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- Remember the Joy!**
- Supporting Kids
 - Coaching Adults
 - Moving From Surviving to Thriving
 - Increasing Joy!

Family Information Form

Date of first contact:

Date of Intake:

Family Name:	Child's/Client's Full Name:			
Parent/Guardian Name(s):	Child's DOB:			
	Child's Family Day: <input type="checkbox"/> Same as above			
Address: City: ZIP:	Others in home:	Age	Gender	Relationship
	Name			
Tel:				
Cell:				
Email:				
Emergency Contact Name: Tel:				

For Therapist to fill out:

Type of Service Requested

- | | | |
|--|--|---|
| <input type="checkbox"/> Onsite Consultation | <input type="checkbox"/> Parent Coaching | <input type="checkbox"/> School/other environment Observation |
| <input type="checkbox"/> Developmental Screening | <input type="checkbox"/> One time? | <input type="checkbox"/> Ongoing? |
| <input type="checkbox"/> Sensory Integration Screening | <input type="checkbox"/> Other screening _____ | |
| <input type="checkbox"/> Training (topic) _____ | <input type="checkbox"/> Workshop (topic) _____ | |
| <input type="checkbox"/> Adult Support _____ | <input type="checkbox"/> Support for Child _____ | |
| <input type="checkbox"/> Class _____ | <input type="checkbox"/> Other _____ | |

Additional Comments: _____

- Referral to: Medical OT/PT MH Community resource
 Class:
 Other:

Insurance Information for

Insurance Company Name:	
Name of Insured:	
Date of Birth:	
Insured SSN:	
Group #:	Copay amt:
Insurance ID # (if different than SS#):	
Relationship to Insured:	
Employer:	
Did you obtain Authorization?: Y N	Authorization #:
Number of Visits Authorized:	
Affirmation of Understanding I verify that the insurance information is correct as of the date below. I understand that if I do not provide accurate information or if my insurance company does not cover my services, I will be responsible for full payment of these mental health services. I authorize Lydia Byhardt Bollinger, LCSW to file claims to my insurance company. I also authorize Lydia Byhardt Bollinger, LCSW to release medical information (e.g., diagnosis) necessary to process my claims. Finally, I authorize the insurance company to pay Lydia Byhardt Bollinger, LCSW directly for my services. Date: _____ Signature of Patient or Guardian of Minor: _____	