

**CENTER FOR HEALTH, LEARNING &
ACHIEVEMENT**

1561 S. Alafaya Trail Suite 200

Orlando FL 32828

Phone (407) 382-5551 Fax (407) 382-5637



Patient

Name (Last, First)	Age	Birth Date		Sex
Mailing Address	City	State	Zip Code	Marital Status
Primary Diagnosis	Primary Numeric Diagnosis		Secondary Numeric Diagnosis	

Responsible Party (Insurance only skip section if Medicaid or Medwaiver)

Name (Last, First)	Age	Birth Date	Sex	Relationship to Patient
Address (put same if same as above)	City	State	Zip Code	Marital Status
Employer	Home Phone		Cell Phone	

Referring Provider

Name (Last, First)	Phone	Fax
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Primary Insurance Information

Primary Insurance Company	Policy Holder Name		Date of Birth	Policy Number
Insurance Address	City	State	Zip Code	Group Number
Phone Number	Co-Insurance %		Co-Pay	Deductible

Secondary Insurance Information

Secondary Insurance Company	Policy Holder Name		Date of Birth	Policy Number
Insurance Address	City	State	Zip Code	Group Number
Phone Number	Co-Insurance %		Co-Pay	Deductible

Patient Release

I verify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies and their agencies, for the purpose of filing and payments of medical claims. I also authorize payment of the medical benefits to the provider. I agree that I am responsible for all deductibles, co pays, and non-covered services.

Signature of insured or authorized person	Date
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