ERIN LIEBMAN
School Psychologist, Reading Specialist, Licensed Clinical Professional Counselor

CLIENT REGISTRATION FORM

Client Information

Legal Last Name:	First Name:
Primary Phone Number:	Cell Phone Number:
Email Address:	Preferred Communication: Email or Phone
Date of Birth:	Age:
Street Address:	
Relationship Status: __Single __Married __Divorced __Separated __Widowed __In Relationship	
Name of Spouse (If Applicable):	Alternative Phone:
Occupation:	Employer:

Insurance Information

Primary Insurance:	ID#:
Group #:	Subscriber's Name (if not patient):
Patient Relationship to Subscriber:	Subscriber's Date of Birth:
Annual Deductable:	Deductible met: YES or NO
If not, how much deductible remains:	

Emergency Contact

Name of Local Friend/Relative:	Relationship:
Primary Phone Number:	Alternative Phone Number:

I have completed this form to the best of my knowledge. I authorize that my insurance benefits, when applicable, are paid directly to Erin Liebman. I also authorize Erin Liebman, or the insurance company, to release any information required to process necessary claims. A copy of this authorization is acceptable in lieu of the original. It is my right to revoke this authorization, at any time, in writing.

I understand that I am financially responsible for all payments that are required to be paid. If a session is not cancelled within 24 hours, I agree to be responsible for a 50 dollar fee.

_____ _____

Client Signature Date