



BEHAVIORAL
THERHAPPY

NEW CLIENT INQUIRY FORMS

"WE TURN THERAPY INTO PLAY AND SMILES INTO PROGRESS"

W: WWW.BEHAVIORALTHERHAPPY.COM

E: INFO@BEHAVIORALTHERHAPPY.COM

P: 281-215-3595

Please complete as many fields below as possible. Once submitted, our Clinical Director will reach out with next steps. Thank you so much for your time. We look forward to speaking with you!

1 Personal Details

Child's Name: (First, Middle, Last)	Child's Date of Birth	Gender	
Address 1	City	State	Zip Code
Address 2	County	Country	
Guardian Name:		Cell Phone:	
Primary Email:		Home Phone:	
Secondary Email:		Service Interest: <input type="checkbox"/> ABA Therapy	
Does your child have a current and valid Autism Diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Diagnosing Provider:			
Date of Diagnosis:			

2 Service Location/Time Availability

Where would you like services to take place (Please check all that apply): <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Clinic <input type="checkbox"/> Other (Please Specify): _____
What is your child's availability for therapy:



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3 Insurance


Primary Funding Source:	Secondary Funding Source:
Primary Insurance Member ID:	Primary Insurance Subscriber Full Name:
Primary Insurance Subscriber DOB:	
Is your current insurance coverage provided through Cobra? <i>Cobra is a temporary health insurance option that allows you to keep your previous employer-sponsored insurance after leaving a job or experiencing certain life events.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Referral source:	
How did you hear about us (Please check all that apply): <input type="checkbox"/> Diagnosing Provider <input type="checkbox"/> Pediatrician <input type="checkbox"/> Internet Search <input type="checkbox"/> Family/Friend <input type="checkbox"/> Social Media <input type="checkbox"/> Paraprofessional	

4 Additional Programs


Is your child in daycare/school program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list program days/times:	
Anything else you'd like us to know:	

5 Files

Front of Insurance Card

 Attach Card

Back of Insurance Card

 Attach Card

Full Diagnostic Evaluation

 Attach File