Proactive Life Skills/PLS Therapy & Learning Center

Initial Contact Date: _____

Patient's Name: _____ DOB: _____

Parent's Name: _____

Address: _____

_____

Home Phone Number: _____ Mom's Cell: _____

Mom /Dad Work Number: _____ Dad's Cell: _____

Email Address: _____

Primary Care Physician: _____

Phone: _____ Fax: _____

Patient's Diagnosis or Concern: _____

Diagnosing documentation is required for Autism

Prescription required prior to treatment.

Services Requested: ☐ ST ☐ OT

Please initial beside each statement below:

_____I acknowledge that my invoices will be received via the email address I have provided above.

_____I understand that all changes to my insurance or address must be made via the website or directly to the office staff, and not to my individual provider.

Insurance Company: _____ ☐ PPO ☐ EPO ☐ HMO

Policy Holder's Name: _____ DOB: _____

Policy ID/ Group ID: _____ / _____

SSN: _____ Insurance contact number from back of card:_____

Secondary (if applicable)

Insurance Company: _____ ☐ PPO ☐ EPO ☐ HMO

Policy Holder's Name: _____ DOB: _____

Policy ID/ Group ID: _____ / _____

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