TherapyOne *Reaching the One*

Augmentative/Alternative Communication (AAC) and Assistive Technology (AT) Services
P.O. Box 27, Mesa, Arizona 85211 Phone: 480-668-1917 Fax: 480-668-2750

CLIENT INFORMATION *Please fill out completely and email to therapyoneinsurance@gmail.com*

Client Name ______________________________ **Gender** ____________

Diagnosis ______________________________ **Date of Birth** ______________________________

Parent or Guardian Name ______________________________

Client Street Address ______________________________

City, State, Zip Code ______________________________

Phone Number(s) home:____________________ **cell:**____________________ **Receive Texts?**______

Email ______________________________ ______________________________

Physician ______________________________ **Physician Phone** ______________________________

Physician Address ______________________________

City, State, Zip Code ______________________________

INSURANCE INFORMATION (*Please fill out completely)*

If you have additional insurance policies, please list them on a separate page

Policy Holder's Name ______________________________ **Date of Birth** ____________________

Insurance Company Name______________________________

Policy Number: ______________________**Insurance Phone #:**______________________________

Effective Date____________________________ **++ HRA/HSA? Yes No Which One?** _____

I authorize the release of all documents and information related to this client, whether medical or educational, to Therapy One, LLC. I authorize payment of insurance or government benefits to Therapy One, LLC. I authorize Therapy One, LLC to share information, including necessary photos, related to this AAC evaluation, training, and/or equipment installation with this client's educational institution(s), equipment vendor, medical/therapy provider(s), day treatment program (DTA), and/or group home; I understand that Therapy One, LLC will not share information with any other person or entity without my written authorization.

Parent/Guardian Signature______________________________________ **Date**_________________________

Photocopy or photograph of <u>all</u> insurance cards (front and back) must be submitted with this form.

++ If your policy is an HRA or HSA, please contact your insurance company and have them switch off auto pay, or put Therapy One on the do not pay list.

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