



# Selman Behavior Solutions

*Finding Solutions \* Creating Change*

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Please initial below:

\_\_\_\_\_ I have reviewed and completed the Registration and New Patient Service Agreement

\_\_\_\_\_ I have completed the SB Solutions Neurodevelopmental History Form

\_\_\_\_\_ I understand the Cancellation/No-Show Policy

\_\_\_\_\_ If the patient is under the age of 18, I am the legal guardian and/or have been provided custodial rights to make decisions pertinent to his or her medical care.

PLEASE PRINT:

Patient's Name: \_\_\_\_\_

Your name (parent/guardian): \_\_\_\_\_

PLEASE SIGN:

\_\_\_\_\_  
Patient (or parent/guardian if patient is a minor)

Date: \_\_\_\_\_