Minding Miracles Learning Center, Inc.

Client Insurance Information

Please fill out the following information in its entirety for Minding Miracles to attain pre-authorization and submit claims to your insurance company. The following information must be complete and accurate. Any person who knowingly files false insurance information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

CLIENT DEMOGRAPHIC

Circle

Patient's Full Name: _____ **DOB**_____/_____/_____ **Gender:** M / F
Street Address: _____ **City, State, Zip:** _____
1) Parent/Guardian Full Name: _____ **Relationship:** _____
Street Address: _____ **City, State, Zip:** _____
Email: _____ **Phone#:** _____ **Alt Phone#:** _____
2) Parent/Guardian Full Name: _____ **Relationship:** _____
Street Address: _____ **City, State, Zip:** _____
Email: _____ **Phone#:** _____ **Alt Phone#:** _____

Emergency Contacts

#1 Full Name: _____ **Relationship:** _____ **Phone#:** _____
#2 Full Name: _____ **Relationship:** _____ **Phone#:** _____

INSURANCE AND DIAGNOSTIC

Date of last diagnostic evaluation: _____ **Performed by:** _____

Primary Insurance

Company Name: _____ **Effective Date:** ____/_____/_____ *Circle*
Policy Holder Full Name: _____ **DOB**_____/_____/_____ **Gender:** M / F
Policy Number: _____ **Group Number:** _____
Claims Address: _____ **Phone#:** _____

Is there a Secondary Insurance Plan? Yes / No **If so, please complete Secondary Insurance section**

Secondary Insurance

Company Name: _____ **Effective Date:** ____/_____/_____ *Circle*
Policy Holder Full Name: _____ **DOB**_____/_____/_____ **Gender:** M / F
Policy Number: _____ **Group Number:** _____
Claims Address: _____ **Phone#:** _____

MEDICAID DDD/DCF

Recipient ID#: _____ **Card Control #:** _____

Please provide the prescription for ABA services with any recent reports or evaluations that may be helpful to the patient's course of treatment. Please understand that Minding Miracles therapists are licensed professionals, not physicians. They cannot diagnose, alter, or change the diagnosis of any patient.

_____ _____ _____
Responsible Party Signature **Responsible Party Name (printed)** **Date**

****Please complete AND sign the reverse side of this form before submitting****
****Submit a copy of your child's Insurance Card(s) and diagnosis report with this form****

Client Financial Responsibility Statement:

When providing services for your child, Minding Miracles works within the specifications of our contract with your insurance company, New Jersey Medical Assistance Program-DXC Technology, the regulations of the NJ Department of Banking and Insurance and Federal/State laws. Therefore, the following financial responsibility statements must be agreed to, in order, to maintain services through Minding Miracles:

1. I understand that I am responsible for knowing the details of my insurance coverage. This includes my financial responsibility of copayments, deductibles, co-insurances, as well as referrals, etc. It is my responsibility to contact my insurance company to obtain this information.
2. I understand that for NJDDD and NJDCF, Respite care and Day Habilitation services:
    a. I am responsible for maintaining Medicaid Coverage and communication with my DDD Support Coordinator and/or DCF Perform Care to maintain approval for covered services.
3. I understand that if Minding Miracles is not participating or does not accept my insurance plan; if my plan does not have benefits for ABA services, or if I do not have insurance coverage, I will be responsible for all charges for services provided.
4. I understand that I am to pay the balance of any amount deemed as my financial responsibility, which may be referred as 'member or patient responsibility' from my insurance carrier (co-payments, deductibles, co-insurance, noncovered, etc.).
5. I understand that Copayments are due at the time of service and if not paid at the time of service Minding Miracles will issue a billing statement for my financial responsibility.
    a. Statements/invoices are issued by Minding Miracles monthly and the balance is due upon receipt. I understand that I am responsible to pay the full balance due or to contact MMLC to request a payment arrangement and if failed to do so, Minding Miracles reserves the right to suspend services and/or forward the account balance forwarded to a collection agency (additional fees apply).
    b. Minding Miracles is contractually obligated to collect copayments, coinsurance, and deductibles, etc., from our clientele. We cannot legally waive these fees. For clarification on your benefit coverage please contact your insurance plan. For questions on statements, please contact our billing office at 848-757-2123. **To request a payment arrangement, please submit your request in writing to Theresa.MMLC@gmail.com.**
6. I will provide all current information (including copies of both sides of my insurance card, updated address/contact information, or changes in coverage) before the date of said change.
7. I agree to immediately inform Minding Miracles billing department of **ANY** change in my insurance coverage (plan, policy #, group#, copay, etc.) and understand that failure to do so may result in me being responsible for the entire amount due for services rendered.
8. I agree to provide Minding Miracles administration with all required documentation including copies of my child's diagnosis letter, physician prescription for ABA services and any other documents required by my insurer.
9. I agree to respond to all inquiries made by my insurer within seven days of the request and to notify Minding Miracles main office of the request.
10. I understand I will be charged a $35.00 fee if my personal check is returned by my bank.

*I hereby give my consent to Minding Miracles to bill my insurance plan for the services rendered for the patient name listed and authorize insurance benefit payments to Minding Miracles Learning Center. In an event that the insurance plan issues payment to the member, I am responsible to send the endorsed check and Explanation of Benefits to Minding Miracles billing department for reimbursement.

In addition, I agree to pay my portion of financially responsibility in accordance to my benefit plan contract.

*I hereby give consent to Minding Miracles to release information necessary to process claims for services rendered with Minding Miracles Learning Center.

*I understand HIPAA privacy guidelines (copy provided upon initial enrollment) and a copy of the guidelines is available at my request.

*I authorize the release of information to my provider with Minding Miracles Learning Center.

I have read the above statements and fully understand and agree to these terms.

Patient's Full Name: _____ **DOB**_____/_____/_____

_____ _____ _____

Responsible Party Signature **Responsible Party Name Printed** **Date**

****Please read AND sign this form before submitting****