www.accessba.com
Phone: 317.802.7447 | Fax: 317.802.7325
info@accessba.com

Registration Form

____
Date

Child's Last Name ______ First Name ______ MI ______ Date of Birth ______ Sex M F

Street Address ______ City ______ State ______ Zip ______

Home Phone Number ______ Cell Phone Number ______

Primary Care Physician ______ Phone Number ______

Child's Diagnosis ______

Financially Responsible Party

Last Name ______ First Name ______ MI ______ Date of Birth ______ Sex ______

Street Address ______ City ______ State ______ Zip ______

Home Telephone ______ Work Telephone ______ Cell ______ Email ______

Insurance Information

Primary Insurance
Insurance Company ______
Subscriber Name ______
Subscriber Date of Birth ______
Address ______
______
ID # ______
Group # ______

Secondary Insurance
Insurance Company ______
Subscriber Name ______
Subscriber Date of Birth ______
Address ______
______
ID # ______
Group # ______

Authorization and Release

I authorize Access Behavior Analysis or its agents to release any or all medical records or information necessary to process medical claims. I authorize a copy of this authorization to be used in place of the original and request payment of benefits either to myself or to the above provider who acquires assignment. I acknowledge that I remain financially responsible for unpaid co-insurance and deductible balances and amounts not covered by commercial third party payers.

____
Signature of Responsible Party

____
Date