



Spring 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.

I am registering for:

_____ **Self Regulation Group – Mondays 5:00-6:15, March 26, 2018- May 21, 2018**

NOTE: no sessions April 16

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 March 26 (**\$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: _____

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