PATHWAYS
COUNSELING CENTER

11121 W. Oklahoma Ave
West Allis, WI, 53227
P (262) 641-9790
F (262) 641-9791

INTAKE FORM

DATE: _____ CLIENT LEGAL NAME: _____

NAME (If different): _____ (While Pathways recognizes a variety of genders, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.)

BIRTH DATE: _____ LEGAL SEX: _____ GENDER/PRONOUNS: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: H (____)_____W (____)_____ C (____)_____

EMAIL: _____ Preferred Contact Method: _____

Okay to leave a voicemail? YES☐ NO☐ Okay to text appointment reminders? YES☐ NO☐ Okay to send emails? YES☐ NO☐

IF A MINOR, GUARDIAN'S NAME: _____ RELATIONSHIP: _____

REFERRAL SOURCE: ☐ Another Professional ☐ Existing Patient ☐Website/Online ☐Friend/Family ☐Other: _____

EMERGENCY CONTACT: Name: _____ Phone: _____ Relationship: _____

PRIMARY INSURANCE COMPANY INFORMATION

CARD HOLDER'S NAME: _____ BIRTH DATE: _____

RELATIONSHIP TO PATIENT? ☐ SELF ☐ SPOUSE ☐ PARENT ☐ LEGAL GUARDIAN

CARDHOLDER ADDRESS: _____ CARDHOLDER PHONE: _____

INSURANCE COMPANY NAME:_____ PHONE: _____

MEMBER ID#: _____ GROUP#: _____ EFFECTIVE DATE: _____

CARD HOLDER'S EMPLOYER:_____

SECONDARY INSURANCE COMPANY INFORMATION

CARD HOLDER'S NAME: _____ BIRTH DATE: _____

INSURANCE COMPANY NAME: _____ PHONE: _____

MEMBER ID#: _____ GROUP#: _____ EFFECTIVE DATE: _____

******************PLEASE READ AND SIGN BELOW******************

INSURED/CLIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize **payment** of any medical benefits to Pathways Counseling Center. I also understand that I am responsible for my bill. I authorize **release** of any medical or other information necessary to process this claim. I permit a copy of these signatures to be used in place of the originals.

_____

SIGNATURE OF CLIENT **DATE**

***Office Use Only: Diagnosis (ICD-10 CODE):** _____ **THERAPIST:** _____

Date: _____ **Time:** _____ **am/pm**

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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.

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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.

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Acknowledgement of Notice of Privacy Practices

Patient/Client Name: _____

DOB: _____

I hereby acknowledge that I have been given an opportunity to read a copy of Pathways Counseling Center's Notice of Privacy Practices (laminated, two-sided Notice). I understand that if I have any questions regarding the Notice or my privacy rights, I can contact David Bedrin or Lynn Dusold at Pathways Counseling Center, 13105 W Bluemound Rd, Suite 100, Brookfield, WI, 53005.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian, or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.) _____

☐ **Patient/Client Refuses to Acknowledge Receipt**

_____

Signature of Staff Member

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Email, Text, and Social Media

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:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- 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.

_____

Signature of Client Date

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Consent for CHILD/ADOLESECENT Admission for Mental Health Evaluation and/or Treatment

1. Consent to Evaluate/Treat: I voluntarily consent that my child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Pathways Counseling Center. I understand that 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 treatment
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

2. 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.

3. 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 my child, 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.

4. 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.

5. Confidentiality, Harm, and Inquiry: Information from my child's evaluation and/or treatment 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 child's care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to herself/himself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

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

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

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

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

Signature of Minor age 14 years or older	Date
Signature of Legal Representative	Date
Signature of Witness	Date

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Patient Bill of Rights

Please note the framed poster in the lobby regarding Patient Rights. Every patient at Pathways Counseling Center has the right to:

1. Be treated fairly regardless of race, national origin, sex, gender, age, religion, disability, or sexual orientation.
2. Receive prompt and adequate treatment.
3. Participate in their treatment planning.
4. Be informed of their treatment and care, including alternatives to and possible side effects of treatment.
5. Refuse treatment and medications unless court-ordered.
6. Be free from unnecessary or excessive medications.
7. Be treated with dignity and respect by all staff.
8. Be informed of their rights.
9. Be informed of any costs of their care.
10. Refuse drastic treatment measures.
11. Not to be filmed or taped without their consent.
12. File complaints about violations of their rights. If you feel your rights have been violated, you may:
    a) Discuss the matter with staff about any concerns. However, you do not have to do this before filing a formal complaint.
    b) If you want to file a written complaint, you may use the "Client Rights Grievance Form" available from the receptionist.
13. Be free from any retribution for filing complaints.

Rights regarding Record Privacy and Access:

1. Staff must keep patient information confidential.
2. Records cannot be released without patient consent with some exceptions.
3. Patients may see their records.
4. During treatment, access may be limited if the risks outweigh the benefits.
5. Patients may challenge the accuracy, completeness, timeliness or relevance of entries in their records.

_____ _____

Signature of Minor age 14 years or older Date

_____ _____

Signature of Legal Representative Date