

**FACE SHEET: Child & Adolescent**

**Child Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Sex:** M F

**Parent A's Name:** \_\_\_\_\_ **Parent B's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Employer Phone:** \_\_\_\_\_ **Employer Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Preferred Contact Number:** \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION:**

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

*I understand payment is due at the time services are rendered.*

**Signature Required**

**Will you be billing your insurance company?** Y N

**If yes, please complete insurance information on reverse side.**

STAR Center • 5655 S. Yosemite Street, Suite 302 • Greenwood Village, CO 80111  
Telephone: 303-221-STAR (7827) • Fax: 303-322-5550

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**CONSENT:**

I authorize release of any medical information necessary to process this claim.

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**INSURANCE INFORMATION:**

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(Parent or Guardian)

**Name of insured:**

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**Insured's Social Security # or Member ID #:**

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**Group #:**

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**Insured's Employer:**

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**Insured's  
Birthdate:**

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**Insurance Company:**

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**Insurance Company Phone #:**

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**Claims Address:**

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**State**

**Zip**



5655 S Yosemite St, Suite 302  
Greenwood Village, CO 80111  
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Fax: 303-322-5550

**Office Use**  
NAME \_\_\_\_\_  
DOE \_\_\_\_\_  
DOB \_\_\_\_\_  
CA \_\_\_\_\_

### CONFIDENTIAL PERSONAL HISTORY FOR CHILDREN AND YOUNG ADULTS

Today's Date: \_\_\_\_\_ Completed by: \_\_\_\_\_

Last Name: \_\_\_\_\_ Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Gender: \_\_\_\_\_

\_\_\_\_\_ Ethnicity: \_\_\_\_\_

### CONTACT INFORMATION

Parent A's Name: \_\_\_\_\_ Parent B's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Name	Relationship	Phone
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**School:** \_\_\_\_\_ **Grade in School:** \_\_\_\_\_

Teacher's Name: \_\_\_\_\_ Type of Classroom: \_\_\_\_\_

### Child's Physician's or Health Care Providers (including Primary Care Physician):

Name: \_\_\_\_\_ Profession: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Profession: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Profession: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Child's Last Medical Checkup: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Are there any medical precautions the therapist should be aware of when working with your child?

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**FAMILY MEMBERS – Detailed Information**

	Age	Sex	Adopted	Occupation	Handedness
Father	_____	_____	Yes No	_____	R L
Stepfather	_____	_____	Yes No	_____	R L
Mother	_____	_____	Yes No	_____	R L
Stepmother	_____	_____	Yes No	_____	R L
Children	_____	_____	Yes No	_____	R L
	_____	_____	Yes No	_____	R L
	_____	_____	Yes No	_____	R L

Marital Status of Parents: \_\_\_Married \_\_\_Separated \_\_\_Divorced \_\_\_Other

Mother's Education \_\_\_Less than High School \_\_\_High School or GED \_\_\_College \_\_\_Post College (grad school)

Stepmother's Education \_\_\_Less than High School \_\_\_High School of GED \_\_\_College \_\_\_Post College (grad school)

Father's Education \_\_\_Less than High School \_\_\_High School or GED \_\_\_College \_\_\_Post College (grad school)

Stepfather's Education \_\_\_Less than High School \_\_\_High School of GED \_\_\_College \_\_\_Post College (grad school)

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**PERSONALITY PROFILE**

What are your child's gifts / strengths? \_\_\_\_\_

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What do you enjoy most about your child and family?

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What are the presenting problems for your child? (All categories below may not apply.)

Academic: \_\_\_\_\_  
\_\_\_\_\_

Activities of daily life (eg. eating, dressing) \_\_\_\_\_  
\_\_\_\_\_

Relationships: \_\_\_\_\_  
\_\_\_\_\_

Sensory: \_\_\_\_\_  
\_\_\_\_\_

Motor: \_\_\_\_\_  
\_\_\_\_\_

Play: \_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_

What kind of interests and activities does your child have? (hobbies, sports, clubs)  
Please list them in order of preference beginning with the favorite activity.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child been diagnosed with (PLEASE CHECK ALL THAT APPLY):

- ADD
- ADHD
- Anxiety Disorder or Mood Disorder (specify): \_\_\_\_\_
- Autistic Spectrum Disorder
- Cognitive Delay
- Down Syndrome
- Dyslexia
- Emotional disorder (specify): \_\_\_\_\_
- Fragile X Syndrome
- Learning Disabilities (specify if possible): \_\_\_\_\_
- Sensory Processing Disorder or Sensory Integration Dysfunction
- Tourette's Syndrome
- Other (specify): \_\_\_\_\_

Please note, who provided the diagnosis and based on what criteria i.e., test scores, comprehensive clinical evaluation, genetic study, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## MEDICATIONS

List any medications has your child received **in the past**:

Medication:\_\_\_\_\_ Purpose:\_\_\_\_\_ When taken:\_\_\_\_\_

Medication:\_\_\_\_\_ Purpose:\_\_\_\_\_ When taken:\_\_\_\_\_

Medication:\_\_\_\_\_ Purpose:\_\_\_\_\_ When taken:\_\_\_\_\_

Medication:\_\_\_\_\_ Purpose:\_\_\_\_\_ When taken:\_\_\_\_\_

Medication:\_\_\_\_\_ Purpose:\_\_\_\_\_ When taken:\_\_\_\_\_

List any medications your child is **currently** taking, its purpose and frequency of dosage:

Medication:\_\_\_\_\_ Purpose:\_\_\_\_\_ When taken:\_\_\_\_\_

Medication:\_\_\_\_\_ Purpose:\_\_\_\_\_ When taken:\_\_\_\_\_

Medication:\_\_\_\_\_ Purpose:\_\_\_\_\_ When taken:\_\_\_\_\_

Medication:\_\_\_\_\_ Purpose:\_\_\_\_\_ When taken:\_\_\_\_\_

Medication:\_\_\_\_\_ Purpose:\_\_\_\_\_ When taken:\_\_\_\_\_

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## FAMILY ADAPTATION

How would you describe your child's general adjustment at home? Poor\_\_\_ Fair\_\_\_ Good\_\_\_ Excellent\_\_\_

How does your child get along with each member of the family?

Father\_\_\_\_\_

Mother\_\_\_\_\_

Siblings\_\_\_\_\_

\_\_\_\_\_

Have there been any traumatic family events in the course of this child's development?

\_\_\_\_\_

\_\_\_\_\_

Have there been any major moves? (city to city, country to country)

\_\_\_\_\_

\_\_\_\_\_

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## PREGNANCY (If child is adopted, skip to Adoption Section)

What kind of experience was the pregnancy for both mother and father?

Parent A\_\_\_\_\_

Parent B\_\_\_\_\_

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Was it planned?	_____	_____	_____
Were there complications?	_____	_____	_____
shock	_____	_____	_____
severe stress	_____	_____	_____
loss of a loved one	_____	_____	_____
accident	_____	_____	_____
health problems, specify	_____	_____	_____
confinement to bed	_____	_____	_____
other	_____	_____	_____
Was mother exposed to loud noises?	_____	_____	_____
Did mother smoke?	_____	_____	_____
Did mother consume alcohol?	_____	_____	_____
Did mother take any medication? specify	_____	_____	_____
Did mother talk much?	_____	_____	_____
Was mother physically active?	_____	_____	_____
Were any previous pregnancies complicated?	_____	_____	_____

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## LABOR AND DELIVERY

Describe your experience during labor and delivery \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

		<b>Comments</b>
Length of labor?	_____ hrs	_____
Premature: specify	Yes____ No____	_____
Forceps used	Yes____ No____	_____
High forceps required	Yes____ No____	_____
Suction	Yes____ No____	_____
Delivery position (ex: breech)	_____	_____
Caesarean birth (reason)	Yes____ No____	_____
Birth weight	_____ lbs _____ oz	_____
APGAR ratings (if known)	_____	_____
Cried immediately	Yes____ No____	_____

Required special treatment  
(i.e. required oxygen,  
had jaundice, etc.)      Yes\_\_\_\_ No\_\_\_\_ \_\_\_\_\_

Birth injuries: specify      Yes\_\_\_\_ No\_\_\_\_ \_\_\_\_\_

Did the newborn have  
immediate physical contact  
with the mother?      Yes\_\_\_\_ No\_\_\_\_ \_\_\_\_\_

Was there a positive bonding  
experience between mother  
and newborn at birth?      Yes\_\_\_\_ No\_\_\_\_ \_\_\_\_\_

Describe any separations from  
mother during first days of life \_\_\_\_\_

Did mother experience any  
post-partum depression?      Yes\_\_\_\_ No\_\_\_\_ \_\_\_\_\_

**ADOPTION**

Describe the circumstances surrounding the adoption.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

More specifically:

Age when adopted: \_\_\_\_\_

Prior foster homes: \_\_\_\_\_

Physical appearance: \_\_\_\_\_

Response to new home: \_\_\_\_\_

Is your child aware of his/her adoption? \_\_\_\_\_

**INFANCY & TODDLERHOOD**

Going back to the **first two years** of the child's life, what type of baby was he/she?  
(feeding, sleeping, activity level)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Breastfed	_____	_____	_____
Extended separations during first two years (over 3 days)	_____	_____	_____
Specific health problems during this period	_____	_____	_____
Thumb sucking / pacifier (until what age)	_____	_____	_____
Feeding problems	_____	_____	_____
Sleeping problems	_____	_____	_____
Colic or "fussy baby"	_____	_____	_____
Prefer certain positions as an infant (describe)	_____	_____	_____
Dislike lying on stomach	_____	_____	_____
Dislike lying on back	_____	_____	_____
Able to self soothe	_____	_____	_____
On a regular schedule	_____	_____	_____
Enjoy bouncing	_____	_____	_____
Become calmed by car rides or infant swings	_____	_____	_____
Become nauseated by car rides or infant swings	_____	_____	_____
Crawled (at what age)	_____	_____	_____
Toe walker (until what age)	_____	_____	_____
Go through "terrible twos"	_____	_____	_____
Describe your child's toddler stage:	_____		
	_____		
	_____		

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**CHILDHOOD ILLNESSES / PROBLEMS**

	Age	Comments / Deficits
_____ ear infections	_____	None / A Couple / Many _____
_____ tubes in ears	_____	_____
_____ respiratory problems	_____	_____
_____ high fever	_____	_____
_____ meningitis	_____	_____
_____ adenoid problems	_____	_____
_____ frequent colds	_____	_____

strep throat \_\_\_\_\_  
 allergies If yes, please specify: \_\_\_\_\_  
 \_\_\_\_\_

Check the items below which have been a problem and provide details:

Asthma \_\_\_\_\_  
 Bronchitis \_\_\_\_\_  
 Skin problems \_\_\_\_\_  
 Gastro-Intestinal problems \_\_\_\_\_  
 Seizures \_\_\_\_\_  
 Epilepsy \_\_\_\_\_  
 Nightmares \_\_\_\_\_  
 Sleep \_\_\_\_\_  
 Bedwetting \_\_\_\_\_  
 Nail Biting \_\_\_\_\_  
 Broken limbs \_\_\_\_\_  
 Other \_\_\_\_\_

Has he/she ever been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, list reasons: \_\_\_\_\_  
 \_\_\_\_\_

Has he/she ever had a serious accident/injury? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, list accidents: \_\_\_\_\_  
 \_\_\_\_\_

Are there any other medical illnesses or conditions which have been diagnosed?  
 \_\_\_\_\_  
 \_\_\_\_\_

Is your child in good general health at the present time? \_\_\_\_\_

## DEVELOPMENTAL MILESTONES

(Give approximate ages if remembered, or comment on anything unusual)

Rolling over \_\_\_\_\_ Walk \_\_\_\_\_ Say words \_\_\_\_\_  
 Sit alone \_\_\_\_\_ Chew solid food \_\_\_\_\_ Say sentences \_\_\_\_\_  
 Crawl \_\_\_\_\_ Drink from a cup \_\_\_\_\_

Was crawling phase brief? Yes \_\_\_\_\_ No \_\_\_\_\_ Absent? Yes \_\_\_\_\_ No \_\_\_\_\_

Did child use a walker (rolling plastic seat)? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how often? \_\_\_\_\_

Experience hesitancy or delays in learning to go down stairs? Yes \_\_\_\_\_ No \_\_\_\_\_

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## VISUAL DEVELOPMENT

Has your child experienced any problems with his/her eyesight or vision? \_\_\_\_\_

Are there any current problems of which you are aware? \_\_\_\_\_

When was the last time his/her eyesight was tested? \_\_\_\_\_

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## AUDITORY DEVELOPMENT

Has your child experienced any problems with his/her hearing? (operations, infections, tubes)

\_\_\_\_\_

Ear infections?      seldom \_\_\_\_      sometimes \_\_\_\_      often \_\_\_\_  
                                 mild \_\_\_\_      moderate \_\_\_\_      severe \_\_\_\_

Are there any current hearing problems of which you are aware?

\_\_\_\_\_

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## SPEECH AND LANGUAGE DEVELOPMENT

How would you describe your child's speech and language development?

normal \_\_\_\_      delayed \_\_\_\_      advanced \_\_\_\_

Did your child begin speaking in single words, then two, then a sentence?    Yes    No

Did your child not talk for a long while, then all of a sudden speak in complete sentences?    Yes    No

Do you or others have difficulty understanding what child says?    Yes    No

First words and at what age: \_\_\_\_\_

Describe any speech related problems: \_\_\_\_\_

\_\_\_\_\_

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## SENSORY and MOTOR DEVELOPMENT

Please check any that apply:

\_\_\_\_ My child seems to be overly sensitive to sensory experiences more so than most people:  
    \_\_\_\_ auditory    \_\_\_\_ tactile    \_\_\_\_ visual    \_\_\_\_ movement    \_\_\_\_ taste    \_\_\_\_ smell

\_\_\_ My child doesn't seem to react to sensory experiences as readily as most people:  
\_\_\_ auditory \_\_\_ tactile \_\_\_ visual \_\_\_ movement \_\_\_ taste \_\_\_ smell

\_\_\_ My child actively seeks out sensory experiences more so than most people:  
\_\_\_ auditory \_\_\_ tactile \_\_\_ visual \_\_\_ movement \_\_\_ taste \_\_\_ smell

\_\_\_ My child has difficulty differentiating sensory experiences.  
(ex. confuse sounds, can't find objects in drawer or bag without looking, bumps into things)

Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_ My child has trouble learning new movements.

\_\_\_ My child tends to be clumsy and has balance and coordination problems.

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## PREVIOUS TESTING AND TREATMENTS

Has your child had any previous ASSESSMENTS or TREATMENT  
**Please attach relevant reports.**

	ASSESSMENTS			TREATMENT		
	Yes	No	Place / Date	Yes	No	Place / Date
Medical	___	___	_____	___	___	_____
Audiological	___	___	_____	___	___	_____
Speech	___	___	_____	___	___	_____
Educational	___	___	_____	___	___	_____
Psychological	___	___	_____	___	___	_____
Occ. Therapy	___	___	_____	___	___	_____
Other	___	___	_____	___	___	_____

Comments: \_\_\_\_\_  
\_\_\_\_\_

Have there been any specific events or traumas linked with the onset of your child's difficulties?

\_\_\_\_\_  
\_\_\_\_\_

Is your marital situation stable and positive at this time? \_\_\_\_\_

What, if any, stresses are affecting your family at this time?

\_\_\_\_\_  
\_\_\_\_\_

Which language(s) is spoken at home? \_\_\_\_\_

Are there other individuals or family members living at home? (other than immediate family)

\_\_\_\_\_

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## EDUCATION

How did your child adapt to the first day(s) at school or pre-school:

Mostly positive \_\_\_\_\_ Mixed \_\_\_\_\_ Mostly negative \_\_\_\_\_

How old was he/she? \_\_\_\_\_ How much time did he/she attend per week? \_\_\_\_\_

In general, how would you describe your child's experience/learning at school from kindergarten to the present time?

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Please give us more detailed information about any difficulties your child encountered in school beginning with the earliest experience:

Initial school adjustment \_\_\_\_\_

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Pre-school/Daycare \_\_\_\_\_

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Primary (K-Gr. 3) \_\_\_\_\_

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Junior (Gr. 4-6) \_\_\_\_\_

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Intermediate (Gr. 7-8) \_\_\_\_\_

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High School (Gr. 9-12) \_\_\_\_\_

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Has there been remedial help given **inside** the school system? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe: \_\_\_\_\_

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**GOALS**

What are your goals for your child's program? Please be as specific as possible.

- 1. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
- 2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
- 3. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
- 4. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
- 5. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear about STAR Center? \_\_\_\_\_

If you were referred:

Referred by: \_\_\_\_\_ Profession: \_\_\_\_\_

Address: \_\_\_\_\_

STAR Center has my permission to send a thank you letter to my referral source indicating the my child has been seen for an evaluation.

Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



## Video and Photo Release

The Sensory Processing Disorder (SPD) Foundation and the Sensory Therapies And Research (STAR) Center are research and education organizations. As such, we often video or photograph children or family members participating in treatment or research projects. The video and photos may include interviews, assessments, treatment and/or other group activities. The rights, titles and interests of these materials belong to the SPD Foundation and/or the STAR Center, which reserves the right to edit the material.

I (please print name) \_\_\_\_\_ voluntarily consent to the taking of photographs or video of myself and/or my child (please print child's name) \_\_\_\_\_.

I understand that these photographs or videos may be used for educational purposes, scientific purposes and/or media purposes in educational training programs, medical/scientific publications, or media publications. I realize that the photographs or videos may be used to create educational training tapes and may be used at SPD Foundation or STAR Center seminars, workshops, on the SPD Foundation or STAR Center websites and/or in webcasts/video on demand presentations. Some video or photographic material may be included in future training tapes that may be sold to support further research and treatment of children with Sensory Processing Disorder. Specific names of children and other family members seen in photos or videos will not be disclosed.

I give permission for use of photographs or video to be used for educational purposes, for news or other media, for webcasts or video on demand and for training tapes.

\_\_\_\_\_  
Print your Child's Name

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Print your Name (Parent or Legal Guardian)

\_\_\_\_\_  
Date



## Acknowledgment of Receipt of Privacy Practices

I, \_\_\_\_\_ have received a copy of STAR Center's Notice of Privacy Practices with an effective date of April 14, 2003.

**Name of Client:** \_\_\_\_\_

**Address of Client:** \_\_\_\_\_

\_\_\_\_\_

**Signature of Client:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name of Witness:

**Signature of Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**CONSENT TO RELEASE CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, do hereby authorize  
(Name of Client or Parent/Guardian)

STAR Center to release and share any and all information pertinent to:

\_\_\_\_\_  
(Last name of Client) (First) (MI) (Date of Birth) (SS#)

the client's pediatrician and/or primary care physician

\_\_\_\_\_  
(Name of Physician and Practice)

\_\_\_\_\_  
(Address) (City) (State/Zip code)

\_\_\_\_\_  
(Telephone)

I do understand that this release and sharing of information will include, but not be limited to conversations, therapy sessions, records, reports, determinations, evaluations and factual information regarding myself and/or family member(s) who are minors. I understand that this action is taken to assist STAR Center in working with me and/or my family.

This authorization is voluntary and remains in effect until \_\_\_\_\_, unless specifically revoked by written notice to the agency or person. A photocopy of this release is as effective as the original.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF CLIENT IF 18 OR OLDER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN



## Financial Agreement

11.8.06

### Payment for Services

Payment is due at the time service is rendered. A 10% pre-pay discount is offered towards the treatment program if the treatment program is paid in full on the first day of treatment. We accept cash, checks and major credit cards. Returned checks will be subject to a \$25.00 returned check fee.

### Billable Services

While there is no ordinary charge for a brief telephone consultation, more lengthy or complex situations may result in charges. Some reports and consultations may also result in charges

### Family Discount

Immediate family members are eligible for a 10% Family Discount. This discount applies only when payment is made at the time services are rendered.

### Late Cancellations

STAR Center reserves the right to charge for any appointment that is missed or canceled without a one business day advance notice. Please note that insurance companies do not reimburse for cancellation fees.

### Illness

Please do not have your child attend treatment if he/she is feeling ill. Our gym must be germ-free to maintain the health of our clients and staff. If your child is not well enough to go to school, he/she is not well enough to attend therapy. If you arrive for a session during which the OT determines your child is too sick to participate in treatment (coughing, feverish) your session will be cancelled and rescheduled.

### Bad Weather Cancellations

Please contact STAR Center if driving conditions are poor and you are unable to attend treatment as a result. We will contact you if one or all of our therapists are unable to get to our location due to hazardous weather.

### Insurance Coverage

Our services are not guaranteed to provide insurance coverage. We will give you a superbill at the time of services. You are responsible for billing your insurance company and insurance reimbursement, if provided, will be sent directly to you.

*I acknowledge that I have read and understand my responsibility to pay for services. By signing this agreement, I agree to the terms of this document.*

\_\_\_\_\_  
Client/Parent or Guardian Printed Name

\_\_\_\_\_  
Client/Parent or Guardian Signature

\_\_\_\_\_  
Date



**PERMISSION TO PARTICIPATE IN RESEARCH**

To Whom It May Concern:

I \_\_\_\_\_, give my permission for the Sensory Processing Disorder Foundation staff to contact me regarding participation in a research project.

Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_