



158 Newark Ave.
Jersey City, NJ 07302
T: (201) 324-1700 / F: (201) 324-1788
info@sensorykidsandsocialminds.com
www.sensorykidsandsocialminds.com

CLIENT INFORMATION & PARENT QUESTIONNAIRE

Please provide us with the following information so we can best serve your child.

Child's Full Name (Last, First): _____

Date of Birth: ___/___/___ Age: _____ Sex: F M

Parent/Guardian Name: (Mr./Ms./Miss) _____
(Mr./Ms./Miss) _____

Marital Status: _____ Language(s) Spoken: _____

Siblings Names: _____

Home Address: _____

Primary Contact #: (____) _____ - _____
Please Circle: (Home/Work/Cell)

Secondary Contact #: (____) _____ - _____
Please Circle: (Home/Work/Cell)

Email: _____

Would you like to receive emails regarding upcoming workshops/programs? Yes No

Person responsible for bill: _____

Date of Birth: _____ Address (if different): _____

Phone # (if different): (____) _____ - _____ Work #: (____) _____ - _____

Employer Name: _____ Occupation: _____

Employer's Address: _____

How did you learn about Sensory Kids & Social Minds?

Reference's Name, if any:

Why are you seeking our services?



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Child's Physician(s)

Other Health Professionals, Agencies, or Medical Professionals working with your child?

List current school or childcare provider:

List previous school/daycare experiences:

List services your child receives in school: (i.e. OT, PT, S/L, EH, TMH, etc.)

TELL US MORE ABOUT YOUR CHILD

Please answer the following to the best of your knowledge:

Describe your child's development as compared to other children of the same age:

What are child's strengths?

What do you find difficult for your child to accomplish?

Does your child have difficulty understanding or following directions?

Describe how your child gets along with other children:

YOUR CHILD'S LIKES/DISLIKES

Please answer the following to the best of your knowledge:

What does your child's dislike?

Please list your child's favorite play activities/toys?

What are your child's favorite foods?

Is your child a picky eater? Yes No If so, please explain below:

YOUR CHILD'S PAST MEDICAL HISTORY

Please answer the following to the best of your knowledge:

Has your child had any ear infections? Yes No

If so, please indicate how often and how they were treated for it below:

Does your child seem overly sensitive to noises, light, crowds, texture/touch, clothing, (etc.)

Yes No If so, please describe below:

Does your child grind their teeth during the day/or night? Yes No

If so, do they clench their jaw? Yes No If so, please describe below:



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Please describe any family history of health, mental, emotional, or learning difficulties:

YOUR COMMENTS/CONCERNS

Please answer the following to the best of your knowledge:

Please describe mealtime routines or concerns:

Please describe bedtime routines or concerns:

Please describe any toileting concerns:

Please share any other information that you feel will be helpful to us in working with your child/family:

INSURANCE INFORMATION:

Sensory Kids & Social Minds, LLC, is an out of network provider. Insurance reimbursement is dependent on your insurance plan and policies. Please be advised that a diagnosis is needed for insurance consideration.

Has your child had any clinical evaluations (e.g. Pediatrician, Neurologist, Psychiatrist)?

Yes No If so, when and where was it conducted?



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Please indicate whether your child received a clinical diagnosis? Yes No
Diagnosis, if any: _____

Primary Insurance Name: _____

Member ID#: _____ Group #: _____

Policy Holder's Full Name: _____

Policy Holder's Date of Birth: ___/___/___ S.S. #: _____-_____-_____

Please indicate whether you have a Secondary Insurance: Yes No
Secondary Insurance Name: _____

Policy Holder's Full Name: _____

Member ID#: _____ Group #: _____
Other _____

Financial Agreement:

Our practice is committed to providing the best treatment for our patients. Patients are responsible for all charges from treatments provided by Sensory Kids & Social Minds, LLC. As a service to you, we will bill most insurance carriers directly. However, primary responsibility for the account is yours. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your insurance card at your next visit.

Minors:

The undersigned will agree to be responsible for payment of balance for services rendered to minors.

Insurance Billing:

Please be aware that some or perhaps all of the services you receive may be non-covered services and are not considered reasonable and/or necessary under your insurance plan. In this instance, you will be responsible for payment.

No Insurance:

Payment for services is due at the time services are rendered.



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Cancellation Policy:

Your appointment time is especially reserved for you. If you need to cancel for any reason, you must allow us at least 24 hours advance notice. **Failure to cancel 24 hours in advance will result in a nonrefundable, \$25 service charge to your appointment.** In trying to do our best to serve you we recommend that you always reschedule and confirm your appointments before leaving the office.

Payment Agreement and Consent for Evaluation, Treatment, and/or Program:

We will gladly discuss your proposed treatment and answer any questions relating to your insurance and/or payment arrangements.

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered.

I am also providing my consent for evaluation/treatment and/or participation in Sensory Kids & Social Minds' Program for _____.

(Print Name of Child)

I have read all the information on this sheet and I will notify you of any changes that might interfere with this financial agreement.

Signature (Parent or Guardian):

Today's Date:

Parent/Guardian's Full Name (Print Name):

Today's Date:



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Permission to Use Photograph and Videography

Please initial one of the following boxes to address photography and videography as a client at Sensory Kids and Social Minds, LLC.

I hereby consent Sensory Kids & Social Minds, LLC, its representatives and employees, the right to take photographs/videos of my child _____. I also grant Sensory Kids and Social Minds, LLC, the right to edit, use, and reuse photos and videos in print, on the internet, and all other forms of media. I agree that Sensory Kids and Social Minds, LLC, may use such photographs/videos of my child for therapeutic intervention purposes, learning purposes, publicity, illustration, advertising, and Web content. I hereby release Sensory Kids and Social Minds, LLC, and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

I do not give permission to Sensory Kids and Social Minds, its representatives and employees, the right to take photographs and/or videos of my child _____.

I have read and understand the above:

Signature of parent/guardian X _____

Parent/Guardian Name (Print) _____

Address of Parent/Guardian _____

Child's Name (Print) _____

Date: _____