Sunny M. Mueller, LPCC

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California LPCC#610

Insurance Authorization – MINOR

I. Client

Last Name	First Name	Date of Birth
Address		
City	State	Zip
Phone #1	Phone #2	

II. Primary Insurance Subscriber

Last Name	First Name	Date of Birth
Address		
City	State	Zip
Phone #1	Phone #2	
Relationship to Client		

III. Primary Insurance Information

Insurance Carrier	Employer	
Identification Number	Group Number	Plan Code

IV. Secondary Insurance Information

Insurance Carrier	Employer	
Identification Number	Group Number	Plan Code
Subscriber: Last Name	First Name	Date of Birth

I attest that the insurance/s listed on the previous page is/are the health contract/s under which the minor covered. I am aware that if the information above is not accurate, true, or the insurance/s fail to cover payment for services rendered, in part or in full, I am responsible for and agree to pay in full all charges incurred with SUNNY M. MUELLER, LPCC to SUNNY M. MUELLER, LPCC.

Client (PRINT)

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*Client (SIGNATURE)** DATE*

**ONLY if minor client is aged 12-17 years seeking independent therapy*

Authorizing Party (PRINT)

Reason for Authorizing Representation:
- ☐ Client is a minor
- ☐ Client is deceased
- ☐ Other: _____

Type of Authorizing Representation:
- ☐ Parent with sole legal and/or physical custody*
- ☐ Parent with joint legal and/or physical custody*
- ☐ Legal Guardian*
- ☐ Estate Representative*
- ☐ Other: _____

** You may be required to provide documentation validating this status*

Authorizing Party (SIGNATURE) DATE