**Client Admission Form**

Client Name ____________________________Client's Nickname _________________________

Date of Birth ____________________________Social Security #___________________________

Sex: Male / Female

Home Address _____________________ City/State____________________ Zip ____________

Mother's Name ______________________________

Phone #______________________________ Work # _____________________________

Mother's Employer ____________________ Occupation __________________________

Email _____________________________________________________________________

Best way to be contacted: (circle) Phone/Email

Father's Name _________________________

Phone #______________________________ Work # _____________________________

Father's Employer _____________________ Occupation __________________________

Email _____________________________________________________________________

Best way to be contacted: (circle) Phone/Email

Emergency Contact Name _______________________________________

Emergency Contact Relationship__________________________________

Phone # ________________________

Primary Insurance________________ Policy #_________________ Group # ________________

Responsible Party/Policyholder:(All required) Name:____________________________________

DOB_____________________________________ SS#___________________________________

Secondary Insurance ______________________Policy #_________________________________

Group#_____________________________________

Responsible Party/Policyholder:(All required) Name:____________________________________

DOB____________________________________ SS#_____________________________________

Secondary Insurance ______________________Policy #_________________________________

Group#_____________________________________

**MAIN PHYSICIAN/PEDIATRICIAN**:____________________________________________

**OTHER TREATING PHYSICIANS**:_____________________________________________

Client's Diagnosis ____________________________________________ Age Diagnosed _______

Siblings of Client (#/names):_________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Please circle any therapies the applicant is currently receiving:

Speech Occupational Physical Psychological Other: _________________________

Is the client toilet trained? Yes/No

On any special diets? Yes/No

List any medication the applicant is currently taking:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

If there are any special considerations, we should know about please list them here and provide us with any documentation deemed necessary for those considerations:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Check the services you wish for your child to receive below:

___ Consultation/Intake
___ ABA Services
___ "Bee Buddies"
___ Other: ___________________

What Are Your Primary Concerns for Your Child?

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

How did you learn about Beehave Therapies? _________________________________

## Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act (HIPAA) of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels. I hereby request the use of the following confidential channels for the communications of information related to my personal health, treatment, or payment for treatment. This request supersedes any prior request for confidential communications I may have made.

1- May we discuss your Child's Personal Health Information with anyone else? (You must fill in the name and phone number if okay.)

_______________________________________________
_______________________________________________

**Beehave Therapies does not discriminate on the basis of disability type or level, sex, race, creed, nationality or ethnic background.**

**Diagnosis & Prescription for services must be received before services can begin for all insurance-based clients. Beehave Therapies holds the rights to release any client at any time due to extreme situations that may endanger the health or safety of staff or others.**

I have read the above statement and understand Beehave Therapies Policy.

**Parent/Legal Guardian's Signature____________________________________ Date ______________**

Beehave Therapies

Los Angeles, CA

(xxx)xxx-xxxx