Sensory Solutions
Occupational Therapy for Children

Winter Self Regulation 2018

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.

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I am registering for:

______Self Regulation Group – Mondays 5:00-6:15, January 8, 2018- March 12, 2018

NOTE: no sessions February 19-23

Payment for the group will be divided into two parts: **Fees for the first four sessions ($500) will be collected at the time of registration**, and payment for the remaining sessions will be due on January 8th **($500)**. 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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