DASI Autism Center: 732 N. Broadway St. I Greensburg, IN 47240 I Phone: 812.663.2273 I Fax: 812.663.2275
DASI Learning Center: 9780 Lantern Rd. Ste. #130 I Fishers, IN 46037 I www.dasikids.com

Enrollment Form

Section 1: Client Information

Last Name | First Name | MI | Date of Birth | Sex M F

Street Address | City | State | Zip

Primary Diagnosis | Diagnosing Physician

Diagnosing Physician Phone Number | Date of Diagnosis (Month, Year)

Diagnosing Physician Address | City | State | Zip

Primary Care Physician (PCP) or Developmental Pediatrician | Primary Care Physician Phone Number

Primary Care Physician Address | City | State | Zip

Section 2: Financially Responsible Party Information

Last Name | First Name | MI | Date of Birth | Sex M F

Street Address - *same as client* | City | State | Zip

Home Phone Number | Work Phone Number | Employer Name

Relationship to Client | Email

Section 3: Insurance Information

Primary Insurance Plan | Primary Insurance Phone

ID Number _____ Group Number _____

Street Address _____ City, State, Zip _____

Policy Holder Name _____ Effective Date _____

Subscriber Date of Birth _____ Social Security Number _____

If a secondary insurance does not apply, please check: No

Secondary Insurance Plan _____ Secondary Insurance Phone _____

ID Number _____ Group Number _____

Street Address _____ City, State, Zip _____

Policy Holder Name _____ Effective Date _____

Subscriber Date of Birth _____ Social Security Number _____

Do you have any other insurances? Please check: Yes No

SECTION 4: FAMILY INFORMATION

Primary Contact _____ Primary Contact Number _____ Email _____

Where are you interested in receiving DASI services? Please check: Home School Clinic Other

Name of school your child attends _____

DASI is excited about the opportunity to provide services to your family, please state how we may support your family:

AUTHORIZATION AND RELEASE

I authorize Disability and Autism Services of Indiana, or its agents, to release any or all medical records or information necessary to process medical claims. I authorize a copy of this authorization to be used in place of the original and request payment of benefits either to myself or to the above provider who acquires assignment. I acknowledge that I remain financially responsible for unpaid co-insurance, deductible balances and amounts not covered by commercial third party payers.

Signature of Financially Responsible Party _____ Date _____

Complete Client Information Sheets can be submitted via fax to (812) 663-2275 or email to info@dasikids.com.

Thank you for choosing DASI.