



**PREAUTHORIZATION FOR HEALTH CARE**

- I authorize **Cheryl D. Bebey, LCSW, CEAP** to keep my signature on file for billing purposes.
- I authorize **Cheryl D. Bebey, LCSW, CEAP** to release to insurance/EAP company all information necessary for claims payment purposes.
- I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to this clinic.

Client's Name: \_\_\_\_\_

Client's D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Client's Home Address: \_\_\_\_\_

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

Tel #1: \_\_\_\_\_ Circle: cell home work Circle: *OK to leave message*

Tel # 2: \_\_\_\_\_ Circle: cell home work Circle: *OK to leave message*

Name of parties with whom we may leave messages: (1) \_\_\_\_\_/Relationship: \_\_\_\_\_

(2) \_\_\_\_\_/Relationship: \_\_\_\_\_ (3) \_\_\_\_\_/Relationship: \_\_\_\_\_

**EMERGENCY CONTACT:** Name \_\_\_\_\_ Telephone # \_\_\_\_\_

**Patient Status:** Single \_\_\_\_\_ Married \_\_\_\_\_ Other \_\_\_\_\_

Employed \_\_\_\_\_ Full-time Student \_\_\_\_\_ Other \_\_\_\_\_

Relationship to Insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Insured's Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Insured's SS# \_\_\_\_\_

Insured's Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Employer's Name: \_\_\_\_\_

Patient or Insured's Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ REFERRED BY: \_\_\_\_\_