1425 N. Killingsworth Street
Portland, OR 97217

(P): 503-575-9402
(F): 888-769-4431

info@sensorykidsot.com
www.sensorykidsot.com

PATIENT AGREEMENT

Sensory KIDS, LLC offers Occupational Therapy, Speech-Language Pathology, and Family and Child Counseling services to all of our patients. Our therapists are highly trained in sensory-based and relationship-rich approaches. Treatment at Sensory KIDS, LLC emphasizes caregiver education, emotion and arousal regulation, and offers a dynamic approach to recognizing your child's strengths, developmental levels, and social-emotional capacities.

Following the initial evaluation, a parent education meeting will be scheduled to review evaluation results, discuss goals, and establish a treatment plan. We will also work with your primary care provider to coordinate your child's care. A treatment schedule will be determined based upon the recommendations and availability of the evaluating therapist, as well as the availability of your family.

We require information from each patient in order to begin providing care. Please complete the following forms to the best of your availability, notating any areas with "n/a" if information is not applicable to your child.

Each insurance provider will have different guidelines and limitations of coverage for Occupational Therapy and Mental Health Services. If your family would like to bill insurance, please provide us with the appropriate insurance information. As a courtesy to our families, Sensory KIDS will verify insurance eligibility and benefits before services are rendered. A document detailing an estimate of coverage for Occupational Therapy or Mental Health services will be sent to your family for review. Since this information is only an estimate, we strongly suggest families contact their insurance representative if there are any questions regarding coverage details.

If your child is enrolled in OHP, an authorization is required for Occupational Therapy services following the initial evaluation. Our office will submit this authorization on your family's behalf. OHP families **must** provide our office with a PCP referral to keep on file in the case additional visits are required. Families whose commercial insurance plans require a prior authorization or PCP referral will be notified upon the initial verification of insurance eligibility and benefits. If your insurance provider does not pay for Occupational Therapy or Mental Health services, Sensory KIDS does offer private pay options and various payment plans.

Sensory KIDS values feedback and asks families to inform our office of anything we can do better so we can ensure that the highest quality of care is being provided to your child.

We look forward to the opportunity to work with your family. Please notify our office if you have any questions. Intake forms can be returned to our office in person, via email at info@sensorykidsot.com, by mail, or by fax at 888-769-4431. Please note that additional policy and release forms will be signed at your child's initial evaluation appointment.

By signing below, I have read and understand the Patient Agreement.

______________________________	______________________
Signature	**Date**

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PATIENT INTAKE FORM

Person Completing This Form: ____________________

Date: ________________

Welcome to Sensory KIDS! We look forward to working with your family. Please fill out this form in its entirety and answer all questions to the best of your ability.

CLIENT INFORMATION		
Child's Full Name:		
Child's DOB:	Child's Age:	Gender Identity and/or Preferred Pronoun:

RESPONSIBLE PARTY

Child Lives With: ☐ Both Parents ☐ Mother only ☐ Father only ☐ Grandparent ☐ Foster Parent ☐ Guardian ☐ Other: ____

What is the custody situation?
____

Parent(s)/Guardian(s):

Gender Identity andor Preferred Pronoun for Parent(s)/Guardian(s):

Mailing Address:
____
(Street) (City) (State) (Zip)

Cell Number:	Home Number:	Work Number:
Email:		

Preferred Method of Communication (please circle): Cell Home Work Email

Legal Guardianship through DHS:

Case Worker Full Name: ______________________________ Medicaid ID#: ____________________

Address: ____
(Street) (City) (State) (Zip)

Phone Number: ______________________________ Fax Number: ______________________________

EMERGENCY CONTACT:

____
(Name) (Relationship) (Contact)

PRIMARY INSURANCE INFORMATION	
Primary Insurance:	Policy Holder Name and DOB:
Member ID:	Group ID or Group Name:
SSN:	Insurance Phone Number:

Send Claims To:

____
(Street) (City) (State) (Zip)

SECONDARY INSURANCE INFORMATION	
*Secondary Insurance (if applicable):	Policy Holder Name and DOB:
Member ID:	Group ID or Group Name:
SSN:	Insurance Phone Number

Send Claims To:

____
(Street) (City) (State) (Zip)

PRIMARY CARE PHYSICIAN INFORMATION	
Child's PCP:	PCP Clinic:

Clinic Address:

____
(Street) (City) (State) (Zip)

Phone Number:	Fax Number:

Referring Physician (if different from PCP):

Referring Physician Address:

____
(Street) (City) (State) (Zip)

Phone Number:	Fax Number:

SCHOOL INFORMATION	
Child's School:	Grade:
Phone Number:	Teacher(s):

Is your child receiving any school accommodations? ☐ 504 Plan ☐ IEP ☐ None ☐ Other: ____________

Is your child receiving services at school? OT ☐ Speech ☐ PT ☐ Behavioral Support ☐ Other: ____________

MEDICAL AND DEVELOPMENTAL HISTORY

Has your child been diagnosed with any medical or educational conditions? If yes, please list diagnoses, includes the date of diagnosis if known. Please provide any records to Sensory KIDS.

Diagnosis: ____________ Date of Diagnosis: ____________ Dr./Facility: ____________
Diagnosis: ____________ Date of Diagnosis: ____________ Dr./Facility: ____________
Diagnosis: ____________ Date of Diagnosis: ____________ Dr./Facility: ____________
Other Diagnoses: ____________

Does your child have any allergies? If yes, please list and describe the severity.

____
____
____

Is your child presently taking any medication? If yes, please list below.

Medication: ____________ Frequency: ____________ Reason: ____________
Medication: ____________ Frequency: ____________ Reason: ____________
Medication: ____________ Frequency: ____________ Reason: ____________

Please list any medical precautions: ____________

Was your child premature? Y or N Length of Pregnancy: _____________ Birth Weight: _________________

Birth was: ☐ Vaginal ☐ Caesarian ☐ Breech

Please describe any illnesses or complications during pregnancy or delivery.

____

____

____

Has your child experienced separation form birth family, adoption, or early stressors or trauma?

____

____

____

Has your child had any hospitalizations? If so, please specify the date and length of stay.

____

____

____

Has your child had any surgeries?

____

____

General impression of child's development (please check accordingly):

	Slow	Normal	Advanced
Gross Motor			
Fine Motor			
Feeding			
Language			
Social/Emotional			

Check each option below that describes your child as an infant:

	Fussy		Like being held
	Passive		Tense when held
	Irritable		Overactive/rarely still
	Quiet		Resisted being held
	Active		Good sleep pattern
	Floppy when held		Irregular sleep pattern

Check all that describe your child presently:

	Mostly quiet		Restless
	Wets bed		Overreacts
	Fights frequently		Tires easily
	Difficulty learning new tasks		Talks constantly
	Poor attention span/concentration		Difficulty following directions
	Overly active		Nervous habits/tics

Does your child tantrum? **Y / N** Does your child bang his/her head or perform other self-abusive behaviors? **Y / N**

If you circled yes to the questions above, please describe these behaviors in more detail:

____

____

____

SPECIALIST INFORMATION

Please provide information for any of the following specialist involved in your child's care:

Specialty	Name of Agency/Provider	Date Started	Date Completed
Occupational Therapy			
Speech Therapy			
Physical Therapy			
Ophthalmology/Vision Test			
Audiology/Hearing Test			
Mental Health (counseling/psychology/psychiatry)			
Other			

Please provide Sensory KIDS a copy of any IEPs, neuro-psych evaluations, or additional testing

PLEASE NOTE: If your child was referred to Sensory KIDS from a PCP or other physician's office, we will send your child's records to the appropriate office for coordination of care purposes.

By signing below, you understand and authorize Sensory KIDS to send records to your child's referring physician for the purposes of coordinating your child's care.

Signature　　　　　　　　　　　　　　　　Date

If you would like your child's records to be sent to any of the providers listed above, please indicate below with the provider's contact and your signature.

I hereby authorize Sensory KIDS, LLC to release my child's medical records to the following providers:

Provider/Facility Name　　　　　Phone #　　　　　Fax #

Provider/Facility Name　　　　　Phone #　　　　　Fax #

Provider/Facility Name　　　　　Phone #　　　　　Fax #

Provider/Facility Name　　　　　Phone #　　　　　Fax #

Signature　　　　　　　　　　　　　　　　Date

BACKGROUND INFORMATION

What is the reason for seeking occupational therapy evaluation or services?

What are your child's strengths? What does your child enjoy doing?

What is your primary concern for your child at this time? What tasks are difficult for your child to perform?

What would you like to be easier for your child and/or your family?

Do you have concerns regarding school? Does your child's teacher(s) have any concerns? If yes, please specify.

Describe your child's preferred activities and/or toys. What does your child do with preferred toys?

Does your child enjoy playing with peers or siblings, prefer solitary play, or prefer adult interaction?

What would you like to learn from our evaluation?

Please provide us with any other information that you feel is important for us to know about your child:

____

____

____

____

____

____

____

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PARENT CHECKLISTS

Please check each description that applies to your child.

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CHECKLIST #1

	These garments bother my child:		**These aspects of self-care bother my child:**
	Seams in clothing		Washing or wiping face
	Tags in clothing		Cutting toenails or fingernails
	Socks		Having haircut or hair clipped
	Changing from long to short pants		Hair washing or drying
	Accessories		Hair brushing or combing
	Elastic on clothing		Getting dressed
	Fuzzy or furry textured clothes (e.g. sweaters, collars, etc.)		Brushing teeth
	Wool clothes		Getting dirty
			Having crumbs around my mouth
			Having messy hands
			Have a messy mouth
	TOTAL		**TOTAL**
	These tactile sensations bother my child:		**These visual sensations bother my child:**
	Mud		Brightly colored or patterned materials (e.g. clothes, upholstery, drapes, wallpaper)
	Finger paint		Fluorescent lights
	Glue		Fast moving images in the movies or TV
	Play dough		Visually cluttered environments
	Foods		Busy pictures in books or complex and busy images in artwork
	Hair care products (greasy/sticky)		
	Kissing		
	Coarse carpet		
	Light stroking touch		
	TOTAL		**TOTAL**
	These smells bother my child:		**These aspects of food and eating bother my child:**
	Perfume/cologne		Salty foods (e.g. nuts or chips)
	Cleaners/disinfectants		Soft foods
	Bath products		Lumpy foods
	Soaps		Slimy foods
	Air fresheners		Soup with vegetables or meat pieces
			Spicy foods (e.g. spicy dip, hot sauce)
			Eating bread crust
			Food preparation/cooking
			New/unfamiliar foods
	TOTAL		**TOTAL**

	These sounds bother my child:		Sounds in these places bother my child:
	Sounds of utensils against each other (e.g. spoon in bowl, knife on plate)		Toilet flushing in the bathroom
	Clothing that makes noise (e.g. swishing cloth, accessories)		Appliances/small motor noises (e.g. blender, vacuum, hair dryer, electric shaver) at home
	Door bell ringing		Concerts
	Dog barking		Large gatherings
	Sirens		Restaurants
	Alarms		Parades
	Radio or TV in the background		Malls
	Fluorescent lights		Gymnasium
	Someone talking when I am trying to concentrate		
	Clock ticking		
	Construction or landscaping equipment		
	Water running or dripping in the background		
	TOTAL		**TOTAL**

	These aspects related to movement bother my child:
	Climbing activities
	Walking or climbing up open stairs
	Experiencing heights
	Walking or standing on moving surfaces
	Playing in the playground jungle gym
	Playing in the playground swings and slides
	Going on amusement park rides
	Going up or down escalators
	Chewing foods
	TOTAL

CHECKLIST #2

	Typically, my child has a less intense response than others to:		Typically, my child does not notice:
	The doctor giving him/her a shot		Food or liquid left on lips
	Bruises or cuts		Hands or face that are messy/dirty
	Hurting self		Drooling or food that has fallen out of mouth
	Being touched on the arm or back (ex. unaware)		The need to use the toilet
	Wet or dirty diapers		Feelings of hunger (does not seek food when hungry)
	Dirt on himself/herself		Over-filling mouth when eating
	Objects that are too hot or too cold to touch		Feelings of being “full” (must intervene to stop over eating
	Bumping into things or falling over objects		Strong or noxious odors
	Typically, my child does not notice		**Typically, my child does not respond:**
	Activity within a busy environment		When name is called or has to be touched to gain attention (hearing is OK)
	An object coming toward eyes quickly		When a new sound is introduced
	Someone entering or leaving the room		To unexpected loud sounds (e.g. fire drills, hall bells or other loud noises)
	Materials or people in the room needed to complete an activity		When given directions or instructions only once
			To a normal volume speaking voice (e.g. others speak loudly to gain his/her attention)

	My child:
	Performs movements in a slow and plodding fashion
	Gives little indication of like or dislike from movement
	Appears to be in his/her own world (tuned out)
	Does not visually scan the environment (look around)
	Leaves clothing twisted on body

CHECKLIST #3

	My child has a constant desire for:		**My child has a constant desire for:**
	Swinging		Looking at spinning objects (ex. ceiling fans, toys with wheels, floor fans)
	Being upside down		Watching fast changing TV or movie segments
	Jumping and crashing (e.g. beds or other surfaces)		Watching flickering or blinking lights
	Bumping, pushing, or hitting other children		Watching visually stimulating scenarios (ex. aquarium)
	Fidgeting, wiggling, and restlessness which interferes with daily routines (ex. can't sit still, fidgets)		Staring at people or objects
	Twirling/spinning throughout the day (ex. likes dizzy feeling or does not get dizzy)		
	Movement in chair during class, at a meal, or a business meeting		
	Deliberately falling when running or playing		
	Movement without regard to safety (ex. climbs high into a tree, jumps of tall furniture)		
	Bumping or pushing body against objects/walls		
	Flapping or clapping hands, biting self or other repetitive actions		
	Changing from on activity to another so that it interferes with completion of activities		
	Pushing, pulling, and hanging off things (e.g. refrigerator doors, cabinets, parents' hands)		

	My child has a constant desire for:		**My child has a constant desire for:**
	Touching people to the point of irritating others (gets in others personal space)		Licking, sucking, or chewing on non-food items (e.g. hair, pencils, clothing)
	Being overly affectionate with others		Eating crunchy, chewy or hard foods to the exclusion of other textures
	Feeling vibrations (e.g. stereo speakers, washer, dryer)		Putting things in mouth
	Touching/feeling objects		Excessive kissing
	Being held		
	Banging head, biting hands, pinching, scratching, or pulling hair		
	Splashing excessively during bath time		

	My child has a constant desire to:		**My child has a constant desire to:**
	Eat foods with strong flavors/tastes (ex. bitter, sour, spicy)		Talk and has difficulty taking turns
	Smell people/pets		Speak in a loud voice
	Deliberately smell or taste objects or toys during play or other activities		Make a lot of noises during play activity
			Increase the volume on the TV, CD, or radio
			Make strange sounds

CHECKLIST #4

	My child does not:		**My child does not have adequate strength so he/she:**
	Have a preferred hand (after age four) for writing, cutting, etc.		Has difficulty turning knobs or handles that require some pressure
	Does not hold paper with other hand while cutting or writing		Has a loose grasp on objects (i.e. pencil, scissors, or things that he is carrying)
	Reach across his/her body to grab a toy		Has a rather tight, tense grasp on objects but cannot sustain
			Can't lift heavy objects
			Seems weaker than other children his/her age
			Holds a pencil differently from most people

	My child has difficulty in these activities:		**My child:**
	Balancing when a bus, car or subway stops quickly		Feels stiff and awkward when held
	Balancing during motor activities (ex. biking, karate, gymnastics, etc.)		Keeps mouth open most of the time

	Keeping good desk posture (slumps, leans on arm, head too close to work, props head on hand)		Tires easily
	Turns head alone (turns whole body to look at you)		Sits partly on and off the chair
	Tires easily, especially when standing or holding particular body position		Feels “loose” or “floppy” when you lift him/her up or move the child’s limbs to help him/her get dressed
	Catching self when falling		Uses one hand or the other but avoids play with the hands together
			Avoids or needs encouragement for heavy work (ex. pushing, pulling, lifting)
My child has difficulty coordinating 2 sides of body to:		**My child has difficulty with the following visual activities:**	
	Play rhythmic clapping games		Keeping track of place on page (ex. reading)
	Pump self on swing		Following a moving object with eyes, copying from blackboard to paper
	Jump with both feet together		
	Ride a bicycle, tricycle or big wheels		

CHECKLIST #5

My child has difficulty in these language activities:		**My child has difficulty with these motor activities:**	
	Is hard to understand when he/she speaks (speech/articulation problems)		Tasks that have several steps
	Unable to follow two or three step directions		Learning exercise steps or routines
			Learning new motor tasks
			Following the steps of a recipe
			Maintaining or copying rhythms
			Balancing
			Hopping, jumping, skipping, or running compared to others his/her age
			Climbing/jumping or walking on bumpy/uneven ground
			Sports or games
			Climbing on and over objects
			Riding a bike, tricycle or big wheel (pedaling or pushing with feet)
			Climbing or playing on playground equipment
			Catching a ball
My child:		**My child has difficulty with these fine motor activities:**	
	Is clumsy or seems not to know how to move body, bumps into things		Playing with small manipulative toys (duplos, beads, blocks)
	Prefers sedentary (quiet) activities to movement activities		Blowing (ex. soap bubbles or whistle)
	Approaches new motor activities in an overly cautious manner		Wrapping a present
	Gets lost easily (even in familiar places)		Snapping fingers
	Is accident prone		Operating a manual can opener
	Talks self through tasks		Putting a belt through all belt loops
	Uses inefficient ways of doing things (ex. wastes time, moves slowly, does things in the hardest way)		Grasping a pencil or crayon
	Tends to break toys/objects and other things when has problems using them		Applying paste to toothbrush
	Has difficulty formulating goals (ideas) for action		
My child has difficulty with these school activities:		**My child has difficulty with these daily living tasks:**	
	Drawing, coloring, or copying		Licking an ice cream cone
	Cutting and pasting		Using a spoon or cup
	Staying between the lines when coloring or when writing		Handling eating utensils
			Clothing off or on
			Placing arm or leg correctly in clothing
			Tying shoes
			Fasteners (ex. buttons, zipper, snaps, buckles)

			Putting on pierced earrings and/or a necklace
			Putting on a watch
My child:			
	Easts in a messy, sloppy manner		
	Eats or dresses slowly		
	Puts clothes on backwards or inside out		
	Looks disheveled		

CHECKLIST #6

My child has trouble finding:		**My child has trouble judging:**	
	Utensils on the table or in the sink		The amount of force needed for a task (ex. pushing grocery cart, kicking a ball)
	Desired item in drawer or on shelf		Appropriate pressure with markers, crayons and glue sticks (w/o breaking or flattening)
	Desired garment in closet or shirt in drawer		Timing and distance (difficulty catching, batting a ball or throwing to a target)
	Socks that match		If he /she is moving or of things around him/her are moving
	Objects in distracting backgrounds (ex. shoes in messy room, favorite in “junk drawer”		Where food is within the mouth (ex. doesn’t chew fully before swallowing)
	Printed figures that appear similar (ex. b and dp, or + and x)		
	A familiar face in a crowd		
	The appropriate aisle in a store		
	Information on a blackboard and copying it to his/her paper		
	Things that are moving from those that are not moving		
My child has trouble distinguishing (without looking):		**My child:**	
	Objects in pocket, purse, or drawer by feel		Tends to examine toys by touching and feeling them rather than looking at them
	What is in his/her hands		Continues to examine objects by putting in the mouth (past age of 1.5 years)
	What is touch him/her		
	Buttons and button holes		
My child has trouble distinguishing:			
	The location of sounds		
	What is said		
	The words to a song when listening on a radio		
	Specific sounds that are similar (ex. caT vs. caP or bacK vs. baT)		
	The taste of different foods		

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PRIVACY POLICY - HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, your protected health information may be provided to a physician or other health care provider who has referred you to Sensory KIDS or one to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, obtaining approval for treatment or specific procedures/treatment may require that your relevant protected health information be disclosed to the heath plan to obtain approval.

- **Health Care Operations** include the business aspects of running our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to occupational therapy students that see patients at our facility. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release

PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Sensory KIDS, LLC
1425 N. Killingsworth St.
Portland, OR 97217
503-575-9402

For more information about HIPAA or to file a complaint, please contact:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll free)

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PRIVACY POLICY SIGNATURE

Privacy Practices Acknowledgment of Receipt

I, ________________________________, have received a copy of Sensory KIDS, LLC Notice of Privacy Practices.

Name (Please print):

____

Signature:

____

Relationship (of signer) to client:

____

Date: _____________________________

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SERVICE COSTS

Sensory KIDS is committed to providing the highest quality care at a fair and reasonable cost. For clients who choose to pay the out-of-pocket rate for our services, the following fees will apply. All fees will be collected at the time of service and are subject to change based on the contractual agreements held by Sensory KIDS.

Sensory KIDS is able to extend the following discounts based on payment type. Please note that the fees listed in the chart below are representative of rates *before* applying discounts.

- 5% Discount on payments, paid in full at time of service, via credit/debit
- 10% Discount on payments, paid in full at time of service, via cash or check

Service	Cost
Evaluations	
• **Comprehensive Evaluation (60-90 minutes)** Includes standardized testing, clinical observation, written summary, and 1-hour parent education meeting	• $500
• **Re-Evaluation (60 minutes)** Includes review of recent external evaluation, clinical observations, and written summary	• $285
• **Written Comprehensive Evaluation Report or Detailed Progress Report**	• $90
Treatment	
• **OT Session (50 minutes)** With or without listening therapy	• $165
Meetings/Consultations	
• **Parent Education Meetings (60 minutes)** Meetings scheduled to review evaluation reports, set goals, discuss progress, and recommend home programs (the parent meeting following an initial evaluation is included in the evaluation cost listed above)	• $165
• **Phone Consultations** After complimentary 15-minute mark	• $33 for every 15 minutes
Additional Fees	
• **No Show**	• $88
• **Late Cancellation** Appointments not cancelled within 24-hours notice (with the exception of illness) or families who arrive 15-minutes into their child's appointment time	• $50
• **Late Pick Up Fee**	• $25 for every 10 minutes
• **Email Communication/Documentation Requests/Legal Consultation** Emails taking over 10 minutes, client requests for additional documentation, court appearance with legal counsel	• Billed at the hourly rate in 15-minute increments
• **School Visits/Observation** If school is more than 5 miles from the clinic	• $50/ $165 for each additional hour of observation
• **Feeding Charge** One-time fee	• $50

Please refer to the Client Agreement for further details regarding our financial policy. Any questions or concerns related to the cost of services at Sensory KIDS can be directed to 503.575.9402 or info@sensorykidsot.com