Engaging Minds
Autism Services

New Client Information

Services Requested: ☐ Diagnostics ☐ Speech ☐ ABA

LAST NAME _____ FIRST NAME _____ DOB _____ ☐M ☐F GENDER

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

Physician: _____ Diagnosis: _____

FINANCIALLY RESPONSIBLE PARTY

LAST NAME _____ FIRST NAME _____ DOB _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE NUMBER _____ EMAIL _____

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Co. _____	Insurance Co. _____
Subscriber Name _____	Subscriber Name _____
Subscriber DOB _____	Subscriber DOB _____
Address _____	Address _____
EMPLOYER _____	EMPLOYER _____
ID# _____	ID# _____
GROUP# _____	GROUP# _____
Ins. Ph.No.: _____	Ins. Ph.No.: _____

AUTHORIZATION AND RELEASE

I authorize Engaging Minds Autism Services, or its agent, Missing Piece Billing and Consulting to release any or all medical records or information necessary to process medical claims. I authorize a copy of this authorization to be used in place of the original & request payment of benefits either to myself, or the above provider who acquires assignment. I acknowledge that I remain financially responsible for unpaid co- insurance and deductible balances & amounts not covered by commercial third party payers.

SIGNATURE of RESPONSIBLE PARTY _____ **DATE:** _____