Deborah Mertlich, LCSW

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A. Identification: **To be completed by a parent**

Name of child:_____ Date of Birth:_____ Age:_____
Nicknames:_____ Sex: M or F

Parent Name(s):_____ Relationship to child: _____
Address:_____
City:_____ State:_____ Zip:_____
Home phone:_____ Cell phone: _____
Work phone: _____ email:_____

Parent Name(s):_____ Relationship to child: _____
Address (if different than above):_____
City:_____ State:_____ Zip:_____
Home phone (if different than above):_____Cell phone: _____
Work phone: _____ email:_____

How did you hear about Deborah Mertlich, LCSW? _____

B. Insurance Information:

Name of insured: _____ Insured date of birth: _____
Address of insured person: _____
City: _____ State: _____ Zip: _____
Relationship of client to insured person: _____
Employer of insured person: _____

Insurance company: _____ Phone: _____

Secondary Insurance company: _____ Phone: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

Signature: _____ Date: _____

It is the patient's responsibility to know the amounts and limits of their insurance coverage. We can assist in determining what their coverage includes. However, they remain responsible for services not covered by their insurance company.

There is a one- time $5 charge for the child workbook to cover the costs of the binder and craft supplies