

**MAUREEN O'BRIEN, MSW, LCSW, ACSW**  
**PSYCHOTHERAPY**  
560 Delaware Ave  
Albany, NY 12209  
518-462-0213

**CLIENT INFORMATION**

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Today's Date (1<sup>st</sup> Visit) \_\_\_\_\_  
Last Name \_\_\_\_\_ SSN \_\_\_\_\_  
Address \_\_\_\_\_ Sex \_\_\_\_\_  
\_\_\_\_\_  
Referred By \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_ Relationship Status \_\_\_\_\_  
Birth Date \_\_\_\_\_ Employer \_\_\_\_\_  
Primary Phone \_\_\_\_\_ Additional Name \_\_\_\_\_  
Other Phone \_\_\_\_\_ — Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Email Address \_\_\_\_\_  
Guardian Name \_\_\_\_\_

**Primary Insurance Policy**

Insurance Company \_\_\_\_\_ Insured's Name \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_  
City, State, ZIP \_\_\_\_\_ City, State, ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Phone \_\_\_\_\_  
Policy ID Number \_\_\_\_\_ Employer \_\_\_\_\_  
Group \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_  
Client Relationship to Insured  
Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

**Secondary Insurance Policy**

Insurance Company \_\_\_\_\_ Insured's Name \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_

City, State, ZIP \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

Policy ID Number \_\_\_\_\_

Employer \_\_\_\_\_

Group \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex \_\_\_\_\_

Client Relationship to Insured

Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

(Alternate Phone) \_\_\_\_\_

**Insurance Authorizations**

1. I authorize use of this form on all of my insurance submission.
2. I authorize the release of information to my insurance company(s).
3. I authorize direct payment to my service provider.
4. I hereby permit a copy of my signature below to be used in place of an original for insurance purposes.
5. I understand that all fees, co-pays, and co-insurance amounts that are not directly reimbursable to Maureen O'Brien from my insurance company are due on the date of service.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name