Client Contact & Insurance Information

Client Information

Last Name, First Name, Middle Initial | Date of Birth | Age

Mailing Address | City & State | Zip

Parent/Responsible Party Information

Last Name, First Name, Middle Initial | Home Phone Number | Cell Phone Number

Email Address | Relationship to Child | Who referred you?

Insurance Information

Name of Insurance Company | Claims Mailing Address | Insurance Phone #

Subscriber Name | Relationship to Child | Subscriber's Date of Birth | Effective Date of Coverage

Place of Employment | Policy Number or ID | Group Number

Emergency Contact Information

Name | Relationship to Child | Phone Number

The following family members/friends are authorized to drop off and pick up my child from their appointment. I understand that the designated contacts must provide photo identification at the time of dismissal from the child's appointment, otherwise the child will not be released.

Name | Relationship to Child | Phone Number

Name | Relationship to Child | Phone Number

Records Release & Assignment

I authorize the release of any information, medical or otherwise, to Foundations Developmental House, LLC. I authorize payment of insurance or government benefits to Foundations Developmental House, LLC. I understand that I am responsible for any and all charges incurred, regardless of insurance coverage. There will be a $20.00 fee assessed for any personal checks returned due to insufficient funds.

Responsible Party Signature | Responsible Party Printed Name | Date