ABA Intake Application

EMAIL TO: SUSAN@TLCGEORGIA.COM- FAX 404-937-2983

Mail To: 11285 Elkins Road Suite G2 Roswell GA 30076

IDENTIFYING INFORMATION:

Patient Name: _____ Date of Birth: _____

Parent/Guardian Names: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____

Home Phone: _____ Cell Phone: _____

Location: ☐ **Roswell** ☐ **Kennesaw**

I am Interested in:

- ☐ **In-Clinic Services**
  - ☐ **Day Program M-F Full day (generally 8:30-3:30 or 9:00-4:00)**
  - ☐ **Day Program M-F Half day**
    - ☐ **8:30-12:30 pm**
    - ☐ **1:00-5:00 pm**
- ☐ **Home Services**
- ☐ **Private School Services**
  - **Private School: Name: _____**
- ☐ **Afterschool- 3-5 pm Social Skills and Target Therapy**

INSURANCE INFORMATION:

☐ **Check this box if you plan to pay privately for services.**

Insurance Company: _____ ID Number: _____

Subscriber Name: _____ Group Number: _____

Secondary Insurance Company: _____ ID Number: _____

Subscriber Name: _____ Group Number: _____

MEDICAL INFORMATION:

Current Diagnoses: _____

EDUCATIONAL INFORMATION:

Name of School: _____

Classroom Type: _____

Please describe your child's current challenges with respect to communication and social skills:

_____

_____

Please describe your child's current challenges with respect to behavior:

_____

_____