Spark
BEHAVIORAL SOLUTIONS & CONSULTING SERVICES

2591 Dallas Parkway, Suite 300
Frisco, TX 75034
Ph: (469) 264 – 8630
Fax: (469) 553 – 0847
intake@sbs-cs.com

CLIENT REGISTRATION/INSURANCE VERIFICATION FORM

Person completing this form: Name/Last name: _____ Today's date: _____/_____/_____

Relationship to the client: ☐ Mother ☐ Father ☐ Legal guardian ☐ Other: _____

Are you authorized to consent to this individual health care? ☐ Yes ☐ No

I understand that a copy of my insurance card will be retained in my child's file for billing purposes ___(initials)

Service requested: Applied Behavior Analysis ☐ Other _____

Please include a copy of the front and back of all your insurance card(s)

CLIENT'S INFORMATION

Client's first name	**Middle**	**Last name**	**Client's DOB**	**Age**	**Gender**

Street address	**City**	**State**	**Zip code**

Diagnosis	**Diagnosing physician's name**	**Diagnosing physician's email**
Diagnosis date	**Phone number**	**Fax number**

Primary care physician	**Email**	**Phone number**

Payment options: Health insurance (in-network, out-network) ☐ Credit card ☐

INSURANCE INFORMATION

Primary insurance

Primary insurance name	**Phone number**	**Fax number**	**Policy number**	
			Group number	
Subscriber's name	**Middle**	**Last name**	**Subscriber's DOB**	
			Subscriber SSN	
Subscriber's address		**Subscriber's phone number**	**Subscriber's relationship to client** Father ☐ Mother ☐ Legal guardian ☐	

Subscriber's employer	**Employer's address**	**Employer's phone number**

☐ **New insurance** ☐ **Old insurance effective date:** _____/_____/_____

Financially responsible name	**Address**	**Phone number**	**Email**

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Secondary insurance if applicable

			Policy number	
Secondary insurance name	**Phone number**	**Fax number**	**Group number**	
			Subscriber's DOB	
Subscriber's name	**Middle**	**Last name**	**Subscriber SSN**	
Subscriber's address		**Subscriber's phone number**	**Subscriber's relationship to client** **Father ☐ Mother ☐** **Legal guardian ☐**	
Subscriber's employer	**Employer's address**		**Employer's phone number**	
☐ New insurance ☐ Old insurance effective date: _____/_____/_____				
Financially responsible name	**Address**		**Phone number**	**Email**

Authorization and Release

By signing this form, I _____certify that the information provided above is accurate to the best of my knowledge. I authorize my insurance carrier to release any information required to cover ABA services to Spark Behavioral Solutions & Consulting Services, LLC. I understand that I am responsible for all financial balances resulting from insurance non-covered services, co-payments, co-insurances, late fees, and cancellation fees. I authorize Spark Behavioral Solutions & Consulting Services to release my child's personal information, records, treatment plan to secure payments from the insurance. I understand that is my responsibility to inform Spark Behavioral Solutions & Consulting Services of any changes in insurance coverage and personal information.

_____ _____
Parent/Guardian Signature Date