



INSURANCE CO. PHONE: \_\_\_\_\_

SECONDARY INSURANCE CO.: \_\_\_\_\_ POLICY NUMBERS: \_\_\_\_\_  
(ID#) (GROUP/PLAN#)

POLICY HOLDER: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
LAST FIRST M.I.

DATE OF BIRTH: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_  
MO DAY YR

INSURANCE CO. PHONE: \_\_\_\_\_

### OTHER CONTACTS

If you want to authorize Children's Autism Treatment Specialists, LLC., to discuss your child's treatment with any other party, please provide the following information regarding that party.

NAME: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_  
LAST FIRST M.I.

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_  
LAST FIRST M.I.

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

### AUTHORIZATIONS and ACKNOWLEDGEMENTS

I have received the Notice of Privacy Practices from Children's Autism Treatment Specialists, LLC.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
Parent/Legal Guardian

I hereby authorize CHILDREN'S AUTISM TREATMENT SPECIALISTS, LLC. to furnish information concerning treatments to INSURANCE CARRIERS, PHYSICIANS, THERAPISTS AND/OR OTHER PERSONNEL, who are involved in taking care of the client or paying for treatment. I authorize payment of any insurance, Medicaid, or other benefits to CHILDREN'S AUTISM TREATMENT SPECIALISTS, LLC. **I certify that the above information is correct and that I AM RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED.** I permit a copy of this authorization to be used in place of the original.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
Parent/Legal Guardian