Belinda A. Walker, Ph.D.
Licensed Psychologist

CLIENT INFORMATION

Client Name: _ _____ Date of Birth ____/____/____

Gender: M/F Marital Status: M D S W TDL#: _____

Home Address: _____ City: _____ State: ____Zip: _____

Home #: ( ) _____-_____ Work #:( ) _____-_____ Cell #: ( ) _____-_____

Name of current School/District: _____/_____ Grade: _____

Employer of client: _____Referred by:_____

Family Physician: _____ Psychiatrist:_____

If Client is a Minor:

Mother's Name:_____ Father's Name:_____

Home Phone: ( ) _____-_____ Home Pone ( ) _____-_____

Work Phone: ( ) _____-_____ Work Phone ( ) _____-_____

Cell Phone: ( ) _____-_____ Cell Phone ( ) _____-_____

Billing Party Information:

Billing Name: _____ Date of Birth: _____/_____/_____

Relationship to Client (Circle One): Self Spouse Parent Other_____

Address: _____ City: _____ State: _____Zip:_____

Home Phone: ( ) _____-_____ TDL#: _____

Employer: _____ Work Phone: ( ) _____-_____

Employer address: _____ City: _____ State: _____Zip:_____

I understand and agree that I am ultimately responsible for the balance on my account. I also understand that payment in full is required at the time of services rendered. I have provided the above information and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I also agree that Belinda A. Walker (or representative) has my permission to communicate with the Billing Party for the purposes of billing and collection.

Consent for Treatment

I, _____, hereby give my consent for (client)_____ to be treated and/or tested by Belinda A. Walker Ph.D. If the above named client is a minor who is involved in any court proceedings, I have/will provide(d) proof by the attached court documents that I have legal right to request treatment for the above minor.

Client/Parent Signature:_____ Date: _____/_____/_____

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