8911 West Lane
Magnolia, TX 77354

Application for ABA Services

Date of Application:

Client's Name____________________ Date of Birth____________________

Diagnosis___________________________________

Home Address_______________________________________

Phone____________________

Good time to call____________________________

E-mail address______________________________

Parent's Names____________________________________

Date you wish to enroll your child__________________________

Days and hours you would like your child to attend; also indicate if you are flexible in scheduling

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Do you wish for us to contact you if space should become available after or before the date you wish to enroll your child?____

I understand that my child is not guaranteed placement at Autism House. I also understand that families are contacted after the application form, verification of benefits form; including front and back copy of insurance and $25 application fee are received.

Parent Signature__________________________________ Date____________________

*At the time of notification of space, families will have a period of 5 working days to respond, if we do not receive a response within this time, your child will automatically be removed from the application waiting list.

☐ Cash ☐ Check / Check No. ________ ☐ Credit/Debit Card: CVV Code______

Autism House Client Verification and Eligibility Form

Client Name	
Date of Birth	
Complete Address	
Insurance Carrier	
Diagnosis	
Parent Contact	Name______________________________ Phone number (____)__________

Name on Insurance Policy	
Name of employer	
Date of birth	
Social Security #	
Email address	
Name of Insurance	
Member ID #	
Group #	
Policy #	
Address & Phone number of Insurance Carrier	

SECONDARY INSURANCE ONLY

Name on Insurance Policy	
Date of birth	
Social Security #	
Email address	
Name of Insurance	
Member ID #	
Group #	
Address & Phone number of Insurance Carrier	

Please provide a copy of the front & back of your insurance card. If you have a Secondary Insurance, please provide a copy of the front & back of the insurance card.

Please allow 3-5 business days for us to verify your benefits and get back with you.

I hereby consent to treatment by, and authorize insurance benefits to be paid directly to Autism House. I agree that I am responsible to pay 1) for services not covered by my insurance company, 2) co-payments and deductibles, and 3) any expenses associated with the collection of a debt owed to them by me (i.e. attorney fee, court cost or collection agency fee.) I also consent to the release of pertinent medical information to my insurance carrier for processing health care claims.

Parent Signature

X____

Date :_______/_______/_______

Witness X____

Autism House Administrative Personnel