Autism Spectrum
Mandate Services

4 Mill Run Court
Medford, New Jersey 08055
www.autismservicesnj.org
609.953.5793

**PATIENT INSURANCE AND CONSENT FORM**
**(Please attach a copy or picture of the front and back of the insurance card)**

**Patient Information**

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Age: _____ SSN: _____

Street Address: _____

Town: _____ State: _____ Zip Code: _____

**Insurance Information of Patient Covered by the Following Legal and Financial Responsible Party**

Primary Insurance

Subscriber Name: _____

Date of Birth: _____

Insurance Company: _____

ID#: _____

Group# _____

Claim Address: _____

_____

Claim Phone No: _____

Secondary Insurance

Subscriber Name: _____

Date of Birth: _____

Insurance Company: _____

ID#: _____

Group# _____

Claim Address: _____

_____

Claim Phone No: _____

**Consent and Release**

**I hereby consent to treatment by, and authorize insurance benefits to be paid directly to Autism Spectrum Mandate Services.**

**I agree that I am responsible to pay for services not covered by my insurance company, co-payments and deductibles, and for any expense associated with the collection of a debt owed to them.**

**I also consent to the release of pertinent medical insurance information to my insurance carrier(s) for the purpose of processing health care claims.**

**Signature:** _____ **Date:** _____ **Witness:** _____