Intake Form

Client Name: ____

Client Address: ____
(address) (city) (state) (zip)

Phone Number: (____)_________________ Gender:____________ DOB: ____/____/_______

Email Address: ____

Parent/Guardian Name(s): ____

Client Doctor(Full Name): ____

Doctor Address: ____
(address) (city) (state) (zip)

Doctor Fax Number: (____)_________________ Diagnosis: ____

Insured Information (Parent/Cargiver info if client is listed under insurance)

If the client is covered is covered under private insurance, you MUST disclose that information here. Department of Developmental Disabilities (DDD) is the payer of last resort, and Arizona Autism is required to bill any active private policies prior to billing DDD. If DDD has private insurance on file for the patient, and you do not disclose it to Arizona Autism, we will obtain the insurance information from DDD and bill your private policy first. *****INITIAL HERE _______**

Name: ____

Address: ____
(address) (city) (state) (zip)

Phone Number: (____)_________________ Gender:____________ DOB: ____/____/_______

Employer: ____ Employer Phone: (____)_________________

Insurance Company Information

Insurance Carrier: ____

Effective Date: ____/____/_______ Plan: HMO / PPO / Other:___________________________

Billing Address: ____
(address) (city) (state) (zip)

Phone Number: (____)_________________ ID#:________________ Group# ____________________

Authorized Signature

I hereby authorize the release of any medical or other information necessary to file a claim with my insurance company. I also request payment of government and/or insurance benefits to Wheels on the Bus Pediatric Therapy. I understand that I am responsible for any and all bills incurred and that any third party coverage or insurance is for the purpose of assisting me with my responsibility. If I receive a payment from the insurance company, I understand that this payment along with the Explanation of Benefits (EOB) needs to be submitted to Wheels on the Bus Pediatric Therapy within five (5) business days of receipt of this information or I will be billed directly for all services rendered.

____ __________________

(Signature) (Date)

Medical Release

I hereby certify that I am a parent or legal guardian of the client listed, and give Wheels on the Bus Pediatric Therapy permission to provide services to the client. I authorize Wheels on the Bus Pediatric Therapy to request, obtain, and provide medical information to and from the appropriate doctors, medical facilities, insurance companies, payment services, and /or any other entity that will assist in rendering therapy services.

____

(Print Name)

____ ________________

(Signature) (Date)

Cancellation Policy

If I need to cancel an appointment, I understand that I will cancel/reschedule an appointment by giving a 24-hour notice when possible. Wheels on the Bus Pediatric Therapy reserves the right to discontinue services at any time. I also understand that the therapist will call if they are going to be more than 15 minutes late for a scheduled appointment. It is my responsibility to ensure that Wheels on the Bus Pediatric Therapy and the therapist have my most up-to-date information to include telephone and address. I also understand that the therapist will keep all appointments and from time to time may need to cancel/reschedule an appointment within less than 24 hours due to illness/emergency. If I feel that the therapists cancels frequently or is not providing quality services, I will contact Wheels on the Bus Pediatric Therapy immediately to resolve these issues.

*****INITIAL HERE _______** I Understand and Agree to the Cancellation Policy