ZACHARY SCHWARTZ, MSW, LCSW, LLC

CLIENT INFORMATION FORM-(Child/Adolescent)

Child's Name: _____ **Date of Birth:** _____

Street Address: _____

City/State/Zip Code: _____

Child's Grade/School: _____

Sibling(s) Name(s)/Age(s): _____
(if applicable)

Parent(s)/Guardian Name(s): _____

Parent/Guardian Phone Number: _____

Additional Parent Phone Number: _____
(if applicable)

Child's Cell Phone Number: _____
(if applicable)

Parent/Guardian Email Address: _____

Additional Parent Email Address: _____
(if applicable)

Insurance Company: _____

Insurance Cardholder's Name: _____

Insurance Cardholder's ID #: _____

Assignment of Benefits

I authorize the release of any medical or other information necessary to process all insurance claims. I also authorize payment of any benefits to Zachary Schwartz, MSW, LCSW, LLC for services rendered. I understand that I am financially responsible for all services provided including copayments, deductibles, etc.

Parent/Guardian Signature: _____ **Date:** _____

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