

PATHWAYS COUNSELING CENTER
CLIENT INFORMATION

CLIENT LAST NAME, FIRST NAME, MIDDLE INITIAL		NICKNAME	SEX
MAILING ADDRESS		CITY	STATE ZIP
PHYSICAL ADDRESS (REQUIRED if different from mailing)		CITY	STATE ZIP
BEST PHONE	ALTERNATE PHONE	WORK PHONE (optional)	CLIENT'S EMPLOYER
DATE OF BIRTH	SOCIAL SECURITY #	MARITAL STATUS	CONFIDENTIAL E-MAIL ADDRESS

CONSENT FOR TREATMENT

I/we, the undersigned, hereby consent to psychotherapeutic evaluation and treatment. I authorize any representative of Pathways Counseling Center to leave messages at any of the phone numbers I have listed above. NOTE: Do not list any phone numbers that you do not want called.

CLIENT SIGNATURE	DATE SIGNED	LEGAL GUARDIAN SIGNATURE
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EMERGENCY CONTACT

(Do not leave blank)

NAME: _____ RELATIONSHIP: _____

BEST PHONE	ALTERNATE PHONE	WORK PHONE	EXT. #
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SUBSCRIBER INFORMATION

(The subscriber is the person who is the *primary* insured on the health insurance policy)

SUBSCRIBER LAST, FIRST & MIDDLE INITIAL	SEX	RELATIONSHIP TO CLIENT	SUBSCRIBER'S PHONE #
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MAILING ADDRESS	CITY	STATE/ZIP
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INSURANCE ID # OR MEMBER ID #	INSURANCE COMPANY NAME	PLAN NAME (HMO, PPO, Etc.)
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GROUP PLAN #	EMPLOYER NAME	SUBSCRIBER SOCIAL SECURITY #	SUBSCRIBER DATE OF BIRTH
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Referred by: _____ Have you applied or will you be applying for disability? _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

NOTE: Pathways Counseling Center will not relay any information to your PCP unless requested by you in writing.

Have you seen another Therapist or Psychiatrist this year? No Yes When? _____

If yes, name of other Therapist or Psychiatrist: _____

PEOPLE LIVING WITH YOU (optional)

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NOTE: List additional on back.

PATHWAYS COUNSELING CENTER

Thank you for choosing us for your counseling needs. We are committed to your treatment.

CLIENT'S BILL OF RIGHTS

As a client, you have the responsibility and right to ask questions regarding therapeutic or office procedures at any time; terminate therapy at any time and ask for a referral; be part of the development of therapeutic goals; confidentiality in accordance to the laws and rules of Chapter 491 of the Florida Statutes; be treated with respect; receive services without discrimination in regard to race, religion, national origin, gender, age or disability; be apprised of fees and payment policies; and ask about alternative procedures available to you.

FINANCIAL POLICIES

Please understand that payment of your bill is considered a part of the treatment process. With that said, our policy is that ALL co-payments, co-insurances, deductibles and other non-covered services and supplies be paid for at the time of service by cash and/or check. Currently, we do not accept credit cards or debit cards. Please come to your appointment prepared to pay for your treatment. Failure to pay for services rendered is considered non-compliance with the treatment process. If your account remains unpaid, collection fees and subsequent charges incurred will be the patient's responsibility.

Returned checks: There will be a **\$25.00 fee** for each check returned by your bank, regardless of the reason. This fee, in addition to the amount of the check, will need to be paid by cash or money order only. All subsequent payments for treatment will also need to be paid by cash or money order.

Insurance: We will accept assignment of benefits from your insurance, providing that you have obtained all necessary authorizations from the insurance company or the company that manages their mental health benefits PRIOR to your initial appointment. We will check your mental health benefits with your insurance company, but regardless of what they tell us by phone you are responsible for the patient responsibility based on the final processed claim. You will be responsible for our normal fees if the claim is denied because of a lack of an authorization, an expired authorization, terminated insurance or other reason beyond our control. Your insurance policy is a contract between you and your insurance carrier and we are not a party to that contract. If your insurance carrier has not paid your account in full within 60 days, the balance will automatically be transferred to you.

Cancellations & Missed Appointments: Please give us a minimum of 24 hours advance notice to cancel an appointment. Otherwise, our policy is to charge our normal office visit rate. Your insurance cannot be billed for missed appointments. If you miss an appointment without contacting us, cancel late or miss consecutive appointments, your future appointments will be removed from the schedule. If an emergency arises, which we understand, a discussion with your therapist may be in order. Please remember that keeping your scheduled appointment is your responsibility and is considered part of the therapeutic treatment process. We make every effort to schedule time for clients whose counseling is a priority. Help us serve you better by making every effort to keep your scheduled appointments.

I hereby authorize assignment of my mental health benefits to Pathways Counseling Center for services rendered until otherwise revoked in writing. I hereby authorize a photocopy of this agreement to be used in lieu of the original.

Signature of Responsible Party _____ Date _____

Note: Please ask us if you would like a copy of this form for your records

PATHWAYS COUNSELING CENTER*
NOTICE OF PRIVACY PRACTICES: HIPPA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

***PATHWAYS COUNSELING CENTER WILL BE ABBREVIATED AS PWCC.**

PWCC is required by law to maintain the privacy of certain health care information about our patients. The law also requires health care providers like PWCC to give you a Notice like this one and to follow its standards.

PWCC AND YOUR PROTECTED HEALTH CARE INFORMATION:

As a part of our day-to-day activities, PWCC may need to use and disclose your protected health care information for several purposes without obtaining your written approval. Those purposes may include:

1. Your treatment, payment for treatment and daily operations of our center. This may include such activities as calling to verify appointments, discussing benefits and services and staffing proper treatment milieu or contacting you regarding your protected health care information.
2. Providing information to government officials who oversee health care or are working on threats to public safety from unsafe products, diseases, abuse, neglect, domestic violence and other crimes.
3. Providing information to licensed researchers who are under strict rules regarding how they use and disclose protected health care information. Those researchers, as an example, may use the information about patients with your condition for a study to improve ways to combat diseases.

No other uses and disclosures of your protected health care information will occur without your written authorization, you have the right to cancel it at any time.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH CARE INFORMATION

Under the law, you have several rights that PWCC is committed to upholding. Those rights include:

1. The right to request restrictions on some of the ways PWCC uses and discloses your information. These restrictions can go beyond the restrictions already in the law. However, PWCC may not always agree to implement these additional restrictions.
2. The right to receive confidential communications. While PWCC cannot promise to communicate in every possible way patients might request, we will work with you to find a practical way of communicating with you in strict confidence if you wish.
3. The right to inspect and get copies of your health care information held by PWCC by making a request in writing. PWCC, however, may charge a reasonable fee to cover only the cost of providing this information.
4. The right to request that PWCC amend or correct information about you. To make such a change PWCC will ask you to make a request in writing with a description of the reasons you want your record changed. PWCC may not always agree to such requests.

5. The right to a list of PWCC disclosures of your protected health care information that were not authorized by you and the disclosures that were unrelated to treatment, payment and PWCC operations.

If you have any questions or complaints about the way PWCC handles your protected health care information or if you believe your privacy rights have been violated, contact PWCC. You can also contact the Secretary of the U.S. Department of Health and Human Services. Please note there will be no retaliation against you for filing a complaint or making requests regarding your health care information, or for disagreeing with PWCC-related decisions.

PWCC may need to change its privacy practices from time to time. Before making such changes, however, PWCC will modify this Notice and begin distributing it to patients when they are treated by PWCC. These new practices will then apply to all information held by PWCC. At any time, anyone has a right to get a paper copy of the latest version of this Notice by asking the PWCC office manager.

Signature below is only acknowledgement that you have read this Notice of our Privacy Practices.

Printed name of patient or representative _____

Signature _____ Date _____

CLIENT QUESTIONNAIRE

Client Name: _____ Date: _____

I am presently having difficulties or problems in the following areas (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Mind goes blank |
| <input type="checkbox"/> Anger/Temper outbursts | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Motivation/Interest is lacking |
| <input type="checkbox"/> Appetite is poor | <input type="checkbox"/> Nausea or upset stomach |
| <input type="checkbox"/> Agoraphobia (fear of certain environments) | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Blame others | <input type="checkbox"/> Odors bother me |
| <input type="checkbox"/> Breath is hard to catch | <input type="checkbox"/> Panicky feeling |
| <input type="checkbox"/> Bullied or taken advantage of by others | <input type="checkbox"/> Parent/Child relationship problems |
| <input type="checkbox"/> Closeness to others is difficult | <input type="checkbox"/> Reading is difficult |
| <input type="checkbox"/> Cold spells | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Communicating is difficult | <input type="checkbox"/> Sad/unhappy/unable to have a good time |
| <input type="checkbox"/> Concentrating is difficult | <input type="checkbox"/> Scared for no reason |
| <input type="checkbox"/> Crowds make me uneasy | <input type="checkbox"/> School is difficult |
| <input type="checkbox"/> Crying more often than usual | <input type="checkbox"/> Seeing things that others do not see |
| <input type="checkbox"/> Death or loss recently | <input type="checkbox"/> Sexual frustrations |
| <input type="checkbox"/> Decisions are hard to make | <input type="checkbox"/> Sexual orientation issues |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Sibling relationship problems |
| <input type="checkbox"/> Disassociation (out of body feelings) | <input type="checkbox"/> Sleep issues |
| <input type="checkbox"/> Divorced or separated recently | <input type="checkbox"/> Socializing is difficult |
| <input type="checkbox"/> Dizziness or faintness | <input type="checkbox"/> Stress (work or other) |
| <input type="checkbox"/> Domestic violence issues | <input type="checkbox"/> Suicidal (thoughts/attempts of hurting myself) |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Thoughts are not my own |
| <input type="checkbox"/> Eating issues | <input type="checkbox"/> Thoughts & speech are uncontrollable |
| <input type="checkbox"/> Euphoric (intense joy for no reason) | <input type="checkbox"/> Tired most of the time |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Traumatized |
| <input type="checkbox"/> Feelings are easily hurt | <input type="checkbox"/> Traveling without knowing how you got there |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Gambles often | <input type="checkbox"/> Trusting people is difficult |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Violent urges to break or smash things |
| <input type="checkbox"/> Health problems | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Hearing trouble | <input type="checkbox"/> Watched or talked about by others |
| <input type="checkbox"/> Hearing voices that others do not hear | <input type="checkbox"/> Weak feeling in parts of my body |
| <input type="checkbox"/> Heartbeat feels fast | <input type="checkbox"/> Weight gain/loss recently |
| <input type="checkbox"/> Home conditions are bad | <input type="checkbox"/> Worrying is excessive |
| <input type="checkbox"/> Homicidal (thoughts of hurting others) | <input type="checkbox"/> Worthless feeling |
| <input type="checkbox"/> Hopelessness | |
| <input type="checkbox"/> Hot spells | |
| <input type="checkbox"/> Impulses are hard to control | |
| <input type="checkbox"/> Inferiority | |
| <input type="checkbox"/> Irritated easily | |
| <input type="checkbox"/> Jobless | |
| <input type="checkbox"/> Legal problems | |
| <input type="checkbox"/> Marital or relationship problems | |
| <input type="checkbox"/> Memory loss | |

Other: _____

MEDICAL HISTORY

Client Name: _____ Date: _____

CHECK ALL THAT APPLY (PAST & PRESENT):

- AIDS
- Allergies
List: _____
- Anemia
- Asthma
- Back pain
- Balance problems
- Blood pressure problems
- Bone disorders/bone loss
- Cancer
Type: _____
- Chest pain
- Constipation
- Depression
- Diabetes
- Diarrhea
- Dizziness
- Endocrine problems
- Epilepsy
- Family history of cancer
- Fatigue
- Growth problems
- Handicaps/disabilities
- Headaches/migraines
- Heart attack
- Heartburn/acid reflux
- Heart defect
- Heart disease
- Heart murmur
- Hemophilia
- Hepatitis _____
- Hernia
- Herniated disc
- High cholesterol
- HIV
- Hormone therapy
- Irritability
- Jaw pain
- Joint problems
- Kidney disease
- Liver disease
- Lung disease

- Memory loss
- Menstrual cramps
- Multiple sclerosis
- Nausea
- Neck pain/stiffness
- Nervousness
- Numbness in extremities
- Osteoarthritis
- Osteoporosis
- Pacemaker
- Pain in extremities
- Pneumonia
- Prostate problems
- Rheumatoid arthritis
- Seizures
- Shortness of breath
- Shoulder pain
- Sinus pain
- Sleeping problems
- Stomach problems
- Stroke
- Tension
- Thirsty
- Thyroid condition
- Tuberculosis
- Urination issues
- Vision loss/problems
- Weight problems

CURRENT HABITS:

Smoking, packs/day _____
Alcohol, drinks/day _____
Caffeine, drinks/day _____
Water, drinks/day _____
Exercise, days/wk _____
Sleep, hours/night _____

IMMUNIZATIONS (AGE 0-18)

UNKNOWN

Check off those that are current:

- Hepatitis A
- Hepatitis B
- Human Papillomavirus
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Polio
- Rotavirus
- Tetanus, Diphtheria,
Pertussis
- Varicella

OPERATIONS/PROCEDURES:

CURRENT MEDICATIONS:

(or provide your own list)

COMPLETED BY: Self Parent/Other REVIEWED BY: _____ (therapist signature)



Pathways

COUNSELING CENTER

3261 Commercial way, Spring Hill, FL 34606

Phone: (352) 686-3188 Fax: (352) 686-9394

Website: pathwayscounselingcenter.net

TELEMENTAL HEALTH INFORMED CONSENT

I, _____ (name of client), hereby consent to participate in telemental health with _____ (provider) as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via telephone, technology-assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services or program benefits to which I would otherwise be entitled.
2. I understand that there are risks and consequences associated with telemental health, including but not limited to: disruption of transmission by technology failures, interruption and/or breach of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any kind by either party. Siri, Alexa, Messenger microphone and the like should be turned off during these sessions to avoid accidental recording. All information disclosed within sessions and written records pertaining to these sessions are confidential and my not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information also apply to telemental health unless an exception to confidentiality applies (i.e.: mandatory reporting of child, elder or vulnerable adult abuse; danger to self or others, etc.).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate & a higher level of care is required.
6. I understand that my therapist may need to contact my emergency contact and/or the appropriate authorities in case of an emergency. Emergency protocol: I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. My location is: _____
My emergency contact person is: _____ Phone: _____
7. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. You may try to reach me at (352) 686-3188 if we are unable to reconnect. If there is no answer, please leave a message & I will call to reschedule.

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian

Signature of therapist

Date signed

I acknowledge that I gave verbal consent to participate in telehealth to my therapist on or after 3/15/20.

(client initials)



Pathways

COUNSELING CENTER

3261 Commercial Way, Spring Hill, FL 34606

Phone: (352) 686-3188 Fax: (352) 686-9394

Website: pathwayscounselingcenter.net

Client name: _____ Therapist name: _____

Today's date: _____ Temperature 100 degrees+ Yes No

Have you traveled outside of Florida in the past month? Yes No

Have you been on a cruise in the past few months? Yes No

Have you been in contact with anyone diagnosed with Covid-19? Yes No

Have you been tested for Covid-19? Yes No

Have you been ordered by a doctor to self-isolate/quarantine? Yes No

Do you currently have a fever, body aches, difficulty breathing, sneezing, persistent cough, loss of taste or smell, chills, sore throat or flu-like symptoms? Yes No

***If yes to ANY of the above questions, please provide explanation:

_____ Date of test & results: _____

_____ List of symptoms: _____

I hereby confirm that the answers above are true & correct regarding the above-named client. I agree to attending face-to-face counseling sessions for myself and/or my child of my own volition and was not coerced by any outside individual. I have been informed that Pathways Counseling Center is taking all necessary precautions to follow social safety guidelines and care.

Signature of client or guardian

Signature of therapist

Additional sessions (date & initials): _____
