Pathways Counseling Center

7413 Maxtown Road
Westerville, Ohio 43082
614.818.4099
www.pathwayswesterville.com

Thanks for choosing Pathways! It is my hope and goal to make the counseling process as comfortable and helpful as possible. You will find a checklist of documents below. Please take time to read and complete each document. You may address any questions or concerns at the time of your appointment.

Please print the documents below, complete, and *bring them with you* to your first appointment. For online video appointments, please return the forms to our office by the day prior to your appointment.

- ☐ **Informed Consent Notice** (information and consent for treatment)
- ☐ **Patient Financial Policy** (our financial agreement with you)
- ☐ **Credit Card Authorization**
- ☐ **Patient Information** (demographic and insurance information)
- ☐ **Health Questionnaire**
- ☐ **Notice of Privacy Practices** and **signature page** (how we comply with HIPAA laws)

Other forms that *may* be relevant (only complete if needed):

- ☐ **Authorization to Disclose Information** (if you would like me to coordinate care with your doctor, psychiatrist, pastor, or other)
- ☐ **Permission to treat a Minor** (if the client is under 18 years old)
- ☐ **Telehealth Informed Consent** (if we will conduct sessions via web-based video)

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Phone: 614.818.4099
Fax: 614.636.4944

Informed Consent Notice

Welcome to Pathways! My goal is to provide you with quality mental health care. Before you begin counseling, there are some things that you ought to know. Legally, this information is called "***Informed Consent***." It will help you understand what you can expect from Pathways, and some limitations.

The nature of Counseling

Counseling is a collaboration between you and your counselor for the purpose of addressing personal, relational, or mental health problems. We will discuss what you would like to change, how we can change it, how we will know we are succeeding, and how long it will take. We will periodically review the plan to see if it needs to be updated.

Pathways' counselors have competency in treating a wide range of issues. However, if I believe your case requires knowledge I do not have, I may refer you for consultation with someone with specialized training. I will discuss any such referral with you before I act.

Benefits & Risks of Counseling

Counseling is not always easy. Your treatment may involve discussing unpleasant aspects of your life, which may lead to feelings of sadness, guilt, anger, frustration, loneliness or anxiety. You also might experience increased conflict with friends, coworkers, or family members. On the other hand, counseling has been shown to have benefits. Treatment often leads to better relationships, solutions to problems, and reduced feelings of distress. Your individual results will depend on a number of factors, and we cannot guarantee a specific outcome. However, we will do our best to help you reach your goals.

Emergencies

Pathways is not a 24-hour emergency facility. If a crisis situation should arise, please dial 911, go to the nearest hospital ER, or contact one of the following:

Delaware-Morrow Helpline, 211 or 800.684.2324
Franklin County Netcare, 614.276.2273
OSU Medical Center, 614.293.8333
Suicide Prevention Hotline, 800.273.8255

Please also call me and leave a detailed message to make me aware of your situation; I will work diligently for your safety and wellbeing.

Confidentiality

All of our work together (our conversations, your records, and any information that you give us) is protected by something called "***privilege***." That means the law protects you from having information about you given to anyone without your permission. At times, you may choose to allow us to disclose privileged information. This permission will be given in writing and you will specify what can be shared with whom. I will honor your privilege except in cases where breaking confidentiality is a professional or legal mandate, including the following:

1. *If we believe there is a risk that you might harm yourself or someone else*. If you are threatening to hurt yourself or someone else, I am obligated to do what I can to keep that from happening. This may includes contacting a family member, civil authorities, or the intended victim to give them the opportunity to protect you or themselves.
2. *If we have cause to believe that you are abusing children, elderly, or disabled people*. It is my duty to report actual or suspected child abuse or neglect. I am also obligated to notify the authorities in cases of abuse or neglect of vulnerable adults, including the elderly, infirm, or mentally or physically disabled.
3. *In cases of a court order*. If you become involved in any lawsuit in which your mental health is an issue, the court or lawyers may subpoena your information from us. Similarly, you would lose the protection of privilege if you file a lawsuit against me or Pathways, or if you file a complaint with the State of Ohio Counselor, Social Worker, and Marriage & Family Therapist Board (CSWMFT Board). In such cases, your information would be subject to review by the court or the board.
4. *When you want your insurance company to reimburse for counseling service*s. Your insurance company may require us to provide clinical information, including, but not limited to, your diagnosis, symptoms, progress, and the day and

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time of your visits. Any diagnosis made will become part of your permanent insurance record.

Our Office Policies

Counseling sessions are typically scheduled for 60 minutes, and we must end each session promptly. Future appointments are generally scheduled at the end of each counseling session.

Payment is expected at the time of your appointment. I accept credit/debit/HSA cards, cash or checks (made payable to "Pathways Counseling Center").

Regardless of your method of payment, we ask that you put a debit or credit card on file with our office. Card numbers are encrypted, and once entered, only the last 4 digits could be seen by Pathways staff. We reserve the right to charge that card for any balance that is accrued after 90 days of non-payment. Returned checks must be resolved before any further appointments are scheduled. Our returned check fee is $35. We reserve the right to refuse personal checks and to require a different form of payment.

The fee schedule for my services is as follows:
$150 for initial intake and
$135 for each 60-minute session
Sliding scale fees are available on a limited basis, based on financial need. Typically, I do not charge for a phone consultation of 10 minutes or less.

Our telephone is answered 24 hours/day by an electronic answering system. During business hours (9am-5pm M-F), we check messages regularly, and we return phone calls the same day whenever possible.

We do not check office messages on weekends or after 5pm on weekdays. If you have an emergency outside our scheduled office hours, please follow the instructions in the "emergencies" section of this form.

Please provide me with 24 hours notice if you need to cancel or reschedule an appointment. If you miss a scheduled appointment, it keeps other clients from benefitting from that opening, and a fee will be charged. Please note that insurance will not pay for missed sessions.

If you have missed a scheduled appointment and you have no future scheduled visits and do not call our office within 10 business days, your counselor will accept that as your notice that you have terminated this agreement and wish to discontinue counseling.

Pathways is happy to accept your insurance and to file claims on your behalf, if I have a contract ("in network") with your insurance provider. I may also file an "out of network" claim with your insurance provider. Any amount that is your responsibility (e.g. deductible, copay, or coinsurance) is due at the time of your visit. If there is a problem collecting payment from your insurance company, you remain responsible for the full fee for each session. If we have not received payment from your insurance company within 60 days, we will bill you directly for past and ongoing visits. In such a case, Pathways will provide you with the information needed for you to pursue the issue with your insurance carrier. For billing questions, please contact our administrator at 614.818.4099.

I have read this Informed Consent Notice and fee agreement. I understand it and agree to the terms described. I also understand that I may request a copy of this agreement if I choose to do so.

_____	_____	_____
Client name (please print)	Client Signature	Date
_____	_____	_____
Parent/ Responsible Party (please print)	Parent/ Responsible Party Signature	Date
_____	_____	
Kelsey Johnson, MA, LPCC-S	Date	

PATHWAYS COUNSELING CENTER

PATIENT FINANCIAL POLICY

Thank you for choosing Pathways Counseling Center! We are committed to your wellbeing and hope our services will help in your path to change, restoration, and healing. We recognize the need for clarity regarding billing, insurance, and payments. The following is a statement of our financial policy, which all patients must read and sign prior to their first appointment.

INSURANCE COVERAGE

Our counselors work with many insurance companies. In the event that your insurance does not cover your treatment within a 90-day time period, your balance will be transferred to you or your guarantor for payment. Please be aware that your coverage depends on your specific insurance plan. Due to numerous rules with different insurance companies, it is not possible for us to always know when your insurance company may disallow payment for a service. It is your responsibility to find out what services your insurance covers and what will be your financial responsibility. If your insurance requires a referral from a physician or psychiatrist and this authorization is not provided, you will be asked to reschedule your appointment and pay for your visit at the time of service.

> **I understand that I am responsible to find out what my insurance covers and what will be my financial responsibility. I will be responsible for any amounts not covered.**

Initials _____

We must emphasize that our relationship is with *you*, and *not with your insurance company*. While we will work with your insurance company to process claims, it is your responsibility to:

- provide correct information about your insurance company
- verify your eligibility for coverage at the time of service
- address any claims your insurance company denies.

While we will file insurance claims as a courtesy to our clients, all charges are ultimately your responsibility. You must notify us of any insurance changes before your visit.

> **I understand that I am responsible to provide accurate insurance information, to verify my coverage, and to address any insurance denials. I understand all charges are my responsibility.**

Initials _____

Pathways is committed to providing the best treatment for our clients, and we charge what is usual and customary for our area. If your insurance applies any portion of your charge to your annual deductible, copay, or coinsurance, that portion is your responsibility and is due at the time of service. If we are outside your provider network, please check with your insurance regarding out-of-network benefits and coverage. It is your responsibility to understand your coverage.

> **I understand that I am responsible for payment of all deductible, copay, coinsurance, and out-of-network amounts at time of service.**

Initial _____

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our clients, we ask that you keep your appointments as scheduled. We understand that illness or other circumstances may occur, and we ask that you notify us as soon as possible if you need to cancel or reschedule an appointment. We require a minimum 24-hour notice to cancel or reschedule an appointment. If you miss an appointment or cancel with less than a 24-hour notice, you will be charged $100 for the missed session or late cancellation. This fee is not covered by insurance, and it will need to be paid before your next appointment.

> **I understand that I am responsible to pay any fees for missed sessions or late cancellations.**

Initial _____

PAYMENTS

We ask that clients pay any charges due at time of service. We accept cash, check, HSA cards, most debit cards, and most major credit cards. Regardless of your method of payment, we ask that you put a credit or debit card on file for payments. Card numbers are encrypted and not visible to our office once entered. We reserve the right to use this card to pay any outstanding balance that may have accrued after 90 days. We will make a reasonable attempt to contact you before running your credit card for this purpose. Any returned checks are subject to a $35.00 fee. Returned checks must be resolved before any future appointments can be scheduled. We reserve the right to refuse any personal check and to require a different form of payment at our sole direction.

I understand that I am responsible to pay charges at time of service. If I accrue an unpaid balance, I understand that my credit card may be charged for this balance after 90 days.

Initial _____

MINORS

Unaccompanied minors will not be seen without proper paperwork signed by a parent or guardian, except as allowed by Ohio law. Depending on circumstances, your counselor may require a parent or guardian to be present during counseling sessions. Parents or guardians of minors are responsible for payment of any fees not covered by insurance for a minor.

CREDITS AND SMALL BALANCE WRITE-OFFS

Occasionally an overpayment is made, and a refund is due to the client. Credits will be applied to existing balances or future services already scheduled. If after 90 days a credit still exists and there are no future services scheduled, credit balances over $5.00 will be refunded. Similarly, any balance under $5.00 due to the practice will be written off after 90 days if no future services are scheduled.

ACCOUNT DELINQUENCY AND CREDIT REPORTING

Our office makes every reasonable effort to collect payment from insurance companies and clients. Once these efforts are exhausted, we may report unsatisfied accounts to a collection agency of our choice for payment and credit reporting. Before an account is sent to collections, any unearned adjustments may be reversed. Additional expenses, usually 35% of the amount sent to collections, are incurred for collection services, and this amount will be added to a client's balance. Unresolved accounts may be referred to court mediation. If you have an account that is referred to our external collection agency, your credit may be negatively affected.

I understand that if my account is sent to collections, I will incur additional expenses, usually 35% above my original balance due, and that it may negatively affect my credit rating.

Initials _____

I have read this financial policy and have had the opportunity to ask questions about it. I understand and agree to the financial policy.

_____	_____	_____
Client's Printed Name	Signature of Client or Responsible Party	Date

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Credit Card Authorization

I give my permission for Pathways Counseling Center to use my credit card (information below) in payment of fees-for-service. This card is not authorized for any other use. This record will be destroyed or returned to me when counseling services are terminated.

Once entered, credit card information is encrypted and is unable to be seen by Pathways employees, except for the last 4 digits of the card number for identification purposes. I understand that I will receive an email notification any time my card is charged, to the email address I provide.

Credit Card Information:

_____
Name on card

_____ _____ _____ _____
Card number

_____ /_____ _____
Expiration MM / YY 3-digit code

_____ _____
Signature of responsible party Date

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CLIENT INFORMATION SHEET

Name: Last _____ First _____ Middle _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email address: _____

Gender: ❒ Male ❒ Female **Date of Birth:** _____ Age: _____ Full-time student? ❒ Yes ❒ No Grade: _____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Other _____

Employer: _____ Occupation: _____

If married, spouse's name: _____ Spouse Occupation: _____

Permission to call & leave message at: ❒ Home ❒ Mobile ❒ Work ❒ Email ❒ Other: _____

RESPONSIBLE PARTY ❒ Self ❒ Other (if insurance is through someone other than yourself, list their information below)

(Note: If client is a minor and parents are separated or divorced, parent bringing the child is considered the responsible party).

Name: Last _____ First _____ Middle _____

Address: _____ City, State, Zip: _____

Primary Phone: _____ Email address: _____ Work Phone: _____

Email address: _____

Date of Birth: _____ Relationship to client: _____

EMERGENCY CONTACT

Full Name: _____ Relationship to Client: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email address: _____

PRIMARY INSURANCE ❒ None ❒ Insurance listed below ❒ Insurance through someone other than myself

Insurance Company: _____ Policy/ID number: _____ Group number: _____

Claims address: _____ Phone: _____

We will bill your insurer directly for applicable services. Please remember that it is your responsibility to pay any deductible, co-pay or co-insurance amounts. WE REQUEST THAT YOUR PORTION OF CHARGES BE PAID AT THE END OF EACH VISIT. Your signature authorizes release of any medical information requested by the insurer in order to process insurance claims and payment of medical benefits to be made directly to the provider of services. Your signature also indicates liability for any balance due.

RESPONSIBLE PARTY SIGNATURE: _____ Date: _____

HEALTH QUESTIONNAIRE

NAME: _____ **TODAY'S DATE:** _____

Birthdate: _____ **Primary Care Physician Name & Phone:** _____

_____

HEALTH HISTORY:
Do you have any FOOD or DRUG ALLERGIES: ☐ No ☐ Yes If yes, please list _____

_____

Do you have any physical impairments or limitations which may require special accommodations, special arrangements, or may affect your treatment (i.e. reading difficulties, hearing loss, vision loss, speech impairment)? ☐ No ☐ Yes
If yes, please explain _____
_____

How would you describe the nutritional value and balance of your diet: ☐ Good ☐ Fair ☐ Poor

Do you exercise regularly: ☐ No ☐ Yes If yes, please list type and frequency of exercise: _____

_____

Symptoms in the past 6 months: (Please check all that apply)

☐ Headaches	☐ Compulsions	☐ Stomach / Bowel Distress
☐ Depressed	☐ Anxious	☐ Excessive Fears
☐ Crying	☐ Worry	☐ Periods of Overactivity
☐ Guilt	☐ Nervous	☐ Mood Swings
☐ Sleep Disturbance	☐ Change in Appetite	☐ Eating Problems
☐ Low Self-esteem	☐ Social Withdrawal	☐ Irritable / Temper
☐ Sad	☐ Change in Energy	☐ Hostile / Angry
☐ Hopelessness	☐ Helplessness	☐ Poor Concentration
☐ Obsessions	☐ Lack of Pleasure	☐ Apathy
☐ Weight Change	☐ Low Motivation	☐ Poor Memory
☐ Sexual Difficulty	☐ Suicidal Thoughts	

Are you **currently** on any physician prescribed medications or regularly take any "over-the-counter" or herbal medications, including any prescriptions for anxiety, depression, or other mental health conditions? ☐ No ☐ Yes
If yes, please list all medications:

Medication / Purpose	Dosage / Times per Day	How long?	Do you take this medication consistently?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

In the **past,** have you ever taken medication for a mental health condition? ☐ No ☐ Yes If yes, please describe:

Hospitalizations / surgeries? ☐ No ☐ Yes If yes, please describe (include dates, complications, & outcomes): _____

Do you have any medical conditions? ☐ No ☐ Yes If yes, please describe:_____

How many pregnancies have you had: _____ Any complications? ☐ No ☐ Yes If yes, please describe: _____

Have you ever had a miscarriage? ☐ No ☐ Yes If yes, when and at what point in the pregnancy did it occur: _____

Have you ever had an abortion? ☐ No ☐ Yes

BEHAVIORAL HEALTH

Have you had prior psychiatric counseling or alcohol/drug treatment? ☐ No ☐ Yes
If yes, please list names and dates below:

OUTPATIENT

Therapist/Doctor or Program Name: **Date:**

INPATIENT

Hospital: **Date:**

Regarding past treatment, what did you find most helpful to you?

What was least helpful?

HOBBIES / INTERESTS: _____

SUBSTANCE USE HISTORY:
Have you experienced any of the following problems as a result of alcohol, prescription medications, or other drug use?
☐ No ☐ Yes If yes, please check any that apply:

_____ financial problems	_____ relationship problems	_____ work problems
_____ increased tolerance	_____ physical problems	_____ emotional problems
_____ blackouts	_____ withdrawal symptoms	_____ cravings
_____ Legal Involvement	_____ DUI	

Comments/details on above: _____

Has anyone in your family had problems with alcohol or other drug use? ☐ No ☐ Yes If yes, please explain:

Please indicate the following:

SUBSTANCE	AMOUNT	FREQUENCY	DURATION	FIRST USE	LAST USE
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opiods / Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Other					

HISTORY OF ABUSE:
Have you ever experienced: Physical Abuse ☐ Rape/Sexual Assualt ☐ Date Rape ☐ Sexual Abuse ☐
Verbal/Emotional Abuse ☐ Early Exposure to Pornography ☐ Domestic Violence ☐ Other Trauma ☐
Please comment:

CULTURAL/ETHNIC/SEXUAL:
Do you have any cultural, ethnic or racial issues that need consideration? _____

Do you have any sexual orientation issues that need consideration? _____

MILITARY SERVICE: ☐ No ☐ Yes Type of Discharge: _____
Were you involved in combat duty? ☐ No ☐ Yes If yes, please describe: _____

EMPLOYMENT: Currently employed? ☐ No ☐ Yes Job Title: _____ Duration _____

EDUCATION: Highest grade completed _____ Diploma: ☐ No ☐ Yes

SPIRITUAL HISTORY:
Is spirituality an important resource for you? ☐ No ☐ Yes If yes, does your practice of spirituality include:
Attendance at religious services? ☐ No ☐ Yes Frequency: _____
Practice of spiritual disciplines such as prayer, reading, or meditation? ☐ No ☐ Yes
Involvement in some type of ministry ☐ No ☐Yes
Involvement in a small group or with a spiritual director or mentor? ☐ No ☐ Yes

FAMILY HISTORY:
Is there any history of emotional / mental health problems, or suicide in the family? ☐ No ☐ Yes
If yes, please explain:

Number of siblings: _____ Please describe your relationship with siblings: _____

Please describe your relationship with your parents:

MARITAL HISTORY:

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐

Spouse's Name and Age: _____

Duration of Marriage: _____

Any Separations? _____

Children's Names & Ages: _____

Number of previous marriages and reasons for divorce: _____

Please describe current status of marriage: _____

LEGAL HISTORY:

Have you ever had involvement with the legal system? ☐ No ☐ Yes If yes, please explain when, what involvement, and the outcome: _____

Do you have any current pending legal charges? ☐ No ☐ Yes If yes, please explain: _____

Are you currently on probation or parole? ☐ No ☐ Yes Have you ever been incarcerated? ☐ No ☐ Yes

The information I have provided above is true to the best of my knowledge.

_____ _____

Client Signature *Date*

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Notice of Privacy Practices

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

INTRODUCTION

This notice describes the privacy practices of Pathways Counseling Center (hereinafter referred to as PCC). This notice applies to all of the health records that identify you and the care you receive from us. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you.

PRIVACY AND THE LAW

PCC is required to give you this Notice of Privacy Policy because of federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We will follow the terms of his notice while it is in effect and inform you of any changes. We are committed to keeping your mental health information private, and we are also required by law to respect your confidentiality.

WHO WILL FOLLOW THIS NOTICE

Any health care professional authorized to enter information into your clinical record, all employees, staff and other personnel at PCC who may need access to your information must abide by this Notice of Privacy Practices. All business associates (such as our billing electronic claims submission service and credit card submission for this practice) may share information with each other for treatment, payment purposes, or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

PROTECTED HEALTH INFORMATION (PHI)

Any information we collect regarding your physical or mental health is called Protected Health Information (PHI). This may include the intake assessment, counseling sessions, psychological testing, records requested from other treating professionals, and payment for your care. All of this information comprises your clinical record, which may be stored as paper charts and files, computer and electronic data. The clinical record is the property of PCC, but the PHI in the clinical record belongs to you.

USE AND DISCLOSURE OF PHI

Use. Use of PHI occurs when your information is read by your counselor or other approved Pathways personnel for routine purposes (e.g. insurance billing).
Disclosure. Disclosure of PHI occurs when is when your information is shared with or sent to other outside PCC.
Consent Form. By law, we may not treat you unless you give us written authorization to use your PHI for the purposes of treatment, payment, and healthcare operations. We may use and disclose this information without your specific consent.
Treatment. We may use and disclose your PHI to provide, coordinate, or manage your mental health care and related services, for example, if we consult with other health care providers regarding your treatment with us, or if we refer you to another professional such as a physician or psychiatrist, for additional services.
Payment. We may use and disclose your PHI to bill you, your insurance provider or others, to be paid for the treatment we provide you. We may contact your insurance company to check exactly what your insurance covers. They may request information from us, such as dates of services, diagnoses, treatment plan, and progress made. We may also disclose limited PHI to consumer reporting agencies related to collection of payments owed to us.
Mental Healthcare Operations. We may use or disclose your PHI for mental health care operations to ensure that you receive quality care. For example, to review our treatment and services and to evaluate the performance of our staff as it relates to your care.

APPOINTMENT REMINDERS, TEST RESULTS, AND TREATMENT INFORMATION

PCC may contact you to provide appointment reminders, test results, or to give you information about other treatments or health-related services that may be of interest to you. Ways we may contact you include, but are not limited to, voice mail messages, postcards, letters and email, unless you direct us otherwise in writing.

OTHER USES AND DISCLOSURES NOT REQUIRING CONSENT OR AUTHORIZATION

The law lets us use and disclose some of your PHI without your consent or authorization, when required by law. There are some federal, sate or local laws, which require us to disclose PHI. By law we are required to report:

- Suspected child and elder abuse or neglect
- Abuse or neglect of an incompetent adult (such as a severely mentally retarded adult)
- Incidents of domestic violence

If you are involved in a lawsuit or legal proceeding and we receive a subpoena, discovery request, or other lawful process, we may have to release some of your PHI. We will only do so after attempting to inform you of the request, consulting your lawyer, or trying to get a court order to protect the information requested. We have to release information to government agencies that check on us to see that we are obeying privacy laws. ***For Law***

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Enforcement Purposes. We may release PHI if asked to do so by a law enforcement official to investigate a crime or criminal. ***For Public Health Activities.*** We may disclose PHI to agencies that investigate for purposes related to preventing or controlling disease, injury, or disability. ***Relating to Descendants.*** We may disclose PHI to coroners, medial examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants. ***For Specific Government Functions.*** We may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment to worker's compensation programs, to correctional facilities if you are an inmate, and for national security reasons. ***To Prevent a Serious Threat to Health and Safety.*** If we believe that there is a serious threat to your health or safety, or that of another person, or of the public, we can disclose some of your PHI. We will only disclose to persons who can prevent the danger.

USES AND DISCLOSURES TO WHICH YOU HAVE AN OPPORTUNITY TO OBJECT

We may share your PHI with your family or other involved in your care, such as close friends or clergy. You may inform us whom you may wish us to contact, and the limits of what we may share. We will honor your wishes as long as your request is not against the law. In an emergency we may share information if we believe it is what you would have wanted and is in your best interest. We will tell you as soon as possible of the action we have taken. We will discontinue such action at your request as long as it is not against the law.

YOUR PERSONAL HEALTH INFORMATION RIGHTS

Right to Request Restrictions. You may submit a written request indicating the PHI about which you wish to restrict disclosure. We are not required to agree with your request, but we will do so if we are able (e.g. if it is not against the law).
Right to an Accounting of Disclosures. When we disclose your PHI, we record to whom it was sent, when and what was sent. You may submit a written request for a list of these disclosures. You must state the time period of disclosures you are requesting (no longer than 6 years and may not include dates prior to April 14, 2003).
Right to Amend. You may request in writing an amendment to your PHI that is incorrect or incomplete, indicating the reason supporting your request. If we deny your request, you have the right to file a statement of disagreement with PCC. Such statements and our rebuttal will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.
Right to Inspect and Copy. You may make a written request to inspect and copy your PHI. We may deny your request in limited circumstances, including psychotherapy notes, information for use in civil, criminal and administrative action, and PHI to which access is prohibited by law. If we deny access, you may request the denial be reviewed by another licensed mental health professional. PCC reserves the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request.
Right to Request Confidential Communication. You may specify in writing how or where you wish to be contacted by PCC regarding the confidential communication of your PHI. You do not need to give us a reason for such a request. We will accommodate all reasonable requests, but we reserve the right to deny those that impose an unreasonable burden on the practice.
Right to a Paper Copy of this Notice. If you have agreed to receive this Notice of our Privacy Practices electronically, you may request a paper copy.

USES AND DISCLOSURES THAT YOU AUTHORIZE

If you need more information or have questions about our privacy practices, please speak to the Privacy Officer whose name and telephone number appear below. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, contact the Privacy Officer. You have the right to file a complaint with PCC and with the Secretary of the Federal Department of Health and Human Services. We promise that we will not in any way limit your care at PCC or take any actions against you if you file a complaint.

US Department of Health and Human Services
233 N Michigan Ave, Suite 240, Chicago, IL 60601
312.886.2359

Office for Civil Rights Department of Health and Human Services
Mils Stop Room 506F
Hubert H Humphrey Building
200 Independence Ave SW, Washington, DC 20201
202.205.8725

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Effective September 1, 2006

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Acknowledgement of Receipt of Notice of Privacy Practices

This is to acknowledge that I have read Pathways Counseling Center's Notice of Privacy Practices (effective September 1, 2006) on the date below and can request a copy to take with me if I would like to do so.

_____
Client name (please print)

_____ _____ _____
Client street address (please print) City, State Zip Code

_____ _____
Client signature Date
(or personal representative's signature)

_____
Name of personal representative (if applicable)

_____
Description of representative's authority to act for the client (if applicable)

PATHWAYS COUNSELING CENTER

7413 Maxtown Road
Westerville, OH 43082
Phone: 614.818.4099
Fax: 614. 636.4944

Authorization to Use and Disclose Protected Health Information

I am completing this form to allow the use and sharing of protected health information about:

Printed name: _____ Date of Birth: _____

The above named person authorizes **Kelsey Johnson, MA, LPCC-S,** of Pathways Counseling Center, to use, disclose, and provide information to the following individual(s) and/or agency

Name(s): _____

Address: _____ Phone/fax: _____

concerning their evaluation, treatment, or contact with:

_____

(clients' names -- include children's names if applicable)

This authorization for the release of information includes, but it not limited to: case notes, written reports, results of psychological evaluations including psychometric test profiles and protocols, and any such records as may have been kept in the course of the clients' evaluation, treatment or contact with the person named above. This release waiver specifically allows release of all medical records including: mental health treatment, diagnosis, or other mental health consultation and including evaluation and treatment for substance abuse. The information may be released by and sent to **Kelsey Johnson,** in written form, as copies of existing records, or be written or verbal report, either in person or by telephone, and may be sent through the mail or provided by fax transmission. A photocopy of this signed release waiver is considered as valid as the original.

After the expiration of this authorization, no more of this information can be used or released to the individual or agency unless I sign a new authorization. I understand that I can revoke or cancel this authorization at any time. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. I understand that I may inspect and have a copy of the health information described in this authorization. I understand that if the individual or agency that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

I affirm that everything in this form that was not clear to me has been explained, and I now understand all of it. The undersigned has the authority to allow the release of information concerning the persons named above. This release waiver becomes effective on _____, and is to remain in effect until _____, or until cancelled by written notification to **Kelsey Johnson,** signed by the client or the client's legal representative.

_____ _____ _____

Authorized person's name (please print) Authorized person's signature Date

I have discussed the issues above with the client and/or their representative. My observations of their behavior and responses give me no reason to believe that they are not competent to give informed and willing consent.

_____ _____

Kelsey Johnson, MA, LPCC-S Date

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Permission to Treat a Minor

I give my permission for _____ (minor's full name) to be treated by **Kelsey Johnson, MA, LPCC-S**, of Pathways Counseling Center.

_____ _____
Signature of parent/guardian Date

_____ _____
Kelsey Johnson, MA, LPCC-S Date

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INFORMED CONSENT FOR TELEHEALTH SERVICES

PURPOSE

The purpose of this form is to obtain your consent to participate in telehealth services. Telehealth is the delivery of counseling services using interactive technologies (audio, video, or other electronic communications) between you and your counselor.

CLIENT LOCATION

I understand that when I receive telehealth services, I must be located within the state of Ohio.

NATURE OF TELEHEALTH SESSION

I understand that we will conduct telehealth counseling sessions as we would a face-to-face sessions, using a HIPAA-compliant and secure telecommunication service incorporating security protocols to protect the confidentiality of any information transmitted. No video, audio, and/or photo recordings will occur during sessions.

PAYMENT

I understand that the payment agreement I signed for counseling services also applies to telehealth.

RISKS OF TECHNOLOGY

I understand there are inherent risks with telehealth that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

EMERGENCIES

I understand that if an emergency arises, it is my responsibility to call 911 or go to my nearest emergency room.

MENTAL HEALTH INFORMATION & RECORDS

I understand that all existing laws regarding my access to mental health information and copies of my mental health records also apply to telehealth.

CONFIDENTIALITY

I understand that reasonable and appropriate efforts have been made to eliminate confidentiality risks associated with telehealth sessions, and all existing protections under federal and Ohio state law apply to information disclosed during telehealth sessions. To ensure my privacy and confidentiality, I will participate in the session in a private space that is free from distractions and other parties.

RIGHTS

I understand I may withdraw consent to telehealth services at any time by notifying my counselor in writing.

IDENTITY VERFICATION

At the beginning of each telehealth session, I am willing to provide the clinician my full name and date of birth to confirm my identity, along with the address of my current location.

I agree that I have been advised of potential risks, consequences, and benefits of telehealth. I have had the opportunity to ask questions about the information on this form and telehealth services. My questions have been answered, and I understand and agree with the information on this form.

_____	_____	_____
Name (printed)	Signature	Date