
**Patient Information:**
Child's Name:_____Nickname:_____
Address:_____City:_____State:___Zip:_____
Phone: (____)_____Parent's Cell: (____)_____
Patient DOB: ____/____/_____
Name of School Child Attends:_____

**Parent / Guardian Info:**
Mother's Name:_____
Mother's Phone:_____Best time to reach:_____
Mother's e-mail:_____

Father's Name:_____
Fathers's Phone:_____Best time to reach:_____
Father's e-mail:_____

Address (if different than above):_____
City:_____State:_____Zip:_____

**Insured Parent Information:** (Please attach copy of front and back of Insurance Card.)
Name of Insured:_____Insured DOB:_____
Relationship to patient:_____ Insured SSN#:_____
Name of employer:_____Work Phone:_____
Address of employer:_____
City:_____State:_____Zip:_____
Name of Insurance Co:_____
Group #_____ID#_____
Member Service Phone # (_____)_____ (located on back of insurance card)
Provider Service Phone (_____)_____ (located on back of insurance card)

**Do you have additional Insurance? If yes, complete the following:**
Name of Insured:_____Insured DOB:_____
Relationship to patient:_____ Insured SSN#:_____
Name of employer:_____Work Phone:_____
Address of employer:_____
City:_____State:_____Zip:_____
Name of Insurance Co:_____
Group #_____ID#_____
Member Service Phone # (_____)_____ (located on back of insurance card)
Provider Service Phone (_____)_____ (located on back of insurance card)

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I hereby accept responsibility for any services provided to me that are not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance. If the center does not participate with my insurance I agree to pay all copayments, coinsurance, and deductibles at the time service is rendered. I also authorize Spectrum Autism Center, or insurance company to release any information required to process my claims.

Parent/Guardian E-Sign:_____Date:_____