engaging minds

Autism Services

New Client Information

Today's Date _____

LAST NAME _____ FIRST NAME _____ DOB _____ ☐M ☐F GENDER

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

DIAGNOSIS _____ PHYSICAN: _____

FINANCIALLY RESPONSIBLE PARTY

LAST NAME _____ FIRST NAME _____ DOB _____ ☐M ☐F GENDER

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

( ) _____ HOME PHONE _____ EMAIL _____ ( ) _____ CELL PHONE

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Co. _____	Insurance Co. _____
Subscriber Name _____	Subscriber Name _____
Subscriber DOB _____	Subscriber DOB _____
Address _____	Address _____
EMPLOYER _____	EMPLOYER _____
ID# _____	ID# _____
GROUP# _____	GROUP# _____
Ins. Ph.No.: _____	Ins. Ph.No.: _____

AUTHORIZATION AND RELEASE

I authorize , or its agent, to release any or all medical records or information necessary to process medical claims. I authorize a copy of this authorization to be used in place of the original & request payment of benefits either to myself, or the above provider who acquires assignment. I acknowledge that I remain financially responsible for unpaid co- insurance and deductible balances & amounts not covered by commercial third party payers.

SIGNATURE of RESPONSIBLE PARTY _____ DATE: _____