

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)

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