LISA K. SCHKLOVEN, LCSW-C, LLC

3635 OLD COURT ROAD STE 305 PIKESVILLE, MD 21208

PHONE: 443-898-8357 FAX: 443-327-4753

NAME: _____ **DOB:** _____

INSURANCE INFORMATION FOR MINOR CHILD

PRIMARY INSURANCE/POLICYHOLDER INFORMATION:			
Policyholder's Name:		SSN#	Date of Birth:
Street, City, State, Zip:			
Phone (H)	(W)	(C)	Other
Email:			
Relationship of Child to Policy Holder: ☐ Self ☐Spouse ☐ Child ☐ Significant Other ☐ Other			
Insurance Company:			
Street, City, State, Zip:			
Providers Phone #		Consumer's Phone #:	
Group #		Member ID#:	
Authorization #:			
What are your mental health benefits?			
Holder's Employer:			
Employer's Street, City, State, Zip:			

AUTHORIZATION FORM TO THIRD PARTY PAYERS ON BEHALF OF A MINOR CHILD

I give my authorization to Lisa K. Schkloven, LCSW-C, to use or disclose the protected health information as described below on behalf of the minor child named here. I give this authorization voluntarily, and authorization will remain in effect until it is revoked in writing.

I authorize Lisa K. Schkloven, LCSW-C to release and furnish on a confidential and a strict need-to-know basis, any/all protected health information related to the services rendered to the minor child named below that may be necessary now, or in the future to process claims to my insurance company. I hereby authorize payment of medical/mental health benefits due on behalf of said child to Lisa K. Schkloven, LCSW-C. I understand that my insurance company will be billed as a courtesy but that I am responsible for the payment of said child's account if my insurance does not cover the services rendered to my child by Lisa K. Schkloven, LCSW-C.

I further authorize the release on a confidential and a strict need-to-know basis, of any/all protected health information required by third party payers to facilitate the collection of data for purposes of utilization review, quality assurance, or medical/mental health outcomes evaluation purposes. Such information may be released to insurance companies or other governmental or third-party payers, or any organization contracting with any of the above entities to perform such functions. I understand that I am responsible for all charges incurred, including any portion not paid by any third party.

A copy of this authorization and agreement shall be considered as an original for insurance purposes.

Name of Minor Child _____

Printed Name of Parent/Legal Guardian _____

Signature of Parent/Legal Guardian _____

Relationship to Child _____

Date _____