ZAC'S PROMISE
ADVANCED THERAPY

YOUR FUTURE IS OUR PROMISE

Autism Services Client Intake & Insurance Verification Request

Today's Date:	Requesting Site:	Rendering Provider:

PATIENT INFORMATION

Patient's Name: (first/last)		Parent/Guardian (if applicable):
Phone Number:		DOB: Gender: M ☐ F ☐
Street Address:		City/State/Zip:
Diagnosis:	Services Requested:	Diagnosing Physician:
Date of Diagnosis:		Diagnosing Physician Contact:
Primary Care Physician:		Primary Care Physician Contact:

INSURANCE INFORMATION

Primary insurance: ☐ **New Insurance** ☐ **Old Insurance** ☐ **Termed Date __ /__/__**

Subscriber's name:	DOB: Gender: M ☐ F ☐	
Subscriber's S.S. no.:	Policy no:	Group No:
Subscriber's Address:		
Employer:		
Patient's relationship to subscriber:		

Secondary insurance:

Subscriber's name:	DOB: Gender: M ☐ F ☐	
Subscriber's S.S. no.:	Policy no:	Group No:
Subscriber's Address:		
Employer:		
Patient's relationship to subscriber:		

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

Financially Responsible Name:	Phone Number:
Address:	Email address:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Zac's Promise Advance Therapy LLC[Name of Practice]or insurance company to release any information required to process my claims

Patient/Guardian signature	Date