Brenda Leiber, MA, LPC & Associates

Client Information Form

Client Name:_____ Date:_____
Home Address:_____ City/State/Zip_____
Social Security #:___-___-_____ Phone #:_____Cell Phone #_____
Birth Date:_____ Age:_____ Gender: ____Male ____ Female

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Client's Primary Care Physician_____ Phone:_____
Referred by:_____ Phone:_____
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Your Employer:_____ Work Phone:_____
Address_____Occupation:_____
****

Responsible Party (if other than client):_____
Social Security #:_____ Relationship to client: _____
Birth Date:_____ Home Phone: _____
Home Address:_____ City/State/Zip: _____
Employer:_____ Work Phone:_____
Address:_____ City/State/Zip:_____
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Health Insurance Coverage (Please provide a copy of your insurance card)
Insurance Company (primary):_____ Member ID# _____
Address:_____ Phone: _____ Group#_____
Authorization #:_____ EAP Authorization #:_____
Policy Holder:_____ Relationship to client: _____
MORE THAN ONE INSURANCE COMPANY PLEASE NOTIFY OFFICE MANAGER:____

How Did Your Hear About Us: __Internet __Yellow Pages__ Insurance Co. __Friend

Authorization to Release Information:

I hereby authorize the release of any information acquired to in the course of my assessment or treatment to any pertinent insurance company for the sole purpose of receiving the medical benefits to which I am entitled.

Signature of Client or Guardian:_____ Date:_____

Authorization to Assign Benefits to Provider:
I hereby authorize payment directly to Brenda Leiber & Associates, all of the medical benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for the payment of the full amount due regardless of benefits paid by my insurance coverage.

Signature of Patient or Guardian:_____ Date:_____

Authorization to Contact Primary Care Physician:
I hereby authorize Brenda Leiber & Associates to contact my or my child's primary care physician about my or my child's treatment for the purpose of coordination of care. This communication is limited to information necessary for my own or my child's care. I understand that I will be informed verbally of any such communication. Further, I understand that I may revoke this authorization at any time and that it will automatically expire at the completion of this treatment.

Signature of Patient or Guardian:_____ Date:_____