Linda S. Klein, LPC, RPT/S

ACCOUNTING REGISTRATION SLIP

(Please print) Date _____

Client's Name _____Date of Birth _____

Client's Address _____
(Zip)

Telephone _____ Cell Phone _____

Email Address _____

Name of Person Filling Out Form: _____

Relationship to Client: _____ self _____ spouse _____parent _____other _____

Financially Responsible Person's Name: _____

Date of Birth of Insurance Carrier: _____

Occupation _____ Work Phone _____

Employed by _____

Employer's Address _____

Insurance Company's Name _____

Insurance Company's Address _____
City/State _____

Social Security # or ID #_____ Group # _____

Emergency Contact: _____

Second Insurance:
Name of Insured _____

Occupation _____ Work Phone _____

Employed by _____

Employer's Address _____

Insurance Company's Name _____

Insurance Company's Address _____
City/State _____

Social Security # or ID #_____ Group # _____

If statements are to be sent to an address other than above, please given name and address:
_____

For Therapist Use Only: DX _____