Date of First Appointment: _____

Autism Services and Programs LLC

Dr. Laurie Sperry Ph.D., BCBA-D

New Patient and Insurance Authorization Form

New Patient Information

Patient Name:_____ Patient Date of Birth:_____

Address: _____ City/State/Zip: _____

Parent/Caregiver Name: _____ Phone Number: _____

E-mail: _____ May we leave a message? YES NO

Relationship to patient: _____ Patient Dx: _____

Case Manager/Resource Coordinator: _____ Phone Number: _____

E-mail Address: _____ Agency: _____

Funding/Insurance Information

Primary Insurance:

Insurance Carrier: _____ Member ID#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Insurance Phone Number: _____

Secondary Insurance:

Insurance Carrier: _____ Member ID#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Insurance Phone Number: _____

Medicaid Only:

Waiver Program (Please Circle One): CES/SLS/HCBS-DD/TBI/CHRP/CWA/EPSDT Par#: _____

Parent/Caregiver Signature: _____ Date: _____