Pathways Consulting

Today's Date:_____Person Completing this form:_____

Child's Name: _____Date of Birth:_____Age:_____
Mother/Legal Guardian 1
Name:_____Relationship:_____Age:_____
Phone 1:_____Phone 2:_____
Address:_____City:_____State:_____ZIP:_____
Occupation:_____Employer:_____
Father/Legal Guardian 2/Secondary Caregiver
Name:_____Relationship:_____Age:_____
Phone 1:_____Phone 2:_____
Address:_____City:_____State:_____ZIP:_____
Occupation:_____Employer:_____
Step-Parent:_____

Siblings (names and ages):

_____

_____

Where is the child's primary residence? List all others living in home (first name, age, relationship to child):

_____

_____

Presenting Problem: What prompted you to bring in your child at this time ?

_____

_____

About how long has this problem been going on? _____

Educational History:
Current School:_____Grade:_____Attending Since:_____
Teacher or primary school contact name: _____
Previous Schools: _____
Concerns at school:_____
Does the child have any of the following? IEP 504 Plan CSI Team Other_____
Does the child see a counselor or social worker at school? Yes No
Name:_____

Medical History:
Who is your child's primary care physician? _____
Location: _____ Phone: _____
Do you want your child's physician informed that he or she has begun therapy? Yes No

Current Medications
Name How Much/How Often Prescribed By Purpose

_____

_____

_____

Known allergies:_____
Has your child ever been hospitalized? Yes No Reason and Location:_____

Is your child currently being treated for any medical condition? Yes No
Please describe:

_____

_____

Developmental History:
Were there any complications during pregnancy? Yes No
Did your child meet developmental milestones such as sitting, walking and talking at average times? Yes No
Has your child ever needed physical, occupational or speech therapy? Yes No

Please further explain any responses as needed:

_____

_____

Family History:
Does anyone in the child's biological or adoptive family have a history of:
alcohol or drug use? Yes No Explain:_____
being incarcerated or on probation? Yes No Explain:_____
medical or mental health concerns? Yes No Explain :_____

_____
past mental health treatment? Yes No Provide (provider/facility/approximate dates):_____

_____

_____

Additional information about your child:

What are some of the strengths/skills your child already has?_____

_____

_____

How do you hope therapy can help your child and how long do you expect it might take?_____

_____

_____

Does your child get along with kids his or her own age? Yes No Sometimes

Does your child get along well with adults (teachers and relatives)? Yes No Sometimes

Has your child experienced too much yelling or fighing at home? Yes No Sometimes

Has your child talked about harming or killing him or herself? Yes No In the distant past

Please let us know anything else that you feel is important for us to know about your child or your family:_____

_____

_____

_____

Please check those behaviors that apply to your child:

_____ Fidgets
_____ Difficulty remaining seated
_____ Easily distracted
_____ Difficulty waiting to take turns
_____ Often blurts out answers at school
_____ Difficulty following directions
_____ Difficulty sustaining attention
_____ Shifts from one activity to another
_____ Difficulty playing quietly
_____ Often talks excessively
_____ Often interrupts
_____ Often does not listen
_____ Often loses temper
_____ Often engages in dangerous activities
_____ Poor impulse control
_____ Repetitive behaviors
_____ Seems anxious
_____ Sleep problems
_____ Fatigued or low energy
_____ Refuses to sleep alone
_____ Suicide attempt
_____ Suicidal thoughts
_____ Feelings of worthlessness or guilt
_____ Sad or hopeless
_____ Unable to enjoy life
_____ Stolen
_____ Runs away from home
_____ Often lies
_____ Often truant
_____ Destroys other's property
_____ Destroys own property

_____ Cruel to animals
_____ Forced someone into sexual activity
_____ Used a weapon in a fight
_____ Often initiates physical fights
_____ Physically cruel to people
_____ Often argues with adults
_____ Defiant
_____ Often annoys others
_____ Blames others for own mistakes
_____ Often angry or resentful
_____ Swears or uses obscene language
_____ Worries about harm to others
_____ Worries about separation from parents
_____ Anxious in social situations
_____ Avoidance of being alone
_____ Fears losing control
_____ Physical complaints
_____ Worries about future events
_____ Worries about past behavior
_____ Worries about own competence
_____ Marked self-consciousness
_____ Excessive need for reassurance
_____ Marked inability to relax
_____ Irritable/easily frustrated
_____ Experienced physical abuse
_____ Experienced sexual abuse
_____ Experienced emotional abuse
_____ Low self-regard
_____ Preoccupied with weight
_____ Worries about body/weight or image
_____ Dieting?
_____ Self-induced vomiting

How did you hear about Pathways Consulting? _____ insurance company ____doctor _____friend
_____Pathways Consulting website _____other website (please list: _____) _____phone book
_____ school ____other (please list:_____)

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 below indicates that I have received a copy of the *Notice of Privacy Practices and this Bill of Rights* and that both documents have been reviewed with me. I understand Pathways Consulting has chosen to not be a state certified clinic in Wisconsin, but that all therapists employed there are state licensed. I also understand that I may receive additional information at my request.

_____ _____

Client/Parent/Guardian signature Date Witness signature Date

Revised 12/2013

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.

Name:_____	Name:_____
Phone:_____	Phone:_____
Address:_____	Address:_____
Relationship:_____	Relationship:_____

Signature: _____ Date: _____

Protected Health Information and phone contact

Clients have the right to restrict how their protected health information is communicated and we support all reasonable requests. If you have any objection to our employees calling at home or at work, placing messages, reminders, or other information which may contain protected health information on any answering machine, or at any telephone number with any person please indicate your preference below with an X.

_____ I AGREE that Pathways employees may call the phone number I have provided and leave me messages with a person who answers or on a voicemail system.

_____ I DO NOT want any messages, reminders regarding appointments, or protected health Information left on any answering machine, voice mail or left with anyone other than myself. This means we will attempt to call but will not leave any message.

_____I DO NOT want any messages left, calls regarding my protected health information or appointment reminders. This means we cannot call you for any reason.

Signature: _____ Date:_____

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 **24 hour notice** 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.**

If you fail to give 24 hour cancellation notice on more than 2 occasions, your treatment at Pathways Consulting may be terminated. 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 that 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 patient or legal guardian. I have no reason to believe that this person is not fully competent to give informed consent.

_____

Therapist Signature Date

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:

- 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.**
- We may have to disclose your health information and billing records to another party if they are responsible for the **payment** of your services.
- 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

Pathways Consulting

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**

_____ _____

Therapist signature **Date**