PATHWAYS
Counseling Center
7413 Maxtown Road
Westerville, OH 43082
P: 614.818.4099 / Fax: 614.818.4099
www.pathwayswesterville.com

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

Please Complete the Following Documents:

- ☐ Information & Consent
- ☐ Patient Information
- ☐ Health Questionnaire
- ☐ Notice of Privacy Practices / Signature Page
- ☐ Authorization to Disclose Information (if you would like me to coordinate care with your doctor, psychiatrist, pastor, therapist)
- ☐ Permission to Treat a Minor (if the client is 17 years old or younger)

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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*." Informed consent will help you better understand what to expect from your work at Pathways, and it will explain some limitations to what we will be doing.

The Nature of Counseling

Counseling is a collaboration between you and your counselor for the purpose of addressing personal, relational, or mental health problems. You should know that counseling is not always easy. You may find yourself having to discuss very personal information. You could find those conversations difficult and embarrassing, and you might be anxious during and after such conversations. As you learn more about yourself, you might encounter increased conflict with friends, co-workers, and family members. It is possible that you might become somewhat depressed. Counseling is intended to alleviate problems, but sometimes, especially at first, and as you get to the root of some things, you may feel them even more acutely than in the past. I may also ask you to do some things that might, at first, make you feel awkward or uncomfortable. Often times counseling requires trying new ways of doing things. You will always be free to move at your own pace, however. I will challenge you and your old ways of thinking and doing things, but I cannot offer any promise about the results you will experience. Your outcome will depend upon many things.

Pathways' counselors specialize in addressing a variety of issues. However, if I believe that your problems require knowledge that I do not have, I may refer you for a consultation with someone with specific training or experience. I will discuss any such referral with you before I act. At the beginning of your counseling work I will create a treatment plan with you. That is, I will look at what you would like to change, what we will do to change it, how we will know you are succeeding, and how long it will take. Every now and then, we will review that plan to see if it needs to be updated.

In the event of an emergency or crisis situation, please take the following steps: 1) call 911 or go to the nearest hospital emergency room; 2) call Netcare at 614.276.2273; and 3) call me and leave a detailed message to make me aware of the situation as I am not available 24 hours a day. While Pathways is not a crisis intervention facility, I will work diligently for your safety and well-being.

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 that the law protects you from having information about you given to anyone without your awareness and permission. At times, you may choose to give us permission to disclose *privileged* information. This permission will be given in writing and you will specify who can receive and share the information. I will respect your privacy and I intend to honor your *privilege* except in cases where intervention 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 includes contacting a family member, the 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/neglect. I am also obligated to notify the authorities in cases of vulnerable adult abuse/neglect including the elderly, infirm, 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 the lawyers may insist upon, and obtain your information from us. Similarly, you would lose

the protection of your privilege if you file a lawsuit against our office or a complaint with the State of Ohio Counselor, Social Worker, and Marriage & Family Therapist Board

4. *When you want your insurance company to reimburse me for counseling services*. As in medical care, your insurance company may require us to provide clinical information including, but not necessarily limited to, your diagnosis, symptoms, progress, and the time of your visits. In this event, I will inform you of the diagnosis I plan to use on the insurance form. Any diagnosis made will become part of your permanent insurance record. Your insurance company is not under the same confidentiality obligations that I am under.

Our Office Policies

I typically schedule appointments to begin at the top of each hour. Counseling sessions usually last 50 minutes, and we must end each session promptly. Payment is expected at the time of your appointment. I can accept cash, checks (made payable to Pathways Counseling Center), or debit/credit/HSA cards for your payment. The fee schedule for my services is as follows: $150 for the initial interview; $110 for each 50-minute counseling session; and $165 for each 75 minute counseling session. Typically, I do not charge for a phone consultation that lasts 10 minutes or less.

Our telephone is answered 24 hours a day by a digital answering system. During the day, we check messages regularly, and whenever possible we try to return phone calls the same day. We do not check office messages after 5:00pm on weekdays or on weekends. If you have an emergency after 5:00pm or on a weekend, please call 911 or go to an emergency room.

Please provide me with 24 hours notice if it becomes necessary to cancel a scheduled appointment. If you miss a scheduled appointment without giving 24 hours notice, the following policy will apply: 1) First no show or less than 24-hour notice - $20 fee; 2) Second no show or less than 24-hour notice - $55 fee; 3) Third no show or less than 24-hour notice - $110 fee. Your insurance will not pay for missed appointments. You must pay for those yourself. Our office charges a $25 fee for a returned check.

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

Pathways is happy to accept your insurance and to file insurance claims to receive payment for our time if I have a contract with your insurance provider. Your co-payment is due at the time of your visit. If there is a problem collecting payment from your insurance company you remain responsible for payment of the full fee for each visit. If we have not received payment from your insurance company within 60 days of any counseling session, we will bill you directly for past and ongoing visits at the customary fee noted above. In such a case, Pathways will provide you with the appropriate information necessary for you to pursue the issue with your insurance carrier. ***Please note that Pathways is partnered with Clinical Support Services to provide all of our insurance and private pay billing. Billing questions will be directed to Nancy Edgar at 614.433.0788***

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
_____		
Counselor Signature	Date	

PATIENT INFORMATION

Patient Name: _____ Sex: M or F Date of Birth: _____ Age: _____

Address: _____
Street City State Zip Code

E-Mail: _____

Phone (H) (_____) _____ (W) (_____) _____ Cell (_____) _____

Is it ok to call and leave messages at all numbers? ☐ Yes ☐ No If no, how may we contact you? _____

Indicate who you authorize to communicate billing information: ☐ Spouse ☐ Parent(s) ☐ Child ☐ Other _____

Social Security # _____

Responsible Party (if patient is a minor) _____ Relationship to Patient _____

Responsible Party Address: _____
Street City State Zip Code

Responsible Party Phone (_____) _____ Patient's Employer/School: _____

Employer/School Address: _____
Street City State Zip Code

PRIMARY INSURANCE INFORMATION

Policy Holder Name: _____ Sex: M or F _____ Date of Birth: _____

Policy Holder Address: _____
Street City State Zip Code

Phone (H) (_____) _____ (W) (_____) _____ Cell (_____) _____

Employer: _____ Employer Address: _____

INSURANCE COMPANY: _____ **MENTAL HEALTH ADMINISTRATOR:** _____

Address to send claims: _____

_____ Phone (800) _____

Policy Holder's Social Security # _____ Policy # _____ Group# _____

Authorization # _____ *for* _____ *sessions. Effective date range* _____ *to* _____

Worker's Compensation Claim # _____ Injury Date: _____

Are you covered by any other insurance carrier? ☐ Yes ☐ No **If yes, please complete secondary insurance section below.**

SECONDARY INSURANCE INFORMATION

Policy Holder Name: _____ Sex: M or F _____ Date of Birth: _____

Policy Holder Address: _____
Street City State Zip Code

Phone (H) (_____) _____ (W) (_____) _____ Cell (_____) _____

Employer: _____ Employer Address: _____

INSURANCE COMPANY: _____ **MENTAL HEALTH ADMINISTRATOR:** _____

Address to send claims: _____

_____ Phone (800) _____

Policy Holder's Social Security # _____ Policy # _____ Group# _____

Clinical Support Services will bill your insurer directly for all services. Your signature expresses your agreement that the dates of service, services rendered, and the diagnosis will be provided to Clinical Support Services for billing purposes only. Signature also indicates liability for any balance due. The patient's or responsible person's signature below authorizes release of any medical information requested by the insurer in order to process insurance claims and authorizes payment of medical benefits to be made directly to the supplier of services.

Signature: _____ Date: _____

FOR OFFICE USE Diagnosis: _____ Joel W _____Eric W _____Maggie H _____Chad W _____ Davia S

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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 **Chad Wilt, PC** of Pathways Counseling Center, to use, disclose, and provide information to the following individual(s) and/or agency:

Name:_____

Address:_____Phone/Fax:_____

concerning their evaluation, treatment, or contact with

_____

(Client's Names – include children's names when applicable)

This authorization for the release of information includes, but is 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 **Chad Wilt, PC** 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 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 believe 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 canceled by written notification to **Chad Wilt, PC** signed by the client or the client's legal representative.

_____ _____

(Authorized Person's Signature) Date

I have discussed the issues above with the client and/or his or her personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Counselor 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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PERMISSION TO TREAT A MINOR

I give my permission for _____
(Minor's Full Name)

to be treated by _____ of Pathways Counseling Center.
(Clinician's Name)

_____ _____
Signature of Parent/Guardian *Date*

_____ _____
Signature of Therapist *Date*