

Learning and Language Specialists, Inc.
1405 Lilac Drive, Suite 200
Minneapolis, Minnesota 55422
763-545-7708

Intake Information Questionnaire

Part I - Client Information:

Client Name _____ Age _____ DOB _____ Sex _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell/School Phone _____

Employer/School _____ Grade _____ Occupation _____

Employer Address _____ City _____ State _____ Zip Code _____

Marital Status _____ If married, spouse's name _____

Spouse's Employer _____ Spouse's Occupation _____

Employer Address _____ City _____ State _____ Zip Code _____

Spouse's Work/Cell Phone _____

Part II - Payment Information:

If Minor, Parent's Name _____

Responsible Party _____ Relationship _____

Address (if different from client) _____

City _____ State _____ Zip Code _____

Home Telephone _____ Work Telephone _____ Occupation _____

Res. Party DOB _____ Res. Party Employer _____

Employer Address _____ City _____ State _____ Zip Code _____

Res. Party Spouse Name _____

Res. Party Spouse Employer _____

Address _____ City _____ State _____ Zip Code _____

Res. Party Spouse DOB _____ Occupation _____ Work/Cell Phone _____

Please See Other Side for Payment Information

Part III - Medical Insurance: If you have health insurance, it should be understood that this is an agreement between you and your insurance company to pay certain amounts for medical care. You are responsible for the payment of your bill to this clinic regardless of the status of your insurance claim. Although we will assist you with the completion of forms, you are responsible for collection from your insurance provider, if any. Insurance companies have a schedule of fees which they will pay. Your fees may be more or less than the schedule of your insurance company.

You are directly responsible to Learning and Language Specialists for your account regardless of your insurance schedule. Visa and MasterCard are accepted. Should you have any questions, please contact our Office Manager.

I hereby authorize any insurance company to pay directly to Learning and Language Specialists, Inc., any benefit due me as a result of the charges incurred with this facility. I also understand and agree that this account incurs a 1.5% per month (18% per year) service charge on any amount 30 days past due for which I am responsible. If for any reason any portion of my bill is not paid by an insurance company, I agree to make arrangements for prompt payment of my bill and I assign to Learning and Language Specialists, Ltd., my interest in any claim I may have against my insurance carrier for payment of all services that Learning and Language Specialists, Inc., has furnished to me.

If the bill is not paid, I understand that I will be responsible for any collection costs, including attorney fees.

Medical Insurance Company _____

Address _____ City _____ State _____ Zip Code _____

Telephone _____ Policyholder's name _____

ID# _____ Group# _____

I hereby authorize payment for the services rendered to me and/or my dependent(s). I also authorize the release of any information necessary to process this claim. A photocopy of this authorization shall be valid as the original.

Signed _____ Date _____

Part IV - Research Study: Learning and Language Specialists is currently engaged in a program of research regarding the inheritance of learning styles. It would be useful to us to be able to use your test results as a part of this data set. All identifying information will be kept in strict confidence. Only summary data will be used in any research report.

I authorize Learning and Language Specialists to include my testing data in their research data set.

Signed _____ Witness _____

Printed Name _____ Date _____