Insurance Verification Form

Client Information

Name *

First Name   Last Name

Date of Birth *

Month   Day   Year

Gender *

Date of Autism Diagnosis

Month   Day   Year

Diagnosing Physician

Additional Diagnosis

Parent/Guardian Information

Name *

First Name   Last Name

Relationship to Client *

Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Phone Number *

Email *

example@example.com

Preferred Method of Communication

Phone

Email

Text (HIPPA Compliant- Free app download required)

Best Time to Contact

Morning (8a-12p)

Early Afternoon (12p-3p)

Late Afternoon (3p-5p)

Have you scheduled or completed an initial consultation with us? *

Yes

No, but I spoke with a representative of Turning Point Therapy Services and I'm ready to get started. No, I would like to schedule an initial consultation.

How did you hear about us? *

Internet search

A fellow parent

Resource event

Another ABA/therapy provider

Insurance Information

Primary Insurance Company/ Plan *

Phone Number (as listed on the back of your insurance card) *

Please enter a valid phone number.

Policy Subscriber's Name (if different from above)

First Name   Last Name

Policy Subscriber's Date of Birth *

Month   Day   Year

Policy Subscriber's Relationship to Client (if different from above) *

Policy Subscriber ID *

Policy/ Group # *

Authorization for the Release of Medical Information

I authorize the release of the above information from **Turning Point Therapy Services** in order to verify my benefits for applied behavior analysis (ABA) therapy.

Signature

Date

Month   Day   Year