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Office: 608-424-9100 Toll Free: 1800-IHWORKS
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Adolescent Group Therapy Registration Form

Date :		
Client's Name:	DOB:	Age:
Address: Email Address:	Phone: OK to leave messages? ☐	
Parent/Guardian Name:	Parent/guardian phone (if different from client's):	

Insurance coverage:

☐ County CCS

Case Manager's Name: Phone:

☐ County (Juvenile Justice, CPS, etc.)

Case Manager's Name: Phone:

☐ Badger Care

Medical Assistance #:

Badger Care HMO:

☐ Private Insurance

Name of Insurance:

Member number: Policy number:

☐ Private Pay

Area of need/interest: **(Check all that apply)** ☐ Depression ☐ Anxiety ☐ Social skills ☐ Distress/frustration tolerance ☐ Self Advocacy/speaking up for yourself ☐ Other _____	**Available Day and time of the Week:** ☐ Thursdays at 5:00 pm **Do you have access to the internet to join a virtual group?** ☐ Yes ☐ No

Past Mental Health Treatment:

Current and Past Diagnosis:

Strengths:

Please fax this form to 608-424-9099 or email to kniekerk@foundationscc.com
Questions? Call Kati Niekerk at 608-669-4255