Pathway Counseling Ministry

P.O. Box 620478
Oviedo, FL 32762-0478
Phone: 407-366-5656/ Fax: 407-386-6658

CLIENT INTAKE-Child/Adolescent History Form

Parent/Guardian completes this section:

Date: _____

Child/Adolescent's Name:_____

Age _____ Date of Birth _____ Sex: O Male O Female Phone: _____

Address _____
Street City/State Zip

Mother's Name _____

May we contact client's mother? O Yes O No

Home Phone _____ Work Phone _____ Cell Phone _____

May we contact her at home? O Yes O No Work? O Yes O No Cell? O Yes O No

Address _____
Street City/State Zip

Father's Name _____

May we contact client's father? O Yes O No

Home Phone _____ Work Phone _____ Cell Phone _____

May we contact him at home? O Yes O No Work? O Yes O No Cell? O Yes O No

Address _____
Street City/State Zip

Parent's Relationship Status: O Single O Partner O Married O Divorced

O Widowed O Separated O Cohabiting and unmarried

Length of parent's relationship _____ year(s) _____month(s)

Primary Custodial Parent or Guardian: _____

Relationship to child/adolescent: _____

Home Phone _____ Work Phone _____ Cell Phone _____

May we contact him/her at home? O Yes O No Work? O Yes O No Cell? O Yes O No

Address _____
Street City/State Zip

Child/Adolescent's Emergency Contacts:

_____
Name Relationship Phone #

_____
Name Relationship Phone #

In case of an emergency, please sign the line provided to authorize Pathway Counseling Ministry to contact the above emergency contacts. _____
Parent/Guardian Signature

Do you regularly attend a church, synagogue, or other religious institution? O Yes O No

If yes, where do you attend? _____

How did you hear about Pathway Counseling Ministry? _____

What has led you to seek counseling for your child/adolescent at this time?

_____

_____

_____

What specific goals do you hope your child/adolescent will achieve during the counseling experience?

_____

_____

Please check any of the following problem areas that pertain to your child/adolescent.

- ☐ Stress
- ☐ Fears
- ☐ Seeing things
- ☐ Recent death
- ☐ Self-esteem
- ☐ Impulsive behavior
- ☐ Guilt
- ☐ Delinquency
- ☐ Communication
- ☐ Self-injurious behavior
- ☐ Family problems
- ☐ Physical or sexual abuse
- ☐ Spiritual/Moral problems
- ☐ Pornography
- ☐ School Problems
- ☐ High Risk Behaviors: _____
- ☐ Depression
- ☐ Panic
- ☐ Pregnancy
- ☐ Attention Problems
- ☐ Confidence
- ☐ Career choices
- ☐ Grief
- ☐ Trauma/Disaster
- ☐ Abortion
- ☐ School problems
- ☐ Relationship problems
- ☐ Verbal abuse
- ☐ Sexual addiction
- ☐ Legal matters
- ☐ Poor concentration
- ☐ Anxiety
- ☐ Hearing voices
- ☐ Temper tantrums
- ☐ Defiant behavior
- ☐ Racing thoughts
- ☐ Gender identity
- ☐ Bad dreams
- ☐ Unwanted thoughts
- ☐ Hopelessness
- ☐ Social problems
- ☐ Health problems
- ☐ Cultural problems
- ☐ Eating problems
- ☐ Drug use
- ☐ Alcohol use
- ☐ Other: _____

Please list your child/adolescent's strengths: _____

_____

_____

Family History:

Does your child/adolescent have stepparents? O Yes O No
If Yes, please list names and ages:
Step-Mother/Age _____/ _____ Step-Father/Age _____/ _____

How would you describe his/her relationship with his/her stepparent?
O Excellent O Good O Fair O Poor

***Please add additional stepparents at the back of this form.**

Sibling(s):

Brother(s):

1. Name: _____ Age: _____ O Living O Deceased
   If Living, how would you describe their relationship?
   O Excellent O Good O Fair O Poor

2. Name: _____ Age: _____ O Living O Deceased
   If Living, how would you describe their relationship?
   O Excellent O Good O Fair O Poor

3. Name: _____ Age: _____ O Living O Deceased
   If Living, how would you describe their relationship?
   O Excellent O Good O Fair O Poor

4. Name: _____ Age: _____ O Living O Deceased
   If Living, how would you describe their relationship?
   O Excellent O Good O Fair O Poor

Sister(s):

1. Name: _____ Age: _____ O Living O Deceased
   If Living, how would you describe their relationship?
   O Excellent O Good O Fair O Poor

2. Name: _____ Age: _____ O Living O Deceased
   If Living, how would you describe their relationship?
   O Excellent O Good O Fair O Poor

3. Name: _____ Age: _____ O Living O Deceased
   If Living, how would you describe their relationship?
   O Excellent O Good O Fair O Poor

4. Name: _____ Age: _____ O Living O Deceased
   If Living, how would you describe their relationship?
   O Excellent O Good O Fair O Poor

What is the primary cultural background with which your child/adolescent most closely identifies?

O Caucasian O Black/African American O Hispanic/Latino O Asian
O Biracial O Other: _____

Education:

School: _____

City: _____ State: _____ Zip Code: _____

Grade: _____

Is your child/adolescent in any special education/exceptional education program?
O Yes O No

If Yes, what kind of program?

- ☐ Physically Impaired
- ☐ Language Impaired
- ☐ Emotionally Handicapped
- ☐ Hospital/Homebound
- ☐ Severely Emotionally Disturbed
- ☐ Occupational Therapy
- ☐ Hearing Impaired/Deaf
- ☐ Learning Disability
- ☐ Deaf/Blind
- ☐ Speech Therapy
- ☐ Vision Impaired
- ☐ Gifted
- ☐ Autistic
- ☐ Educable Mentally Handicapped

Has your child/adolescent ever had any disciplinary problems in school?
O Yes O No

If Yes, check all the following that apply:
O Suspension O Expulsion O Referrals O Alternative Schools

O Other: _____

Please describe: _____
**Use back of form as needed.

How do you rate your child/adolescent's school experience on a scale from 1-5 where 1 is extremely negative and 5 is extremely positive?

O 1	O 2	O 3	O 4	O 5
Negative		Average		Very Positive

Legal History/Social Agency Involvement:
Has your child/adolescent been involved with the Justice System? (arrest, detention, court, etc.) O Yes O No
If Yes, please describe: _____

Has the child/adolescent ever had involvement with the Department of Children & Families or a similar agency in Florida or another state? O Yes O No
If Yes, please describe: _____
Medical History:

Has your child/adolescent ever had:

Physical injury:
O Yes, one physical injury O Yes, more than one O No
If Yes, please describe: _____

Accident:
O Yes, one accident O Yes, more than one O No
If Yes, please describe: _____

Major Illness:
O Yes, one major illness O Yes, more than one O No
If Yes, please describe: _____

How would you describe your child/adolescent's current health?
O Excellent O Good O Fair O Poor

Please describe any current medical problems: _____

Does your child/adolescent take any prescription or over the counter medications?
O Yes O No

Please list medications: _____

Who prescribed these medications? _____

Does your child/adolescent take any over the counter herbal medication? O Yes O No

Please list: _____

Has your child/adolescent ever received outpatient psychiatric/psychological/counseling in the past? O Yes O No
If Yes, please describe: _____

Has your child/adolescent ever been in the hospital for psychiatric/psychological problems? O Yes O No
If Yes, please describe: _____

Has a physician ever recommended any anti-anxiety ,anti-depressant, ADHD, or anti-psychotic medication for your child/adolescent? O Yes O No
If Yes, please describe: _____
What diagnosis was your child given? _____

Has anyone in your child/adolescent's family ever been treated or hospitalized for mental health issues, substance abuse, or psychiatric conditions? O Yes O No
If Yes, please describe: _____

Has your child/adolescent ever been abused or experienced a trauma? O Yes O No
If Yes, please describe: _____

Child/Adolescent completes this section:

What has led you to seek counseling at this time?

_____
_____
_____

What specific goals do you hope to achieve during the counseling experience?

_____
_____
_____

Please list your strengths:

_____
_____
_____

Family History:

How would you describe your relationship with your mother?
O Excellent O Good O Fair O Poor

How would you describe your relationship with your father?
O Excellent O Good O Fair O Poor

Do you have stepparents? O Yes O No
If Yes, how would you describe your relationship with your stepparents?
O Excellent O Good O Fair O Poor

Do you have siblings? O Yes O No
If Yes, how would you describe your relationship with your siblings?
O Excellent O Good O Fair O Poor

Education:

How would you rate your school experience on a scale from 1-5 where 1 is extremely negative and 5 is extremely positive?

O 1	O 2	O 3	O 4	O 5
Negative		Average		Very Positive

Substance Usage:

Which of the following have you tried or used?

- ☐ Wine
- ☐ Acid
- ☐ Cocaine
- ☐ Cigarettes
- ☐ Beer
- ☐ Speed
- ☐ Marijuana
- ☐ Liquor
- ☐ Downers
- ☐ Over the counter medicine
- ☐ Ecstasy
- ☐ LSD/Heroine
- ☐ Tobacco
- ☐ PCP
- ☐ Prescription Drugs
- ☐ Other: _____

At what age did you first use? _____

Have you ever used drugs before or during school? O Yes O No

Have you ever missed school (or been truant) because of substance use? O Yes O No

Do you ever feel pressure to use? O Yes O No

If you use alcohol or drugs, how often do you use them?

- ☐ Everyday
- ☐ Once/twice a month
- ☐ Two or more times per week
- ☐ Once a year
- ☐ Holidays
- ☐ Weekends
- ☐ Other: _____

About how often do you use more than one drug at a time? _____

Abuse/Trauma History:

Have you ever been abused? O Yes O No
If Yes, please describe: _____

Have you ever been sexually abused? O Yes O No
If Yes, please describe: _____

Have you ever been emotionally or mentally abused? O Yes O No
If Yes, please describe: _____

Have you ever experienced any other severe trauma? O Yes O No
If Yes, please describe: _____

Religious/Spiritual Issues:

Are spiritual or religious issues important to you? O Yes O No

Do you wish to discuss them in counseling? O Yes O No

How would you rate your overall involvement in spiritual or religious activities on a scale from 1-5 where 1 is not involved at all and 5 is very involved?

O 1	O 2	O 3	O 4	O 5
Not involved		Average		Very involved

Currently, how would you rate your spiritual or religious experiences on a scale from 1-5, where 1 is very harmful and 5 is very helpful?

O 1	O 2	O 3	O 4	O 5
Very Harmful		Average		Very helpful

Please describe your relationship with God: _____
_____
_____
_____
_____

Suicide Assessment:

Have you attempted suicide? O Yes O No

If Yes, how long ago was the last attempt: _____ Year(s) _____ Month(s)

If Yes, how many times have you attempted suicide? o 1 o 2 o 3 o 4 o More than 4

Do you have current thoughts of ending your life? O Yes O No

If Yes, do you have a plan? O Yes O No
If Yes, please describe: _____

Who is part of your support system? _____

If you feel like hurting yourself, who would you tell? _____

Mental Status:

How would you describe yourself?
O Happy O Sad O Depressed O Lonely O Hurt O Angry
Other: _____
Do you see or hear things others do not? O Yes O No
Describe: _____

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

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1) ***Pathway Counseling Ministry has on staff many qualified therapists. All counselors have a minimum of a Master's Degree and are either a Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Licensed Social Worker, a Registered Intern in Mental Health or Marriage and Family Therapy or an Ordained Minister.***
2) ***During your counseling at Pathway Counseling Ministry, you, the client, will be expected to be an active participant in your own therapy. It is impossible to come to counseling for 1 hour per week and expect change to occur without doing "homework." It is also expected for you to keep your regularly scheduled appointment and to be there on time.***
3) ***During each session, the therapist will "work" to assist you in dealing with the issues you present. Your therapist will also respect the "scheduled appointment" and will attempt to start and end on time.***
4) ***Goals of Treatment: As your therapist, it is my intention to help you in the areas that you would like assistance without creating dependence…Specific goals will need to be negotiated in the therapy session and revisited on a regular basis to assess the effectiveness of the interventions being utilized.***
5) ***Guarantees: As much as we would like to be able to do so, there are NO GUARANTEES that the counseling sessions will produce the results you are seeking. We will work together to attempt to meet those results.***
6) ***Risks associated with counseling: There are risks associated in beginning a therapeutic counseling relationship. During counseling, you will deal with difficult issues in your life that can produce "emotional, behavioral, and relational difficulties." At times, making your presenting issues even more difficult than when you first began counseling.***
7) ***Contacting Clients: Unless otherwise noted by you to your therapist, each counselor will use the numbers you provide to them in order to reach you. We will work to be very discreet in our messages which are left for you.***
8) ***Regarding E-mail, Cell Phones, and Messages: As stated in our "Notice of Privacy" policy (located at the counseling office) we will not provide "any type or form of therapy" through the use of E-mails, nor can we guarantee "confidentiality" when you choose to contact us in this manner or in leaving messages on our cell phones. If you choose to contact us through E-mails, we will respond with appointment times and answers to questions that are not related to your therapy.***
9) ***Client Emergencies: If you are experiencing an emergency, please contact 911 or the Central Florida Hotline. If you choose to call the answering service for Pathway Counseling Ministry, there is NO GUARANTEE of when we will be able to return your call during this emergency.***
10) ***Therapist vacations: During vacations, you can leave your message with the answering service, BUT there are times in which the messages you leave***

CANNOT be received by the therapist. Each therapist determines IF and WHEN they are able to return calls left to them while they are on vacation.

11) ***In cases of emergencies "while in the counseling session:" At times, during a counseling session, a client may become "very depressed or suicidal." At which point we (PCM) may need to contact a family member to provide assistance. It is important for you to provide a "list of names: along with "authorization" for your counselor to contact these individuals.***

12) ***Confidentiality and Privilege: The State of Florida, HIPPA, and our Notice of Privacy policy outline your rights to confidentiality and privilege during your counseling sessions. All information being dealt with during the therapy session is considered confidential and privileged UNLESS the information you provide meets the following EXCEPTIONS: (A) Client authorizes release of information in writing and waives privilege, (B) Client reports current abuse of a child, disabled person, elderly individual, or someone who is vulnerable and unable to leave a place of abuse due to institutionalization, (C) Client poses a danger to self or others, (D) Ordered by a "court of law" to make records available, (E) Bill collection/collection agency (as long as stated in the Informed Consent), (F) Parent-child relationship where parent has legal authority over the records.***

13) ***Counseling Approach: Pathway Counseling Ministry is a Christian Based counseling center where (depending on the individual client) we may use "prayer, the Bible, references to scripture or homework using books by Christian writers." Other approaches to counseling are based upon the personality of the therapist and the form of therapy which is most beneficial for the issues you are presenting. Your therapist will describe for you the various approaches they use in counseling. For example: Cognitive/behavioral, Family and Relational are just some of the types of therapy which are provided by Pathway Counseling Ministry.***

14) ***Counseling and Financial Records: All records are maintained as in accordance with HIPPA and the State of Florida guidelines for Mental Health counseling. You have the right to see and make amendments to your records by contacting your therapist. All records are kept for a minimum of 7 years (as described by law) but may be kept indefinitely. To insure your confidentiality, your records are kept behind a minimum of 2 locked doors.***

15) ***Ethical Guidelines: Creating a safe therapeutic environment is essential for a healthy relationship to develop between the client and therapist. For this to occur, ethical guidelines are very important. Three of the most significant are: sexual contact, dual relationships and fees for service. (A) <u>Sexual Contact</u>: There is to be <u>NO FORM</u> of sexual contact between the client and therapist. This includes inappropriate and/or unwanted sexual conversations by phone, e-mail, or personal communication, touch, or any form of private meetings outside of the normal scheduled appointment. (B) Dual relationships is best defined as a "relationship which exists both in the therapeutic environment and social or family settings. For example: employer/employee, family members, or close friendships. A "DUAL RELATIONSHIP" decreases the effectiveness of the counseling and puts undue pressure on the client. (C) Fees for service: There is a "fee for service" based upon the "household income" of the individual or family***

who is seeking therapy. There shall be <u>NO FORM</u> of "bartering" or exchanging of services for the counseling provided.

16) ***Dispute and complaints: If you have a dispute with one of the therapists at Pathway Counseling Ministry, please contact the Director of the Ministry in an attempt to have the issue resolved. Also, since Pathway is a Church-based counseling center, this is also the option of meeting with the Director of Ministry along with your Pastor (all releases must be signed). If there is a need to go beyond the Director of the Ministry, you may contact the State of Florida Licensing Board for Mental Health Counselors.***

17) ***Licensing Regulations: All therapists of Pathway Counseling Ministry ore either: Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, Licensed Social Workers, Registered Interns or Ordained Ministers. All Licensed therapists are required to complete 30 hours of continuing education (CEU) every two years. This is to ensure that you are receiving the best possible care by a qualified professional. For a minimum of 2 years, all Registered Interns meet regularly with a "Clinical Supervisor" to review their "case load" and they met regularly with the Director of the Ministry to ensure they are providing the best quality of care for their clients. Once the Registered Intern completes their STATE REQUIRED hours of supervision, they are allowed to take the State Exam to become a licensed therapist.***

18) ***<u>Fees, charges, and responsibility for payment:</u> PCM charges fees for the counseling which is provided to the client. Those fees are based upon a "sliding scale" which is based upon the "household income" of the client. (A) A "fee schedule" is provided by the therapist and is placed in the client file. It is your responsibility to pay for services rendered at the end of each session. (B) Based upon the "fee schedule" your counseling fee shall be _____ per session. (C) Due to unforeseen issues in the life of the client, the therapist, at their discretion, may reduce the "fee amount" per session for up to 4 sessions. After that time, the fee amount will return to the original amount as determined by the "fee schedule." (D) Payment can be made by: check, cash or credit card. (E) There are additional charges for which you will be responsible if you choose the other services provided by PCM:***

   a. ***Witness fee/Court Appearance: a fee of $300 per hour which is determined from the time the therapist leaves their home until they return. This fee is to be PAID IN FULL before the court appearance.***
   b. ***Depositions: a fee of $300 per hour which is determined from the time the therapist leaves their home until they return. This fee is to be PAID IN FULL before the date of the deposition and is to be PAID REGARDLESS of who's attorney is requesting the deposition.***
   c. ***Preparation time for Deposition, Witness and Court Appearance: a fee of $150 per hour and is to be PAID IN FULL along with the payment fees for parts A and B listed above.***
   d. ***Pre-marital program: $100 per session normally lasting 3 to 5 sessions, based upon the couple and the issues being presented.***
   e. ***Testing and Evaluations for Learning Disabilities, Behavioral, Personality, Career, and ADD/ADHD: Prices vary based upon testing and materials. Cost shall be determined by your therapist.***

19) ***<u>Insurance Reimbursement:</u> Due to the increased cost of "billing" for insurance reimbursement, delayed payment by the insurance company for the services rendered, and the expense of running the counseling ministry, PCM no longer accepts insurance as a means of "payment" for services being rendered. For this reason, the "sliding scale" and "fee reduction" is being offered to assist clients as they come to PCM for counseling or testing. To assist you in submitting your insurance claims, we will provide the necessary claim forms which can be used to receive the benefits under your medical insurance.***

20) ***<u>Cancellation Policy:</u> In order to provide the best possible care to you and each of our other clients, PCM requires a minimum of 24 hours advanced notice of the cancellation of your scheduled appointment. Our answering service is open 24/7 and they will take all messages and inform your therapist of the cancellation. Based upon the reason for your missed appointment (if no notice is given) you can (or will) be charged for your missed session at the RATE OF YOUR STANDARD FEE. *** PLEASE NOTE*** By signing the INFORMED CONSENT you are AUTHORIZING PCM to charge your credit card for the amount of your standard fee. A credit card number shall be placed on file in our LOCKED file cabinet to be used for this purpose. When counseling is completed or terminated, the paperwork shall be destroyed.***

21) ***<u>Supervisory relationship and Colleague consultations:</u> As stated in section 17, under "licensing regulations," each therapist of Pathway who is a Registered Intern is required by law to meet regularly with their "Clinical Supervisor" to review their client case load. Guidelines are used to ensure your "confidentiality" when discussing your counseling sessions. Also during our regular staff meetings, or at times when assistance is needed in dealing with a "particular" situation, the staff of Pathway will discuss various client situations. This is done to ensure that each client received the best possible care.***

******** <u>Counseling Minor Clients</u> ********

A minor can enter treatment in ONE of FOUR ways:

1) ***Parental Consent***
2) ***Involuntary at a parent's insistence***
3) ***By order of a Court of Law***
4) ***The individual has become an "emancipated minor" as described by the American Bar Association as "living separately from parents and is managing his or her own financial affairs" (ABA, 1980, p. 66)***

In order for Pathway to provide the best possible care of Minor Clients, we require the "consent and involvement" of the parent or legal guardian.

In cases of DIVORCE, Pathway must receive copies of guardianship orders, general and limited power of attorney, custody orders, or letters of authority, showing that you have the authority to provide "CONSENT" for the child to be seen by a therapist.

Also note that in cases of "joint legal custody," parents have equal legal responsibility of the child and are required to sign the "informed consent" of the minor child to be

seen by a counselor at Pathway. Both parents, in this case, shall be responsible for payment of counseling fees as is dictated in the "final divorce decree." Please note it is the responsibility of the Parent to obtain reimbursement from the EX-SPOUSE for the counseling fees which were paid.

******** <u>Counseling Families and Couples</u> ********

In order to provide counseling for either FAMILIES or COUPLES at Pathway Counseling Ministry, the following issues are to be agreed upon:

1) ***Each individual is committed to preserving the "confidentiality" of all information disclosed during the therapy sessions.***
2) ***Although CONFIDENTIALITY is strongly encouraged or even required, the therapist CANNOT GUARANTEE that other family members will not violate this trust.***
3) ***There will also be a "NO SECRET" policy in dealing with family or couples. According to the "no secret" policy, any information obtained by the counselor from one partner can or may be shared with the other partner or family member.***
4) ***The client recognizes the difficulty in maintaining confidentiality and will not hold the counselor "liable" for information which is shared between spouses, partners, or family.***

I, the undersigned, agree to the terms of the INFORMED CONSENT and desire to seek counseling at Pathway Counseling Ministry.

Client Name: _____ Date: _____

Signature:

Spouse Name: _____ Date: _____

Signature:

Parent Name: _____ Date: _____

Signature:

Therapist Name: _____

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Notice of Privacy Practices

SUMMARY OF NOTICE
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
Federal law, commonly called HIPAA, requires that we describe for you our medical privacy practices and your rights as a patient under the law.
If you have any concerns about your medical privacy please notify us at 407-366-5656.

How we may use your personal medical information.

Pathway creates and receives medical information about you as a part of your care. This information is called protected health information, or PHI. It is personal and private. We may use this information in many ways. We release only the information necessary to accomplish a task.

First, we use the information when we treat you or refer you for treatment. We may communicate with other professionals and referral agencies.

Second, we may use the information to submit bills for your medical care to insurers, Medicare, or third party payers.

Finally, we may use this information for our health care operations. This means the work we must do to provide quality services to you and all of our patients.

We will see your authorization when state or federal law requires it.

We may use PHI without your permission for the following reasons:

- As required by state or federal law
- For public health purposes, such as reporting child or elder abuse, or if you are a danger to yourself or to others.
- To treat you in an emergency
- To inform you of alternative treatments.
- When ordered by a regulatory agency, such as Health and Human Services.
- For law enforcement purposes or in response to a court order.
- For agencies involved in a disaster situation.
- For lawsuits and disputes.
- To communicate with coroners, medical examiners, and funeral homes when necessary.
- To communicate with federal officials involved in security activities authorized by law.
- To communicate with correctional officials if you are an inmate.
- To carry out treatment and billing operations through a billing or transcription service.

Your authorization is required for other disclosures.

The following PHI receives special protections under federal and/or state law.

Psychotherapy Notes are kept separate from the medical record and receive special protection.

Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

Alcohol and drug abuse information has special privacy protections. Pathway will not disclose any information identifying an individual as being a client or provide any mental health or medical information relating to a client's substance abuse treatment unless: 1) the client consents in writing; 2) a court order requires disclosure of the information; 3) medical personnel need the information to meet a medical emergency; 4) qualified personnel use the information for the purpose of conducting research, management audits, or program evaluation; or 5) it is necessary to report a crime or a threat to commit a crime or to report abuse or neglect as required by law.

Your right to access and control your PHI

You have the following rights regarding your protected health information (PHI), provided that you make a written request.

- Right to request restriction. You may request limitations on your mental health information we may disclose, but we are not required to agree to your request.
- Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or when you wish to be contacted.
- Right to inspect and copy. You have the right to inspect and copy your mental health information regarding decisions about your care; however, psychotherapy notes may not be inspected and copied. We may charge a fee for copying, mailing, and supplies.
- Right to request clarification of the record. If you believe that the PHI we have about you is inaccurate, you may ask to add clarifying information. WE are not required to accept the information that you propose.
- Right to accounting of disclosures. You may request a list of the disclosures of your mental health information that have been made to entities other than for routine treatment, payment, or health care operations.
- Right to a copy of this Notice. You may request a paper copy of the full Notice at any time.

<u>Complaints</u>

If you believe your privacy rights have been violated, you may file a complaint with Pathway or with the Department of Health and Human Services at 1-877-698-6775.

You will not be penalized or retaliated against in any way for making a complaint.

We are required to provide you with this notice that governs our privacy practices. We will provide any forms necessary to enforce your rights.

State law may affect the enforcement of some rights.

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CONSENT FOR TREATMENT OF MINORS

RE: _____ Date of Birth: _____

Counselor(s): _____

At Pathway Counseling Ministry, we respect the rights of parents. Confidentiality cannot be given without the permission of parents. The reality is that a child will have no reason to talk to a counselor if the counselor were to disclose all communication to a parent. Due to this problem, we ask you to permit your child to have a confidential relationship with the counselor assigned to them.

This is to certify that I, _____, give permission to Pathway Counseling Ministry and the counselor(s) listed above for the treatment of my minor child. This document permits my child to have a confidential counseling relationship with a counselor. I understand that the information disclosed by my child is private.

This treatment may include individual counseling, group counseling, testing, and life coaching. This treatment may also include consultations with other associates of Pathway Counseling Ministry.

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

_____
Street Address

_____
City/State/Zip Code

_____ _____
Home phone with area code Work phone with area code

_____
Witness/Title

Pathway Counseling Ministry

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Phone: 407-366-5656/ Fax: 407-386-6658

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client
Name: _____
Date of Birth: _____
Social Security Number: _____

I acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices for Pathway Counseling Ministry, Inc. I understand that if I have any questions regarding the Notice or my privacy rights, I an contact Charles Wise at 407-366-5656.

_____

Signature of Patient/Client Date

_____

Signature of Parent/Guardian/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 Date

Pathway Counseling Ministry

P.O. Box 620478
Oviedo, FL 32762-0478
Phone: 407-366-5656/ Fax: 407-386-6658

Credit Card Authorization

I, _____, understand the importance of notifying my therapist at Pathway Counseling Ministry in the event of having to re-arrange my counseling session due to an emergency.

I also understand that according to the INFORMED CONSENT, which I signed, I must give 24 hours notice if I am unable to attend my scheduled appointment, and if the notice is not given, I will be charged for my missed session at my standard fee rate.

I, _____, give Pathway Counseling Ministry, the authorization to charge my credit card $_____ for each missed counseling appointment.

I am also aware that when the counseling services at Pathway Counseling Ministry ended, this form shall be destroyed

Client Name: _____

Client Signature: _____

Date Signed: _____

Therapist Name: _____

Credit Card Number: _____

Expiration Date: _____

Name on Card: _____

**Sorry, we do NOT accept American Express Credit Cards.

Pathway Counseling Ministry

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Professional Counseling Agreement

For the services rendered by _____ at Pathway Counseling Ministry, I agree to pay all debts for testing, counseling sessions, and other customary charges in accordance with the terms set below:

1) I acknowledge that each 50-minute counseling session will cost $ _____. The amount is to be determined by the "fee schedule" which is based upon household income.

2) I agree to pay my fee-for-service charge at each appointment by cash, check, or credit card.

3) I understand that if I miss two or more sessions without giving 24 hours notice, Pathway Counseling Ministry and my therapist reserve the right to terminate our therapy relationship by letter or phone call.

4) As stated in my copy of the INFORMED CONSENT, I understand that I must give a "minimum" of 24 hours notice, to cancel a scheduled appointment. If a notice is not given, I can or will be charged my standard fee for the missed session.

I have read the above and understand its contents. I agree to abide by the provisions set forth above.

Charles Wise, MA LMHC
Clinical Supervisor

_____ _____ _____
Client Therapist Date

Pathway Counseling Ministry

Rev. Charles Wise, MA LMHC

P. O. Box 620478, Oviedo, Fl 32762-0478

407-366-5656 (work) 407-386-6658 (fax)

Fee Schedule

As of April 15, 2009

Gross Income	Charge
**********	Therapist discretion
Under $35,000	$ 75.00
$35,000 – $70,000	$100.00
$70,000 – $100,000	$125.00
Above $100,000	$150.00

Witness Fee / Court Appearance ..... $250.00 per hour (portal to portal)

Pre-Marital Program..... $100.00 per session (per couple)

Testing and Evaluations..... Varied Based upon testing

- Based upon the situation, the therapist may lower the minimum "fee" for a specific number of sessions.
- Insurance forms will be provided at the end of each session upon request so you can submit claims to your insurance carrier for benefit reimbursement