PARTNERS IN LEARNING, INC.

Teaching to the ♥ of What Matters Since 1999

Client Information

Student Name: _____ Student Date of Birth: _____

Address: _____ Sex: _____

_____ Home Phone: _____

Mother/Guardian Name/Address (if different): Father/Guardian Name/Address (if different):

_____ _____

_____ _____

Mother/Guardian cell phone: _____ Father/Guardian cell phone: _____

Mother/Guardian work phone: _____ Father/Guardian work phone: _____

Mother/Guardian email: _____ Father/Guardian email: _____

Insurance Information

Insurance Carrier: _____

Behavioral Health Phone #: _____

Member ID #: _____

Group #: _____

Behavioral Health Co-Pay: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Subscriber's Social Sec. #: _____

Employer Name: _____

Secondary Insurance Policy: ☐ YES ☐ NO

Medical Information

Official diagnosis (ex. 299.00 - Autism Spectrum Disorder): _____

Diagnosing Physician: _____ Physician's facility/hospital: _____

Current Medications: _____

Service Information

1. What services are you currently receiving? (Check All That Apply) ☐ Early Intervention ☐ ABA in home

☐ ABA at school/center ☐ Speech ☐ OT ☐ Not Currently Receiving Services ☐ Other _____

2. What services are you seeking from Partners in Learning? (Check All That Apply) ☐ Full-Time ABA Inclusion Program

☐ Part-Time ABA Inclusion Program ☐ Outreach ABA Program (In-Home) ☐ Peer/Social Group (At Center)

3. How did you learn about Partners in Learning, Inc? (Check All That Apply) ☐ PIL Website ☐ Web Search

☐ Friend/Family ☐ School District ☐ Conference ☐ Insurance Referral ☐ Fundraising Event

☐ Print Ad - If so, please provide name ___________________________ ☐ Other ______________________________