

Date:		
<b>Basic Information</b>		
Name:	_Date of Birth:	Age:
Phone 1:Address:	City:State:	ZIP:
Occupation:	_Employer:	
Relationship Status: Single Married Divorced	Long Term Relationship Widowed	Other
Spouse or Partner Information		
Name:	_Date of Birth:	Age:
Phone 1:	_Phone 2:	
Address:	City:State:	ZIP:
Occupation:	_Employer:	
Please list the names and ages of your children:		
List all others living in your home (first name, relation		
Why have you chosen to begin therapy at this time?_		
How long have you been experiencing this problem?		
How do you hope therapy can help and how long do	you expect it might take?	
What are some of the strengths/skills you already haConsistent Employment HistoryCan maintaGood personal careHobbies, sports, exercisCultural/Ethnic connectionsKind/generou Please list others:	ave?Intellectual capabilities ain supportive relationshipsMar seOrganizational skillsOpe sTruthfulPositive self-este	Resilience nages Finances n-Minded
Medical History:		
Who is your primary care physician?		
Location: Do you want your physician informed that you have	Phone:	
Do you want your physician informed that you have	begun therapy? Yes No	

Adult Intake 1



Prescribed By	Purpose
d Location <u>:</u>	
n? Yes No	
concerns:	
-	
_ behavioral problems	
repeated grades	
I have trouble in re	lationchine
	-
-	•
	E
I become easily fru	atura to al
I have problems at	
I act impulsively	
I act impulsively	work
I act impulsivelyI am easily distracte	work ed
I act impulsivelyI am easily distracteI have difficulty sta	work ed ying focused
I act impulsivelyI am easily distracte	work ed ying focused
I act impulsivelyI am easily distracteI have difficulty sta	work ed ying focused ings
I act impulsivelyI am easily distractoI have difficulty staI frequently lose the	work ed ying focused ings
I act impulsivelyI am easily distracteI have difficulty staI frequently lose thI am restless "hype	work ed ying focused ings r"
	Prescribed By  d Location:  on? Yes No  ves: where?  High School to grade, Hicollege, college degree, gradue_ behavioral problems repeated grades  I have trouble in rel I can't control my at I am overly aggress I am overly sensitive

Adult Intake 2



I have had panic attacksI feel like I will lose controlI feel fearfulI am afraid to go placesI feel compelled to repeat my actionsI am anxious in social situationsI fear or avoid insects, heights, blood etcI fear germs or disease	<ul> <li>I use alcohol/drugs excessively</li> <li>I feel I should cut down on my drinking or use of drugs.</li> <li>I have an "eye opener" first thing in the morning</li> <li>I have trouble in relationships because of my drinking/drug use</li> </ul>
I wash my hands excessively I avoid leaving my house I have intrusive distressing thoughts I horde things  I feel excited I get upset easily My thoughts are fast and sometimes race I have more energy than normal I don't sleep I have trouble sitting still I am easily distracted I impulsively spend a lot of money I have mood swings I gamble I sometimes have a unusual sex drive I sometimes feel hopeless I have an inflated sense of self-esteem I feel like I'm on an emotional roller coaster	I have gotten a DUI times  I have been emotionally abused I have been physically abused I have been sexually abused I have frightening dreams  I have unusual eating habits I diet daily I self-induce vomiting I am told I am too thin I am told I am too heavy  I have lost my job A loved one has died I have a chronic illness I am separating/divorcing
Please let us know anything else that you feel is imporfamily:	
How did you hear about Pathways Consulting?Pathways Consulting websiteother website schoolother (please list:	

Adult Intake 3

#### **Client Bill of Rights**

AS A CLIENT YOU HAVE THE FOLLOWING RIGHTS UNDER THE FEDERAL HEALTH INSURANCE PROTABILITY AND ACOUNTABILITY ACT (HIPAA), AND WISCONSIN DHS CHAPTER 35 AND HFS 94 WISCONSIN ADMINISTRATIVE CODES.

You have the right:

To be treated with dignity and respect

To prompt, fair, reasonable and adequate treatment and care

To equitable treatment regardless of race, national origin, sex, age, religion, disability or sexual orientation

To the least restrictive method of treatment

To informed consent, including alternative treatments and possible side effects

To participate in the development of a treatment plan

To be informed of the cost of your care and any personal responsibilities you may have

To refuse treatment or medications at any time

To confidentiality of conversations and medical records

To receive or request a copy of the Notice of Privacy Practices

To obtain and accounting of disclosures of protected health information for purposes of the than treatment, payment and health care operations

To see and copy your records

To request an amendment of protected health information

To refuse authorization for the use or release of your medical records

To request restrictions on certain uses and disclosures of protected health information

To ask that we communicate health information to you in different ways or places

To file a grievance or petition the court according to law

To not be threatened or penalized in any way for filing a grievance

To contact the Privacy Officer to file a grievance or learn more about the grievance process

By law there are specific limits to confidentiality. Your therapist is a mandated reporter. This means if there is any reason to believe that you may hurt yourself or another person, your therapist may need to act to protect. Any suspected child abuse (of persons under age 17) needs to be reported. This includes sexual activity of minors. Suspected abuse of the elderly or otherwise vulnerable adults also falls under mandated reporting laws. Please talk to your therapist if you have any questions about these limits to your confidentiality in treatment.

I understand that signing my name bei	low indicates	inai i nave received a copy of the	e Nouce of Privacy
Practices and this Bill of Rights and th	nat both docur	nents have been reviewed with n	ne. I understand
Pathways Consulting has chosen to no employed there are state licensed. I al			*
request.	iso unacistanc	that I may 1000110 additional mi	ionnation at my
Client/Parent/Guardian signature	Date	Witness signature	Date

#### **Consent to Use and Disclose Health Information**

When we assess, diagnose, or treat you, we will be collecting Protected Health Information (PHI) about you. We use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who need it to arrange payment and other business operations.

The Notice of Privacy Practices explains your rights in more detail and tells you just how we can use and share your information. By signing this form you are acknowledging that you have reviewed the Notice. Do not sign this form if you have not reviewed the Notice of Privacy Practices. In addition, you have the right to request that we restrict how protected health information is used or disclosed to carry out treatment, payment or operations. Although we will try to respect your wishes, we are not required to agree to these limitations. If we do agree, we are required to comply. You have the right to revoke this consent at any time by writing a letter telling us you no longer give consent. However, if we have already used or shared some of your information we cannot change that. If we make changes in our Notice of Privacy Practices you can get a copy at our office or call our Privacy Officer at this location.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you. By signing this form you are acknowledging that you consent to how we use and disclose your protected health information. Signature of client or representative Date **Consent for Treatment** My signature below indicates that I am freely giving consent to treatment. I have received a copy of the Patient's Bill of Rights, I understand that I have the right and responsibility to participate in the development and implementation of the treatment plan with my therapist, I understand how to use the clinic's grievance procedures, I understand how to obtain emergency mental health services during periods outside normal operating hours and I understand the clinic's discharge policy, including circumstances under which a patient may be involuntarily discharged for inability to pay or for behavior reasonably the result of mental health symptoms. I also understand that treatment may result in changes or dissatisfaction in relationships and/or an increase in awareness that may lead to additional issues. I have reviewed the financial policy and understand the cost of services, charges for missed appointments, guidelines for finance charges. Signature of client or representative Date I have discussed the above information with the client or personal representative. My observation of this person's behavior and responses give me reason to believe that he/she is fully competent to give informed consent. Signature of Therapist Date

Rev. 09/2013

### **Pathways Consulting**


### **Emergency Contact Authorization**

Pathways Consulting LLC has my permission to contact the following persons in the event of my illness or injury, the threat of my becoming harmful to myself or others, or in the event that I am in need of emergency care.

Phone:	Phone:
Address:	Address:
Relationship:	Relationship:
Signature:	Date:
Protected Health Information and phone contact	
requests. If you have any objection to our employees call	th information is communicated and we support all reasonable ling at home or at work, placing messages, reminders, or other tion on any answering machine, or at any telephone number ith an X.
I AGREE that Pathways employees may call the phoperson who answers or on a voicemail system.	one number I have provided and leave me messages with a
	ng appointments, or protected health Information left on any than myself. This means we will attempt to call but will not
I DO NOT want any messages left, calls regarding means we cannot call you for any reason.	ny protected health information or appointment reminders.
Signature: Da	ate:

#### **Participation Agreement and Financial Policy**

Your understanding of our financial policy and participation agreement is an essential element of your care and treatment. If you have any questions please take the opportunity to discuss them with our billing assistant or your therapist.

As our patient you are responsible for:

- Understanding your insurance coverage. Your insurance policy is a contract between you, your employer and your insurance company. As a courtesy, we file your insurance claims to your carrier, check on benefits, and try to keep you informed of your coverage; however you are ultimately responsible for any charges incurred by you for treatment here at Pathways Consulting. Should your insurance coverage change during your treatment you will need to notify our office immediately. Also, if you have secondary coverage through another company we will need to know that carrier at the onset of your treatment or at the time that it becomes available to you. You will be financially responsible for any lapse in insurance coverage or any change in insurance that was not reported to Pathways Consulting.
- Being responsible for any co-payments at the time of each visit. In addition, you may have a deductible and/or co-insurance. Pathways Consulting will attempt to determine your co-pay or deductible amounts as soon as possible. Kindly pay all co-payments at each visit.

Session fees are as follows: Initial session: \$200.00, Subsequent sessions: 60 min: \$180.00

45 min: \$160.00 30 min: \$130.00

Your consistent participation in treatment is important. Treatment works best when the frequency of sessions is determined together between you and your therapist. If you must cancel an appointment, a <u>24 hour notice</u> is required. There is a Failure to Show or Missed Appointment charge of \$60..00 for all appointments not canceled 24 hours prior to the scheduled time. If you call over a weekend to cancel for Monday and we are unable to fill your time with another client you will be charged \$60.00. There is also a fee of \$40.00 for all returned checks.

<u>If you fail to give 24 hour cancellation notice on more than 2 occasions, your treatment at Pathways</u>
<u>Consulting may be terminated</u>. Also, anyone who has not been participating in treatment for the last 3 months will have their file closed, and treatment with Pathways Consulting with be considered concluded.

Some services offered through Pathways Consulting are not covered by insurance. For example, any letters written to the court, lawyers, social service agencies, or schools etc. include an additional fee, as do any formal assessments if specific measures are used and scored. The extra fees associated with these services will be discussed with you in advance.

All accounts past 60 days are subject to a late charge. A late charge of 1% per month will be added to all account balances. This is an annual percentage of 12 percent. If your account becomes delinquent, you may be referred to a third party for collection.

I have read and understand the financial policy and participation agreement described above. I request the therapist named below provide professional services to me or to who is my		
Signature of Patient or legal guardian	Date	
I, the therapist, have discussed the issues above with the p this person is not fully competent to give informed conser		
Therapist Signature	Date	

## Pathways Consulting of Kenosha, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

# **Notice of Privacy Practices - Brief Version**

We are required by law to provide you with information about how we may use or disclose your protected health information. Please be assured that we are committed to protecting your privacy and your personal health information.

There are several circumstances in which we may need to use or disclose your health information:

- ε We may have to disclose your health information to another health care provider if it is necessary to refer you to them for diagnosis, assessment, or **treatment.**
- ε We may have to disclose your health information and billing records to another party if they are responsible for the **payment** of your services.
- E We may have to use your health information within our practice for **operational purposes** and/or to meet requirements for clinical supervision.

A more complete notice detailing how your health information may be used or disclosed is available to you upon request. You have the right to review that notice before you sign the consent form. Please feel free to request a copy of the complete notice at any time.

You may request that we not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, you may do so in writing. We are not required to agree with your restrictions, but if we do agree, the restrictions are binding.

You may revoke your consent in writing at any time. Of course, your revocation request will not be honored if we have already released your health information before we received your written request. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have the right to access your health information if any of your insurance claims are contested.

If you have any questions regarding this notice please contact our Privacy Officer – Lora Reinders. She can be reached at this office or by phone at 262-652-7222.

The effective date of this notice is November, 2011



## **Litigation Process Information**

Please be advised that, if you are involved in a court process, law suit, or any other legal action and you would like your therapist to communicate with an attorney or any other professional involved in the case, you will be responsible for payment for these services. Health insurance does not reimburse for services outside the therapeutic hour. These services may include, but are not limited to: telephone calls, conferences, letter writing, faxing of information, copying records, report writing, attendance and/or testifying in court, meeting with other professionals involved in the case, travel time, any subpoena to appear as a witness or to appear to invoke confidentiality, any time spent waiting to appear in court, and out of office meetings or appearances.

Services will be billed at the hourly rate of \$240.00. There is a separate fee of \$0.25 per page for copying records. The copying charge must be paid before any information is sent. Prior to providing any of these services, your therapist will discuss what services are being requested, and the estimated cost. You will be asked to submit an estimated payment, similar to a legal retainer, for the anticipated services in advance. A consent for release of information must be signed before any information can be released to anyone.

I understand that I am responsible for payment for any services related to a legal/court matter. My health insurance will not be billed for these services. I understand that I will be required to pay the estimated retainer prior to the services being rendered. If, when therapy is ended, there is an unused balance, it will either 1) be applied to a therapy balance or 2) if there is no balance it will be returned to me.

Client/Parent signature	 Date
Chent/I arent signature	Date
Therapist signature	Date