

CHERYL M. CEBULA, MSW, ACSW
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CONFIDENTIAL CLIENT INFORMATION

NAME: _____ AGE : _____ DOB: _____
SOC.SEC. # _____
ADDRESS: _____ APT. # _____
CITY: _____ ZIP: _____
HOME PHONE: _____ WORK: _____
CELL: _____
EMPLOYER: _____
EMPLOYER ADDRESS: _____

SPOUSE/PARTNER/PARENT: _____
ADDRESS: _____ HOME PHONE: _____
CITY: _____ WORK PHONE: _____
EMPLOYER: _____ CELL PHONE: _____
RESPONSIBLE PARTY RELATIONSHIP TO CLIENT:
IF OTHER THAN SELF: _____

INSURANCE INFORMATION: IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN INSURANCE BENEFITS, INCLUDING COPAY AMOUNT AND AUTHORIZATION REQUIREMENTS.)

PRIMARY INSURANCE:

INSURED'S NAME: _____ RELATIONSHIP TO CLIENT: _____
INSURANCE COMPANY _____ POLICY/GRP # _____
INSURANCE BILLING ADDRESS _____ INSURED'S ID _____
INSURED DOB _____

SECONDARY INSURANCE:

INSURED'S NAME _____ RELATIONSHIP TO CLIENT _____
INSURANCE COMPANY _____ POLICY/GRP # _____
INSURANCE BILLING ADDRESS _____ INSURED'S ID # _____
INSURED'S DOB _____

FINANCIAL RESPONSIBILITY:

I HEREBY ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT OF SERVICES REGARDLESS OF INSURANCE COVERAGE.

Patient or responsible party DATE _____

I AUTHORIZE CHERYL M. CEBULA, OR HER REPRESENTATIVES, TO BILL MY INSURANCE COMPANY AND TO USE MY PERSONAL HEALTH INFORMATION TO THE DEGREE IT IS NECESSARY TO ACCESS PAYMENT FOR SERVICES.

Patient or responsible party DATE _____