Cedar Bridge Counseling

N. 9507 Division St. STE B
Spokane, WA 99218

509-624-3561

Client Information

Date ___/___/20____

Name _________________________________ DOB ___/___/___

Address _____________________________________

City ________________ Zip ________

Phone _______________________ Type? (circle one) home / mobile / work

Mobile _____________________

SSN# _______________

E-mail ______________________________

Employer ____

Address ____

Phone ________________

Using EAP benefits? Y / N

EAP Provider ____________________________________

Primary Insurance (Not needed if using EAP) _______________________

Subscriber Information

Name ____

DOB ___/___/___

SSN# ____________________

Address if different from client

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Employer Address ____

Employer Phone ____

Insurance Information

Insurance Company ____

Insurance Co. Address ____________________________________

Phone (____)_________________

Member #___________________________________

Group #___________________

Authorization or Referral required? Y / N

Co-Pay __________

Financial Responsibility if other than client (if client is a minor)

Name _____________________________ DOB ___/___/___ SSN# _____________

Address ____

Secondary Insurance Coverage (If Applicable)

Subscriber Information

Name _______________________________ DOB___/___/_____

Address ____________________________________

Phone _____________________

Employer ______________________

Insurance Company _____________________

Member #__________________

Group #____________________________________

Assignment of Benefits and Authorization to Release

Payment, or if billing insurance, co-payment/co-insurance , for services is due at the time of services. Billing may be arranged however the provider reserves the right to charge a fee for billing and bookkeeping if the account is not kept current.

The undersigned authorizes the assignment of all medical /insurance benefits to which they are entitled and are applicable to be paid directly to the provider or the providers office. The release of information necessary to process this claim and check eligibility, the exchange of information necessary for supervision, training, or other lawful purposes, the providing of credit or collection of any fees due and that should a complaint of any nature be instituted against the provider, or should any collection of fees due the provider be initiated, the undersigned waives their right to confidentiality and agrees to hold providers harmless for any and all subsequent disclosures by the provider. The use of a copy of this assignment is to be considered as the original. This document shall be valid for the duration of the therapeutic relationship. The undersigned has read and understands the above.

By signing this document you are indicating that you have read and agree with the information in the disclosure statement and Authorization for Treatment form and have received a copy of that form if requested. Client signature also authorizes release of billing information to the Responsible Party.

Client Signature (Client signature if 13 year or older)

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Signature of Responsible Party (if client is under 13 or disabled)

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