TREATMENT ENROLLMENT CARD

Name:_____ DOB:_____ AGE_____

Parent/GuardianNames:_____

Address_____ Disorder Type:_____

_____ Email:_____

Home Ph.#_____ Office/Cell_____

To be scheduled in: Fall ☐ Spring ☐ Summer ☐

Preferred days/times for treatment:_____

Method of Payment:_____

TO BE COMPLETED WHEN SCHEDULED

Clinician:_____ Appt days/times:_____

Supervisor:_____ Start date:_____