Walter'sWalk
...a caring path to wellness

Welcome! My name is Stephen Stewart, a mental health counselor, and I'm excited about the opportunity to speak with you. Described below is a bit of information about me and my clinical supervisor.

Stephen is a Provisionally Licensed Professional Counselor (PLPC) under the clinical supervision of Julia Dooley, MA, LPC, RPT-S. He is board-certified as a Nationally Certified Counselor (NCC) and received a Master of Arts degree (MA) in Clinical Mental Health Counseling from Webster University in 2021. Additionally, Stephen completed a certificate training program in Global Mental Health: Trauma and Recovery from Harvard Medical School in 2022. He has continued to enhance his professional development and skills by enrolling in additional training offered by Harvard and other laudable institutions of higher learning.

Stephen has been involved in providing mental health-related care and social services for more than a decade. In his career, Stephen has served as a sexual health educator, victim's advocate and crisis responder for those impacted by violent or sexual crime, Ryan White medical case manager serving newly diagnosed individuals living with HIV/AIDS disease, and clinical mental health counselor in both agency and private practices. Stephen is proud to be an LGBTQ+ affirming therapist who has been active in the queer community for many years. Additionally, he has been involved in HIV/AIDS advocacy for over 30 years and was involved in the congressional process and passage of the Ryan White CARE Act of 1990.

Stephen is dedicated to helping individuals find greater peace, strength, and joy in life. He uses a compassionate counseling process implementing a combination of evidence-based therapeutic practices that may include Cognitive Behavioral (CBT), Dialectical Behavioral (DBT), Gestalt Experiential Technique, Mindfulness-based Stress Reduction (MBSR), Eye Movement Desensitization and Reprocessing (EMDR), and other approaches based on the client's goals for the therapeutic relationship and setting. Stephen offers both video/telehealth and in-person sessions.

Julia Dooley is a Licensed Professional Counselor. She has been practicing as a counselor at Walter's Walk since 2015. Julia earned her Master of Arts in Counseling from Lindenwood University in 2015, and a Bachelor of Sciences in Psychology from Southeast Missouri State University in 2012. She is trained in trauma recovery, communication skills, play therapy, play therapy supervision, mandated reporting, responding to disclosures of sexual abuse, and mindfulness. She seeks common ground and focuses on shared similarities.

In 2018, Julia began the honor and privilege of supervising others, wanting to gain expertise in the field of counseling. She quickly found that encouraging other providers was very rewarding. In 2021, she became the Clinical Director of Walter's Walk. Working alongside a dedicated team towards a necessary and heartfelt mission has been fulfilling for her.

Stephen Stewart, MA, PLPC, NCC
Tel. 314-465-0605
Email: StephenStewart422@gmail.com

Julia Dooley, MA, LPC, RPT-S
Tel. 636-497-9750
Email: jdooley@walterswalk.org

Walter's Walk Client Intake Form

1) Full Name:_ ____ Birth Date: ______________ Age _______

2) Full Name:_ ____ Birth Date: ______________ Age _______

Preferred Name/Pronouns:1) ______________________________2) ___________________________________

Address: ______________________________ City: _______________________ State: _____Zip:___________

Home phone: ______________________Work phone: 1) ______________________ 2) ________________________

Cell phone: 1) ____ 2) _____________________________________

Email: 1) ____ 2) ____

Employer 1) ______________________________________ 2) ____

Is it okay to leave you a message? Yes No
I prefer messages left on the following number: (Please Circle) Home Work Cell

INSURED/RESPONSIBLE PARTY & INSURANCE INFORMATION

Name: _________________________________ Relationship to Client: ________________ Birth Date_____________

Address: ____ City: ____________________ State: _____ Zip:________

Home Phone: ______________________________________ Work phone: _______________________________

Employer: ____ SS#: _________________________________

Insurance Company: ______________________________ ID # __________________________Group # __________

General Information:

Marital Status: ___ Single ___ Married ___ Other

Employment Status: _____ Employed ___ Full-time ___Part-Time ___ Not employed ___ Student

I authorize the use of this form with all of my insurance submissions. I authorize the release of information to my insurance company. I understand that I am responsible for the full amount of my bill for services provided. I authorize direct payment to my service provider. I hereby permit a copy of this to be used in place of an original. If I decide not to use my insurance and self-pay, I understand no information will be given to my insurance company.

Print Your Name 1): ____

Signature 1):____ Date:_________________________

Print Your Name 2):____

Signature 2):____ Date:_________________________

Referred By:____

How did you learn about Walter's Walk? ___Physician ___Friend ___ Website ___ Insurance Company

___Employee Assistance Program (EAP) ___Other:__________________

PRIMARY CARE PHYSICIAN CONSENT TO USE & DISCLOSE YOUR PROTECTED HEALTH INFORMATION

I authorize Walter's Walk to contact my Primary Care Physician (PCP) regarding my medical conditions as well as information pertaining to my psychological and emotional functioning. This information will be useful in treatment planning. I authorize the release of the information verbally or in writing. I am aware that this is encouraged by my insurance company.

Primary Care Physician: ____ Telephone: ______________________

I have the following health problems: ____

I take the following medications: ____

____

_____ I do permit Walter's Walk to contact my Primary Care Physician
_____ I do not have a Primary Care Physician.
_____I do not permit Walter's Walk to contact my Primary Care Physician.

____ ___________________________________

Client Signature Date

PSYCHIATRIST CONSENT TO USE & DISCLOSE YOUR PROTECTED HEALTH INFORMATION

I am currently under the care of a psychiatrist. I authorize Walter's Walk to contact my psychiatrist regarding my mental health care, services, and treatment planning. I authorize contact to be verbal or written.

Psychiatrist Name: ____ Telephone: ___________________________

I take the following medications: ____

____ I do permit Walter's Walk to contact my psychiatrist.
____ I do not have a psychiatrist.
____ I do not permit Walter's Walk to contact my psychiatrist.

Have you ever seen another therapist, counselor or mental health professional? YES NO
If so, who ____

Reason for changing therapist. ____

****

I give permission for the following people to receive and give information regarding my mental health:

_________________________________ _________________________________ _________________________________

Name & relationship Name & relationship Name & relationship

_________________________________ _________________________________ _________________________________

Name & relationship Name & relationship Name & relationship

____ ________________________________

Client Signature Date

Walter's Walk
737 Dunn Rd.
Hazelwood, MO 63042

CLIENT INFORMATION & CONSENT

THERAPY

You will be placed with a qualified, licensed professional counselor or social worker that we feel will be a good match for your needs. If for any reason you would like to change therapists, we will do our best to place with you another therapist we feel would be a good match for your needs.

MENTAL HEALTH SERVICES: BENEFITS & RISKS

While it may not be easy to seek help from a mental health professional, at Walter's Walk we hope that this experience will assist you in understanding your situation or problem and moving toward a resolution of this issue. A therapist has professional training and knowledge of human development and behavior and will make observations about your situation and will assist you in finding options for resolution of your issue(s). The therapist may utilize various therapeutic approaches in order to assist you in resolving your problem(s). You should be aware that entering into psychotherapy is a risk. Psychotherapy sessions can be painful at times. Oftentimes, you may learn new information about yourself that you may not like. Often personal growth cannot occur until you are able to confront your issues and experience the associated feelings. These feelings may include pain, sadness, anger or shame. The success of our work depends on the quality effort of both therapist and client and the realization that you are ultimately in control of and responsible for the changes that result from psychotherapy. Specifically, one risk of psychotherapy is encountering (positive or negative) reactions from significant others to your new lifestyle choices/changes.

GOALS, PURPOSES, AND TECHNIQUES OF THERAPY

Psychotherapy may be one way to effectively treat your problem. There may be alternative ways to treat your problem. It is important for you to discuss any concerns you have regarding the therapist's treatment recommendations. The therapist encourages you to provide input into setting your goals for therapy and the therapeutic techniques used for treatment. As therapy progresses, these goals and techniques may change.

RELATIONSHIP

Your relationship with your therapist is a professional relationship. In order to preserve this relationship, the therapist cannot have any other type of relationship with you. Any personal or business relationships with you will undermine the effectiveness of the therapeutic relationship and therefore is strictly prohibited. Your therapist is committed to your mental health but is not in the position to become socially or personally involved with you. Please note that the therapist cannot accept any gifts, or barter/trade services.

SESSIONS

Therapy sessions vary in length from 45 to 90 minutes. The number of sessions and length needed depends on various factors and can be discussed during your session. Some insurance companies may provide a limited number of sessions under your designated plan. If your insurance company requires authorization for mental health services, it is your responsibility to obtain this authorization prior to our initial appointment. Requests for additional sessions from your insurance company will be requested by the therapist.

APPOINTMENTS & CANCELLATIONS

To schedule an appointment, please call your therapist; see the attached therapist information sheet or website for contact information. If you think that you will be unable to attend a scheduled appointment, please notify your therapist with 24-hour advance notice. **You will be charged $25.00 for missed appointments or for less than 24-hour notice of cancellation.** Exceptions to this fee include documented medical illness or emergencies. If you miss an appointment, it is your responsibility to contact the therapist to reschedule. <u>If you do not show up for an appointment, and do not call to cancel your appointment within 48 hours of the missed appointment, all future scheduled appointments may be canceled.</u>

CONFIDENTIALITY: All sessions with your therapist are confidential. No information will be released without your written consent. However, there are some exceptions including, but not limited to, the following:

1. All insurance companies require that a provider furnish a diagnosis and sometimes a treatment plan on each client in order to justify the necessity of treatment and payment. Your insurance company paying for services may have a right to review all of your treatment records.
2. Missouri State Law demands that all providers report any suspected physical or sexual abuse to the appropriate Child or Elderly Hotline Services, which is then reported to the appropriate agency for investigation.
3. Missouri State Law and Professional Ethics require all providers to report if a client is homicidal or suicidal. This is reported in order to help the client rather than harm the client. Therapist also has a duty to warn any person who is a potential target for harm by a client. Your therapist will notify the targeted person and law enforcement of any such threats.
4. If a Federal or State Court requests the release of records, the provider has to comply, with certain exceptions.
5. Most insurance companies require that a provider keep a patient's "Primary Care Physician" informed of his/her mental health treatment. By signing the consent, you agree to allow me to keep your physician informed at my discretion.

6. A fee dispute between the therapist and client.
7. A negligence suit brought by the client against the therapist, or a complaint filed with a licensing board or other state or federal regulatory authority.

For further information, please review the Notice of Privacy Practices handout provided to you by Walter's Walk. If you have additional questions, please address them with your therapist. By signing this information and consent form, you are giving consent to your therapist to share confidential information with all persons mandated by law and with the managed care company and/or insurance carrier responsible for providing your mental health services and payment for those services. You are also releasing and holding the undersigned therapist harmless from any departure from your right of confidentiality that may result.

DUTY TO WARN
I designate the following people to be contacted if I am in danger:

NAME	RELATIONSHIP	TELEPHONE NUMBER

FINANCIAL POLICY
Walter's Walk requires that your copayment or deductible be paid at the time of service. The balance is your responsibility if your insurance company does not pay. Walter's Walk cannot bill your insurance company unless you give them your insurance information. Your insurance policy is a contract between you and your insurance company. Walter's Walk is not a party to this contract. Please be aware that perhaps some or all of the services provided, may not be covered services and/or not considered medically necessary, under your insurance plan. It is your responsibility to inform Walter's Walk of any changes in your insurance company prior to the effective date of change.

FEES & PAYMENTS
See fee sheet for all fees. All payments and co-payments MUST be paid at the time of service. For your convenience, Walter's Walk accepts cash, checks, Mastercard, Discover, and Visa. Returned payments will have a $25 fee. If there are questions or concerns about the therapy fee, please discuss this matter with your therapist or Walter's Walk: (314) 731-2433.

Walter's Walk has my permission to charge the following credit card on file for any outstanding fees or charges:

Card Type: ____________________________ Card Number: ____

Exp. Date: ____ CCV: ____

Name on Card: ____

Address Associated with Card: ____

ADULT PATIENTS
Adult patients are responsible for payment of their own accounts.

MINOR PATIENTS
The adult accompanying a minor and the parents/guardians of the minor are responsible for payment of the minor's account.

DOCUMENTATION
Walter's Walk does not provide written documentation, summaries or completion of forms requested by you or other agencies (i.e., Social Security Administration, Short-Term Disability Companies, etc.). However, if any formal request for this service is requested, **a fee of $50.00 per document will be charged.** The fee will be collected from the client prior to the completion of the document.

LEGAL PROCEEDINGS
The therapist does not attend court proceedings. If you believe any situation you are involved in will require the therapist being involved in legal matters, a referral to another agency will be provided to you. If the therapist is subpoenaed on your behalf or if for testimony on behalf of another party, which involves you, a fee of $200/hour will be charged for the therapist's time, preparation and expense spent in responding to a subpoena. This fee also applies to travel time and time spent in court. This fee will be charged from when the therapist leaves their residence, the duration of court proceedings and until the time the therapist returns to their residence. You will be required to pay the estimated fee prior to the court date. Any amount collected in excess of the actual time spent will be refunded to you.

AFTER HOURS CONTACT

Clients are assumed to be self-responsible and autonomous and not in need of day-to-day supervision. Therefore, we cannot assume responsibility for day-to-day functioning as can an institution (hospital, mental health agency). In order for us to provide the best care for our clients, if you believe you are in a life-threatening crisis, please call 911 and go to the nearest emergency room. For assistance between sessions call your psychiatrist, call Life Crisis 314-647-4357 or Behavior Health Response (BHR) at 314-469-6644.

THERAPIST'S INCAPACITY OR DEATH

In the event your therapist is unable to continue facilitating therapy sessions with you due to an emergency situation, it will be necessary for another mental health professional to take possession of your records to gain access to your contact information and treatment plan. I give permission to allow another Walter's Walk therapist to take possession of my file and records and refer as necessary. I am aware that I may request a copy of portions of the file or request that my entire file be transferred to a mental health professional of my choosing.

ELECTRONIC MESSAGING POLICY

It is understood that any written communication via the Internet, including e-mail, or via texting may be susceptible to unauthorized interception. In the event that you do not wish any communication via e-mail or other means, please notify us in writing. Counseling sessions will NOT be held via texting.

___ I give Walter's Walk permission to communicate with me by electronic messaging. I understand this form of communication may be susceptible to unauthorized interception.
___ I do NOT want to communicate by any form of electronic messaging.

CONSENT TO TREATMENT

I voluntarily agree to receive mental health services which include assessment, care, treatment, or services through the understated therapist.

I agree to participate in the planning of my care, treatment or services and I acknowledge that I may discontinue care, treatment, or services at any time.

I have thoroughly read and understand this Client Information and Consent Form. I agree to all the terms and information contained in this document. I have been given the opportunity to ask questions and seek clarification of this document. I acknowledge that I have been given the choice to receive a copy of this signed Client Information & Consent Form.

1)____ ______________________________
Client Signature Date

2)____ ______________________________
Client Signature Date

____ ______________________________
Responsible Party if other than client Date

____ ______________________________
Therapist Signature Date

____ ______________________________
Supervising Therapist Signature Date

☐____Client received a copy ☐____ Client declined a copy

Notice of Privacy Practices
Walter's Walk
(Effective April 15, 2003; amended August 1, 2013)

This notice is developed in compliance with the Health Insurance Portability and Accountability Act of 1996 (45CRF)

If you are a client of Walter's Walk this notice describes how your health information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

I. Understanding Your Health Record/Information
As a client of Walter's Walk, a record is kept of your visit. This record contains your reason for seeking services, symptoms, diagnosis, and a plan of treatment for future services. Although this record is the property of Walter's Walk the information within the record belongs to you. This information is considered your "Protected Health Information" (PHI) and is afforded certain protections under the law.

II. HITECH Amendments: Walter's Walk has included HITECH Act provision to its Notice as follows:
HITECH Notification Requirements. Under HITECH, Walter's Walk is required to notify clients whose PHI has been breached. Notification must occur by first-class mail within sixty (60) days of the event. A breach means the acquisition, access, use or disclosure of PHI in a manner not permitted under the Privacy Rule which compromises the security or privacy of such information. This Notice must: (1) contain a brief description of what happened, including the date of the breach and the date of discovery; (2) the steps the individual should take to protect themselves from potential harm resulting from the breach; and (3) a brief description of what Walter's Walk is doing to investigate the breach, mitigate losses, and to protect against further breaches.

Cash Clients
HITECH provides that if a client pays in full for their services out of pocket, they can demand that the information regarding the service not be disclosed to the client's health plan since no claim is being made to the health plan.

Access to E-Health Records
HITECH expands this right, giving individuals the right to access their own e-health record in electronic format, and to direct Walter's Walk to send the e-health record directly to a third party. Walter's Walk may only charge for labor costs under these new rules. Walter's Walk currently participates in E-Health Records.

How I May Use and Disclose Your Protected Health Information: Walter's Walk will not disclose your health information without your authorization, except as described in this notice.

Other
Walter's Walk: may also provide your contact information (name, address and phone number) to Walter's Walk., which handles fundraising efforts. However, you may opt out from these efforts. To opt out, please notify Walter's Walk.

Treatment: Walter's Walk will use your health information to provide treatment. For example, information obtained will be recorded in your record and used to determine the course of treatment/services. Your therapist may consult with other health care professionals to coordinate treatment/services. This will only be done to ensure the course of treatment/services is appropriate to your situation.

Payment: Walter's Walk will use your health information to receive payment for services rendered. For example, Walter's Walk may release portions of your health information to an insurance plan or other payer in order to receive payment for services provided to you.

Health Care Operations: Your health information may be reviewed by regulatory and accrediting organizations to ensure compliance with their requirements.

When Required by Law: Walter's Walk may disclose your health information when a law requires that the therapist report information about suspected abuse, neglect, domestic violence, relating to suspected criminal activity, or in response to a court order.

Duty to Warn: Walter's Walk may disclose protected health information when a client communicates a serious threat of suicide or physical violence against himself, herself or a reasonably identifiable victim(s). In such an instance, Walter's Walk will notify either the threatened person(s) and/or law enforcement.

Notification: In an emergency, Walter's Walk may use or disclose health information to notify or assist in notifying a family member, personal representative or another person responsible for your care, of your location and general condition.

Workers Compensation: Walter's Walk may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by the law.

Public Health: As required by federal and state law, Walter's Walk may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution: Should you be an inmate of a correctional institution; Walter's Walk may disclose to the institution health information necessary for your health and the health and safety of others.

Charges Against Walter's Walk: Walter's Walk may disclose your health information to defend against any legal action you may take against.

Appointments/Treatment: Walter's Walk may contact you about appointment reminders or treatment alternatives.

In all of the above stated circumstances, other than for treatment, Walter's Walk will release only the minimum amount of information necessary to accomplish the purpose of the use or disclosure.

Other:
In any other situation, Walter's Walk will request your written authorization before using or disclosing any of your identifiable health information. For instance, most uses and disclosures of psychotherapy notes (if recorded by a therapist) and most uses and disclosures for marketing purposes, including subsidized treatment communications, will require your authorization. Additionally, most disclosures of PHI that constitute the sale of PHI will require your authorization. If you choose to sign such an authorization to disclose information, you can revoke that authorization at any time to stop future uses/disclosures.

III. Your Rights Regarding Your Health Information
You have the following rights with respect to your protected health information:

1. You have the right to request in writing that your protected health information not be used or disclosed by Walter's Walk for treatment, payment or administrative purposes or by persons involved in your care except when specifically authorized by you. Walter's Walk will consider the request but is not legally bound to agree to the restriction unless it pertains to disclosures to a client's health plan concerning an item or service for which Walter's Walk has been paid out-of-pocket in full. To the extent that Walter's Walk does agree with any restriction, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.
2. You have the right to request that Walter's Walk contact or send you information at an alternative address or by an alternative means. We will agree to your request as long as it is reasonably easy for us to do so.
3. You have the right, within the limits of Missouri statutes, to inspect and copy your protected health information. Any such requests must be made in writing. Walter's Walk will respond in writing to such a request within 30 days. If you request copies, Walter's Walk may charge you a reasonable cost for copying.
4. You have the right to submit a request to amend your information if you believe that information in your record is incorrect or if important information is missing.
5. You have the right to receive an accounting of certain disclosures of your protected health information.
6. You have a right to receive this Notice in paper and/or in electronic format.

IV: Walter's Walk Duties
1. Walter's Walk is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
2. Walter's Walk is required to abide by the terms of this Notice currently in effect, and
3. Walter's Walk reserves the right to change the terms of this Notice and make the new Notice provisions effective for all protected health information that it maintains. Should Walter's Walk make changes in its Notice, we will post the changed Notice in the office waiting area. You may request a copy of the Notice at any time.

VI. *Complaint Procedure*
If you are concerned that Walter's Walk has violated your privacy rights, please contact us. You have the right to file a complaint with us or with the Board of Walter's Walk and/or with the Secretary of the Federal Department of Health and Human Services. Under no circumstances will any action be taken against you for filing a complaint.

By signature, I confirm that I have received this Notice relative to the use of my protected health information.

____ _______________________
Client or Guardian Signature Date

☐ Client received a copy

☐ Client declined a copy

____ _______________________
Signature of Professional Date

____ _______________________
Supervising Therapist Signature Date

Walter’s Walk
737 Dunn Road
Hazelwood, MO 63042

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that Walter’s Walk invited me to engage in a telehealth consultation.
2. It has been explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client visit due to the fact that I will not be in the same room as my therapist.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my therapist or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my therapist , during which I had the opportunity to ask questions in regard to this process. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language which I understand.

CONSENT TO USE TELEHEALTH OPTION

Telehealth through Zoom through Therapy Appointments/Doxy.me/telephone/Google Meets is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth through Doxy.me or Zoom through Therapy Appointments/Doxy.me/telephone/Google Meets is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my therapist and I may be in direct, virtual contact through this Telehealth Service, neither provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services
3. Telehealth through Doxy.me or Zoom through Therapy Appointments/Doxy.me/telephone/Google Meets facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that Walter’s Walk has access to any or all of the technical information in the Telehealth through Doxy.me or Zoom through Therapy Appointments/Doxy.me/telephone/Google Meets or that such information is current, accurate or up to date. I will not rely on Walter’s Walk to have any of this information on the telehealth through Doxy.me or Zoom through Therapy Appointments/telephone/Google Meets.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

____ __________________
Signature Date

Email to: paperwork@walterswalk.com OR mail to Walter’s Walk, Inc. 737 Dunn Road Hazelwood MO 63042

Walter'sWalk
...a caring path to wellness

TABLE OF SERVICES AND FEES

Client Name:____

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90791	Initial Diagnostic Evaluation	$150.00
	90834	Psychotherapy, 38-52 minutes	$125.00
	90837	Psychotherapy ≥ 53 minutes (This fee is my hourly rate & used for all prorated calculations as indicated)	$135.00
	90839	Psychotherapy for a Crisis (30-74 minutes)	$150.00
	+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	$75.00
	90846	Family Psychotherapy without Patient Present, 50 minutes	$135.00
	90847	Family Psychotherapy with Patient Present, 50 minutes	$135.00
	90853	Group Psychotherapy	$100.00
	98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at hourly rate
	98970-98972	Online Digital Evaluation & Mgt (Responding to Email & Text Messages)	Prorated based on the amount of time spent at hourly rate
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Fee	You are Responsible for the Fee of $25.00 for the Appointment Missed
	Production of Records		$50.00
	Legal Fees		$200.00 per hour

Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.

Signature: ____ **Date:** ____________

(Form will be reviewed by Walter's Walk Executive Director or Clinical Director)

Client Name: ____ Age: ________ Birthdate _________ Zip Code ________

If Client is under 18: Responsible party Name _______________________________ Relationship _______________________

Racial Identification:
___White
___Asian
___ Black/African American
___Bi-Racial/Mixed
___Native Hawaiian or Pacific Islander
___ American Indian or Alaskan Native
___ Other ______________________

Ethnicity:
___Not Hispanic/Latino
___ Hispanic

Gender
___Male
___Female
___ Binary
___ Other __________

Type of Client *(if applicable)*
___ Police ___ family member
___Firefighter ___ family member
___EMT ___ family member
___Veteran ___family member

Referral Source: ___ BJC ___Hospital/MD

Other: ____

EMAIL ADDRESS: ____ **PHONE**: ______________________________

Insurance Plan: ____ Not using Insurance ______No Insurance __________

Monthly household income ____________________ OR Yearly Household income ______________________________________

Gross Annual Household Income	1-3 Persons in Household	4+ Persons in Household	V I D E
Below $22,330	$1 — $25.00	$1— $19.00	
$22,331 — $25,999	$25.00	$20.00	
$26,000 — $30,999	$35.00	$30.00	
$31,000 — $37,999	$45.00	$40.00	
$38,000 — $45,999	$55.00	$50.00	
$46,000 — $53,999	$65.00	$60.00	
$54,000 — $60,999	$75.00	$70.00	
$61,000 — $69,999	$85.00	$80.00	
$70,000 — $79,999	$95.00	$90.00	
$80,000----$89,999	$105	$100	
$90,000----$99,999	$115	$110	
$100,000 and over	$125	$120	

Financial Hardships: ____

____

____

Client Issue: ____

Clinician: ___________________________________ Supervisor: _________________________________ Date: _________

Client/Guardian ____

Approval by: __________________________________date______________

No Surprises Act Calculation Worksheet

Gross annual household income	1-3 persons in household Price per session	**1-3 persons in household** **Annual** Good Faith Estimate for sessions every other week (26)	4+ persons in the household Price per session	**4+ persons in household** **Annual** Good Faith Estimate for sessions every other week (26)
Below $22,330	$1 - $24.00	$624.00	$1-19	$494.00
$22,331-- 25,999	$25	$650.00	$20	$520.00
$26,000- 30,999	$35	$910.00	$30	$780.00
$31,000- 37,999	$45	$1,170.00	$40	$1,040.00
$38,000- 45,999	$55	$1,430.00	$50	$1,300.00
$46,000- 53,999	$65	$1,690.00	$60	$1,560.00
$54,000- 60,999	$75	$1,950.00	$70	$1,820.00
$61,000- 69,999	$85	$2,210.00	$80	$2,080.00
$70,000- 79,999	$95	$2,470.00	$90	$2,340.00
$80,000- $89,999	$105	$2,730.00	$100	$2,600.00
$90,000- $99.999	$115	$2,990.00	$110	$2,860
$100,000 and over	$125	$3,250.00	$120	$3120

Total Estimate:	This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.

No Surprises Act
(OMB Control Number: 0938-1401)
GOOD FAITH ESTIMATE
For Health Care Items & Services

Effective January 1, 2022, a ruling went into effect called the **"No Surprises Act"** which requires practitioners to provide a **"Good Faith Estimate"** about out-of-network care.

Under Section 2799B-6 of the Public Health Service Act (PHSA), health care providers and health care facilities are required to inform individuals who are not enrolled in an insurance plan or a Federal health care program, or not seeking to file a claim with their plan, that prior to service and upon request they are entitled to receive (both orally and in writing) a "Good Faith Estimate" of expected charges.

Note: The PHSA and GFE does not currently apply to clients who are using insurance benefits, including "out of network benefits" (i.e., submitting superbills to insurance for reimbursement). However, we are furnishing this information to all clients so that you may understand your estimated charges in the event that your health insurance expires or you choose to become a cash-pay client. These charges would also apply if you received services after the expiration of your health insurance plan and did not give us prior notification of the expiration.

Good Faith Estimate Disclaimer
This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill. If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 800-985-3059. Keep a copy of this Good Faith Estimate in a safe place.

GOOD FAITH ESTIMATE

Provider name: **Walter's Walk**	WW NPI: 1609442441	WW Tax: 27-2595936
Facility: **Walters Walk** **Service Address:** 737 Dunn Rd Hazelwood, MO 63042		

For Health Care Items & Services

CLIENT INFORMATION		
First Name:	Initial: Last name:	Date of Birth:
Address:		
City, State, Zip:	Primary phone:	
Responsible Party Name: Relationship to client:		

TREATMENT & FEES		
Diagnosis/ Code Primary:	R69 Z65.9	Diagnosis deferred Problem related to unspecified psychosocial circumstance

Primary Services Scheduled: 45- or 60-minutes Individual Psychotherapy
Additional Services: *Missed appt fee assessed at $25 a missed session*

Estimated Duration of services: One year **Scheduled dates of service:** every other week (total of 26), recurring appointment

Service Code:	Service Type:	Fee:	Frequency:	Annual Estimate:
90834 or 90837	**Individual**		approx.26 visits per yr.	$
90847/46	**Family Session,** *minors*	$_____	Approx.26 visits per year	$
			TOTAL ANNUAL COST:	$

Date of Agreement: ______________________________________

Client or Parent____ **Date:** _____________