

THE LEARNING ENHANCEMENT CENTER

BRAIN INTEGRATION TECHNIQUE CLIENT INFORMATION

CLIENT'S NAME: _____

ADDRESS: _____

_____ ZIP CODE _____

SCHOOL: _____ GRADE/YEAR _____

DATE OF BIRTH _____

STUDENT'S AGE _____ PARENTS' FIRST NAMES: _____

HOME PHONE: _____ BUSINESS PHONE: _____

EMAIL ADDRESS: _____

Referred by: _____

Brief description of Learning and other problems that brought you to the Learning Enhancement Center:

Relevant history of above complaint or problem:

I declare that the above information is correct to the best of my knowledge.

I also understand that payment is due on date of rendered service, and that 24 hour notice of cancellation is requested.

Signed: _____ Date: _____