POSITIVE PATHWAYS Consent to Treatment and Privacy Practices

Client Name: _____ **Date of Birth:** _____

I voluntarily agree to undergo mental health treatment and understand that I may end treatment at any time. I understand that my therapist or counselor cannot guarantee results (e.g., less depressed, improved marital satisfaction, etc.) of mental health services. However, there will be clearly stated reasons, goals, and objectives for continuing/discontinuing mental health treatment. This will be discussed with my mental health provider. I understand that there may be some risks in participating in mental health services. These may include, but are not limited to, addressing painful emotional experiences and/or feelings; being challenged or confronted on a particular issue; re-uniting with family members; or being inconvenienced due to costs/fees of counseling.

I am aware that I can discuss any unforeseen risks vs. benefits with my mental health provider at any time. Furthermore, I understand that this "Consent to Treatment and Privacy Practices form" is not intended to be "all inclusive" of aspects of my mental health treatment. It is only intended to provide some useful information before deciding to engage in mental health treatment.

Notice of Privacy Practices

Positive Pathways is committed to the protection of your mental health information as required by federal and state law. Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

- **Duty to Warn and Protect**
  When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
- **Abuse of Children and Vulnerable Adults**
  If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
- **Prenatal Exposure to Controlled Substances**
  Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
- **Insurance Providers (when applicable)**
  Insurance companies and other third-party payers are given information that they request regarding services to clients.
- **Collaborative Practice**
  Positive Pathways clinicians engage in regular team consultations to address and monitor care plans, discuss client progress, and develop plans for best treatment practices.

Please note: Under HIPAA laws and regulations, psychotherapy notes are not considered to be part of a client record or medical file. Psychotherapy notes are considered the property of the clinician and are protected from normal release to the client or any other party.

By signing this form, I certify that I have read, fully understand, and agree to Positive Pathways' Consent to Treatment and Privacy Practices. I have had an opportunity to ask questions about this information and I understand that a copy of this information is available upon request. Furthermore, if I have elected to complete the on-line questionnaire in place of the printed paperwork, I verify that the information that I provided is complete and accurate.

_____ _____

Signature of Client or Legal Guardian **Date**

POSITIVE PATHWAYS Fee's and Billing

Fees for Therapy (amount billed to insurance not to you)

These rates do not apply if a previously arranged out-of-pocket rate has been established.

Initial (Intake) Assessment - **$185.00**
45 minute Individual Session - **$125.00**
45 minute Family Session - **$145.00**
30 minute Session (Individual or Family) - **$105.00**
60 minute Session (Individual or Family) - **$145.00**

Fees for Other Services

Letter Writing - **$35.00 and up**
Disability Claims - **$35.00 and up**
Copying Case Notes/Records – **1st copy, no charge; additional copies, $1.00 /page plus postage**
Half Day Court Attendance - **$500.00 (due up-front, non-refundable in the case of postponement)**
Full Day Court Attendance - **$1000.00 (due up-front, non-refundable in the case of postponement)**
Missed Appointment (No Call, No Show) Fee - $60.00
Late Cancellation (Less than 24 hours) Fee - $40.00 (48 hours is appreciated)
Phone calls lasting longer than 5 minutes are assessed at **$1.00 / minute**
Return Check Fee - **$30.00**

Please understand that these fees are due at the time that they are incurred. Payment may be made in person, via phone, or online at www.positivepathway.com/billpay.

Billing Practices

We require payment at the time of service. If you have a deductible, co-pay, or co-insurance, payment is expected at the time of service. Balances remaining on an account 30 days from the date of service will be considered past due.

If you have insurance, please understand that this is an agreement between you and your insurance company. If you have not done so already, you should contact your insurance company to obtain a quote of your outpatient mental health benefits. Find out if your deductible or co-pay applies, and if your insurance requires an authorization for your visits, please make sure that you obtain this authorization before your first appointment.

As a service to you, Positive Pathways may contact your insurance company to verify eligibility and obtain a benefits quote, but please understand that we are not responsible if benefits are misquoted. Also, please be aware that insurance benefits quoted by your insurance company are not a guarantee of payment and that you are ultimately responsible to know the benefits of your policy. If your insurance company denies your visits for any reason, you will be responsible for the full fee of each of visit.

If your insurance company requires you to meet a deductible, Positive Pathways will accept a payment of the contracted rate that has been established by your insurance company, until the deductible has been met. Actual amounts collected will be based on your Insurance Company's current reimbursement rates. We would ask you to please be aware of the status of your deductible.

If you have any questions about our billing practices, we are happy to help. You can contact our billing department by phone at (859) 746-9272, option 2, or by e-mail at billing@positivepathway.com.

By signing this form, I certify that I have read, fully understand, and agree to Positive Pathways' Fee Schedule and Billing Practices. I have had an opportunity to ask questions about this information and I understand that a copy of this information is available upon request.

_____ _____

Signature of Client or Legal Guardian **Date**

POSITIVE PATHWAYS

Patient and Insurance Information

Patient Information

Name _____ Date of Birth _____

Social Security # _____ Marital Status _____ Gender ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____

Primary Phone _____ ☐ Home ☐ Mobile ☐ Work

Secondary Phone _____ ☐ Home ☐ Mobile ☐ Work

Email _____ Employer _____

Insurance Policy Holder Information

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

If other than self, please complete the following:

Name _____ Date of Birth _____

Social Security # _____ Marital Status _____ Gender ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____

Primary Phone _____ ☐ Home ☐ Mobile ☐ Work

Secondary Phone _____ ☐ Home ☐ Mobile ☐ Work

Email _____ Employer _____

Insurance Policy Information

This is not necessary if a copy of your insurance card was obtained or if you are paying out-of-pocket.

☐ Medicare ☐ Medicaid ☐ Champ US (Tricare) ☐ Private/Commercial Insurance Plan

Primary Insurance Company _____ Member ID # _____

Secondary Insurance Company _____ Member ID # _____

EAP (Employee Assistance Program): _____

Authorization # (If Applicable) _____ Number of Authorized Visits _____

POSITIVE PATHWAYS Patient and Insurance Information (continued)

Responsible Party Information

Who is responsible for this patient? ☐ Patient (Self) ☐ Other

If other than self, such as a parent or guardian, please complete the following:

Name _____ Date of Birth _____

Social Security # _____ Email _____

Address _____

City _____ State _____ Zip _____

Primary Phone _____ ☐ Home ☐ Mobile ☐ Work

Secondary Phone _____ ☐ Home ☐ Mobile ☐ Work

Emergency Contact Information

Name _____ Relationship _____

Primary Phone _____ ☐ Home ☐ Mobile ☐ Work

Secondary Phone _____ ☐ Home ☐ Mobile ☐ Work

How did you hear about us?

☐ Website ☐ Phone Book ☐ Doctor: _____

☐ Insurance Company ☐ Brochure ☐ Other: _____

By signing this form, I certify that the information that I have provided is complete and accurate. I understand that this is crucial for Positive Pathways to maintain accurate records and billing practices.

_____ _____

Signature of Client or Legal Guardian Date

POSITIVE PATHWAYS

Medical and Personal History

General Medical Information

Briefly describe. (Headaches, stomachaches, thyroid, etc.) _____

_____

_____

Name of Family Doctor _____

Address _____

Phone _____ Date of last physical _____

Have you ever been hospitalized for a medical condition? ☐ Yes ☐ No

Most recent hospitalization _____ Where? _____

Current Medications _____

_____

Mental Health History

Briefly describe. (Depression, anxiety, etc.) _____

_____

Previous Treatment? ☐ Yes ☐ No Name of Counselor or Psychiatrist _____

Address _____

Phone _____ Date of last visit _____

Have you ever been hospitalized for a mental health condition? ☐ Yes ☐ No

When? _____ Where? _____

Sleep Habits

Number of Hours _____ Any sleep issues? _____

☐ Nightmares ☐ Frequent waking ☐ Early AM wakening

☐ Trouble falling asleep ☐ Difficulty waking ☐ Sleeping too much

Personal History

Any difficulties with concentration or learning problems? ☐ Yes ☐ No

Explain _____

Education Level Completed _____ Current School _____

Current Employment _____ How Long? _____

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Consultation Notice

Positive Pathways is a collaborative practice, with regular meetings focused on case consultation, development and monitoring of treatment plans in accordance with state licensing requirements. Clinicians have independent licenses or are under supervision as required by their licensure board. Anne Mangold is the supervising clinician with LISW-S designation in Ohio and LCSW-S designation in Kentucky. Terry Coy, LMFT/IMFT, is the Clinical Director and assists in facilitating consultation. Life Coaches and university-level student interns are present for consultations and are beholden to HIPAA regulations in the same manner as clinicians.

_____ _____

Signature of Client or Legal Guardian Date

POSITIVE PATHWAYS

Cancellation and No Show Fee Policy

CLIENT NAME: _____

PARENT OR GUARDIAN: _____

DATE: _____

I, _____, understand that *Positive Pathways* has a cancellation policy of **24 hours** or more. I will be charged a **$40 LATE CANCEL** fee if I cancel an appointment less than **24 hours** prior to my scheduled appointment.

I, _____, understand that *Positive Pathways* has a **NO CALL, NO SHOW** policy. If I do not show up for a scheduled appointment and/or I do not call to cancel I will receive a **$60 NO SHOW** fee.

I, _____, understand that *Positive Pathways* will no longer schedule appointments for me or my family if my balance goes unpaid or reaches **$100.00**.

We do understand that sometimes things can happen that may prevent you from being able to attend your scheduled appointment(s). The office staff is unable to adjust these fee's. If you have a concern please discuss with your therapist.

By signing this form, I certify that I have read, fully understand, and agree to Positive Pathway's Cancellation and No Show Fee Policy. I have had an opportunity to ask questions about this information and I understand that a copy of this information is available upon request.

_____ _____

Signature of Client or Legal Guardian **Date**