# Accelerated Learning Clinic, Inc.

Providing Effective and Efficient Autism Treatment

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Name: _____

Email address: _____ Phone: _____

Name:_____ Child's Age: _____ M____ F____

Currently Enrolled in ABA Services: Y___ N___ If Yes, how many hours per week? _____

Date of Autism Diagnosis: _____ By: _____

Do you have a referral for ABA Therapy? Y____ N_____

Request for ABA Services:

- ◯ After School
- ◯ All Day program
- ◯ Other: _____

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Insurance:

- ◯ Anthem
- ◯ Healthplan of NV/Sierra Health & Life
- ◯ Healthscope
- ◯ HPN Medicaid
- ◯ Medicaid
- ◯ Self Pay
- ◯ Tricare
- ◯ UMR

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COMMENTS: