Child's Name: Child's date of birth:

Parent's Name: Best Phone Number:

Home Address:

Preferred e-mail/s:

Insurance Carrier:

ID number: Group number:

Subscriber Name: Subscriber's date of birth:

Provider phone number on back of insurance card:

***Please include diagnostic report/s, a copy (front and back) of your insurance card, and a completed privacy practices form.**

____ By initialing, you are agreeing to having your child's insurance benefits screened for ABA services by Springling Therapy.

____ By initialing, you are opting-in to receive and send SMS (text) messages between yourself and Springling staff. You will only receive text messages related to staff adjustments or session cancellation. All other messages should be sent via email to your provider.