Pathways Counseling
3939 W Green Oaks Blvd, 211
Arlington Texas 76016
www.PathwaysDFW.com

GENERAL OFFICE POLICIES

1. At least a 24 hour notice is required to cancel a psychotherapy appointment. Clients who fail to cancel their appointment twenty-four hours prior to the scheduled time will be subject to the following fees:

   First No-Show/Non-Cancellation: **$50.00** Second: **Full Session Fee of $150**

2. Pathways Counseling would like each client to have an emergency contact on-file. This is an additional person for us to contact should there be an emergent issue with your care or well-being.
3. No use of cellular telephones, cameras, or video equipment is allowed inside the office. Please have your cellular phone on silent at your visits.
4. Please do not bring children and/or infants to your appointment. We are aware that childcare issues arise, but please do your best to limit bringing your children to our office.
5. At Pathways Counseling, your medical records are kept strictly confidential. Disclosure of information to physicians, treatment centers, attorneys, or others must be requested via written authorization by the client.
6. Work excuses, disability forms, calls to employers, and return to work letters will be provided on a fee basis. The fee must be paid prior to Pathways Counseling completing the required task. The fee will be based on the time required to complete the client's request.
7. **COURT APPEARANCES** It is the policy of Ms. Reed to avoid court appearances whenever possible. As mental health professionals, we view our role in an individual's or family's life to be one of assessment and treatment, not to provide testimony in a legal setting. Please be advised that the only time a professional from Pathways Counseling appears in court is when required by court and issued a subpoena. Attending and preparing for court hearings is time consuming and costly, not only to Ms. Reed, but to other clients as well. Attending court requires that all clients be cancelled and re-scheduled during that time, which may delay, inconvenience or prohibit their ability to receive needed services. This time demand directly impacts Ms. Reed's ability to maintain her commitment and service to all her clients. It is important that client understand that testimony in court may or may not help your case.
   A. If required to testify, the only information that will be provided is any truth of which there is firsthand knowledge.
   B. Fees for court testimony are: **$350.00 per hour**, beginning from the time of departure from the office until return to the same location, with a minimum of four hours billed. Fees are also required for copying of records or creating summaries or documents for court, billed at $150 an hour. **All fees are due at least 1 week prior any legal related activities.**

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Professional Fees & Fee Agreement

Session Fee Schedule is as follows:

Regular Office Visit:
Intake: 150.00
60 minutes: 150.00
90 minutes 180.00

EMDR Intensives:
3 Hour: $400
6 Hour: $800

The following is a fee agreement between you and Pathways Counseling. You are expected to pay for each session in the amount of $_____ at the beginning of each session.

INSURANCE: Fees and/or co-payments vary according to insurance companies. I authorize the release of any medical or other information necessary to process an insurance claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to **Pathways Counseling**.

Insurance company: _____ ID # _____
Group#:_____ Insurance Provider phone#: _____
Policy Holder: _____ Relation: _____ Policy Holder Date of Birth: _____

Secondary Insurance: _____ ID # _____
Group#:_____ Insurance Provider phone#: _____
Policy Holder: _____ Relation: _____ Policy Holder Date of Birth: _____

Financial Consent & Accountability Statement

I am aware that I must call to cancel an appointment within 24 hours of that appointment in order to avoid full financial responsibility for that session. It is my responsibility to call my counselor to cancel my appointment.

Furthermore, I agree to the one-time charge or debit to my credit/debit card in the amount of my regular appointment fee plus the service charge, following any missed session or appointment cancelled with less than 24 hour's notice. **Pathways Counseling** is not required to notify me of this charge.

I am aware that payment is due at the beginning of each session. All checks should be made out to **Pathways Counseling**. If paying by cash, only exact amounts will be accepted. If you do not bring exact cash, your counselor will not be able to make change and the excess will be applied to your next session. If you choose to pay ahead for sessions, please be aware that we do not provide refunds for unused sessions.

If my check is returned for insufficient funds I agree to bring cash payment for the session and the NSF bank charge before my next scheduled appointment. If no cash payment is made, I agree to a one-time credit/debit charge to my account plus the NSF fee and the service charge to be made. **Pathways Counseling** is not required to notify me of this charge.

Credit /Debit Card Information:
Name as it appears on the card_____
Credit/Debit Card #_____ Expiration Date_____ CCV _____
Cardholder's Zip Code _____

_____ _____
Signature – Client Date

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PHONE CALLS/AFTER-HOURS CALLS/PHONE CONSULTATIONS

1. We typically return routine/non-emergent phone calls within one business day if the message is left during normal business hours. Our policy is to provide quality care through scheduled office visits, not unscheduled phone calls. Based on the nature of your call, you may be required to make an appointment.

2. At this time, Pathways Counseling does not offer after-hour services, nor do we check messages outside of business hours. If you feel your issue is an emergency, please go to the nearest emergency room, call 911 for assistance, or the national suicide hotline at 1.800.273.8255.

3. Pathways Counseling does not offer any counseling or psychotherapy over the phone. Phone conversations that require more than 10 minutes of time will be billed as an office visit.

When leaving a phone message, please leave your full name and your phone number. Please speak slowly, if we cannot understand who you are or what your concern is, then we cannot call back in a timely manner.

LIMITS OF THE COUNSELING RELATIONSHIP

Although sessions with your counselor may be very intimate psychologically and interpersonally, the relationship is a professional relationship rather than a social one. Contact must be limited to sessions you arrange with your counselor.

Due to ethical guidelines, you are asked not to invite your counselor to social gatherings, offer gifts, ask your counselor to write references for you or relate to you in any way other than the professional context of the counseling sessions (this includes any interaction involving social networking sites).

Your counselor is required to keep the identity of clients confidential. Therefore, your counselor cannot and will not acknowledge you outside of counseling sessions unless you first acknowledge them.

Again, in order to maintain proper ethical standards, when the counseling relationship ends, the limitations of contact with your counselor must remain the same.

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FMLA POLICY

- If you feel you need FMLA and this was not discussed at your recent appointment, you will have to schedule a new appointment to discuss why you cannot work and which symptoms have changed.
- **Due to the time involved, FMLA paperwork will be subject to a $50 fee based on the amount of time it takes your provider to complete paperwork.**
- Patients at our office placed on FMLA will be required to have weekly appointments and be compliant with all treatment recommendations.
- Wanting FMLA is not a guarantee that we will concur with you being on FMLA.

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HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY

This notice describes how medical information about you may be used and disclosed and how you, as a client, can get access to this information. Please review it carefully.

As an entity providing health care, the law requires us to protect the privacy of your health information, known as "protected health information" or PHI. It is also our responsibility to protect your PHI and explain our privacy guidelines.

Copies of this notice are available from Pathways Counseling.

Your Health Information Rights:

- You are entitled to a copy of your health information that we have concerning you. An exception would be separate psychotherapy process notes kept by the individual serving as a psychotherapist. These notes are not part of the medical record and cannot be released to anyone. There are certain reasons why you can be denied access to your health information, and if your request is denied, you must be provided the reason for denial. You are also entitled to a summary of your health information.
- You can ask that your health information be corrected if you feel that information in your medical record is incorrect.
- You can request a list of when we have given your health information concerning you to other people in the last six years.
- You can request that we limit the way we use/share your health information. All requests will be considered, however, we are not obligated to adhere to your request.

Responsibility of Pathways Counseling:

- The law requires us to protect the privacy of your health information. We will not use or let other people see your health information without your permission except in the ways outlined in this notice. We will not let anyone know that you sought, are receiving, or have ever received services from anyone in this office, unless the law allows us to disclose that information.
- We are required to give you this notice of our legal duties and privacy practices, and we must do what this notice says. We can change the contents of this notice and, if we do, we will have copies of the revised notice available to you at our office.
- We are required to notify you if we are unable to agree to a requested restriction.
- We are required to accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- We will not use or disclose your health information without your authorization, except as described in this notice. We will not disclose information about you related to HIV / AIDS without your specific written permission.

Disclosures Regarding Treatment, Payment, and Health Operations:

□ A primary use of your health information is for treatment.

o We may use health information about you to provide you with medical treatment or services. This includes providing care to you, consulting with another health care provider about you, and referring you to another health care provider.

o Unless you ask us not to, we may also contact you to remind you of an appointment or to offer treatment alternatives or other health-related information that may interest you.

□ Another primary use of your health information can be for payment

o Your health information can be disclosed to obtain payment for providing health care under medical insurance plans, such plans as Medicare. Your health information can be used to bill your insurance company for care provided to you. Applicants for and recipients of financial assistance or payments under federal benefit programs are advised that any information provided by you may be subject to verification through matching programs.

□ Another primary use of your health information can be for health care operations

o Your health care information can be used for activities to improve health care, evaluating programs, and developing procedures; reviewing the competence, qualifications, and performance of health care professionals and others; conducting accreditation, certification, licensing, or credentialing activities; providing medical review, legal services, or audit functions; and engaging in business planning and management or general administration.

Other Disclosures or Limits of Confidentiality:

It is important you understand all identifying information about your therapeutic treatment is kept confidential. Information solicited by phone, written, or in person about clients is not provided. You will need to sign consent to release information before any information is provided to a 3rd party outside of this office. This condition applies to cases where coordination of treatment is necessary with another health professional (e.g. physician, psychiatrist). However, there are exceptions and/or limitations to confidentiality. The following are some exceptions that allow or require the release of confidential information, without client consent. Examples include:

- In cases of immediate risk/threat of suicide or homicide on the part of the client.
- In cases of child or elderly abuse or neglect.
- In cases required by law or court subpoena.
- In case consultation. As professionals, we do consult with one another from time to time. Any clinical material is conveyed without identification whenever possible. At other times, it will be necessary (for example, if another therapist is covering calls during a vacation).
- Case material is sometimes used in training, research, writing, etc. This is always done with identifying information removed and with great care and respect for privacy.

UNLESS YOU ARE RECEIVING TREATMENT FOR ALCOHOL OR DRUG ABUSE, WE ARE PERMITTED TO USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT PERMISSION FOR THE FOLLOWING PURPOSES:

Business associates: It is possible that some services will be provided in our organization through contracts with business associates. Examples may include but are not limited to inpatient mental health services at certain hospitals, certain clinical laboratories, and private providers of medication management. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill for services rendered. To protect your health information we require the business associate to appropriately safeguard your information.

Medical Examiners/Coroners: We may disclose health information to Medical Examiners or Coroners consistent with applicable law to carry out their duties.

Workers compensation: We may disclose private health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or their respective agents, private health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid court order.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

REGARDING PATIENT RECORDS FOR SUBSTANCE ABUSE AND TREATMENT:

Confidentiality of Alcohol and Illicit Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by Pathways Counseling is protected by Federal law and regulations. Generally, we may not disclose any information identifying a patient as an alcohol or drug abuser unless one of the following conditions is met:

1. The patient consents in writing.
2. The disclosure is allowed by a court order.
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If have questions and would like additional information, you may contact Pathways Counseling at 817.933.4878. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

U.S. Department of Health and Human Services:

200 Independence Avenue. S.W. Washington, D.C. 20201
(800) 368-4019 (toll free)

HIPAA Effective Date: April 14, 2003

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NOTICE OF PRIVACY PRACTICES ACKNOWLDEGMENT

The Health Insurance Portability Act of 1996 (HIPAA) requires that health agencies provide a Notice of Privacy Practices to all persons receiving services. This form acknowledges that you have received a Notice of Privacy Practices statement from Pathways Counseling.

_____ Printed Name and date

_____ Signature

SIGNATURE PAGE

Please initial each line and sign at the bottom to acknowledge that you have read and understand our current office policies.

General Office Policies: _____
Concerning Insurance: _____
Phone Calls/After Hours/Limits of Counseling Relationship: _____
FMLA: _____
HIPAA: _____

_____ Signature and Date

_____ Printed Name

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

While it is generally expected that you will benefit from therapy, there may be periods of feeling worse before feeling better and there is no guarantee of success in therapy. There may be alternative treatments or modes of therapy to consider. I will encourage you to become aware of these factors and to ask any questions you may have at any time during our work together.

_____ _____
Signature – Client Date

_____ _____
Therapist Date

Pathways Counseling

Adult Personal Information

Name _____ Date _____

Address _____ Apt _____

City _____ State _____ Zip _____

E-mail _____ Okay to contact? ☐ Yes ☐ No

Home Phone _____ Okay to contact? ☐ Yes ☐ No

Cell Phone _____ Okay to contact? ☐ Yes ☐ No

Work Number _____ Okay to contact? ☐ Yes ☐ No

Date of Birth _____/_____/_____ Age _____ Gender: ☐ Male ☐ Female

Driver's License# _____ State _____

Employer _____ Occupation _____

Number of different jobs in past 3 years: _____ Highest Schooling Completed: _____

Mental Health Coursework: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

If married, partnered, separated, divorced, or widowed, how long: _____

Name of Spouse/Partner: _____ Date of Birth _____/_____/_____

Have Children? ☐ Yes ☐ No If yes, how many? _____

Name of Children/Other in Household	Relationship	Date of Birth	Age	Lives with You?
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No

Physician Name _____ Date of last physical: _____/_____/_____

What medications are you taking? _____

_____

Current health issues: _____

Past, Chronic, or Significant Health Issues/Surgeries: _____

_____

In Case of Emergency, I authorize Pathways Counseling to contact _____

Relationship _____ Phone Number _____ Alternate Number _____

How did you hear about us? Please circle: Friend/Family Pathway's Website Psychology Today

Insurance/EAP Referral _____ Other _____

PATHWAYS COUNSELING ASSESSMENT and HISTORY INFORMATION

This information will help you & your therapist begin to clarify your therapy goals.

Name _____ Date _____

☐ Yes ☐ No Have you ever been treated by a psychiatrist?
☐ Yes ☐ No Have you ever been hospitalized for mental or chemical dependency treatment?
☐ Yes ☐ No Have you ever been to counseling before? If yes, when? _____
☐ Yes ☐ No Have you seen another therapist in the **past 24 months**?
If yes, whom did you see? _____
☐ Yes ☐ No Have you ever attempted suicide?
If yes, when? _____
Briefly describe your reasons for seeking counseling services: _____

_____

_____

What have you tried so far to handle this situation? _____

_____

_____

Please place a number that best corresponds to issues listed below that are currently issues. For issues were in the past, please mark "P" for past, with a number to indicate how long ago it was an issue. For example, if you had an issue with prescription drug use 10 years ago, mark "P-10" next to "Drug Use."

Rarely			Sometimes			Often			Always
0-1	2	3	4	5	6	7	8	9	10

_____ Abuse—physical
_____ Abuse—sexual
_____ Abuse—emotional
_____ Abuse—neglect
_____ Aggression, violence
_____ Alcohol Use
_____ Anger, Hostility, irritable
_____ Anxiety, Nervousness
_____ Appetite/Weight Changes
_____ Attention, Distraction
_____ Career concerns, goals, choices
_____ Co-dependence
_____ Confusion
_____ Combat/Combat Exposure
_____ Cruelty to animals
_____ Crying, Sadness
_____ Custody of Children

_____ Decision-making, Indecision
_____ Delusions (false ideas)
_____ Depression
_____ Divorce, Separation
_____ Drug Use _____
_____ Eating Problems
_____ Financial
_____ Gambling
_____ Grieving
_____ Goals
_____ Guilt
_____ Headaches
_____ Impulsiveness
_____ Judgment
_____ Loss of Control
_____ Marital/Partner
_____ Memory Problems

_____ Menstrual, PMS, Menopause
_____ Mood Swings
_____ Obsessions/Compulsions
_____ Panic/Anxiety Attacks
_____ Parenting
_____ PTSD
_____ Sexual Assault
_____ Self-Esteem
_____ Sexual Issues
_____ Sleep Problems
_____ Stress
_____ Suicidal Thoughts
_____ Tobacco Use
_____ Temper/Low Tolerance
_____ Thought Disorganization
_____ Work Problems
_____ Worry

Other _____ Other _____

Pathways Counseling

In the past 36 months has there been a death of a family member or someone close to you? ☐Yes ☐No
If yes, who? _____ When? _____ Relationship? _____

Prior to the 36 month, has there been a death of someone that was close to you? ☐ Yes ☐ No
If yes, who? _____ When? _____ Relationship? _____

Please rate below on a scale of 1 through 10, 1 = not at all and 10 = very much so:

_____ I was very close and had a good relationship with my father.
_____ I was very close and had a good relationship with my mother.
_____ I was very close and had a good relationship with my siblings.
_____ I have several good friends.
_____ I have a tendency of agreeing with other people to avoid confrontations.
_____ I like myself.
_____ I have a healthy interest in sex.
_____ I sometimes am confused with my identity.
_____ I put the needs and wishes of others first before myself even if I'm not comfortable with it.
_____ Others make me mad, disappointed, or sad easily.

Any Current Legal Issues? _____
Any Past Legal Issues? _____
Have you ever filed a complaint against a professional? Yes ☐ No ☐ If yes, please explain: _____
_____

Spiritual/Religious identity growing up: _____ Now: _____
Describe your spiritual and religious practice today: _____
_____
_____

Alcohol: I drink ____ servings of alcohol per ___day, ____week, ____month.
____do not drink alcohol _____in sobriety since __/___/____
Tobacco use: _____
Drug use (including marijuana)
In the past month: _____
Past year: _____
Lifetime: _____

Mother's Occupation _____ Her age _____ Age at Death _____

Cause of death _____

Father's Occupation _____ His age _____ Age at Death _____

Cause of death _____

How would you rate your parent's marriage/relationship? Very happy☐ Happy☐ Ave☐ Unhappy☐

If divorced, what was your age when this occurred? _____

Number of Brothers _____ Number of Sisters _____ You are the _____ child.

Number of previous marriages/partners _____ First names of previous mates, years together, and children from that relationship:

_____

_____

_____

_____

Fears or concerns of counseling: _____

_____

My biggest strength is _____

_____

My biggest weakness is _____

_____

Goal or expectation of counseling: _____

_____

_____