



1425 N. Killingsworth Street  
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[info@sensorykidsot.com](mailto:info@sensorykidsot.com)  
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## INTAKE PACKET - CHILD

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Sensory KIDS, LLC offers Occupational Therapy 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.

**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.**

- 1. Patient History Form**
- 2. Parent Checklists**
- 3. Privacy Policy**

Each insurance provider will have different guidelines and limitations of coverage for Occupational Therapy. 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 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.

\*OHP families **must** provide our office with a PCP referral to keep on file before services are rendered or following the initial evaluation appointment. Most OHP plans require prior authorization before services are rendered following the initial evaluation. 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 services, Sensory KIDS does offer private pay options and various payment plans. A detailed overview of our service costs is included at the end of this packet.

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](mailto:info@sensorykidsot.com), by mail, or by fax at 888-769-4431.



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# PATIENT HISTORY 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: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother only <input type="checkbox"/> Father only <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____			
What is the custody situation? _____			
Parent(s)/Guardian(s): _____			
Gender Identity and/or 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)
<b>SECONDARY INSURANCE INFORMATION</b>			
*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)
<b>PRIMARY CARE PHYSICIAN INFORMATION</b>			
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:		
<b>SCHOOL INFORMATION</b>			
Child's School:			Grade:
Phone Number:	Teacher(s):		
Is your child receiving any school accommodations? <input type="checkbox"/> 504 Plan <input type="checkbox"/> IEP <input type="checkbox"/> None <input type="checkbox"/> Other: _____			
Is your child receiving services at school?   OT <input type="checkbox"/> Speech <input type="checkbox"/> PT <input type="checkbox"/> Behavioral Support <input type="checkbox"/> 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?

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 from 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:

<input type="checkbox"/>	Fussy	<input type="checkbox"/>	Like being held
<input type="checkbox"/>	Passive	<input type="checkbox"/>	Tense when held
<input type="checkbox"/>	Irritable	<input type="checkbox"/>	Overactive/rarely still
<input type="checkbox"/>	Quiet	<input type="checkbox"/>	Resisted being held
<input type="checkbox"/>	Active	<input type="checkbox"/>	Good sleep pattern
<input type="checkbox"/>	Floppy when held	<input type="checkbox"/>	Irregular sleep pattern

Check all that describe your child presently:

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

Does your child tantrum?

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

If you answered 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?

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

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

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

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

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

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

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What would you like to learn from our evaluation?

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What is your preferred learning style/How do you learn best? (i.e. visual learner, auditory learner, etc.)

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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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<b>CHECKLIST #1</b>	
<b>These garments bother my child:</b>	<b>These aspects of self-care bother my child:</b>
<input type="checkbox"/> Seams in clothing	<input type="checkbox"/> Washing or wiping face
<input type="checkbox"/> Tags in clothing	<input type="checkbox"/> Cutting toenails or fingernails
<input type="checkbox"/> Socks	<input type="checkbox"/> Having haircut or hair clipped
<input type="checkbox"/> Changing from long to short pants	<input type="checkbox"/> Hair washing or drying
<input type="checkbox"/> Accessories	<input type="checkbox"/> Hair brushing or combing
<input type="checkbox"/> Elastic on clothing	<input type="checkbox"/> Getting dressed
<input type="checkbox"/> Fuzzy or furry textured clothes (e.g. sweaters, collars, etc.)	<input type="checkbox"/> Brushing teeth
<input type="checkbox"/> Wool clothes	<input type="checkbox"/> Getting dirty
	<input type="checkbox"/> Having crumbs around my mouth
	<input type="checkbox"/> Having messy hands
	<input type="checkbox"/> Have a messy mouth
<b>TOTAL</b>	<b>TOTAL</b>
<b>These tactile sensations bother my child:</b>	<b>These visual sensations bother my child:</b>
<input type="checkbox"/> Mud	<input type="checkbox"/> Brightly colored or patterned materials ( e.g. clothes, upholstery, drapes, wallpaper)
<input type="checkbox"/> Finger paint	<input type="checkbox"/> Fluorescent lights
<input type="checkbox"/> Glue	<input type="checkbox"/> Fast moving images in the movies or TV
<input type="checkbox"/> Play dough	<input type="checkbox"/> Visually cluttered environments
<input type="checkbox"/> Foods	<input type="checkbox"/> Busy pictures in books or complex and busy images in artwork
<input type="checkbox"/> Hair care products (greasy/sticky)	
<input type="checkbox"/> Kissing	
<input type="checkbox"/> Coarse carpet	
<input type="checkbox"/> Light stroking touch	
<b>TOTAL</b>	<b>TOTAL</b>
<b>These smells bother my child:</b>	<b>These aspects of food and eating bother my child:</b>
<input type="checkbox"/> Perfume/cologne	<input type="checkbox"/> Salty foods (e.g. nuts or chips)
<input type="checkbox"/> Cleaners/disinfectants	<input type="checkbox"/> Soft foods
<input type="checkbox"/> Bath products	<input type="checkbox"/> Lumpy foods
<input type="checkbox"/> Soaps	<input type="checkbox"/> Slimy foods
<input type="checkbox"/> Air fresheners	<input type="checkbox"/> Soup with vegetables or meat pieces
	<input type="checkbox"/> Spicy foods (e.g. spicy dip, hot sauce)
	<input type="checkbox"/> Eating bread crust
	<input type="checkbox"/> Food preparation/cooking
	<input type="checkbox"/> New/unfamiliar foods
<b>TOTAL</b>	<b>TOTAL</b>



<b>These sounds bother my child:</b>		<b>Sounds in these places bother my child:</b>	
	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		
	<b>TOTAL</b>		<b>TOTAL</b>
<b>These aspects related to movement bother my child:</b>			
	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		
	<b>TOTAL</b>		

## CHECKLIST #2

<b>Typically, my child has a less intense response than others to:</b>		<b>Typically, my child does not notice:</b>	
	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
<b>Typically, my child does not notice</b>		<b>Typically, my child does not respond:</b>	
	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)
<b>My child:</b>			
	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)
<b>My child has difficulty coordinating 2 sides of body to:</b>		<b>My child has difficulty with the following visual activities:</b>	
	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

<b>My child has difficulty in these language activities:</b>		<b>My child has difficulty with these motor activities:</b>	
	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
<b>My child:</b>		<b>My child has difficulty with these fine motor activities:</b>	
	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		
<b>My child has difficulty with these school activities:</b>		<b>My child has difficulty with these daily living tasks:</b>	
	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
<b>My child:</b>		
	Eats in a messy, sloppy manner	
	Eats or dresses slowly	
	Puts clothes on backwards or inside out	
	Looks disheveled	

### CHECKLIST #6

<b>My child has trouble finding:</b>		<b>My child has trouble judging:</b>	
	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		
<b>My child has trouble distinguishing (without looking):</b>		<b>My child:</b>	
	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		
<b>My child has trouble distinguishing:</b>			
	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

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**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 health 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)



1425 N. Killingsworth Street  
Portland, OR 97217

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

[info@sensorykidsot.com](mailto:info@sensorykidsot.com)  
[www.sensorykidsot.com](http://www.sensorykidsot.com)

## PRIVACY POLICY SIGNATURE

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### 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

<p><u>Evaluations</u></p> <ul style="list-style-type: none"> <li>• <b>Comprehensive Evaluation (60-90 minutes)</b> Includes standardized testing, clinical observation, written summary, and 1-hour parent education meeting</li> <li>• <b>Re-Evaluation (60 minutes)</b> Includes review of recent external evaluation, clinical observations, and written summary</li> <li>• <b>Written Comprehensive Evaluation Report or Detailed Progress Report</b></li> </ul>	<ul style="list-style-type: none"> <li>• \$500</li> <li>• \$285</li> <li>• \$90</li> </ul>
<p><u>Treatment</u></p> <ul style="list-style-type: none"> <li>• <b>OT Session (50 minutes)</b> With or without listening therapy</li> </ul>	<ul style="list-style-type: none"> <li>• \$165</li> </ul>
<p><u>Meetings/Consultations</u></p> <ul style="list-style-type: none"> <li>• <b>Parent Education Meetings (60 minutes)</b> 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)</li> <li>• <b>Phone Consultations</b> After complimentary 15-minute mark</li> </ul>	<ul style="list-style-type: none"> <li>• \$165</li> <li>• \$33 for every 15 minutes</li> </ul>
<p><u>Additional Fees</u></p> <ul style="list-style-type: none"> <li>• <b>No Show</b></li> <li>• <b>Late Cancellation</b> Appointments not cancelled within 24-hours notice (with the exception of illness) or families who arrive 15-minutes into their child's appointment time</li> <li>• <b>Late Pick Up Fee</b></li> <li>• <b>Email Communication/Documentation Requests/Legal Consultation</b> Emails taking over 10 minutes, client requests for additional documentation, court appearance with legal counsel</li> <li>• <b>School Visits/Observation</b> If school is more than 5 miles from the clinic</li> <li>• <b>Feeding Charge</b> One-time fee</li> </ul>	<ul style="list-style-type: none"> <li>• \$88</li> <li>• \$50</li> <li>• \$25 for every 10 minutes</li> <li>• Billed at the hourly rate in 15-minute increments</li> <li>• \$50/ \$165 for each additional hour of observation</li> <li>• \$50</li> </ul>

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](mailto:info@sensorykidsot.com)