# LESLIE E. SPIETH, PHD

## New Client Registration Form

Today's Date: _____

Child's Full Name: _____ Date of Birth: _____

Parent(s)' Name(s): _____

Home Address: _____

City / Town: _____ State: _____ Zip: _____

**CONTACTING YOU:**

Home Phone: _____ Voicemail messages okay? Yes No

Work Phone: _____ Permission to use? Yes No

Cell Phone: _____ (Parent initials: ___ ) Text reminders? Yes No

Cell Phone: _____ (Parent initials: ____) Text reminders? Yes No

Email address: _____ Appointment reminders?: Yes No

Email address: _____ (for Monthly Statements)

Child's Pediatrician: _____ Phone: _____

Who referred you to this office? _____

**PLEASE NOTE:** This office accepts payment directly from clients at the time of service. The fee for the initial consultation is $250.00 and the fee for each subsequent 45-minute session is $200.00. Payments may be made by cash, check, credit card, or electronic transfer. Please circle your payment preference. Statements are emailed at the end of each month so that you may submit an insurance claim.

Signature of Parent (#1): _____

Signature of Parent (#2) _____

226 Massachusetts Ave, Suite 2A, Arlington, MA 02474 781.316.0175