Pathways Counseling Center
11121 W Oklahoma Ave West Allis WI 53227-0000

Patient Forms

Basic Information

Full Name _____
First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Unknown

Date of Birth ___ / ___ / ___

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number _____

Email _____

Social Security Number _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____ **Zip** _____

Marital Status _____

Maiden Last _____

Driver's License State _____

Driver's License # _____

Demographics

Sexual Orientation _____

Gender Identity _____

Hispanic or Latino? ◯ Yes ◯ No ◯ Decline to Specify

Ethnicity _____

Race _____

Language _____

Emergency Contact

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number _____

Email _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____ **Zip** _____

Financial Information

Responsible Party

Who will be financially responsible for you? ◯ Myself ◯ Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ◯ **Home** ◯ **Mobile** ◯ **Work** **Phone Number** _____

Method of Payment

What will be your method of payment? ◯ Insurance ◯ Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company _____ **Policy Number** _____

Insurance Plan _____ **Insurance Phone Number** _____

Group Number _____

Insurance Company Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Relationship to Primary Policy Holder _____

If you are not the primary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** ____ / ____ / ____

Policy ID Number _____ **Social Security Number** _____

Policy Holder Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company **Policy Number**

Insurance Plan **Insurance Phone Number**

Group Number

Insurance Company Address **Address Line 2**

City **State** **Zip**

Relationship to Secondary Policy Holder

If you are not the secondary policy holder, please fill out the following:

Full Name
First Middle Last

Sex ○ Male ○ Female ○ Unknown **Date of Birth** / /

Insurance ID Number **Social Security Number**

Policy Holder Address **Address Line 2**

City **State** **Zip**

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us?

Mental Health Center
Patient Safety Contract

I, _____ (patient), hereby contract with Pathways Counseling Center, that I will take the following actions if I feel suicidal.

1. **I will NOT attempt suicide.**
2. I will phone _____ at _____.
3. If I do not reach _____, I will phone any of the following services:

Name/Agency:	**Phone:**
_____	_____
_____	_____

4. I will further seek support from any of the following people:

Name:	**Phone:**
_____	_____
_____	_____
_____	_____

5. If none of these actions are helpful or not available, I will go to the ER at one of the following:

Hospital and Address:	**Phone:**
_____	_____
_____	_____

6. **If I am unable to get help or unable to go to the hospital, I will call 911 and request help.**

Patient's Signature: _____ Date: _____

Pathways Intake Packet 2022

Due to insurance and legal restrictions, all printed documentation will be printed with your legal name. However, we respect your true identity and want to address you by the name you have chosen. Please let us know if you have a name that you would prefer us to call you when speaking with our staff either in the office or over the phone.

Legal Name (first/last): _____

Preferred Name / Nickname (optional): _____

Pronouns? Questions / Concerns? (optional): _____

Referral Source: _____

Consent for Admission for Mental Health Evaluation and/or Treatment

Consent to Evaluate/Treat: I voluntarily consent that my child (or I if I am an adult) will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Pathways Counseling Center. I understand that the following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

a) The benefits of the proposed agreement

b) Alternative treatment modes and services

c) The manner in which treatment will be administered

d) Expected side effects from the treatment and/or the risks of side effects from medications (when applicable)

e) Probable consequences of not receiving treatment

A psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed will conduct the evaluation or treatment. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Therapy.

Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as

the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

Charges: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. I have received a fee schedule pertaining to my therapist.

Confidentiality, Harm, and Inquiry: Information from my child's evaluation and/or treatment (or my evaluation and/or treatment if I am an adult) is contained in a confidential record at Pathways Counseling Center, and I consent to disclosure for use by Pathways Counseling Center staff for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions:

a) if my child (or I if I am an adult) is deemed a present danger to myself or others;

b) if concerns about abuse or neglect arise; or

c) if a court order is issued to obtain records.

Discharge Policy: There are circumstances under which I may be involuntarily discharged. I have read and understand the discharge policy of the clinic.

Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

Expiration of Consent: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

Patient's Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

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

Your health record contains personal information about you and your health. This information about you that may identify you and relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA") and regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required By Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization only in a limited number of situations.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of

preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI, if necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Pathways Counseling Center, 11121 W. Oklahoma Ave, West Allis, 53227.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in those separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have questions.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or healthcare operations, and the PHI pertains to a health care item or services that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS: If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Pathways Counseling Center at 11121 W. Oklahoma Ave, West Allis, 53227 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (262) 619-0257. We will not retaliate against you for filing a complaint.

The effective date of this Notice is August 2015.

Patient's Signature: _____ Date: _____

Patient Bill of Rights

Every patient at Pathways Counseling Center has the right to:

- Be treated fairly regardless of race, national origin, sex, gender, age, religion, disability, or sexual orientation.
- Receive prompt and adequate treatment.
- Participate in their treatment planning.
- Be informed of their treatment and care, including alternatives to and possible side effects of treatment.
- Refuse treatment and medications unless court-ordered.
- Be free from unnecessary or excessive medications.
- Be treated with dignity and respect by all staff.
- Be informed of their rights.
- Be informed of any costs of their care.
- Refuse drastic treatment measures.
- Not to be filmed or taped without their consent.
- File complaints about violations of their rights. If you feel your rights have been violated, you may:

1. Discuss the matter with staff about any concerns. However, you do not have to do this before filing a formal complaint.
2. If you want to file a written complaint, you may use the “Client Rights Grievance Form” available from the receptionist.

- Be free from any retribution for filing complaints.
- Rights regarding Record Privacy and Access:
- Staff must keep patient information confidential.
- Records cannot be released without patient consent with some exceptions.
- Patients may see their records.
- During treatment, access may be limited if the risks outweigh the benefits.
- Patients may challenge the accuracy, completeness, timeliness or relevance of entries in their records.

Patient’s Signature: _____ Date: _____

Notice & Consent - Electronic Communication

It may become useful during the course of treatment to communicate by email, text message (e.g. “SMS”) or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with your therapist, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with your therapist
- Third parties on the Internet such as server administrators and others who monitor Internet traffic
- If there are people in your life that you don’t want accessing these communications, please talk with your therapist about ways to keep your communications safe and confidential. As a practice policy, we do not communicate with patients and/or their families via social media nor accept any “friend” requests.
- Consent for Transmission of Protected Health Information by Non-Secure Means

I consent to allow you to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

1. Information related to the scheduling of meetings or other appointments
2. Information related to billing and payment
3. Acknowledgement of emails and phone calls received

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Patient’s Signature: _____ Date: _____

TELEHEALTH

Due to the extraordinary circumstances of the current COVID-19 pandemic, Pathways Counseling Center is supporting our patients' mental health by providing ongoing services via telecommunication technologies, called Telehealth. Telehealth is defined by Health Services and Resources Administration as the use of electronic information and telecommunication technologies to support long-distance clinical healthcare, patient, and professional health related education, public health, and health administration. The information that may be used for diagnosis, therapy, follow ups and may include any of the following:

- Live two-way audio and video
- Psychotherapy notes and records
- Output data from computer devices and sound and video files.

Security of your account and electronic Patient Health Information (ePHI) is fundamental to us. The systems we use include Kareo, Zoom, WebEx and/or Doxy.Me. They have gone above and beyond the standard security and privacy requirements to protect your data. In the event you/we have connectivity issues, we may use Skype or FaceTime. Kareo always transmits account information securely with multiple layers of encryption. Kareo Telehealth is 100% secure and HIPAA- and HITRUST-compliant.

Expected Benefits

Some of the benefits Telehealth provides include:

- Maintaining rapport and relationship with original therapist to improve clients overall mental health.
- More efficient mental health evaluation and management given the amount of time client has been seeing psychotherapist.
- Obtaining expertise of a distant specialist.

Possible Risks
As with any form of psychotherapy, there are potential risks associated with the use of telehealth. These risks include, but may be not be limited to:

- In rare cases, information may not be transmitted accurately (ex. poor resolution of images, noise in the background) for the therapist to appropriately assess and diagnose.
- In rare occasions, security protocols could fail, causing a breach of privacy of personal psychotherapy information.
- Potential networks are subject to interruptions, delays, system overloads, or technical difficulties.

CONSENT FOR TELEHEALTH

1. My therapist has explained to me how video conferencing technology will be used for our sessions in order to consult with me about my condition.

2. I understand that I will not be in the same room as my therapist.
3. My health care provider has explained the risks, benefits and alternatives to telehealth services.
4. I understand there are risks to using technology, including unauthorized access and technical difficulties.
5. I understand that individuals may be present at either location to operate the audio or video equipment and that these individuals must maintain the confidentiality of health information disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Pathways Counseling Center privacy practices.
6. I understand that I am responsible for securing protected health information (PHI) transmitted to my device.
7. I understand that my therapist practices in the state of Wisconsin and therefore abides by the ethical, legal and professional standards of conduct as outlined in Wisconsin.
8. I understand that telehealth is not commensurate to in-person sessions and that results cannot be guaranteed.
9. I understand that my therapist can reassess the suitability of telehealth for my condition at any time.
10. I understand that I have a right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time. I may revoke my consent orally or via email at any time by contacting my therapist
11. I understand that it is my responsibility to verify if my medical insurance provider covers telehealth services.
12. I understand that I am responsible for session fees if my medical benefits do not cover telehealth services.
13. I understand that if a session is scheduled and the therapist attempts to reach me through the HIPPA approved electronic program and I do not answer, this is considered a no-show and a fee may be charged to my account as this fee is not covered by insurance. I understand that if I need to cancel a scheduled session, I shall give the therapist 24 hours prior to the scheduled appointment in order to receive no charge.
14. I understand that it is my obligation to report any significant changes in my financial status to my therapist.
15. I understand all of the information that has been provided to me.
16. My questions about telehealth services have been answered by my therapist to my satisfaction.

Patient's Signature: _____ Date: _____

Consent for IN-PERSON Services during COVID-19 Public Health Crisis - 2022

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.
Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, (my other staff, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement.

You will only keep your in-person appointment if you are symptom free.

You will take your temperature before coming to each appointment. Some therapists will administer a temperature reading themselves. If it is elevated (100 degrees Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee.

You will wait in your car or outside until no earlier than 5 minutes before our appointment time.

You will wash your hands or use alcohol-based hand sanitizer when you enter the building.

You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.

You will wear a mask in all areas of the office (Staff will too).

You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me (or staff).

You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.

If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.

You will take steps between appointments to minimize your exposure to COVID.

If you have a job that exposes you to other people who are infected, you will immediately let me know.

If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know.

If a resident of your home tests positive for the infection, you will immediately let me (and my staff) know and we will then begin or resume treatment via telehealth.

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, our staff and all of our families safe from the spread of this virus. If you show up for an appointment and I (or our office staff) believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I (or our staff) test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release. Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together. Checking the box below shows that you agree to these terms and conditions.

Patient's Signature: _____ Date: _____