Authorization To Bill Health Insurance/Assignment of Benefits

I, _____, parent of _____

(child's name), do hereby give full permission and authorize Autism From The Start®, to bill _____ (name of insurance company) for services rendered by Autism From The Start®. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to: Autism From The Start® 9426 Pflumm Rd, Lenexa, KS 66215.

By signing this document I also agree to the following statements below:
I understand that I am responsible for understanding information about my child's health insurance policy and providing such information to Autism From The Start®, for correct billing. I am also responsible to notify Autism From The Start® in the case of changes to my child's health insurance status – including benefits and any information I receive relating to my child's current or future treatment.

I understand that Autism From The Start® will be providing services and billing my health insurance for those services at various times during the course of my child's treatment with our practice. I understand that ultimately I am responsible for all payment relating to any and all charges for treatment and services that I have received at Autism From The Start® during my child's care. I also understand that my insurance company and related policy plan may offer benefits for services provided at Autism From The Start®, but that such benefits do not necessarily guarantee payment for those services.

I understand that the policy of Autism From The Start® requires payment in full for all services rendered at the time of visit or when I receive an electronic invoice, unless other financial arrangements have been made. If my account is not paid within 90 days from the date of service or from the date I receive an invoice (whichever is later) and no other financial arrangements have been made, I understand that treatment will be discontinued and I will be responsible for all legal fees, collection agency fees, and any other expenses incurred in collecting my account. I understand the above information and agree that it is my responsibility to alert Autism From The Start® of any change in my child's insurance coverage.

The undersigned does agree to observe and abide by all of the statements made above.

Parent or Guardian's Signature Date

Representative of Autism From The Start® Date