Albert Knapp & Associates

THE FAST TRACK TO BETTER BEHAVIOR

INSURANCE ELIGIBILITY

Client Name_____ DOB_____ Ph: _____

Home Address_____

Insurance Company_____

Insurance Ph:_____

Member Insurance ID No_____ Group ID No _____

Policy Holder Name_____ DOB _____

Policy Holder SSN_____ Relationship to Patient _____

Reason for treatment: Please CHECK all that apply and LIST details below:

☐ *Therapy* ☐ *Psych Testing* ☐ *Applied Behavioral Analysis (ABA)*

_____

_____

_____

If referred, by who?_____ Your availability_____

Typing your name in the signature line below will be used and considered as your electronic signature.

Signature below authorizes Albert Knapp & Associates to disclosure information to your insurance company to check benefits and if benefits are used, to bill the insurance company.

Date_____

Signature_____

Send this form and a copy of the front/back of the insurance card to AKAadmin@akatherapy.com

_____

Print Name

_____

Contact Email Address