KAMALA
MIND. BODY. WELLNESS.

New Client Information Sheet

Dr. Jamie Walker

Licensed Clinical Psychologist
Registered Yoga Teacher

OFFICE
15366 140th PL NE
Woodinville, WA 98072

PHONE
425-283-2674

EMAIL
jamietwalker@gmail.com

WEB
www.KamalaMindBody.com

DATE:_____

CLIENT INFORMATION:

Name:	
Address:	
Phone:	
Email:	
Age & Birthdate:	
Occupation/Employer:	
Emergency Contact:	
Relation to this person:	
Emergency Contact Phone:	
Who referred you? or How did you find me?	

BRIEF DESCRIPTION OF THERAPEUTIC FOCUS:

RATES:

SERVICE	LENGTH OF VISIT	FEE FOR SERVICE	BILLING CODE
Intake	50-90 minutes	$225	90791
Psychotherapy	50-60 minutes	$150	90837
Family/Couple Therapy	50-60 minutes	$150	90847/90846
Psychotherapy for Crisis	60 min/add 30 min	$200/$100	90839/90840
Group Therapy	60/90/120 min	$35/$50/$65	90853
Phone Calls, Letters, Emails, Reports	15 minute units	$40/unit	Billed to Client

Sliding scale fees are available for those with financial hardship, these are offered on a limited basis and are to be agreed upon based on a case by case basis.

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FINANCIAL RESPONSIBILITY

Most health insurance plans include behavioral health coverage, however, the exact coverage varies widely with the different health insurance plans. Clients are responsible for services received not covered by insurance; therefore, we strongly recommend you call your insurance company to verify your coverage. When you call your insurance company, ask to verify your coverage for outpatient mental health. It is also your responsibility to keep us up-to-date with any changes in your benefit plan and/or insurance coverage.

FEE AGREEMENT:

Person responsible for payment:	
Method of Payment: In-Network Insurance? Out of Network? Out of Pocket Payment? (not using insurance)	

PRIMARY INSURANCE INFORMATION:

Carrier:	
Carrier Phone Number:	
ID Number:	
Group Number:	
Policy Holder:	
Relation to Policy Holder:	
Their Date of Birth:	
Policy Effective:	

(IF APPLICABLE) SECONDARY INSURANCE INFORMATION:

Carrier:	
Carrier Phone Number:	
ID Number:	
Group Number:	
Policy Holder:	
Relation to Policy Holder:	
Their Date of Birth:	
Policy Effective:	

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Kamala Mind Body Wellness (Kamala Psychology & Yoga, LLC), reserves the right to change the policies, practices, and procedures described in this document. We will notify you in writing of any significant changes. My signature below indicates I am consenting to treatment at Kamala Mind Body Wellness, and have received and understand the contents of the clinic's counseling policies, including the Notice of Privacy Practices (HIPAA). If I have questions, the information has been explained and/or summarized for me.

SIGNATURE: _____ **DATE:** _____
(client or legal guardian if client is under 18)

My signature below certifies my consent to the billing and payment policy. All of my questions have been answered and the policy regarding billing is fully agreed to. I also, by signing below, consent to taking full responsibility for any outstanding bill for services rendered. I also agree that my signature authorized Kamala Mind Body Wellness (Kamala Psychology & Yoga, LLC) to pursue any outstanding balance due to them should I not follow the clinic policy.

SIGNATURE: _____ **DATE:** _____
(client or legal guardian if client is under 18)