BRAIN INTEGRATION TECHNIQUE CLIENT INFORMATION

Client's Name: _____

Parent's Name (if minor): _____

Address: (enter street address) _____

(enter city, state & zip code) _____

School: _____ Grade / Year : _____

Date of Birth: _____ Student's Age: _____

Contact Number(s): _____ Home ☐ Work ☐ Cell ☐

_____ Home ☐ Work ☐ Cell ☐

Email Address: _____

Referred by: _____

Brief description of learning difficulties or life frustrations that brought you to Brain Integration: (maxiumum of 800 characters)

Relevant history of difficulties/frustrations referenced above: (maxiumum of 800 characters)

- I declare that the above information is correct to the best of my knowledge.
- I also understand that all payments are due on date of rendered service.
- A $15 late fee will be assessed if I am over 15 minutes late for a scheduled appointment, and is due upon my arrival.
- A $35 fee will be assessed if I do not give a 24 hour notice of my need to cancel an appointment.

Signed: _____ Date:_____