Behavioral Learning Center, Inc.
Unlocking Autism One Piece at a Time

Medical Insurance Client Intake Form

Client Information		
Client's Name (last, first, middle initial):	**Insured's ID Number**	**Primary Caregiver**
		☐ Father ☐ Other ☐ Mother ☐ Both
Group Health Plan	**Client's DOB** (mm/dd/yy):	**Client's Status:**
	 Sex: ☐ Male ☐ Female	☐ Employed ☐ Full-Time Student ☐ Part -Time Student
Client's Address:	**City, State, Zip Code:**	**Client's Relationship to Insured:**
		☐ Self ☐ Child ☐ Other

Insured Information		
Insured's Name (last, first, middle initial)	**Insured's Policy/Group Number:**	**Insured's DOB** (mm/dd/yy):
 Sex: ☐ Male ☐ Female		
Insured's Address:	**City, State, Zip Code:**	**Phone Number:**
Employer's Name:	**Insurance Plan Name:**	**Secondary insurance plan?**
		☐ No ☐ Yes (please complete *)
	Out of Pocket Maximum:	**Medical Waiver:**
		☐ No ☐ Yes (provide copy)
Total Annual Deductible:	**Out of Pocket Maximum:**	**Co-Pay Per Visit:**
☐ Deductible or ☐ Medical Deductible ____________ ☐ Behavioral Deductible ___________	 **Current Funds Paid:**	☐ Per visit ____________ ☐ Per day ____________ ☐ Credit Card on file ☐ PayPal account
* 2nd **Insured's Name** (last, first, middle initial)	* **2nd Insured Policy/Group #**	* **2nd Insured's DOB** (mm/dd/yy):
 Sex: ☐ Male ☐ Female		
* **2nd Insured Plan Name:**	* **2nd Employer's Name:**	* **2nd Insured's Phone Number:**
Name of Referring Physician:	**Address:**	**Phone Number:**
Diagnosis	**MM/YY of Diagnosis:**	

Please attach the following documents:

1. Copy of current diagnostic report from a licensed psychiatrist or MD
2. Doctor's Prescription – stating "ABA Therapy medically necessary" & the recommended amount of monthly hours including supervision
3. Copy of Insurance card(s) front and back