MELISSA WOOD BREWSTER, LICSW, PLLC
PSYCHOTHERAPIST & CONSULTANT

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CLIENT INFORMATION FORM

Name ____ Date _____ / ______ / ________

Address ____

City ____ State ________ Zip ______________

Phone (______) ______________ __ Home __ Work __ Cell Date of Birth _____ / ______ / ______

Email _______________________________________

Occupation __________________________ Employer _________________________________

Primary Care Physician _____________________________________ (______) ______________

Person Responsible For Bill (if not self) ____

INSURANCE INFORMATION

Insured's Name (if not self) ____

Date of Birth _____ / ______ / _______ Relationship to Insured ____________________________

Address ____

City ____ State ________ Zip ______________

Insured's Employer _____________________ Primary Insurance Plan _______________________

Insurance ID # ___________________________ Policy Group # __________________________

Insurance Phone (______) _____________

I hereby acknowledge full responsibility for payment of services regardless of insurance coverage.
I authorize Melissa Wood Brewster, LICSW, PLLC or its representatives, to bill my insurance company and to use my personal health information to the degree it is necessary to access payment for services.

Name ____ Date _____ / _____ / _____

Name ____ Date _____ / _____ / _____