PATHWAYS COUNSELING CENTER
CLIENT INFORMATION

CLIENT LAST NAME, FIRST NAME, MIDDLE INITIAL | **NICKNAME** | **SEX**

MAILING ADDRESS | **CITY** | **STATE/ZIP**

HOME PHONE | **CELL PHONE** | **WORK PHONE & EXT. #** | **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 to confirm and/or change appointments.

CLIENT SIGNATURE | **DATE SIGNED** | **LEGAL GUARDIAN SIGNATURE**

EMERGENCY CONTACT

(Do not leave blank)

NAME: _____ **RELATIONSHIP:** _____

HOME PHONE | **CELL PHONE** | **WORK PHONE EXT. #**

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 #**

MAILING ADDRESS | **CITY** | **STATE/ZIP**

INSURANCE ID # OR MEMBER ID # | **INSURANCE COMPANY NAME** | **PLAN NAME (HMO, PPO, Etc.)**

GROUP PLAN # | **EMPLOYER NAME** | **SUBSCRIBER SOCIAL SECURITY #** | **SUBSCRIBER DATE OF BIRTH**

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 below or on back.

ANY ADDITIONAL INFORMATION? _____

_____

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. **In addition to the authorization number, how many sessions they are authorizing and when the authorization expires, we will also need to know if you have a deductible for mental health, how much of the deductible has been met for this year, what your co-pay and/or co-insurance will be and how many visits you are allowed per year.** 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_____

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)

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:_____