech and Occupational Therapy for Children

PARENT'S OR GUARDIAN'S ADDITIONAL IDENTIFICATION
(Must be completed for participants under the age of 18)

In consideration of _____(print minor's name) ("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.

Parent or Guardian Signature:_____
Print Name:_____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form is being provided to acknowledge your receipt of our Notice of Privacy Practices.

What is the 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.

Acknowledgement of Receipt
By signing below, you are acknowledging that the Notice of Privacy Practices has been provided to you:
I, _____ (Print Patient's Name)
Residing at _____(Print Patient's Address) have received the Notice of Privacy Practices from Sensory Solutions LLC.

_____ _____
Signature/relationship Date

PATIENT AGREEMENT

Assignment of Insurance Benefits

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 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 patient 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.

Sensory Solutions, LLC

Physical, Speech and Occupational Therapy for Children

Agreement and Consent for Sensory Solutions Products and Services

Patient's Name ("Patient"): _____
Street Address: _____ Apt. #: _____
City: _____ State: _____ Zip: _____
Telephone: _____
Patient's Signature: _____

IF PATIENT IS A MINOR

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.

Printed or Typed Name of Parent or Legal Guardian: _____

Relationship to Patient: _____ Date: _____
Street Address if Different than Patient: _____
Signature of Parent or Legal Guardian: _____

I have read and understand the above information. 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_____
Cardholder name_____ Signature_____
Name of patient_____
Address:_____
Home #:_____Cell#:_____

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 session or in addition to his/her session. Please understand that the 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 as an insurance visit.

Parent Signature:_____

Sensory Solutions, LLC
Physical, Speech and Occupational Therapy for Children

Toileting Permission Form

I (parent / guardian) _____ 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 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 them self, I will be called, and it will be my responsibility to come to the clinic immediately to tend to my child.

_____ _____
Print name of parent/guardian Relationship to child

_____ _____
Signature of parent/guardian Date

Activities of Daily Living (ADLs) Parent Authorization

I (parent / guardian)_____ 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 been signed.

_☐_ I DO understand the consent form above and 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)

_____ _____
Print name of parent/guardian Relationship to child

_____ _____
Signature of parent/guardian Date

Corporate Office
10332 Old Olive St. Rd.
Creve Coeur, MO 63141
314.567.4707
fax 314.567.4505

St. Peters Location
4200 N Cloverleaf Drive, Suite J
St. Peters, MO 63376
636.922.4700
fax 636.922.4505

Florissant Location
235 Dunn Rd
Florissant, MO 63031
314.912.4704
fax 314.866.5849

sensorysolutions.com

Sensory Solutions, LLC
Physical, Speech and Occupational Therapy for Children

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.

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.

Parent/Legal Guardian Printed Name:_____
Signature:_____ Date:_____

Custody/Release of Information

Patient name:_____DOB:_____
The following individual(s) have current custody of the above child:
_____
I, _____, give Sensory Solutions, LLC permission to disclose information to the following parties regarding patient care:
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Please specify:

- ☐ Test results via verbal communication and/or email
- ☐ Progress toward goals via verbal communication and/or email
- ☐ Written reports which includes patient's doctor, primary caregiver, and home address
- ☐ All of the above

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

Signature of primary caregiver: _____ Date: _____

Sensory Solutions, LLC
Physical, Speech and Occupational Therapy for Children

Cancelation/No Call-No Show Policy

Our fee for cancellations and no call/no shows to $50 per session/discipline missed. If you fail to call within 24 hours, you will be charged the appropriate fee. For example, if you do not show up for both your speech therapy and occupational therapy sessions, you will be charged $100 for the services missed.

We do understand there are certain circumstances which may arise, including sudden sickness, etc., and we do take that into account and consideration before charges are made. We thank you for your understanding.

By signing below, you are acknowledging receipt of this policy.

_____ _____

Parent's/Guardian's Printed Name Parent's/Guardian's Signature

_____

Date

Corporate Office
10332 Old Olive St. Rd.
Creve Coeur, MO 63141
314.567.4707
fax 314.567.4505

St. Peters Location
4200 N Cloverleaf Drive, Suite J
St. Peters, MO 63376
636.922.4700
fax 636.922.4505

Florissant Location
235 Dunn Rd
Florissant, MO 63031
314.912.4704
fax 314.866.5849

sensorysolutions.com