Therapy Center Application

1:1 Intensive Sessions

<table>
<tr><th colspan="5">Student Demographics</th></tr>
<tr><td>Student name (last, first)</td><td colspan="4"></td></tr>
<tr><td>Date of Birth</td><td colspan="2"></td><td>Current age:</td><td></td></tr>
<tr><td>Address (street, city state zip)</td><td colspan="4"></td></tr>
<tr><td>Insured's Name</td><td colspan="4"></td></tr>
<tr><td>Insured's relationship to student</td><td colspan="4"></td></tr>
<tr><td>Insurance Plan Name</td><td colspan="4"></td></tr>
<tr><td>Insurance number</td><td colspan="4"></td></tr>
<tr><td>Secondary Insurance Plan Name</td><td colspan="4"></td></tr>
<tr><td>Secondary Insurance Number</td><td colspan="4"></td></tr>
<tr><td>Secondary Insurance Insured's Name</td><td colspan="4"></td></tr>
<tr><th colspan="5">Family Demographics</th></tr>
<tr><td>Caregiver 1 name:</td><td></td><td colspan="2">DOB:</td><td></td></tr>
<tr><td>Caregiver 1 address:</td><td colspan="4"></td></tr>
<tr><td>Caregiver 1 phone</td><td colspan="2"></td><td>Cell phone:</td><td></td></tr>
<tr><td>Caregiver 1 email:</td><td colspan="4"></td></tr>
<tr><td>Caregiver 2 name:</td><td></td><td colspan="2">DOB:</td><td></td></tr>
<tr><td>Caregiver 2
Address:</td><td colspan="4"></td></tr>
<tr><td>Caregiver 2 phone</td><td colspan="2"></td><td>Cell phone:</td><td></td></tr>
<tr><td>Caregiver 2 email:</td><td colspan="4"></td></tr>
<tr><td>Marital Status:</td><td>M S D</td><td colspan="2">Parents with Custody:</td><td></td></tr>
<tr><td>Student lives with:</td><td colspan="4"></td></tr>
<tr><td>Emergency contact name/relationship/ and phone number:</td><td colspan="4"></td></tr>
<tr><th colspan="5">Medical Information</th></tr>
<tr><td>Primary Diagnosis/ code:</td><td colspan="4"></td></tr>
<tr><td>Diagnosis by:</td><td colspan="2"></td><td>Date of diagnosis:</td><td></td></tr>
<tr><td>Date of most recent psychological evaluation:</td><td></td><td colspan="2">Doctor name and phone number:</td><td></td></tr>
<tr><td>Date of most recent physical:</td><td></td><td colspan="2">Doctor name and phone number:</td><td></td></tr>
</table>

Therapy Center Application

1:1 Intensive Sessions

Other medical conditions/allergies:				
		Behavioral Information		
Primary behavioral concern:				
Primary communication concern:				
Primary socialization concern:				
		Other concerns:		
Independent toileting:	Y N	Independent Eating	Y N	
Aggression towards others	Y N	Aggression towards self	Y N	
Other services	SLP:	OT:	PT:	
Brief description of student:				
I am interested in:	4days/wk		2 days/wk	
Who can pick up and drop off: (name, relationship, phone number. Please also provide a picture of individual	1.			
	2.			
	3.			
I consent to having my child work on toilet training	(signature/date)*additional form provided			
I will pack 2 extra pairs of clothes daily:	(signature/date)			
I consent to video of therapy sessions of my child	(signature/date)*additional form provided			

By Filling out this form you agree to our terms and conditions:

Your Health information is personal and private. Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for health care is considered "Protected Health Information" (PHI). We are required to extend certain protections to your PHI, and to give you this Notice about our privacy practices that explains how, when, and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

Completion of this application does not guarantee a position at the Therapy Center and does not imply any guarantee of services.

Therapy Center Application
1:1 Intensive Sessions

____ ____________
Parent/caregiver print name date

____ ____ ________
Parent/caregiver signature date

Additional comments or questions: