INSURANCE ELIGIBILITY

Client Name_______________________________DOB________________Ph: ________________

Home Address____

Insurance Company____

Insurance Ph:____

Member Insurance ID No________________________________Group ID No __________________

Policy Holder Name______________________________________DOB ______________________

Policy Holder SSN_____________________________Relationship to Patient __________________

Reason for treatment:

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If referred, by who?______________________________Your availability________________________

Typing your name in the signature line below will be used and considered as your electronic signature.

Signature below authorizes The Play Lab by Albert Knapp to disclosure information to your insurance company to check benefits and if benefits are used, to bill the insurance company.

Date_______________________

Signature_______________________

____

Print Name

____

Contact Email Address

Send this form and a copy of the front/back of the insurance card to Scheduling@akatherapy.com