Insurance Eligibility & Service Referral Form

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_____

Please CHECK all that apply and LIST details below:

☐ ***Mental Health Therapy (Insurance/Private Pay)***

☐ ***Psychological Testing (Insurance/Private Pay)***

☐ ***Applied Behavior Analysis (ABA) Therapy (Insurance/Private Pay)***

☐ ***Group Social Skills (PlayLab or Clubhouse Ages 3-16) (MUST HAVE ASD DX FOR INSURANCE FUNDING; Private Pay, and Regional Center Funding also available)***

☐ ***Parenting Group (Insurance/Private Pay)***

☐ ***Home-Based Mental Health Therapy (Out of Network Insurance or Private Pay Only)***

Reason for treatment: Check one: New Client ☐ Returning Client ☐

_____

If referred, by who? _____ Your availability _____

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

_____
Print Name

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

_____
Contact Email Address