SENSORY SOLUTIONS, LLC

Physical, Speech, Occupational, Nutritional, and Behavioral Health Therapy for Children

Feeding Team History Form

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

Child's Name: _____ Birth Date: _____
Referred by: _____ Person Completing Form: _____
Diagnosis(es): _____
What are your concerns regarding your child?
_____
_____

Parent/ Guardian Name: _____
Address: _____
Zip Code: _____ Cell Phone: _____ Home Phone: _____
Email: _____
Education: _____ Occupation: _____
*Last 4 SSN: _____ Work Phone: _____

Parent/Guardian Name: _____
Address: _____
Zip Code: _____ Cell Phone: _____ Home Phone: _____
Email: _____
Education: _____ Occupation: _____
Employer: _____ Work Phone: _____

Siblings (and ages): _____

Parental 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: _____

Corporate Office
10332 Old Olive St. Rd.
Creve Coeur, MO 63141
314.567.4707 (Phone)
314.567.4505 (Fax)

St. Peters Location
4200 N. Cloverleaf Drive, Ste. J
St. Peters, MO 63376
636.922.4700 (Phone)
636.922.4505 (Fax)

North County Location
235 Dunn Road
Florissant, MO 63031
314.912.4707(Phone)
314.866.5849 (Fax)

SENSORY SOLUTIONS, LLC

Physical, Speech, Occupational, Nutritional, and Behavioral Health Therapy for Children

Zip Code:_____ Phone:_____ Fax:_____
How long has your child been under this physician's care?:_____

MEDICAL HISTORY:

Pregnancy: ☐ Full Term ☐ Premature
Length of Gestation:_____
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

Child's birth weight: _____ lbs. _____ oz.

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

_____

Length of hospitalization:_____
Complications:
☐ Jaundice
☐ Cyanosis
☐ Congenital defects
☐ Other:_____

Was there a need for:
☐ Oxygen

☐ Transfusions
☐ Tube Feedings
If so, please explain:

Were there any feeding difficulties in infancy: ☐ Yes ☐ No
Explain:

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:

SENSORY SOLUTIONS, LLC

Physical, Speech, Occupational, Nutritional, and Behavioral Health Therapy for Children

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

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			
Opthamologist/ Optometrist			
Orthopedist			

Physical Therapist _____ _____ _____

Psychologist/ Psychiatrist _____ _____ _____

Speech Pathologist _____ _____ _____

Neurologist _____ _____ _____

GI _____ _____ _____

Other _____ _____ _____

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:

☐Usually happy
☐Mostly quiet
☐Overly active
☐Tires easily
☐Talks constantly
☐Too impulsive
☐Restless
☐Resistant to changes
☐Poor attention span
☐Easily frustrated
☐Cries often
☐Cries infrequently
☐Rocks self frequently
☐Has difficulty learning new tasks
☐Stubborn
☐Overreacts

☐Clumsy
☐Fights frequently
☐Difficulty separating from primary caretakers
☐Falls often
☐Wets bed
☐Frequent temper tantrums
☐Nervous habits or tics

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 two words:
Obeying simple commands:

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):

SENSORY SOLUTIONS, LLC

Physical, Speech, Occupational, Nutritional, and Behavioral Health Therapy for Children

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

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:

Placement of Tube: 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 revision completed?

◯ Yes ◯ No

*If yes, who completed the revision?

Position during feeding:

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	Items Consumed
Protein	
Dairy	
Vegetables	
Fruits	
Grains	
Other	

Comments on above:_____

List avoided foods:_____

Corporate Office
10332 Old Olive St. Rd.
Creve Coeur, MO 63141
314.567.4707 (Phone)
314.567.4505 (Fax)

St. Peters Location
4200 N. Cloverleaf Drive, Ste. J
St. Peters, MO 63376
636.922.4700 (Phone)
636.922.4505 (Fax)

North County Location
235 Dunn Road
Florissant, MO 63031
314.912.4707(Phone)
314.866.5849 (Fax)

RESPONSE TO FEEDING:

Behavior	Answer	Additional Comments
Arching Back	CHOOSE ONE	
Choking	CHOOSE ONE	
Coughing	CHOOSE ONE	
Crying	CHOOSE ONE	
Gagging	CHOOSE ONE	
Difficulty Chewing	CHOOSE ONE	
Fails To Chew Food	CHOOSE ONE	
Drooling	CHOOSE ONE	
Eating Too Fast	CHOOSE ONE	
Eating Too Slow	CHOOSE ONE	
Frequently Changes Nipple	CHOOSE ONE	
Getting Down from Table	CHOOSE ONE	
Hiccupping	CHOOSE ONE	
Holding Food in Mouth	CHOOSE ONE	
Pockets Food	CHOOSE ONE	
Poor Intake	CHOOSE ONE	
Refuses to Open Mouth	CHOOSE ONE	
Refuses to Eat	CHOOSE ONE	
Spillage of Food/Liquid	CHOOSE ONE	
Spits Out Food	CHOOSE ONE	
Stuffs Mouth	CHOOSE ONE	
Throws Food	CHOOSE ONE	
Turns Head Away	CHOOSE ONE	
Vomiting	CHOOSE ONE	

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 feeding takes place. Please include any nutritional supplements, vitamins and other supplements. The first entry is an example of how to complete.

Time	Solids/Liquids	Amount	Duration	Location
9 AM	Scrambled egg Toast, wheat Butter Whole milk Flintstone V/M	1 egg w/fork 1 piece w/o crusts 1 teaspoon 4 ounces 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 doesn't recognize hunger

◯ Child's appetite is consistent from day to day

◯ Child doesn't recognize fullness

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:

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. Explain:

Bowel movements: ◯ Regular ◯ Irregular
How Often: Consistency: ◯ Pebble-like ◯ Formed ◯ Loose

Number of wet diapers:

Sleep schedule:

SENSORY SOLUTIONS, LLC

Physical, Speech, Occupational, Nutritional, and Behavioral Health Therapy for Children

Current weight:

Percentile for Weight:
Current Height:
Percentile for Height:

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:
☐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
☐Dislikes diaper changes and will attempt to sit up
☐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
☐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:_____

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
☐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

SENSORY SOLUTIONS, LLC

Physical, Speech, Occupational, Nutritional, and Behavioral Health Therapy for Children

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

☐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:

SENSORY SOLUTIONS, LLC

Physical, Speech, Occupational, Nutritional, and Behavioral Health Therapy 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.
- 24 hour **CANCELLATION NOTICE** is appreciated; otherwise, there will be a $30 charge.
- 2 **NO CALL/NO SHOWS** will forfeit your standing appointment time.
- **CANCELLATIONS** must be made up within the following week; 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 30 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 _____

Corporate Office
10332 Old Olive St. Rd.
Creve Coeur, MO 63141
314.567.4707 (Phone)
314.567.4505 (Fax)

St. Peters Location
4200 N. Cloverleaf Drive, Ste. J
St. Peters, MO 63376
636.922.4700 (Phone)
636.922.4505 (Fax)

North County Location
235 Dunn Road
Florissant, MO 63031
314.912.4707(Phone)
314.866.5849 (Fax)

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 its terms.

SENSORY SOLUTIONS, LLC

Physical, Speech, Occupational, Nutritional, and Behavioral Health Therapy for Children

Participant Name:
Parent Signature (if child is minor)
Date:
Address:

E-Mail: Phone#: DOB:

I would like to receive special offers, notices of events and updates from SENSORY SOLUTIONS, LLC, via email
YES NO

Please tell us how you heard about SENSORY SOLUTIONS:

EMERGENCY CONTACT: Phone #:
Relationship to participant:

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 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.

Agreement and Consent for Sensory Solutions Products and Services

Patient's Name ("Patient"):
Street Address: Apt. #:
City: State: Zip:
Telephone: Last 4 of SSN:
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 patients 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 understood 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:

SENSORY SOLUTIONS, LLC

Physical, Speech, Occupational, Nutritional, and Behavioral Health Therapy for Children

VISA/MASTERCARD/DISCOVER/AMEX (**REQUIRED**)

For your security, once entered, card numbers can no longer be accessed. You will only be charged the amount discussed. All charges send an automatic email receipt.

Card#: Expiration Date: CVV:
Cardholder Name: Signature:
Name of Patient:

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 consultation 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.

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 consultation 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: