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Print Form Reset Form

INTAKE FORM

(Please Print)

Today's date:	Diagnosis:	Physician Ordering ABA Therapy:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Nickname:

Birth date: / /	Age: Years	Sex: ☐ M ☐ F

Street address:	Social Security#:	Home phone #:

Apt #:	City:	State:	ZIP Code:

Cell Phone #:	Email Address:	

Parent(s) last name:	Parent(s) first name:	Marital status (circle one): ☐ Single ☐ Married ☐ Divorced ☐ SeparatedWidow

MEDICAID INFORMATION

☐ Check here if coverage is through Medicaid, list the Medicaid ID#: _____
(Skip to In Case of Emergency Section)

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):

Home phone #:	Cell Phone #:	Employer:	Employer phone #:

Primary insurance:	Claims Address:	Insurance Phone #:	Coverage Effective Date:

Subscriber's name:	Subscriber's SSN:	Birth date: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Work phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorizeABA Solutions, Inc.or insurance company to release any information required toprocess my claims.

Patient/Guardian signature or E- Signature *Date*

Prescription for ABA Assessment/Therapy and documentation from when child was originally diagnosed under the Autism Spectrum must accompany this form if covered under insurance.

The Medicaid Authorization Letter must accompany this form if covered under Medicaid.