

# Deborah Mertlich, LCSW

4550 SW Kruse Way, Suite 225 ~ Lake Oswego, OR 97035 ~ P: (971) 252-1545 ~ F: (503) 427-7856

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## A. Identification: To be completed by client

Name of client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M or F  
Home street address: \_\_\_\_\_ Apt: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_ email: \_\_\_\_\_

## B. EMERGENCY CONTACT:

Name: \_\_\_\_\_ Telephone number: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How did you hear about Deborah Mertlich, LCSW? \_\_\_\_\_

## C. 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: \_\_\_\_\_  
Insurance company address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance identification number: \_\_\_\_\_ Group number: \_\_\_\_\_

Secondary Insurance company: \_\_\_\_\_ Phone: \_\_\_\_\_  
Secondary Insurance company address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Secondary Insurance identification number: \_\_\_\_\_ Group number: \_\_\_\_\_

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.