Learning Solutions LLC

APPLICATION FOR SERVICES

Please complete the entire application form and return to our office so we may best assess the client's needs and interests. After the application forms are received, we will reach out to you to schedule a sixty minute intake interview with one of our clinical staff.

Client Name: ______________________________ D.O.B. ______________ Gender: M / F

Street Address: ______________________________ State: __________ Zip Code ______________

Phone Number: ______________________________ Email Address: ______________________________

Does the client have a medical diagnosis? Y / N

If yes, please include medical documentation of diagnoses. ______________________________

Does the client have any physical limitations? Y / N

If yes, please provide a detailed list. ______________________________

____

Does the client have any allergies/dietary restrictions? Y / N ______________________________

____

Who else lives in the residence? Name: ______________________ Age: __________ Relationship: ______________

Name: ______________________ Age: __________ Relationship: ______________

Name: ______________________ Age: __________ Relationship: ______________

How did you hear about, or who referred you to, Learning Solutions? ______________________________

If the client is a dependent or under the age of 18, please complete the rest of page 1. Please inform Learning Solutions, LLC, of any applicable custody arrangements.

Parent/Guardian Name: ______________________________

Street Address: ______________________________

State: ______________ **Zip Code** ______________

Occupation: ______________________________

Phone Number: ______________________________

Email Address: ______________________________

Parent/Guardian Name: ______________________________

Street Address: ______________________________

State: ______________ **Zip Code** ______________

Occupation: ______________________________

Phone Number: ______________________________

Email Address: ______________________________

Is your child on an IEP or 504 Plan? Y / N

If yes, please attach copies of your child's most recent plan, and/or evaluations.

Is your child currently participating in a school program? If so, please list: ______________________________

Please describe the client's:

LIKES/INTERESTS:____

____

DISLIKES/DISINTERESTS:____

____

STRENGTHS: ____

____

CHALLENGES: ____

____

REACTION TO NEW PEOPLE: ____

____

REACTION TO NEW ENVIRONMENTS: ____

____

REACTION TO NEW EXPERIENCES: ____

____

HELPFUL STRATEGIES / COPING SUPPORTS: ____

____

COMMUNICATION SKILLS: ____

____

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW?: _______________________________________

____

____

Please list 1-3 skills or goals you would like to work on while attending services at Learning Solutions:

1. ____
2. ____
3. ____

Please attach a recent photo here.

Availability for Services

*Please indicate which times would be possible for your child. Please note that we **CANNOT GUARANTEE** preferred assignment.*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning: 9:00am-12:30pm							
Early Afternoon: 12:30pm-3:30pm							
Afterschool: 3:30pm - 5:30pm							
Evening: 5:30pm - 8:00pm							

PLEASE NOTE THE FOLLOWING PARAMETERS AND POLICIES:

- Enrollment - Enrollment for new clients is contingent on an intake interview meeting to assess the appropriate services, peers, and clinical staff.
- Payment - Payment is required in full, even if clients must miss one or more days (except by written approval of Learning Solutions owner).
- All participants are required to have an authorized and signed credit card on file at Learning Solutions, or a commitment to pay letter from a school or other third party payer.
- Discontinuation-Learning Solutions requires one month's notice for discontinuation of services. In the case of client cancellation thirty days prior to services, clients will be entitled to a full refund of cancelled dates less $150 deposit.
- Absences - Clients are expected to attend and pay for any sessions - whether attended or not – unless given one day notice of an expected absence. Please note the exceptions to this:
  (1) documented emergency/medical reasons, (2) if Learning Solutions cancels session and is unable to re-schedule at a time the family can attend (this includes snow days), and (3) any other exceptions provided in writing by Learning Solutions owner.
- **$125.00 non-refundable application fee is due upon submitting an application and completing an intake appointment.**

Signature: ____

Printed Name:______________________________________ **Date:** ____________________

INSURANCE INFORMATION

***Information provided will be protected in accordance with HIPAA requirements and other applicable confidentiality regulations.**
*****Learning Solutions does not guarantee that your specific Insurance Policy/Coverage provides authorized benefits for services and/or treatments provided to client(s) by Learning Solutions' Clinicians and Staff.***

Client Insurance Information:

Client: First Name _______________________ M.I. ______________ Last Name _______________________________

Address: ____

City: ___________________________________ State: _________ Zip Code: __________________________________

Home Phone: _____________________________________ Work/Cell Phone: _________________________________

Social Security # ________-_______-_________ Birth Date ______________________ Gender: M F

List specific diagnosis, condition, or concern which precipitated coming for services/treatment: Y N _____________

____

Date of medical diagnosis or onset of concern: ____

Has there been Hospitalization due to current medical diagnosis or concern: Y N

From _________________________ to _____________________________

Primary Insurance Coverage:

Client/Subscriber Insurance Company: ____

Subscriber Information: Full Name: ______________________________ Relationship to Client: __________________

Subscriber Address if different than Client: ____

Marital Status: Single Married Other

Subscriber Social Security # ________-_______-_________ Subscriber Birth Date ______________________

Subscriber Employment Status: Full-Time Part-Time Not Employed Student Subscriber Gender: M F

Subscriber Employer Name, Address and Phone Number: ____

____

ID/Policy #: _________________________________ Group #: ____

******Please attach a copy of Client/Subscriber Insurance Card and sign authorization below.***

Client/Subscriber or Authorized Person's Signature*: I authorize payment of medical and/or behavioral health benefits to Learning Solutions, LLC or other information necessary to process this claim or any further claims. I understand I am responsible to pay any fees for service/treatment, and/or charges not provided coverage under my insurance plan.*Print: ____________________________Signature: _________________________________ Date: _____

Secondary Insurance Coverage, if applicable:

Client/Subscriber Insurance Company: ____

Subscriber Information: Full Name: _____________________________ Relationship to Client: _________________

Subscriber Address if different than Client: ____

Subscriber Social Security # ________-_______-_________ Subscriber Birth Date ______________________

Subscriber Employment Status: Full-Time Part-Time Not Employed Student Subscriber Gender: M F

Subscriber Employer Name, Address and Phone Number: ____

____

ID/Policy #: ________________________________ Group #: ____

***Please attach a copy of Client/Subscriber related Insurance Card, and sign authorization below.*

Client/Subscriber or Authorized Person's Signature*: I authorize payment of medical and/or behavioral health benefits to Learning Solutions, LLC or other information necessary to process this claim or any further claims. I understand I am responsible to pay any fees for service/treatment, and/or charges not provided coverage under my insurance plan.* Print: _____________________________Signature: ________________________________ Date: _____

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