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

Pathways Christian Counseling
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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

_____ _____

Signature of client Date

_____ _____

Signature of spouse
(for couples counseling) Date

_____ _____

Signature of parent or guardian
(*for clients who are minors)* Date

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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(s):

Name: _____ Phone: _____ Relationship to client: _____

-or-

Name: _____ Phone: _____ Relationship to client: _____

Others living in the home:

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____

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_____

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PRE-COUNSELING SELF REPORT

Name _____ Date_____

PERSONAL

1. What brought you to seek treatment?

   _____

   _____

2. What are your goals for 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 OF ORIGIN 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.

   _____

   _____

   _____

   _____

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Name _____ Date_____

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.

   _____

   _____

   _____

STRENGTHS AND RESOURCES

1. List some of your strengths - things you're good at, character traits you/others like about you…

   _____

   _____

2. List some of your passions, interests, hopes, dreams (even if they're just day-dreams!)…

   _____

   _____

Please feel free to include any further pertinent information about yourself below.

_____

_____

_____

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Name _____ 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: _____
- □ Weight - Lost or gained (circle)
  How Much? _____
  Over How Long? _____
- □ Physical Energy: _____

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 thoughts: _____
  Did you have a plan? _____
  If yes, please describe: _____
  _____
  _____
  _____
- □ Harming Others
- □ Suicide
- □ Self-Mutilation (cutting, burning):
  _____

LIFE CHANGE:

- □ Death in Family:
  Relation: _____
  When: _____
- □ Divorce/Separation
  □ of own relationship
  □ of parents/guardian
- □ 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: _____
  _____

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

(Continued on next page)

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Name _____ Date_____

FEELINGS OF:

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

ABUSE:

- □ Sexual
- □ Physical

Explain:_____
_____
_____
_____
_____

OTHER:

- □ Legal/Criminal troubles (Explain) _____

EXPERIENCE OF:

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

PROBLEM WITH:

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

SUBSTANCE USE:

Substance:	Course of Usage - Including Frequency, Amount, and Duration: *Example: "a/b 3-5 bears a day on the wknds. during college. Currently only drink occasionally - maybe 1-2 on a weekend."*	Any Past Concerns?	Any Current Concerns?

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

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MEDICAL HISTORY

Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

Conditions	Yes√	Condition	Yes√	Condition	Yes√
AIDS/ARC		Chronic Bronchitis		Juvenile Diabetes	
Arthritis		Asthma		Heart Attack/MI	
Rheumatoid Arthritis		Other Lung Disorders		Coronary Artery Disease	
Osteoarthritis		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	
Crohn's Disease		Alzheimer's Disease or Dementia		Anorexia/Bulimia	
Gastric/Peptic Ulcer		Other Neurological Disorder		Chronic Depression	
Other Bowel/Stomach Disorders		Kidney/Urinary Disorders		Other Mental/Emotional Disorders	
Stroke (date)		Hemophilia		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 taken by client (include current dosage and when medication began):

_____

_____

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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 RE-IMBURSEMENT

Applies only if you would like us to bill your insurance.

Sometimes, insurance companies send checks for client's services directly to the agency - but filled out to the client. By signing below, client authorizes the agency to deposit these checks received on Client's account when made out to the Client.

Signature: _____ Date: _____

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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 at least 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 LATE CANCELLATION*** - If you miss a scheduled appointment without notifying us of your inability to attend, this is considered a "No Show" and you will be charged **$75.00**. If you cancel an appointment the *day of* the scheduled appointment (within 24 hours of the appointment), this is considered a "Late Cancellation" and you will be charged **$50.00**. 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 take them into consideration. However, 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 for additional services that <u>cannot</u> be billed to insurance

_____ ***DOCUMENT FEE*** - If you request a letter or other documentation regarding your treatment, a documentation fee will be charged at the hourly rate - to the nearest quarter hour. This cannot be billed to insurance.

_____***COURT APPEARANCE or TESTIMONY*** - If you become involved in a legal matter during the course of your counseling and the court requires your therapist to make a court appearance, the appearance is billed at our current 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

_____ _____
Signature Date

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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/her 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.

Printed Name: _____

Signature: _____ Date: _____

Office Copy

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CONSENT FORCOUNSELING 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: _____ Date: _____

Therapist: _____ Date: _____

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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: _____