Sensory Solutions
Occupational Therapy for Children

Fall Self Regulation 2017

Child's Information

Name_____Birth Date_____Age_____Grade_____

Parents' Names_____

Address_____

Contact info. (home)_____(cell)_____

(e-mail)_____

Emergency Contact information

Name / Relationship_____ Phone # _____

Please list allergies, food allergies, medical conditions, or special considerations.

_____

I am registering for:

_____Self Regulation Group – Mondays 5:00-6:15, September 11 – November 30, 2017

Payment for the group will be divided into two parts: **Fees for the first five sessions ($625) will be collected at the time of registration**, and payment for the remaining sessions will be due on September 11th **($625)**. Upon your request and provision of diagnostic codes, a Superbill will be provided to help you request reimbursement from your insurance provider. We are unable to refund missed sessions and will accommodate missed sessions by providing missed content to parents and providing reviews within the class.

*By registering my child I agree to the payment schedule as listed above. I give permission for my child to receive occupational therapy treatment from Sensory Solutions, LLC.

*In the event of the need for emergency medical attention, I give consent for 911 personnel to provide essential care.

*I understand that my child may be photographed or videotaped for therapeutic purposes while participating in this group.

*I also agree to allow my child to be observed in the group by parents of the other group members for the purposes of parent education.

Parent's Signature_____Date:_____

Parent's Signature_____Date:_____

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