New Client Information:

Date of Initial Contact: _____ Referral Source: _____

Client:	Street Address:
DOB:	City/State/Zip Code:
Parent/Guardian:	Phone Number:
Diagnosis(es):	Email:
Comments:	

Medical Information:

Date of Diagnosis(es):	Date of Most Recent Diagnostic Report:
Diagnosing Physician:	Diagnosing Physician Contact Information:
Primary Care Physician:	Primary Care Physician Contact Information:

Please Include a copy of diagnostic report(s) ☐

Insurance Information:

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:

Address:	Address:
Employer:	Employer:
ID #:	ID #:
Group #:	Group #:
Insurance Phone #:	Insurance Phone #:

Please Include a copy of the front & back of insurance card* ☐

Responsible Party: _____ Date: _____

Financially Responsible Party Information:

Last Name: _____ First Name: _____ Relationship: _____

Street Address: _____ City: _____ State: _____

Zip: _____

Phone Number: _____ Email: _____

Authorization and Release:

The above information is true to the best of my knowledge. I authorize Alphabet Soup ABA, LLC, or it's agent 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 request payment of benefits either to myself, or 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 third-party payers.

Parent/Guardian (print): _____

Date: _____

Parent/Guardian (sign): _____