Updated 5/04/2021

COVID-19 GUIDELINES AND POLICIES

Please note: All members of our staff are fully vaccinated! Due to increased patient appointments, your child may be in a **shared** space during session (no more than 15 minutes). This ONLY applies to our big gym and will occur as transitions take place. If you are uncomfortable with sharing of space, please let our office or your therapist know. There will be no sharing of space with any unmasked child 4yrs or younger.

In order to help maintain in-person services, and ensure the safety and well-being of our clients, families, and staff, Sensory KIDS has the following guidelines in place at the clinic. Before coming to your appointments, please ensure that:

- You and/or your child are not exhibiting any signs of illness, including but not limited to: high temperature, congestion, coughing, difficulty breathing, pain or pressure in chest, vomiting, or sore throat in the last 72 hours of the scheduled session.
- You and/or your child have not traveled out of the country in the last 14 days.
- If you and/or your child have travelled within the U.S., to please allow 10 days of quarantine from the clinic upon your return.
- You and/or your child have not come into contact with any person who tests positive for COVID-19 in the last 14 days

CLINIC REQUIREMENTS

1. You and/or your child are allowed to be accompanied by other family members to session, however siblings are not allowed in the gyms. Sensory KIDS has two observation rooms available for families to stay in while the session is taking place. If you are bringing siblings or other individuals to the session, please contact our office, or your/your child's therapist, in advance so appropriate arrangements can be made.

2. Masks are required, with the exception of those under 4 years of age. Though there is a mask exception, our clinic strongly prefers that all children try to wear a mask during the session, if tolerable.

3. Temperatures are taken when entering the clinic. If you and/or your child's temperature exceeds 100.4 F, the session will be cancelled and rescheduled once symptoms have cleared for 72 hours.

4. Staff at Sensory KIDS, clients, and family members are expected to adhere strictly to social distancing (6 feet) before, after, and during session (as appropriate for effective service delivery).

5. Clients and families will be allowed entrance to the clinic **at their scheduled appointment time**.

6. All payments will be handled remotely 9if possible), by credit/debit card, or by mail.

WHAT WE ARE DOING TO KEEP YOU SAFE

1. 15-minute gaps have been scheduled between each therapy session to allow for proper cleaning of therapy areas and gym equipment.

2. Restroom areas, door handles, counters, and shared spaces will be regularly disinfected.

3. Cloth chairs, books, and toys have been removed from the general waiting area. All gym equipment and small items that cannot be easily sanitized or washed have been removed from the gyms. All crash pad covers have been replaced with washable vinyl coverings. Balls from the ball pit have been removed and smaller therapy rooms have been temporarily closed off for use.

4. Hand sanitizer and disinfecting wipes will be made available for use to all families and clients.

5. Our clinic is thoroughly cleaned by a professional cleaning crew twice a week.

1425 N. Killingsworth Street
Portland, OR 97217

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

info@sensorykidsot.com
www.sensorykidsot.com

INTAKE PACKET for CHILD

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**
4. **Release Form**
5. **Client Agreement**

INSURANCE NOTES

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. Our clinic does not medically diagnose. All referrals must include a diagnosis that is listed under Line 377 on OHP's Prioritized List of Health Services or else your child may not be eligible for authorization approval. Please contact our office with any questions regarding this.

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.

***Care Oregon**: Families with Care Oregon should expect a delay in scheduling treatment and the parent meeting following the initial evaluation. Authorization requests take 2 weeks to process through Care Oregon.

***EviCore**: For families who require authorization through eviCore, please note that eviCore only authorizes a small number of visits with each submission, no matter the number of visits allowed in your insurance plan per calendar year. A denial can be received at any point in therapy even if you have not used all of your plan's visits.

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.

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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: ☐ 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? 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 <u>infant</u>:

☐	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 <u>presently</u>:

☐	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**?** No

Does your child bang his/her head or perform other self-abusive behaviors? No

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

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?

What is your preferred learning style/How do you learn best? (i.e. visual learner, auditory learner, etc.)
Please provide us with any other information that you feel is important for us to know about your child:

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.

MEDICAL RECORD REQUESTS

As a requirement of HIPAA and The Privacy Rule, Sensory KIDS will provide individuals, upon request, access to their/their child's protected health information. This includes the right to inspect or obtain a copy (or both) of your medical record, as well as to direct our office to transmit a copy of your/your child's record to a designated entity or person.

Medical documentation can be requested at any point in therapy. If you would like our office to send you/your child's records to another entity or individual, a signed Release of Information Form will be required and must include the appropriate contact information of the entity or individual you would like us to send records to. Our office will provide you with the Release of Information Form upon your request for records.

Records can be transmitted by secure fax, secure email, or by mail. Records transmitted electronically to another entity or individual will not be subjected to a fee, however if a physical copy of your record is required to be sent to another entity or individual, your request may be subject to a fee if over 25 pages in length. Requests for records can be made by phone, in person, in writing, or by email. Please allow our office up to 1 week to process any and all record requests.

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PARENT CHECKLISTS

Please check each description that applies to your child.

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)

1425 N. Killingsworth Street
Portland, OR 97217

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

info@sensorykidsot.com
www.sensorykidsot.com

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: _____

1425 N. Killingsworth Street
Portland, OR 97217

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

info@sensorykidsot.com
www.sensorykidsot.com

CLIENT AGREEMENT

Welcome to Sensory KIDS! We are looking forward to working with you and your family! Please review the following policies to better understand our therapy process. At the end of each section, please indicate your agreement to abide by these policies by initialing or signing where indicated. Any questions regarding the information included in this agreement can be directed to our front office at 503-575-9402 or by direct email to info@sensorykidsot.com. Thank you!

Included in this Client Agreement are the following:

1. Financial Policy
2. Cancellation Policy
3. Scheduling and Consultation Policy
4. Office Etiquette and Acknowledgement of Risk
5. Releases

FINANCIAL POLICY

BILLING, COPAYMENTS, OUT-OF-POCKET EXPENSES, AND VISIT TRACKING

BILLING AND BALANCES

1. **Payments including co-payment, private pay dues, and other out-of-pocket expenses are collected at the time of service.** We accept payment by cash, check, VISA, MasterCard, American Express, and Discover Card. Families are financially responsible for all charges whether or not services are covered and paid by insurance.

2. Insurance is pre-verified. Our billing team, MBA Medical Billing, sends out statements on the first of each month. Please be aware that some services provided may be non-covered services and/or not considered reasonable and necessary under Medicaid, as well as other medical insurance companies. If for any reason a portion of a bill or service is not paid by insurance as expected, you are responsible for prompt payment of the remaining charges. You are responsible for payment of all services provided by Sensory KIDS, LLC. In the even that your insurance company refuses payment for services for any reason, or if any other source of payment falls through, you will be responsible for all past, current, and future service charges.

3. It is your sole responsibility to financially cover payment for the evaluation service if an evaluation has already been rendered at another facility and submitted to insurance for payment within a given period of time. Insurance will only cover one evaluation per set number of days.

4. Families can set up a payment plan at any point in therapy, if this is more of a financially feasible option.

5. We request prompt payment on all statements sent by MBA Medical Billing. **Balances after insurance reimbursement are due within 30 days of the statement date**, unless other payment arrangements have been made with Sensory KIDS.

6. **Outstanding Bills:** Sensory KIDS reserves the right to request payment for any outstanding balances. All outstanding balances greater than 45 days past due will result in treatment termination. In order for treatment to be reinstated, the due balance must be paid in full or a payment plan agreement must be signed. All outstanding balances 120 days past due will be sent to a collection agency.

    - **FOR MEDICAID MEMBERS ONLY:** Medicaid members cannot be balance billed or accrue interest on unpaid claims, however Sensory KIDS reserves the right to terminate treatment due to any issues related to unpaid claims. Medicaid members can be billed out-of-pocket expenses related to no-show or late cancellation fees, per this signed client agreement**.** All Medicaid members are required to maintain active Medicaid status throughout therapy.

7. Personal checks that do not clear due to insufficient funds shall be resubmitted to Sensory KIDS, along with payment for any charges associated with the bounced check.

INSURANCE

Sensory KIDS is the preferred provider for the following insurance companies: Aetna, Moda Health, TriCare, Cigna, OHP/Care Oregon, and Regence BCBS. Sensory KIDS is able to bill as an out-of-network provider to United Health Care, Providence, and Pacific Source. If your family has an insurance plan that we do not bill for, Sensory KIDS will provide a superbill at your request to submit to insurance on your own.

As a courtesy to our families, Sensory KIDS provides a verification of insurance benefits and eligibility before services are rendered. This information is **not a guarantee of payment** and all services are subject to the terms and agreement of your insurance plan. Your insurance is a contract between you, your employer, and your insurance company. As such, Sensory KIDS is not a part of this contract and bills insurance as a courtesy. It is the responsibility of your family to clarify the terms and conditions of your insurance plan. Accurate information on covered services is only available once a claim has been made.

1. Should your insurance coverage change, it is your responsibility to notify our office within **30 days** of the effective date. If no new insurance information is received, Sensory KIDS will no longer bill on your family's behalf, and all future claims and/or charges will be patient responsibility.

2. Sensory KIDS will obtain any prior authorizations required by your insurance plan. If a PCP referral is required, it is your family's responsibility to obtain one before services can be rendered. **All OHP plans MUST have a PCP referral on file for insurance requirements before treatment can begin.**

3. Sensory KIDS will **assist** with tracking visits; however, it is your responsibility to track used visits in accordance with the number of visits allowed and/or approved by your insurance plan.
    - The number of visits approved by your insurance plan is NOT related to the recommendation of our therapists. If therapy exceeds the number of allowable and/or authorized visits, you will be responsible for any out-of-pocket expenses. It is important to understand hard limits to the number of visits allowed by your insurance plan. Sensory KIDS may request additional visits on your family's behalf based upon the recommendations of the therapist and the limitations of your plan, but we cannot guarantee that additional visits will be approved.

4. If at any point in your child's therapy, insurance no longer covers a service due to a lack of medical necessity, our office will appeal on your family's behalf at your request (when applicable). However, it is your responsibility to pay for any uncovered charges. We do not accept responsibility for paying or negotiating any settlements on unpaid claims, especially in the case of an appeal denial.

Sensory KIDS understands that financial problems may unexpectedly arise and affect payment on your family's account. If this is the case, we urge families to contact Sensory KIDS or MBA Medical Billing for assistance in managing their accounts. Families can contact our office at any point to establish a payment plan.

CREDIT OR DEBIT CARD

For your convenience, your family has the option of placing a card on file for automatic payments related to copays, private pay dues, or co-insurance charges. If your family would like to keep a card on file, please provide the appropriate information below. Please note, that if your family does not choose to place a card on file, any payments due will be billed to you.

MasterCard: _____ Visa: _____ Discover: _____ American Express: _____

Card Number: _____ Expiration: _____

CSV Number: _____

Card Holder Name: _____ Card Holder Signature: _____

Billing Address:

_____

Street City State Zip

If providing credit or debit card information, please initial the following:

1. _____ I understand Sensory KIDS, LLC will charge my card automatically for any co-payments and/or private pay fees at the time of service.

2. _____ I would like Sensory KIDS, LLC to charge my card automatically on the first of each month regarding any due balances on my account.

3. _____ I would like Sensory KIDS, LLC to send me a copy of my purchasing receipt via email for each transaction ran on my card.

If a credit or debit card was NOT provided, please initial the following:

1. _____ I understand that all private pay fees and/or out of pocket expenses are expected to be paid in-person, at the time of service. If fees are not collected at the time of service, I understand that any due balance will be billed to me on the first of each month.

By signing below, I hereby understand the financial policy of Sensory KIDS, LLC and agree to abide by it.

_____ _____

Parent/Legal Guardian Signature **Date**

CANCELLATION POLICY

LATE CANCELLATION, NO SHOWS, AND ASSOCIATED FEES

Sensory KIDS is committed to providing exceptional care and support to the children and families we serve. Our therapists are dedicated to using best-practice and evidence-based methods to help your child reach goals and feel successful. That means putting time and effort into planning each individual session Please respect our dedication by committing to scheduled appointment times and the agreed-upon treatment plan. **In order to ensure the most effective use of your child's therapy time, we ask that you carefully review the statements below.**

PLEASE NOTE: Insurance companies DO NOT REIMBURSE for any of the fees listed in this policy.
All fees in this Cancellation Policy are parent/guardian responsibility

General Policy Statement: Sensory KIDS, LLC recommends an intensive approach to therapy, however, we understand that not all of our families can accommodate this in their busy schedules. Following the first parent meeting with your therapist, an ongoing treatment schedule will be established based upon the availability of both the therapist and your family. Any changes to your child's ongoing treatment schedule should be requested to our front staff, not the therapist. Sensory KIDS cannot guarantee that your schedule request will be met, however, we will do our best to accommodate. We understand that abrupt endings to therapy may occur in the face of difficult financial situations or life events, but we do ask that families provide at least a 48-hour notice prior to their child ending, so the therapist may prepare the next session for a transition out of therapy.

Appointment Reminders: Our scheduling system, Clinic Source, will send families a reminder email 48 hours before their child's appointment. Families may choose to cancel or confirm their child's session via this reminder email. However, Sensory KIDS asks that families follow-up by phone or email if their child's session needs to be cancelled.

Inclement Weather Policy: The clinic is open except in cases of severe conditions requiring businesses to close. It is the responsibility of our families to call the clinic to determine whether changes in the scheduled time of treatment are needed, and if the opening of the clinic is delayed. Families may cancel treatment if they do not wish to travel because of inclement weather, however, if the clinic is open, a $50 late cancellation fee will be charged for missed appointments that were not given at least 24-hours'notice.

THERAPY POLICY AND ASSOCIATED FEES

1. It is your responsibility to communicate any schedule changes or requests to the front desk, not your child's therapist.

2. Your child should always be accompanied by a guardian at the start and end of each therapy session (unless your child is 16 years or older). Drop-offs are allowed when planned with the front staff and your child's therapist, but cannot become a common occurrence.

3. Parents/Guardians who arrive later than 15 minutes into their child's appointment time will be charged a **$50 late cancellation fee**, and will result in the child's appointment being cancelled for that day. Appointments cannot be extended, as they are scheduled back-to-back. Therapy is not effective if not given the full amount of time. We ask that you respect the therapist's time, as well as your own, and allow your family plenty of time to make it to your appointment.

4. If an appointment is cancelled with less than 24-hours' notice, except in the case of illness, the appointment will count as a late cancellation and you will be charged a **$50 late cancellation fee**. Three cancelled appointments in a row will result in the termination of your child's scheduled treatment times. Exceptions to this are previously planned absences made with our front office at least 1 week prior to the cancelled dates.

5. Treatment sessions are 50 minutes long. Parents/Guardians are expected to show at the 50-minute mark to assist with the transition out of therapy and check in with the therapist. If you do not show at the 50-minute mark, a **$25 late pick-up fee** will be charged to your account for every 10 minutes over your child's therapy time.

6. An **$88 no-show fee** will be charged to your account if your child misses an appointment with no notice. Furthermore, 3 no-shows will result in the termination of your child's scheduled treatment times.

7. If your child is sick with a temperature over 100 degrees, a cough, or has vomited in the last 24 hours, please immediately call our office to cancel your child's appointment. Cancellations due to illness will not be charged a cancellation fee.

8. **Feeding sessions** require a significant amount of money and time for planning and preparations. If my child is doing feeding therapy, a **one-time fee of $50** will be charged to your account, which will cover food costs for all of your child's feeding sessions. Additionally, if you need to cancel your child's feeding session, please give 48-hours' notice, except in the case of illness.

Sensory KIDS is happy to work with families when there are scheduling issues. If problems arise with your child's ongoing treatment schedule, please inform our front office staff. Sensory KIDS is able to hold therapy spots for up to two weeks. If your child is pulled off the schedule for any reason, we will do our best to fit your child back in as soon as possible.

By signing below, I hereby understand the cancellation policy of Sensory KIDS, LLC and agree to abide by it.

_____ _____

Parent/Legal Guardian Signature **Date**

SCHEDULING AND CONSULTATION POLICY

COMMUNICATION, PARENT MEETINGS, LEGAL/PROFESSIONAL CONSULTATION

General Scheduling Statements: Treatment sessions run 50 minutes long, but are scheduled for 1 hour. The last 10 minutes of a child's session is utilized for transitions out of therapy, parent check-ins, and therapist notes. Treatment sessions are scheduled back-to-back, and as a result, treatment time cannot be extended.

Following the initial evaluation, Sensory KIDS recommends a round of 30 treatment sessions and 3 parent education meetings. Treatment sessions will be scheduled based upon the availability of the therapist and your family. Parent education meetings run 50-minutes long, are ADULT ONLY, and will be scheduled as follows:

- **1st Meeting:** Scheduled after the evaluation to review evaluation results, establish goals, and discuss the details of the therapeutic model at Sensory KIDS.
- **2nd Meeting:** Scheduled mid-way through your child's treatment to review goals, strategize on a home plan, and discuss progress.
- **3rd Meeting:** Scheduled at the end of your child's treatment to discuss the transition out of therapy and finalize home strategies/supports.

Returning Families: All families who plan to return to Sensory KIDS after taking a break will be placed on the therapist's priority list with a projected return date. Our office will reach out to your family close to this projected return date in an effort to establish a new treatment schedule. Sensory KIDS prioritizes all returning families, as well as siblings when scheduling.

Parent Commitment: We believe strongly that parent involvement is the key to success in therapy. While therapists may require some one-on-one time to develop a strong relationship with your child, we encourage parents to be involved in the process by observing or participating in your child's treatment sessions.

Please review the following:

1. If you bring siblings to your child's session, you are expected to stay with them in the waiting area or in one of the observation rooms. Siblings can only participate in your child's treatment session when previously planned or requested by the therapist.

2. Any payments or scheduling needs should be taken care of at the beginning of your child's session.

3. Longer conversations about your child's therapy should be saved for designated parent education meetings or email. You may request a parent meeting or phone consultation at any point in your child's therapy, and will be responsible for all service charges related to your request.

4. Parent education meetings are **adult-only**. Children are not allowed in parent education sessions and cannot be left unsupervised during these sessions.

5. Around the half-way mark of your child's therapy schedule, you will receive an email reminder of how many sessions your child has left and what the recommendation is to continue. Temporary end dates may be established for scheduling purposes, but these can be adjusted in the case of cancellations, absences, or office closures.

6. Cell phones are disruptive and are not to be used in the clinic during sessions, especially in the waiting area. If observation rooms are open, families may take any necessary calls in these rooms with the door closed upon notifying front staff. All other calls should be taken outside the clinic.

PROFESSIONAL/LEGAL CONSULTATION

Communication: Discussions about your child are not appropriate to have with your child present. We offer families the opportunity to schedule a 15-minute complimentary phone consult when a short consultation is sufficient. Additionally, families may request an adult-only parent meeting with the therapist at any time.

Legal Consultation: Any fees associated with legal counsel or court appearances will be billed to the family's lawyer, or the family directly, at the out-of-pocket rate of $165/hour. This fee is NOT COVERED by insurance. All requests for legal counsel should be directed to Sensory KIDS front staff for scheduling purposes. Therapists are not obligated to discuss legal matters over email.

Professional Consultation: Therapists at Sensory KIDS are willing to work closely with any professionals related to your child's care. Information can be shared once a Release of Information Form has been filled out appropriately and returned to our front staff. **Consultations with related medical professionals will be billed to insurance when applicable**. Private pay families will be billed for professional consultations in 15-mintue increments at the hourly therapy rate. Therapists are not obligated to discuss your child's therapy with related medical professionals over email.

Emails: Email communication should be used for quick updates regarding your child's therapy. Email communication taking over 10 minutes will be billed in 15-minute increments at the hourly therapy rate to your family. This fee is NOT COVERED by insurance.

Professional consultations require a signed Release of Information form, and all requests should be made directly to the front staff. You will be responsible for any charges associated with your request.

By signing below, I hereby understand the scheduling and consultation policy of Sensory KIDS, LLC and agree to abide by it.

_____ _____

Parent/Legal Guardian Signature **Date**

COMMUNICATION NOTICE

At Sensory KIDS, we handle most of our communication to families through our main email account: info@sensorykidsot.com. This email is HIPAA protected, making it safe to discuss your child's therapy and to send any documentation related to your child's therapy. The following will be handled by email, unless otherwise requested by phone:

- Initial intake
- Scheduling the initial evaluation, any parent meetings, as well as treatment sessions
- Appointment reminders through Clinic Source
- Notices of therapist absences
- Notices of office closures
- Cancellation and rescheduling of treatment sessions
- Schedule requests and/or changes
- Insurance related inquiries or issues
- Payment questions and receipt sending
- Sensory KIDS Monthly Support Group emails
- End of treatment surveys
- Recruitment for research projects

By signing below, I hereby understand Sensory KIDS, LLC's communication notice. By signing below, I am giving Sensory KIDS permission to email me for anything associated with my child's therapy.

_____ _____

Parent/Legal Guardian Signature **Date**

OFFICE ETTIQUETTE AND ACKNOWLEDGEMENT OF RISK

ETTIQUETTE, SAFETY, DISCHARGE

Sensory KIDS, provides support for all kids and families without regard to race, color, religion, sex, disability, gender identity, sexual orientation, or age. We hope to provide a place of comfort and safety to our families, in addition to an atmosphere that is positive, fun, and inviting. So Sensory KIDS can make a comfortable and safe space for all, we ask the families respect the following:

1. Closely monitor your child's behavior in the waiting room to ensure playing is safe and appropriate for other children in the room. Children are prohibited from climbing walls and/or jumping from any surfaces or office furniture. Office toys, books, or crafts should be handled with care under the supervision of a parent/guardian.
2. Please clean up after your children in the waiting room. We ask that all books and toys are put back where they were found. Trash and recycle can be found in the waiting room under the front desk.
3. All children should be accompanied by a parent or guardian when going to the restroom. Any families with children who require diapers or pull-ups should bring a diaper bag to therapy and be prepared to change your child if necessary.
4. Children are NOT allowed in the treatment area unless accompanied by the therapist.
5. Before entering treatment areas, we ask that shoes be removed and placed by the front door. Any coats/jackets can be placed on the available wall hooks.
6. No outside food should be taken beyond the waiting room, with the exception of food therapy sessions. Please clean up any food messes that occur, and notify the front staff immediately if further assistance with cleaning is required.
7. Families are always invited to participate in the child's session, however siblings are not allowed in the treatment areas unless otherwise planned with or requested by the therapist.
8. Please refrain from cell phone conversations in the waiting area. Please keep tablet use to a minimum, ensuring the volume is on silent. Necessary phone conversations can be carried out in an available observation room or outside the clinic.
9. In compliance with HIPAA, front staff and therapists are unable to discuss any other families/clients who may be receiving therapy at the clinic. Please be mindful of the content discussed with your family members, as well as the therapist.

Acknowledgement of Risk: There is some risk inherent in the use of therapy equipment at Sensory KIDS. By signing below, you agree to indemnify and hold Sensory KIDS, LLC harmless from any and all losses and claims for injuries or damages that may occur to you, your family, and your belongings from the use of our therapeutic equipment. Siblings are not allowed into treatment spaces unless otherwise requested and supervised by your child's therapist, as this poses a risk to safety for children and liability for Sensory KIDS, LLC.

Discharge: It is the policy of Sensory KIDS to discharge clients when they have met the following criteria:

- **Sufficient Progress** – When a child has demonstrated sufficient progress, the therapist will review the child's progress with the family and recommend a break. A hard end date will be established mid-way through the child's treatment for families whose therapist has recommended a break.
- **Financial Responsibility** – If a family is not accepting financial responsibility as outlined in our financial policy, the child's therapy may be terminated.
- **Attendance** – If three consecutive sessions are cancelled or marked as no-shows, the child's therapy will be immediately terminated.
- **Family Request** – Discharge of a child can be requested by the child's family. We ask that families provide 48-hours' notice if they know their child will be ending therapy.
- **Agency Discretion** – Sensory KIDS reserves the right to discharge any client at any time for any reason

By signing below, I hereby understand and will adhere to the office etiquette and acknowledgement of risk as outlined by Sensory KIDS, LLC. I hereby understand and agree to the Discharge Policy

_____ _____

Parent/Legal Guardian Signature **Date**

RELEASES

TEACHING ACTIVITIES

Sensory KIDS is a teaching facility that values learning and education. Master and doctorate level students studying occupational therapy complete internships at our facility, and therefore, will frequently observe and take part in therapy sessions, with the therapist giving notice. Additionally, volunteers are frequently onsite to support therapists and administrative staff, and may observe sessions as deemed appropriate by the therapist. Both intern students and volunteers adhere to our clinic policies and federal privacy guidelines.

Please initial the following:

_____ I give permission for occupational therapy students to participate in my child's therapy session.

_____ I understand that volunteers may observe my child's session, as deemed appropriate by my child's therapist.

By signing below, I hereby understand and agree to the teaching and research activities outlined by Sensory KIDS, LLC.

_____ _____

Parent/Legal Guardian Signature **Date**

PHOTOGRAPH AND VIDEO RELEASE

In compliance with federal and state regulations your permission is sought to allow your son/daughter/self to appear in photographs and/or videos recorded in our clinic. Children and adults involved in recording will not be identified in any manner.

Please initial each individual condition and sign below to express permission for photographs, videos, and their use:

_____ Photo for Medical Software System.

_____ Photos and video recordings may be used for review by our therapists.

_____ Photos and video recordings may be used for educational purposes.

_____ Photos and video recordings may be used for marketing purposes.

Child's Name: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____