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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Phone: (614) 818-4099
Fax: (614) 818-4096

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

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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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 **Maggie Herrman, PCC-S, LICDC**, 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 **Maggie Herrman, PCC-S, LICDC** 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 **Maggie Herrman, PCC-S, LICDC**, 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

Pathways
Counseling Center

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 READ 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 LAWS
We are required to give you this Notice of Privacy Policy because of the federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPPA). We will follow the terms of this Notice while it is in effect and inform you of any changes. At PCC we believe that your mental health information is personal. We keep records of the care and services that you receive at our facility. 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 this practice 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.

THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
Use. This is when your information is read by your counselor or other approved PCC personnel for routine purposes (i.e.: insurance billing)
Disclosure. This is when your information is shared with or sent to others outside of 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, your diagnosis, treatment received and planned and progress made. We may also disclose limited PHI to consumer reporting agencies relating to collection of payments owed to us.
Mental Health Care Operations. We may use and 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 e-mail 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, state or local laws, which require us to disclose PHI. By law we are required to report:

- Suspected child and elder abuse or neglect
- Abuse and 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 due 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 the government agencies which check on us to see that we are obeying the privacy laws. **For Law 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 which investigate for the purposes related to preventing or controlling disease, injury or disability. **Relating to descendants.** We may disclose PHI to coroners, medical 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 another person, or the public, we can disclose some of your PHI. We will only do this 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 others involved in your care such as close friends or clergy. You may inform us as to whom you 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 you wish to restrict or limit being disclosed. We are not required to agree with your request.

Right to an Accounting of Disclosures. When we disclose your PHI we keep records of 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 that is not longer than 6 years and may not include dates before April 14, 2003.

Right to Amend. You may request in writing an amendment to your PHI that is incorrect or incomplete indicating a reason that supports 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 you PHI. You do not need to give us a reason for such a request. We will accommodate all reasonable requests, but 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 WHICH YOU AUTHORIZE

If you need more information or have questions about the privacy practices described in this brochure, please speak to the Privacy Officer whose name and telephone number appears 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 here or take any actions against you if you complain.

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

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

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Effective September 1, 2006

Pathways
Counseling Center

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.

_____ _____

Date of patient's or personal representative's signature | Signature of patient or personal representative

_____

Patient's name (please print)

_____

Street address (please print)

_____

City State ZIP Code

_____

Name of personal representative (if applicable)

_____

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

_____

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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*