DESTINation Little Learners

ABA Therapy Interest Form

Destin, Florida

Child's Full Name:

Date of Birth / Age / Gender:

Parent/Guardian Name:

Phone:

Email:

Address:

Insurance Information (Critical for Verification)

Please provide details below and attach a copy of the front and back of your insurance card(s) if possible.
We will verify benefits and discuss coverage, copays, deductibles, and authorization.

Primary Insurance Carrier:

Member ID #:

Policyholder Name & DOB:

Relationship to Child:

Secondary Insurance (if applicable):

Secondary Member ID #:

Authorization to Bill Insurance & Release Information

☐ I authorize DESTINation Little Learners to release necessary medical and treatment information to my insurance carrier(s)

I understand I am responsible for any non-covered services, copays, deductibles, or balances.

Signature: