Client Insurance Intake Form

Client Demographics:

Client Name: _____ Sex: Male___ Female___

SS#:_____ Date of Birth: _____ Age: _____

Parent/Guardian Names: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address (s): _____

Primary Contact Number: _____ Relationship: _____

Secondary Contact Number: _____ Relationship: _____

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Diagnosing Physician: _____Date Diagnosed: _____

Address: _____ Physician Phone #: _____

Primary Diagnosis: _____ Diagnosis: _____ Diagnosis_____

Referring Physician: _____(Please provide referral form)

Address: _____ Physician Phone #: _____

Diagnosis: _____ Diagnosis: _____ Prescription?: Yes or No

Primary Insurance Information
(Please provide a copy of your insurance card with this document)

Insurance Carrier: _____

Policy Holder's Employer: _____

Policy Holder Name: _____ Relationship to Client: _____

Policy Holder's Date of Birth: _____ Effective Date of Policy: _____

Policy Number: _____ Group Number: _____

Provider/Customer Service Phone Number: _____

Secondary Insurance Information
(Please provide a copy of your insurance card with this document)

Do you have Secondary Insurance: Yes_____ No _____

Insurance Carrier: _____

Policy Holder's Employer:_____

Policy Holder Name: _____ Relationship to Client: _____

Policy Holder's Date of Birth: _____ Effective Date of Policy: _____

Policy Number: _____ Group Number: _____

Provider/Customer Service Phone Number: _____

Parent/Guardian Signature: _____ Date: _____

Financial Responsibility Notification
(Initial next to each line)

_____I understand that I am ultimately responsible for payment to CTAC for all services provided.

_____I understand that CTAC will verify my benefits for contracted insurance carriers, however I understand a quote of benefits and/or authorization does not guarantee payment or eligibility. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the member's contract at the time of service. If CTAC cannot verify coverage for ABA therapy, invoices to the parent/guardian of the client for services will be due weekly until we establish coverage/preauthorization with your insurance company.

_____ I understand that my health insurance company will only pay for services that it determines to be 'reasonable and necessary'. Every effort will be made by CTAC to have all services and procedures preauthorized by my health insurance company. If my insurance determines that a particular service is not reasonable and necessary or that a particular service is not covered under the plan, my insurer will deny payment for that service. Home and school visits may not be covered by insurance and may be invoiced to me.

_____ I understand my health insurance company may deny payment of services for any reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible or coinsurance that applies.

_____ I understand that if CTAC is not in network with my insurance company, CTAC will not file claims and payment of service is due upon receipt of my weekly invoice. *In order for me to submit claims to my insurance company for out of network coverage, I understand that I will need a diagnosis code from a physician, CTAC does not diagnose and insurance will deny a claim without a diagnosis code. If I wish to have the diagnosis code included on my weekly invoice, I must request the physician to fax CTAC a copy of my child's diagnosis so we can include this on your weekly invoice.*

Parent/Guardian Signature: _____ **Date:** _____