

MELISSA WOOD BREWSTER, LICSW, PLLC

PSYCHOTHERAPIST & CONSULTANT

753 N 35 St. #102 • Seattle WA 98103

(206) 409-1266 • melissa@woodbrewster.com • woodbrewster.com

CLIENT INFORMATION FORM

Name _____ Date ____ / ____ / ____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____ _ Home _ Work _ Cell Date of Birth ____ / ____ / ____

Email _____

Occupation _____ Employer _____

Primary Care Physician _____ (_____) _____

Emergency Contact _____ (_____) _____

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 ____ / ____ / ____