Personal and Financial Information: *(Please Print)*

Child's name: _____ Date of Birth: _____

Parent name(s): _____

Address _____ City: _____ State: _____ Zip: _____

Day phone: _____ Evening phone: _____

Cell phone: _____ Email address: _____

Insurance Information: ***(Please include a copy of your insurance card.)***

Primary Insurance: _____	Secondary Insurance: _____
Policy Holder and DOB: _____	Policy Holder: _____
Identification Number: _____	Identification Number: _____
Group Number: _____	Group Number: _____

Physician Information:

Referring Physician Name: _____

Clinic: _____ Address: _____ Phone: _____

I understand that I am financially responsible for payment of any services provided by Autism Matters, Inc., including co-pays, deductibles, and co-insurance.

I request that payment of authorized insurance benefits be made to Autism Matters, Inc. for any services furnished to my child.

I authorize Autism Matters, Inc. to release and/or exchange any information with other providers/organizations who are involved in my child's treatment.

I acknowledge that I have been given the opportunity to read and/or receive Autism Matters, Inc. Notice of Privacy Practices.

This authorization and assignment will remain in effect until revoked by me in writing.

_____ _____

Parent Signature **Date**