

INITIAL INTAKE INFORMATION

Date: _____

Client Name: _____

SSN: _____

Date of Birth: _____

Age: _____

Marital Status: _____

Name of Spouse/Parent: _____

Date of Birth: _____ Age: _____

Responsible Party SSN: _____

Home Address: _____

Home Phone: _____ Msg ok? Y/ N Best Time to Call:

Work Phone: _____ Msg ok? Y/N Best Time to Call:

Cell Phone: _____ Msg ok? Y / N Best Time to Call:

Emergency Contact Name: _____ Phone: _____

INSURANCE INFORMATION

Name of Insurance Co.: _____ Phone No.: _____

Membership ID: _____ Group No.: _____

Name of Insured: _____ Relationship to Client: _____

Insured Date of Birth: _____ Insured's Employer: _____

* Permission to Release Information to Insurance Company: _____

Signature of Client (OR) Responsible Party

** Permission to Assign Benefits to Nicole K. Albertson, Psy.D., LLC: _____

Signature of Client (OR) Responsible Party

Referring Person/Entity: _____

Do we have your permission to thank this person? Yes No