Walter's Walk
737 Dunn Rd.
Hazelwood, MO 63042
(314) 731-2433

Walter'sWalk
...a caring path to wellness

Walter's Walk Client Intake Form

Full Name:

1) _____ Birth Date: _____Age _____

2) _____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 Celll

INSURED/RESPONSIBLE PARTY INFORMATION

Name:_____ Relationship to Client:_____ Birth Date_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work phone:_____

Employer: _____ SS#: _____

Insurance Company:_____ID#_____Payor 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 Walters 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 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. By providing the following information, 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

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 therapist, we will do our best to place with you another therapist we feel would be a food match for your needs.

MENTAL HEALTH SERVICES: BENEFITS & RISKS
While it may not be easy to seek help from a mental health professional, I 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 treat your problem effectively. 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. 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 are 45-90 minutes in length. The number of sessions 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 directly, website for contact information. If you think that you are unable to attend a scheduled appointment, please notify your therapist with 24-hour advance notice. provide **You will be charged $25 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. 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.

Scholarship Clients
Clients who are uninsured and unable to pay a minimum of $35.00, will be offered 12 sessions at the sliding scale rate. If clients do not show - do not call to cancel at least 24 hours in advance- twice, will be referred to another counseling office. At the end of 12 sessions, finances will be reviewed, progress on goals will be reviewed. The client may be offered 12 more sessions until client goal is met.]

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. Therapist will notify 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 the therapist. If you have additional questions, please address them with the therapist. By signing this information and consent form, you are giving consent to the understated 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 harmless the undersigned therapist 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.

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 the payment of their 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 other therapists 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 her 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 9 1 1 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

_____ _____

Supervisor Therapist Signature Date

Walter's Walk
737 Dunn Rd.
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