Sarah Walker, M.Ed.

1304 W Walnut Hill Ln, Suite 100
Irving, TX 75038
(972)756-1100

Section I: Patient Information

Date ____________________

Name: ______________________________ Date of Birth ______________ Age: ________

Address: ______________________City:______________ State: ________ Zip: __________

Phone: ________________________ Email: ________________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If parents are divorce or if applicable please provide custody/guardianship documents.

If Minor: Please provide Mother and Father's (or legal guardian's) Information

Mother: ________________________ Phone: ______________________DOB:________

Father: ________________________ Phone: ______________________DOB:________

Referral Source: ____

Is it okay if we contact you and leave messages at the above emails and phone numbers? If it is please sign the line below. If it is not, please let the receptionist know.

____

Name:________________________________ Relationship to Patient:______________

Section II: Responsible Party Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: ____

Address____

City:____________________ State:______________ Zip:________

Phone:______________________________ Cell Phone: ______________________

Employer: ____________________________ DOB: ______________________

Part III: Insurance Information

Name Primary Insured: ____________________ DOB: ________ Relation to Patient: __________

Insurance Company Name: ____________________ Phone Number: ____________________

Member ID: ______________________________ Group#:______________________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, ASK THE RECEPTIONIST FOR AN ADDITIONAL FORM.

Notice of Privacy Practices for Sarah Walker, M.Ed.

To our patients: this notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information is certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request

that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Sarah Walker.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted Sarah Walker. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the office at 972-756-1100. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the office at 972-756-1100.

I,________________________________ authorize Sarah Walker's office to release information to the following individuals.

Name:____________________________Relationship:______________Phone:______________

Name:____________________________Relationship:______________Phone:______________

I hereby acknowledge that I have been presented with a copy of Sarah Walker Notice of Privacy Practices.

Signature:____

Date:____

Name of patient:____________________________________

Sarah Walker, M.Ed.

1304 W Walnut Hill Ln., Suite 100

Irving, TX 75038

PH: 972) 756-1100 FAX: 469) 209-6075

Office Policies

- If you are unable to keep your appointment, please cancel with at least 1 business day advance notice.
- If you do not cancel your appointment with at least 1 business day advance notice, you will be charged a $85 no-show/ late cancellation fee. You will not be able to schedule an appointment until that fee is paid.
- Please note that it is the patient's responsibility to pay any portion of the bill not covered by insurance.
- After 3 Missed appointments, we will no longer provide services unless all missed appointments are paid in full either with cash, money order or cashier's check.

____________________ ____________________

Patient Name Date of Birth

____________________ ____________________

Legal Guardian's Name Relationship to patient

____________________ ____________________

Signature Date

Sarah Walker, M.Ed

1304 W. Walnut Hill Lane Suite 100
Irving, TX 75038
Phone: 469-941-0444 Fax:469-209-6075

Please fill out before your session and send back to us through fax, mail or as a message on your Luminello account (preferred method).

Who referred you or recommended you to us?

What are your main concerns/issues?

Past Psychiatric History (have you seen a therapist, been on psychiatric medications):

Past Medical History (any medical diagnoses):

Current Medications (if any):

Previous Psychiatric Medications (if applicable):

Education (how far did you go in school or what grade are you in?)/Job history (where do you work, how long have you been there, etc.):