



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: _____ Age: _____ Birth Date: _____
Street Address: _____ City: _____ Zip: _____

RESPONSIBLE PARTY INFORMATION:

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

INSURANCE INFORMATION:

Primary
Company: _____ ID #: _____ Group #: _____
Insurance Address: _____ City: _____ State: _____
Name of Insured: _____ Birth Date: _____
Relationship: _____ Self _____ Spouse _____ Child _____ Other
Secondary: YES NO (INFORMATIONAL ONLY, NTS DOES NOT FILE SECONDARY)
Company: _____ ID #: _____ Group #: _____
Insurance Address: _____ City: _____ State: _____
Name of Insured: _____ Birth Date: _____
Relationship: _____ Self _____ Spouse _____ Child _____ Other

Treating Physician: _____ Office #: _____

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: _____