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:** ☐ Employed ☐ Full-Time Student ☐ Part -Time Student
	Sex: ☐ Male ☐ Female	
Client's Address:	**City, State, Zip Code:**	**Client's Relationship to Insured:** ☐ Self ☐ Child ☐ Other

Insured Information		
Insured's Name (last, first, middle initial) **Sex:** ☐ Male ☐ Female	**Insured's Policy/Group Number:**	**Insured's DOB** (mm/dd/yy):
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: ☐ Deductible or ☐ Medical Deductible _____ ☐ Behavioral Deductible _____	**Out of Pocket Maximum:** **Current Funds Paid:**	**Co-Pay Per Visit:** ☐ Per visit _____ ☐ Per day _____ ☐ Credit Card on file ☐ PayPal account
* 2nd **Insured's Name** (last, first, middle initial) **Sex:** ☐ Male ☐ Female	* 2nd **Insured Policy/Group #**	* 2nd **Insured's DOB** (mm/dd/yy):
* 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