LEIGH M. BAKER, PSY.D.
6740 E. HAMPDEN AVENUE 303
DENVER, COLORADO 80224
303-790-5585

CLIENT INFORMATION

Patient Name _____Date of Birth _____ Marital Status _____

Address _____ City _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____ Other_____

If Patient is a child: Mother's Name_____ Father's Name:)_____

Child's School Name_____School Phone_____

Pediatrician_____ Phone#_____

Emergency Contact (Nearest relative or friend)_____ Phone _____

Person Financially Responsible _____

Employer _____ Location _____

Email address:_____

Family Members (living in home):

1. _____Date of Birth _____ Relationship_____

2. _____Date of Birth _____ Relationship_____

Primary Insurance _____ Insurance # _____

Subscriber _____ SS# _____ Date of Birth _____

Secondary Insurance Type and # _____

Referred By _____

Clinician Signature: _____ Date: _____

PAYMENT IN FULL IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE THROUGH THIS OFFICE. YOU AGREE THAT IF IT BECOMES NECESSARY TO FORWARD YOUR YOUR ACCOUNT TO OUR COLLECTION AGENCY, YOU WILL BE RESPONSIBLE FOR REASONABLE COST OF COLLECTION, INCLUDING ATTORNEY FEES, IN ADDITION TO THE AMOUNT OWED. ALSO YOU WILL BE RESPONSIBLE FOR PAYMENT OF ANY MISSED APPOINTMENTS IF LESS THAN 24-HOUR NOTICE IS GIVEN, EXCEPT IN THE CASE OF EMERGANCY, WHICH SHALL BE DETERMINED BY THE PROVIDER.

Client Signature: _____ Date: _____

Patient Signature (or Guardian/Parent)_____Date_____

Clinician Signature_____ Date_____