

# DAVID L. TERLETZKY, Psy.D.

■ LICENSED PSYCHOLOGIST ■

Child, Adolescent & Adult Therapist

author of DR. DAVE'S TOOLS  
...a parenting system for Parent and Child

Specializing with Children, their Families, and Couples

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## BILLING AND INSURANCE INFORMATION

Name of minor Child or Client

: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Message Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_  Ok to call and thank them Phone: \_\_\_\_\_

**Minor Child** Biological Mother: \_\_\_\_\_ Legal Custody / Joint Custody / Visitation (Step-Father): \_\_\_\_\_

Biological Father: \_\_\_\_\_ Legal Custody / Joint Custody / Visitation (Step-Mother): \_\_\_\_\_

Different address than child's for Mother / Father: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Person financially responsible

: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip \_\_\_\_\_

Employed by: \_\_\_\_\_ Wk Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Serve as the contact person?  yes  no

In case we need to reach you but are unable to reach you at the phone numbers above, who should be contacted for a message? Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Insurance Company

: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Name of the Insured: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address of Insured: \_\_\_\_\_

Insured's D.O.B. \_\_\_\_\_ Insurance I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_

Amount of Deductible: \$ \_\_\_\_\_ Has this amount been met for this client?  Yes  No

I have completed the above to the best of my knowledge. I give permission for David L. Terletzky, Psy.D. to bill my insurance company, and I authorize the release of information necessary to process these claims. I authorize payment of medical benefits directly to David L. Terletzky, Psy.D. I understand billing and collection services may be used. I understand I am financially responsible for all charges not paid by insurance or any other agreement.

\_\_\_\_\_  
Signature of legal custodial parent of minor child or Client

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date signed