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* After completing, please fax or email

Applied Behavior Analysis (ABA) Services Intake Form

1. Patient Information

Client First Name		Client Last Name	
DOB		Gender	
Address		City/State/Zip	
Does the client have Autism Spectrum Disorder (ASD)?			
If not, what diagnosis does the client have?			
Name of diagnosis doctor		Date of Diagnosis	

2. Family Information

Parent/Guardian Name		Relationship	
Home Address Apt/Unit#		City/State/Zip	
Home Phone		Cell Phone	
Email Address			
Parent/Guardian Name		Relationship	
Home Address Apt/Unit#		City/State/Zip	
Home Phone		Cell Phone	
Email Address			

3. Primary Insurance

First Name of Subscriber		Last Name of Subscriber	
Relationship to Client		Subscriber DOB	
Insurance Company		Policy/Member ID	
Subscriber Address (Street, Unit, State, Zip)			

4. Secondary Insurance

First Name of Subscriber		Last Name of Subscriber	
Relationship to Client		Subscriber DOB	
Insurance Company		Policy/Member ID	
Subscriber Address (Street, Unit, State, Zip)			

5. Insurance Card

*Please attach a picture of the **front & back** of the insurance card(s)

6. Authorization

I authorize the release of insurance and benefits information to Flex Learning, LLC. I understand that a quote of benefits and/or authorization does not guarantee agreement for services or payment from my insurance company. _____ (initials)

I authorize the above referring agency and/or its designated employees to exchange/receive the protected information regarding the individual/patient indicated above with Flex Learning and/or its designated employees—if applicable. _____ (initials)

Signature _____ **Today's Date** _____