230 W. Sandusky Street Findlay OH 45840
419-423-7812 * 419-423-9877 (fax)

Pathways Christian Counseling

230 W. Sandusky St, Findlay, OH 45840
419-423-7812 419-423-9877 (fax)

Client Acknowledgement of Receipt of Information

I have read, understood and agree to the Pathways Christian Counseling Office Policies, Informed Consent and Service Agreements. I agree to pay Pathways Christian Counseling the designated fees for services provided to me as described in their Office Polices. I understand that I am personally responsible for all payments. I authorize the provider to furnish information to my insurance carrier concerning my treatment, as well as to receive payment of medical benefits. If insurance is not being used, I am responsible to pay the amount agreed upon with my provider.

I have received copies of Pathways Christian Counseling Client's Rights and Responsibilities and Privacy Policies.

_____ _____

Please print client name Date

_____

Signature of client

_____ _____

Signature of spouse Date

_____ _____

Signature of parent or guardian (if minor) Date

PATHWAYS
CHRISTIAN COUNSELING

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Client Confidential Information

Client Name _____ Date of Birth _____

Client Address _____

City_____State_____ Zip_____ County_____

Phone Number: (home) _____ (work) _____ (cell)_____

Can we leave a message Y/N Social Security# _____

Client Employer _____ Occupation _____

Spouse's Name _____ Spouse's DOB _____

Spouse's Occupation _____ Spouse's SS# _____

Parent's Name (for Minors)_____

Parents Address (if different from client) _____

Emergency Contact:
Name _____ Phone: _____ Relationship to client _____OR

Name _____ Phone _____ Relationship to client _____

If you have had previous psychiatric care or counseling, please indicate where, for what purpose and for how long _____

_____

Who referred you to us? _____ May we thank him/her for the referral? _____

Is your visit employment or accident related? _____Please Explain _____

Insurance Information: Please complete or ask receptionist to make a copy of your insurance card.

Primary Insured name_____ ___ Insurance Company_____

Policy Number _____ Group Number _____

Phone Number_____ Claims Address_____

PATHWAYS CHRISTIAN COUNSELING
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CHILD AND ADOLESCENT CLIENT INFORMATION QUESTIONNAIRE

Your cooperation in completing this questionnaire will be helpful in planning our services for you and your child. Please answer each item carefully, or ask for clarification if you do not understand an item.

Child's Full Name: _____ Age: _____
School/Grade: _____
List family members and others residing in your home:
Name Age/Birth Date Relationship Occupation

_____
_____
_____
_____

When was your child last examined by a physician: _____

Physician's name: _____ City:_____
List any major health problems for which your child currently receives treatment, and any medications presently used:

_____
_____

Please briefly state your reason for coming to counseling: _____

Please have your child circle any of the following symptoms that they are feeling:

Shyness	Depression	Health Problem
Fears	Separation	Stomach Problems
Friends	Anger	Bowel Problems
Self-Control	Unhappiness	Appetite Problems
Stress	Relaxation	Headaches
Memory	Energy	Insomnia
Decision Making	Loneliness	Nightmares
Inferiority Feelings	Concentration	Tiredness
Learning Issues	Temper	Sleep
Other Children	Authority Problems	Drug Use
Lying	Stealing	Alcohol Use
School Truancy	Fire Setting	Sexual Problems
Legal Issues	Suicidal Thoughts	Abusive Behavior

PATHWAYS CHRISTIAN COUNSELING
230 W. Sandusky Street Findlay OH 45840
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PRE-COUNSELING SELF REPORT

Name _____ Date_____

PERSONAL

1. What brought you to seek treatment?
   _____
   _____
2. What are your goals in counseling?
   _____
   _____
3. What have you done about these concerns before coming to counseling?_____
   _____
4. Please share any other information about yourself that would be helpful in the counseling process:_____
   _____
   _____

FAMILY ORIGIN AND HISTORY

1. List siblings and ages: _____
   _____
2. Names of parents (biological, adoptive, step, etc.) and ages (note if deceased)
   _____
   _____
3. Please list any known substance abuse/addictions, depression, anxiety, mental illness, etc. with yourself or family history.
   _____
   _____

MARITAL HISTORY

1. Please provide information about your current marriage and any past marriages if applicable. Include year married, length of marriage and children (name, age and custody) from each marriage.
   _____
   _____
   _____
2. Current living arrangement. _____
   _____

LEGAL HISTORY

1. Please explain any legal history you have had.
   _____
   _____

Please feel free to include any further pertinent information about yourself on the back of this page. Thank you.

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230 W. Sandusky Street Findlay OH 45840
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Name and Date _____

DESCRIPTION OF SYMPTOMS

Please check all the boxes which apply to you even if it seems unrelated to your current counseling issue.

CHANGE IN:

- □ Sleep _____ increase ____decrease
- □ Average hours/night
- □ Trouble falling asleep
- □ Trouble staying asleep
- □ Appetite _____increase _____decrease
- □ Health (explain) _____
- □ Weight
- □ Lost or gained (circle)
  How Much? _____
  Over How Long? _____
- □ Physical Energy
  (explain) _____

RECENT HISTORY OF:

- □ Nausea and Vomiting
- □ Diarrhea
- □ Shortness of Breath
- □ Rapid Breathing
- □ Severe headache
- □ Confusion
- □ Bleeding
- □ Crying Spells
- □ Other Illness: _____

THOUGHTS OF:

- □ Harming Self

Date of most recent episode____
Did you have a plan? _____
If yes, please describe _____

- □ Harming Others
- □ Suicide
- □ Self Mutilation (cutting, burning)
  (explain) _____

LIFE CHANGE:

- □ Death in Family
  Relationship _____When_____
- □ Divorce/Separation
  of parents/guardian/Spouse
- □ Loss of Friend
- □ Physical Illness
- □ Other _____

FEAR OF:

- □ Death
  _____ your own _____ someone else
- □ Being Alone
- □ Animals
- □ A Place or Situation
- □ AIDS
- □ "Going Crazy"
- □ Germs

CONFLICT WITH:

- □ Spouse
- □ Children
- □ Parents
- □ Brother or Sister
- □ Another student/peer
- □ Girl/boy Friend
- □ School Authority
- □ Police
  (explain)_____

(continued on next page)

PATHWAYS CHRISTIAN COUNSELING

230 W. Sandusky Street Findlay OH 45840
419-423-7812 * 419-423-9877 (fax)

Name and Date: _____

FEELINGS OF:

- □ Anxiety
- □ Depression
- □ Low Self Worth
- □ Jealousy
- □ Tension
- □ Anger/Rage
- □ Boredom
- □ Loss of Interest in pleasurable things (explain) _____
- □ Excessive need for pleasure/thrills (explain)_____
- □ Hopelessness
- □ Thoughts racing
- □ Poor concentration/distracted
- □ Difficulty in making decisions

ABUSE:

- □ Sexual
- □ Physical

Explain:_____
_____
_____
_____
_____

PROBLEM WITH:

- □ Time Management
- □ Work
- □ Class Work
- □ Homework
- □ Social relationships
- □ Family relationships

OTHER:

- □ Legal/Criminal troubles (explain) _____

EXPERIENCE OF:

- □ Vivid Dreams (explain) _____
- □ Nightmares (explain) _____
- □ Hearing voices
- □ Memory problems (explain)_____
- □ Loss of orientation to time, place, or person (explain)_____
- □ Hallucinations (describe)_____
- □ Sexual problem (describe)_____
- □ Accelerated heart rate
- □ Increased sweating
- □ Chest pain
- □ Choking
- □ Difficulty breathing
- □ Hot flashes

SUBSTANCE USE:
Type Of substance(s) used (e.g. alcohol, marijuana)
_____
_____
_____

Last date of use:_____

History of alcohol/substance use: _____
_____
_____
_____

Frequency of use:_____
Amount of use:_____

Please review the boxes you checked and circle those of greatest concern to you right now.

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230 W. Sandusky Street Findlay OH 45840
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MEDICAL HISTORY

Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

Conditions	Yes√	Conditions	Yes√	Conditions	Yes√
AIDS/ARC		Chronic Bronchitis		Juvenile Diabetes	
Arthritis		Asthma		Heart Attack/Ml	
Rheumatoid Arthritis		Other Lung Disorders		Coronary Artery Disease	
Osteo Arthritis		Hepatitis/Other Liver Disorders		Coronary Bypass Surgery	
Back/Spinal Disorders		Congenital Disease/Defect		Congestive Heart Disease	
Back/Spinal Strain		Paralysis		Pacemaker	
Scoliosis		Multiple Sclerosis		Heart Disease	
Spina Bifida		Cerebral Palsy		Other Heart Disease	
Ulcerative Colitis		Epilepsy		Alcohol or Drug Dependency	
Diverticulitis		Parkinson's Disease		Attempted Suicide	
Crolm's Disease		Alzheimer's Disease or Dementia		Anorexia/Bulemia	
Gastric/Peptic Ulcer		Other Neurological Disorder		Chronic Depression	
Other Bowel/Stomach Disorders		Hemophilia		Other Mental/Emotional Disorders	
Stroke (date)		Kidney/Urinary Disorders		Sexually Transmitted Disease	
Cancer (type)		Tumors/Growths		Deafness	
Emphysema		Diabetes Mellitus (give 3 blood sugars with dates)		High Blood Pressure (give last 3 pressures with dates)	

Please list all allergies:

_____

_____

Please list any other serious medical conditions you may have experienced (i.e. automobile accidents or surgeries - including date, description of event and length of treatment) and medications (including name, dosage, and length of time taken):_____

_____

Current Medication (and dosage) taken by client: _____

_____

PATHWAYS CHRISTIAN COUNSELING

230 W. Sandusky Street Findlay OH 45840
419-423-7812 * 419-423-9877 (fax)

Consent to Treat Minor

I/We _____ (Parents and Legal Guardians print your full name(s) on this line), authorize providers of Pathways Christian Counseling to provide mental health treatment to my/our dependent child, _____ whose birthday is ____/____/____/.
(print your child's name on this line)

I/We authorize Pathways Christian Counseling providers and their designees to perform routine examinations, order or perform diagnostic or routine procedures pertaining to the care and to counsel my/our child.

I/We acknowledge that no guarantee or assurance has been made to me/us or my/our child regarding the result of any examination or treatment. In the event of a medical emergency, I/We authorize Pathways Christian Counseling to provide necessary emergency care.

I/We understand that a counselor may meet with my/our minor child individually during a session when I/We am/are not present.

I/We also understand that a counselor may discuss some issues with my/our child that are considered confidential. In most instances, Ohio and most other state and federal laws allow the parent/legal guardian to obtain this confidential information because a minor is involved, but in the interests of having my/our child reveal information and obtain help, to the extent allowed by law I/we am/are waiving my/our right to obtain this information. I/We understand that the counselor will inform me/us about any matters pertaining to the minor hurting himself or herself or anyone else, and the counselor may be required by law to report suspected child abuse or neglect to the proper authorities.

When we examine, diagnose, treat or refer your child, we will be collecting what the law calls Protected Health Information (PHI). We need to use this information to decide what treatment is best for your child and to provide treatment to your child. We may also share this information with others who provide treatment to your child. THE NOTICE OF PRIVACY PRACTICES EXPLAINS IN MORE DETAIL ABOUT YOUR CHILD'S RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA), AND HOW PATHWAYS CHRISTIAN COUNSELING CAN USE AND SHARE YOUR CHILD'S PROTECTED HEALTH INFORMATION.

PLEASE READ THE NOTICE OF PRIVACY PRACTICES FORM BEFORE YOU SIGN THIS CONSENT TO TREAT.

In the future, Pathways Christian Counseling may change how we use and share your child's information, and so we may change our Notice of Privacy Practices. If we do change our form, you may get a copy by calling us at (419)423-7812.

After you have signed this Consent to Treat Minor Form for your child, you have the right to revoke it (by writing a letter telling us that you no longer consent) and we will comply with your wishes regarding your child's treatment from that point forward.

I/WE UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE. I/WE UNDERSTAND THAT THE PARENT THAT BRINGS THE CHILD IN IS RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE. PATHWAYS CHRISTIAN COUNSELING WILL NOT BILL THE PARENT RESPONSIBLE FOR THE BALANCE.

I/WE HAVE READ THIS ENTIRE FORM AND I UNDERSTAND ITS CONTENT. I/WE HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THIS FORM AND I/WE HAVE HAD THE QUESTONS THAT/WE HAVE ASKED SATISFACTORILY ANSWERED.

I/WE HEREBY ACKNOWLEDGE THAT I/WE HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

_____/____/____ _____

Date Child's name

____/____/____ _____

Date Parent's Signature

NAME AND RELATIONSHIP OF EMERGENCY CONTACT:

List all appropriate phone numbers for your emergency contact:

Work _____ Home _____

Cell _____ Other _____

PATHWAYS CHRISTIAN COUNSELING

230 W. Sandusky Street Findlay OH 45840
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CHILD DEVELOPMENT

Child's Full Name: _____ Date: _____

Developmental History:

Circle any of the following that apply to your child and list the age on the available space:

__Night terrors __Bed Wetting __Sleep walking __ Thumb Sucking

__Nail-biting __Stammering __Fears __Happy Childhood

__Unhappy Childhood __ Any Other (please list) _____

How does the child get along with:

	Poor	Fair	Good	Excellent
Father	x	x	x	x
Mother	x	x	x	x
Siblings	x	x	x	x
Others	x	x	x	x

Explain: _____

Are there any family circumstances that seem to have bad or positive effect on your child's development, such as a support from relatives, or outside activities, etc? _____

_____

Are there family circumstances that seem to have created difficulty for the client, such as family separation, financial strain, etc? _____

_____

What do you see as your child's strengths or strong points? _____

_____

Birth and Development:

While pregnant, did the mother experience any problems? _____

Was the child?

___Full Term Birth Weight _____

__Premature Birth Weight_____

__Overdue

Describe any problems during the child's birth: _____

_____

PATHWAYS CHRISTIAN COUNSELING
230 W. Sandusky Street Findlay OH 45840
419-423-7812 * 419-423-9877 (fax)

What was the mother's age when the child was born? _____

Were parents living together at the time of birth? _____

If not, what was status of their relationship? _____

Describe any medical problems with your client immediately after birth, or within six months of birth? _____
_____

At about what age did your child:

Smile ____ Sit Up _____ Crawl _____ Walk _____

Talk _____ Stay dry overnight _____ Control bowels _____

Early Childhood:

Between age 1 & 5, has your child been separated from the family for long periods of time? Reason?
_____

How was your child's health during this period of time? _____

School:

Last school attended: _____ Last grade completed? _____
List schools attended: Years:
_____
_____

_____

Does/did your child miss much time from school? _____

What does/did your child usually do after school? _____

Does/did your child have any reading or writing difficulties? _____
Explain: _____

Was your child ever suspended, expelled, or put on probation from school? (explain)_____
_____

Community Involvement:
Is your child involved in any after school activities? _____

Does your child have any special interest or hobbies? _____

Ethnic and Cultural Influences:

To which of the following ethnic groups does your child identify:

__White __Black __Hispanic __Asian __Native American __biracial _other

How much does your ethnic/cultural identification affect you or your child's life? _____

_____

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Supervision/Internship

Pathways Christian Counseling has several therapists with supervising licenses. This gives students from area colleges the opportunity to participate in an Internship at our facility. Our interns have completed or are completing their practicum hours which is observation of clients, and the internship students are then able to observe, participate and facilitate sessions.

You may be asked in advance of your session(s) if you are willing to have an intern "sit in" or facilitate your session.

If you are willing to have an intern observe, participate and/or facilitate those counselors in training will be provided with "clinical supervision" and "work supervision". These types of supervision are in accordance with the laws of the State of Ohio and the rules and regulations of the State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board, as well as, the State of Ohio Psychology Board. Supervisors are the primary responsible persons for the clinical services you receive.

The supervisors and the counselors in training are under the same confidentiality guidelines. Please be open to these internship opportunities.

☐ Yes, I am willing to have an intern included in my session.

☐ No, I am not willing to have an intern included in my session.

Insurance Simple Agreement Form

Client authorizes the Therapist to deposit checks received on Client's account when made out to the Client,

Signature: _____

Date: _____

(This form only needs to be filled out if we are billing insurance.)

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NO SHOW/CANCELLATION POLICY

At Pathways Christian Counseling, your scheduled **50 Minute** appointment time is reserved just for you. We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of twenty-four (24) hours in advance if you are unable to do so. When we receive advanced notice of cancellation we are able to accommodate other clients needing services. Failure to comply with this policy will necessitate the assessment of the following fees:

Please read and initial.

_____***NO SHOW or CANCELLATION*** of a scheduled appointment with less than 24 hours' notice or will result in a No Show Charge of **$50.00**. A "no show" is defined as when a client does not show for an appointment and does not cancel their appointment at least 24 hours in advance. Situations do unexpectedly arise which makes it necessary to cancel appointments – i.e. illness, inclement weather, family emergencies, etc. We understand that these situations occur and are taken into consideration. Continued cancellation and/or no show may result in discontinuation of services. **This fee cannot be billed to insurance.**

ADDITIONAL FEE SCHEDULE

These are additional fees that you may incur that cannot be billed to insurance

_____ ***DOCUMENT FEE*** is billed when you request a letter or other documentation from your therapist regarding your treatment. This will be billed at $10.00 per document.

_____***COURT APPEARANCE or TESTIMONY*** is billed at an hourly rate, portal to portal, plus mileage and expenses if needed. An additional copy and file preparation charge may be billed for records or other materials subpoenaed.

_____
Printed Name

_____

PATHWAYS
CHRISTIAN COUNSELING

230 W. Sandusky Street Findlay OH 45840
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Signature and Date

Credit Card Authorization Form

(Optional)

This form is used to assist clients in being responsible for fees incurred in the counseling process. Please fill this out and return.

1 hereby authorize Pathways Christian Counseling to charge my (circle one).,.

Visa MasterCard American Express Novus Diners Club Discover

. . . . for my deductible amount and/or copayment amount (where insurance applies) or for the full amount of my fees (as agreed upon with my counselor). I understand that no charges to my credit card will be made in advance of charge incurred through sessions.

PRINTED NAME: _____

CARD NUMBER: _____

EXPIRATION DATE: _____

YOUR ZIP CODE: _____

CREDIT CARD BILLING ADDRESS (home billing address---needed by credit card companies for verification of ownership of card)

_____

CVV NUMBER (last three digits above signature on the back of the card): _____

SIGNATURE AND DATE: _____

PATHWAYS CHRISTIAN COUNSELING

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NOTICE OF PRIVACY PRACTICES

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

Our commitment here at Pathways Christian Counseling is to serve our clients with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Licensed Supervisors. The following are examples of instances where information may be shared:

In privileged communication, the client is protected from having communications revealed without their explicit permission to do so. For example, we will not release psychological reports about you to schools, agencies, physicians, etc., without your written approval. There are exceptions to this statement on confidentiality, which are outlined below.

- The therapist may discuss your case with a supervisor as a means of determining the most appropriate diagnosis or treatment plan.
- If your fees are paid by a third party (such as an insurance company), certain details of your treatment {e.g. dates, treatment and diagnosis) must be revealed to obtain reimbursement. Many insurance companies now allow you to file claims directly with them so that your employer will not see this information.
- If a client reveals information that indicates a clear danger of injury to him/herself or to others, the therapist will need to contact appropriate authorities or family members.
- By Ohio law, we have a legal responsibility to notify appropriate social agencies of any suspicion or knowledge of the physical or sexual abuse or neglect of a child, a disabled person, or an elderly person.

We here at Pathways Christian Counseling are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization maybe revoked at any time by the individual, as provided for by law.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer.

I have read and understand the above Notice of Privacy Practices.

Signed _____ Printed Name _____ Date
(Patient/Guardian) (Print Name)

Office Copy

PATHWAYS CHRISTIAN COUNSELING

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Consent for Counseling from a Christian Worldview

I desire psychological counseling from a holistic perspective involving assessment and interventions in the spiritual, emotional, physical, and social realms from a Christian worldview by my therapist at Pathways Christian Counseling ("PCC").

Since I embrace the Christian spiritual perspective, I desire that my therapist use the language and practices applicable to that worldview. I do not want language and practices used from other worldviews, such as secular, humanist, New Age, atheistic, or Eastern worldviews.

From my Christian perspective, I agree to the use of one or more of eighteen commonly used Christian disciplines described on the following page as part of my treatment plan when spiritual issues are being addressed in my session with my PCC therapist(s).

I understand that no organized religion or religious denomination is being promoted by my therapist or by PCC in general, but he/she is working solely from a biblical worldview.

I understand also that I may experience spiritual confusion or interference in my thoughts by the interplay of spiritual and psychological realities as described below:

- Distressing, unresolved memories may surface through the use of spiritual conflict procedures.
- Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensations.
- Subsequent to the treatment sessions, the process of incidents/material may continue, and other dreams, memories, flashbacks, feelings, and the like may surface.

I further understand that the spiritual dimension if focused on as a part of my overall treatment plan and is not exclusively the focus of treatment.

I understand that I will seek support from my own church and pastoral resources for questions and issues that involve specific doctrinal, religious, or personal spiritual questions and practices.

I understand that spiritual interventions are used when they are intertwined with my psychological and social issues.

I further give my permission for my therapist to discuss with me issues of the afterlife.

☐ Accept ☐ Decline

Client: _____ Therapist: _____

Date: _____ Date: _____