PATHWAYS COUNSELING CENTER

CLIENT INFORMATION

CHILD'S LAST NAME, FIRST NAME, MIDDLE INITIAL | NICKNAME | SEX

CHILD'S MAILING ADDRESS | CITY | STATE | ZIP | CHILD'S SCHOOL

CHILD'S PHYSICAL ADDRESS (if different from above)

PARENT'S BEST PHONE | PARENT'S ALTERNATE PHONE | PARENT'S WORK PHONE (optional)

CHILD'S DATE OF BIRTH | CHILD'S SOCIAL SECURITY # | E-MAIL ADDRESS OF ☐ Parent ☐ Child

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.

PARENT/LEGAL GUARDIAN SIGNATURE | DATE SIGNED

INSURANCE & SUBSCRIBER INFORMATION

(The subscriber is the person who is the *primary* insured on the health insurance policy. If this is a Medicaid plan then the child is the subscriber)

SUBSCRIBER LAST, FIRST & MIDDLE INITIAL | SEX | RELATIONSHIP TO CHILD

SUBSCRIBER'S MAILING ADDRESS | CITY | STATE/ZIP | SUBSCRIBER'S PHONE #

CHILD'S INSURANCE ID # | INSURANCE COMPANY NAME | PLAN TYPE (HMO, PPO, Etc.) | GROUP #

NAME OF SUBSCRIBER'S EMPLOYER | SUBSCRIBER'S SOCIAL SECURITY # | SUBSCRIBER'S DATE OF BIRTH

CHILD'S EMERGENCY CONTACT

(DO NOT LEAVE BLANK)

NAME: _____ RELATIONSHIP: _____

BEST PHONE | ALTERNATE PHONE | WORK PHONE EXT. #

PEOPLE LIVING IN CHILD'S HOUSEHOLD

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NOTE: List additional on back

ADDITIONAL INFORMATION

REFERRED TO PATHWAYS BY: _____

CHILD'S PEDIATRICIAN: _____ PHONE: _____
NOTE: Pathways Counseling Center will not relay any information to your PCP unless requested by you in writing.

Has your child previously seen a Therapist or Psychiatrist? ☐ No ☐ Yes When? _____ Name:_____

Have you applied or are you planning on applying for disability? ☐ No ☐ Yes

MOTHER'S NAME: _____ Is mom's address same as child's? ☐ Yes ☐ No

If no, address & phone: _____

FATHER'S NAME: _____ Is dad's address same as child's? ☐ Yes ☐ No

If no, address & phone: _____

Who has custody of child? ☐ Both biological parents (shared) ☐ Mom (sole) ☐ Dad (sole) ☐ Grandparent(s)

Other (explain): _____

Visitation schedule: _____ ☐ Not applicable

If anyone other than the biological parents will be bringing the child to Pathways, please sign a Release of Information form.

Any additional information or comments? _____

_____

NOTES TO PARENTS:

Pathways policy, in most cases, is that an adult must be present on our property while the child is in session with the therapist. _____initial

If the child is old enough to bring him/herself to their appointment, please let the therapist know that this will be happening & make sure they have a current phone number to reach you in case of an emergency during the therapy session. _____initial

If an adult, other than the parent of the child, will be bringing them to their appointment, please make sure they bring any required copayments with them. We will not be able to schedule appointments with anyone but the parent unless we have a release of information signed by the parent allowing us to do so. _____initial

The therapists at Pathways are committed to your child's confidentiality. Therefore, we do not appear in court for divorce and/or custody cases. You will need to use a court approved Professional Guardian for this type of issue. _____initial

Divorced parents, guardians, foster parents, etc. are asked to present court issued paperwork confirming who has responsibility for the children. _____initial

Parents agree to be familiar with their child's healthcare insurance policy & make sure it is in effect. Some policies will terminate without your knowledge (ie: Medicaid HMO's). We do not accept straight Medicaid. We can give you a list of other options if needed. _____initial

I will inform the therapist if my child has any severe allergies. _____initial

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 thee 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):

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

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, Diptheria, 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

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): _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

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)