Deborah Mertlich, LCSW

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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.