NEURODEVELOPMENTAL THERAPY SERVICES, INC.

CLIENT INFORMATION

Your responses will be regarded as confidential, as is any other information you may give.

CLIENT INFORMATION:

Client's Full Name: _____ Birth Date: _____ Age: _____ M__F__
Street Address: _____ City: _____ Zip: _____

RESPONSIBLE PARTY INFORMATION:
Responsible Party: _____ Birth Date: _____ Home #: _____
Place of Employment: _____ Work #: _____ Cell #: _____
Driver's License Number and State:_____
E-Mail Address:_____

Spouse's Name: _____ Birth Date: _____ Home #: _____
Place of Employment: _____ Work #: _____ Cell #: _____

INSURANCE INFORMATION:
Primary
Company: _____ ID #: _____ Group #: _____
Insurance Address: _____ City: _____ State: _____
Name of Insured: _____ Birth Date: _____ SS #: _____
Relationship: _____ Self _____ Spouse _____ Child _____ Other

Secondary: ☐ YES ☐ NO

Company: _____ ID #: _____ Group #: _____
Ins. Address: _____ City: _____ State: _____ Zip: _____
Name of Insured: _____ Birth Date: _____ SS#: _____
Relationship: _____ Self _____ Spouse _____ Child _____ Other

Treating Physician: _____ Office #: _____
Fax #: _____

Referral Source: _____ May we thank him/her: Yes No
Address: _____ Contact #: _____

Assignment of Benefits: I hereby authorize payment to Neurodevelopmental Therapy Services for treatment of my child for therapeutic services.

Date: _____ Signature: _____