



Client Contact Information Date: _____

Client's name: _____ Age: _____ M/F DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work phone: _____

Pager/Cell (Circle one): _____ Fax: _____

Occupation: _____ Company: _____

Work Address: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

Please add my e-mail address to: [] Autistic Spectrum group [] Clients Support group

Responsible party & relationship, if a minor: _____

Address: _____

City: _____ State: _____ Zip: _____

Referred by: _____

How did you hear about us? [] Internet Search [] Age of Autism [] Conference _____

[] Another client [] Other (please specify): _____

In case of emergency, please notify:

Name: _____

Phone: _____ Other number: _____

I understand that consultations and products are provided on a fee for service basis, that is, **all fees and costs are due and payable at the time service or products are rendered** and I accept responsibility for their payment by check, cash, VISA or MasterCard. I understand there will be a \$30 fee for checks returned for any reason. ***I also understand any charges unpaid by 20 days after a consult will incur a \$10 late fee PER INVOICE DUE. For minor clients, both parents must sign below:***

Signed: _____ **Date:** _____

Signed: _____ **Date:** _____