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:_____ Birthdate:_____
Referred by:_____
Diagnosis(es):_____
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):_____

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:_____
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:_____

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
__Clumsy
__Fights frequently
__Difficulty separating from primary caretakers
__Falls often
__Poor attention span
__Easily frustrated
__Cries often
__Cries infrequently
__Rocks self frequently
__Has difficulty learning new tasks
__Stubborn
__Overreacts
__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):_____
_____

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:_____
_____
_____

RESPONSE TO FEEDING:

Behavior	Yes/No	Additional Comments
Arching Back		
Choking		
Coughing		
Crying		
Gagging		
Difficulty Chewing		
Fails To Chew Food		
Drooling		
Eating Too Fast		
Eating Too Slow		
Frequently Changes Nipple		
Getting Down from Table		
Hiccupping		
Holding Food in Mouth		
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 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 ounces 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:_____

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
__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 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
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:_____
_____
_____

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 $25 charge
- 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 40 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.

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 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

Sensory Solutions, LLC

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

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.

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_____

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

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

www.sensorysolutions.org

Sensory Solutions, LLC
Physical, Speech, Occupational, Nutritional and Behavioral Health Therapy for Children

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, Occupational, Nutritional and Behavioral Health Therapy for Children

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

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

www.sensorysolutions.org