Colleen Moloney, LCSW
Intake Information

Date:_____
Client Name:_____
Insured Name:_____Relationship to Client_____
Address:_____
_____
Phone#:_____Alternate#:_____
Email Address:_____
Client Date of Birth:_____ Insured DOB:_____
Employer:_____
Insurance Co:_____
Address:_____
_____
Insurance Co Phone #:_____
Group #:_____
ID #of Insured:_____
Secondary Insurance:_____
Group#:_____ID#:_____

ASSIGNMENT OF BENEFITS

- I understand that I am responsible for payment in full for all services.
- I authorize the release of any information necessary to process insurance claims for services provided by Colleen Moloney, LCSW.
- I authorize payment of benefits from my insurance company directly to Colleen Moloney, LCSW.
- I have read and understand the policy statement for this practice, including the late cancelation/no show fee.

Signature_____