A Pathway to Healing Counseling Services, LLC

31 West 1st Street Unit 1, Wind Gap, PA 18091-1515

(Office) 610-881-4545

(Fax) 610-881-4158

Adult Demographic Information

Client's Name:_____ Date of Birth:_____

Gender Identity: _____Male _____Non-Binary _____FTM

_____Female _____ MTF

Address:_____

City _____. Zip code_____

Can we mail a discharge letter or any correspondence to your home: **YES or NO**

Home Number:_____ Cell Number_____

Can we leave a message ?: **YES OR NO**

E-Mail Address:_____

Social Security Number: **XXX**-**XXX**-_____

Name of Primary Insurance: _____ ID#_____

Primary Insurance Subscriber's Name:_____ D.O.B_____

Client's Relationship to the Subscriber: Spouse____ Self____ Child____ Other_____

Name of Secondary Insurance:_____ ID#: _____

Secondary Insurance Subscriber's Name:_____ D.O.B_____

Client's Relationship to the Subscriber: Spouse____ Self_____ Child____ Other_____

Limits of Contact: (example: *Contact if I can't speak for myself*, *…only contact if my life is at risk*)

Emergency Contact: Spouse____ Friend____ Family_____ Other_____

Name and Number of Emergency Contact:_____

Client's Initials_____

Are there any limits to what can be shared in and **EMERGENCY? If so , please list**

_____

Any Allergies? or Special Health Needs? If so, please list

_____

If you have children or pets in your household, what are the arrangements if you are having a hard time or have to be away from the home?

_____

Cultural Heritage/ Spirituality:_____

In case of an Emergency/Crisis situation, DO NOT CALL THE OFFICE Please call 911 or go to the nearest Emergency Room.

By signing this you acknowledge that you have been given the Crisis Center phone numbers.

Client's Name: _____

Provider's Name:_____

Date: _____

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Telehealth Consent Form

1. I understand that my mental health counselor is available to engage in telehealth phone/video sessions.
2. My mental health counselor has explained to me how the phone/video conferencing technology will be used. It will not be the same as the traditional in-person counseling visits due to the fact that I will not be physically in the same room as my mental health counselor. This technology is HIPPA Compliant.
3. I understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my mental health counselor or I can discontinue the telehealth session if it is felt that the phone/video connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
5. Others may also be present during the consultation (other than my mental health counselor) if I consent. Some examples of "others" can include another mental health professionals, client's family members or the client's paramour) The professionals will maintain confidentiality of the information obtained expect in cases of dangerousness/life threatening behaviors to self, others, or property (**DUTY TO WARN)**. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my history that are personally sensitive to me; (2) ask personnel to leave the telehealth room: and or. (3) terminate the session at any time. **I will not record my session without permission from my mental health counselor. My mental health counselor will not record my session without my consent.**
6. I have had the alternatives to a telehealth consultation explained to me, and am choosing to participate in a telehealth session at the is time. I understand that some parts of the session might involve testing (examples: assessments for Depression and Anxiety levels, Adverse Childhood Experience (ACE) scoring, as well as Safety Planning.
7. In an Emergency/Crisis consultation, I understand that I/or my insurance may be billed at a different rate.
8. For CRISIS… **I MAY ALSO TEXT "PA" TO 741741 (PENNESYLVANIA MENTAL HEALTH CRISIS HOTLINE)**
9. I understand the risks, benefits an any practical alternatives to telehealth (waiting for an appointment in-person, attending a support/bereavement group. Visiting my medical provider, texting/calling a CRISIS HOTLINE)

Client's Name: _____
Client's Signature:_____
Date:_____
Signature of Counselor:_____

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2020/2021

COVID-19

- **DURING THE PANDEMIC**
  - Clients are required to stay in their car and the therapist will go out and wave or call/text them to let them know it is time for their appointment.
  -
  - We respectfully ask that there are no additional people in the waiting room.
  -
  - Everyone is expected to **wear a mask** unless you have discussed it with your doctor (and therapist) due to a physical health condition that prevents you from wearing a mask.
  -
  - If you cannot wear a mask, please be respectful and cover your mouth and nose with a covering such as a paper towel, a scarf, or several tissues, when walking through the waiting room or towards the restroom (common areas).
  -
  - If you are not feeling well or have any COVID-19 symptoms, please reschedule your appointment.

- **SESSIONS**
  - If you are not feeling well or have any COVID-19 symptoms, please reschedule your appointment.
  - Thank you. We are all trying to stay safe. We're all in this together. Let's all get through this and do our part.

Client's Signature: _____

Date: _____

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Payments

Please be aware that if your insurance fails to pay for your session, you will be responsible to pay for the session fee. Payment arrangements can be made if this happens.

We accept cash, credit/debit cards and personal checks. Checks can be made out to:

A Pathway to Healing Counseling Services, LLC.

If a check is presented and is not able to be cashed due to lack of funds (bounced check) you will be fully responsible for the fee and any additional fees that the bank charges our business

_____ I would like to keep my credit card on file with the last four digits ending in _____

_____ I DON'T want my credit card on file

Your credit card **will not be charged without your permission**.

Signature_____ Date:_____

****** If you have not made arrangements to pay the fees, or if the balances have not been completely paid in full within **30 Days,** a claim will be filed against you with the DISTRICT MAGISTATE to collect the fees that are owed for your counseling services and collection fees associated with the process (example: registered mail postage, and court costs).

By signing this form, you confirm understanding that you are responsible for any balances not paid by your insurance company and A Pathway to Healing Counseling Services, LLC may take legal action against you to recover the fees owed.

Client's Name:_____ (Please Print)

Client's Signature:_____ (Age 18 or older)

Date: _____

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CANCELATION NOTICE

A 24 HOUR NOTICE IS REQUIRED or the following will apply:

1st Late cancelation fee: NO CHARGE

2nd Late cancelation fee is $25. (less than 24 hour notice)

3rd Late cancelation fee is $50 and possible discharge from services

1st No Call/ No Show fee $50

2nd No Call/No Show fee $50 and possible discharge from services

Unless prohibited by Law or regulations. *For Medical Assistance and Medicare Insurances

Client's Name:_____

Client's Signature: _____

Date: _____

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Client's Name: _____ D.O.B _____

1. **Consent to Evaluate/Treat:** I voluntarily consent to participate in a Mental Health Evaluation and Mental Health Treatment by a Master's level therapist from A Pathway to Healing Counseling Services, LLC. I understand the following evaluation needs complete and accurate information. I will be provided with information concerning each of the following areas:

A. The benefits of proposed treatment

B. Alternative treatment modes and services

C. The manner in which treatment will be administered

D. Probable consequences of not receiving treatments

The evaluation will be conducted by Pennsylvania Licensed THERAPIST. (LSW, LCSW, LPC)

Treatment will be conducted within the bounds of Pennsylvania Law.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews or assessments. The evaluation includes diagnosis, treatment plan, prognosis and psycho-education about the disorder, behavioral treatments, possible benefits to treatment to include improved cognitive performance, health status, quality of life, and an awareness of strengths and limitations.

3. **Charges:** are based on the length of type of the evaluation or treatment, which are determined by the nature of the service. I will responsible for any charges not covered by insurance, including co-payments/co-insurance and deductibles.

4. **Medical Records**: Effective immediately, ALL records from APTHCS, LLC will be electronically stored with Office Ally/ Practice Mate. They are HIPPA compliant and are mandated to uphold all HIPPA regulations.

5. **Confidentiality, Harm, and Injury:** Information from the evaluation/treatment is contained in confidential medical records. A Pathway to Healing Counseling Services, LLC and I consent to disclosure by A Pathway to Healing Counseling Services, LLC staff for the purpose of continuity of care. Per PA Mental Health Law, Information will be kept confidential with the following exceptions:

1. If I am deemed to present a danger to myself or others

2. If concerns about possible abuse or neglect arise:

3. If a court order is issued to obtain records

Client's Initials_____

6. **Crisis:** This signifies that I have been aware NOT TO CONTACT the office in case of a crisis and have been given the phone numbers for local Crisis Centers:

Client's Name:_____

Client's Signature or Caregiver:_____

7. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and for treatment at any time by providing a written request to the treating clinician.

8. **Expiration of Consent:** This consent to treatment will expire 12 months from date of signature unless otherwise specified.

I have read and I understand the above information, have had the opportunity to ask questions about the above information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions in regards to the services that will be provided to me and about the above information.

Signature:_____

Date*:*_____

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Authorization for Primary Care Physician/Nurse Practitioner/ Physician's Assistant

_____I authorize A Pathway to Healing Counseling Services, LLC to communicate with my Primary Care Physician/Nurse Practitioner/ Physician's Assistant if needed to coordinate better health care services for me.

____ I DO NOT authorize A Pathway to Healing Counseling Services, LLC to communicate with my Primary Care Physician/Nurse Practitioner/ Physician's Assistant if needed to coordinate better health care services for me.

Health Provider's Name:_____
Health Provider's Number:_____

Client Name:_____(Print)
Client Signature:_____

Parent/Legal Guardian Signature:_____
Date:_____

Counselor's Signature:_____

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Limits of Confidentiality

Contents of all therapy are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent off the or the client's legal guardian. Noted exceptions are as follows.

DUTY TO WARN: 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 cares 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 VUNERABLE ADULTS: If a client states or suggest that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult, or a child (vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social services and or legal authorities.

PRENTAL EXPOSURE TO CONTROLLED SUBSTANCES: Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

MINORS/GUARDIANSHIP: Parents or legal guardians of non-emancipated minor client's have the right to access the client's records.

ISURANCE PROVIDERS: (When applicable) Insurance companies and other third-party payers are given information that they request regarding services to the client.

Information that may be requested includes, but is not limited to: types of services, date/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, care notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client's Signature: _____ (Client's Parent/ Guardian if under 18)

Date: _____

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Crisis Phone Numbers:

National Crisis Text Line- 741741

Carbon, Monroe and Pike County: 570-992-0879

New Perspectives 800-849-1868

Warm Line: 866-654-8114

Lehigh County: 610-782-3127

Warm Line 610-820-8451 accepts calls between 6 AM- 10 AM and then 4 PM -12 AM

Northampton County: 610-829-4801

The crisis unit is located at **1201 Emrick Blvd, Bethlehem PA 18020 for Walk in Crisis**

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Client's Rights and Responsibilities

A Client has the right to:

- Be treated with dignity and respect,
- Fair treatment, this is regardless of their race, religion, gender, ethnicity, age, disability.
- Have their treatment and other client information kept private. Only where permitted by law, may records be released without client's permission.
- Easily access timely care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by the client's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- Have a clear explanation of their condition.
- Information about Magellan Health Choices, and or any other insurance companies, it's practitioners, services and role in the treatment process. Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Client's Rights and Responsibilities Policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.

Statement of Client's Responsibilities:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care, to help them understand about their care.
- Follow the treatment plan/and goals. The plan of care is to be agreed upon by the client and provider.
- Keep their appointments. Client's should call the office (610-881-4545) or their provider as soon as the client would need to cancel or reschedule an appointment time.
- Let their provider know when the treatment plan/goals are not working for the client.
- Report Abuse
- Report Fraud
- Openly report concerns about the quality of care the client receives.
- I agree that I will **NOT** bring in illegal substances into A Pathway to Healing Counseling Services, LLC.

Should you have any questions or concerns, please contact Bernadette Gaumer, LCSW. 610-881-4545

I have read and understand my rights and responsibilities as a Mental Health Client at APTCHS, LLC.

Client Name: _____

Client Signature: _____ Date: _____

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Advance Directive for Mental Health Decision Making

If you are concerned that you may be a subject of involuntary psychiatric commitment or treatment at some future time, you can prepare a legal document in advance to express your choices about treatment.

A Mental Health Advance Directive is a document that allows a person to make preferences regarding mental health treatment known in the event that the person is incapacitated by their mental illness. In effect, the person is giving or withholding consent to treatment in advance of when treatment is needed. This allows a person to make more informed decisions and to communicate their wished more clearly. A new law was passed in Pennsylvania, effective January 28, 2005, that makes it possible for a person to make and enforce a Mental Health Care Advance Directive.

The document must me the following requirements:

- The person making the Advance Directive must be at least 18 years of age or an emancipated minor.
- The person must not have been deemed incapacitated, such as by a guardianship proceeding or an involuntary commitment.
- The document must be signed, witnessed and dated. Witnesses must be at least 18 years old. If the person cannot physically sign the document themselves, another person may sign on behalf of the person, but the person signing may not be a witness.
- Neither a provider no an employee of the provider may serve as an agent unless they are also blood relative
- And, the document must express preferences regarding the initiation, continuation, or refusal of mental health treatment. Other instructions may include, but are not limited to, designating an agent, nominating a guardian, temporary custody of children or pets, family notification, or dietary or religious preferences.

The Advance Directive is valid for 2 years form the date of execution unless one of the following happens first: The Person revokes the entire Advance Directive, or the person makes a new Advance Directive.

An Advance Directive can include a Power of Attorney where and individual authorizes a designated Mental Health Care Agent to make treatment decisions on their behalf in the event of a mental health crisis.

If you have additional questions, contact any of the following organizations:

- Pennsylvania Mental Health Consumer's Association 1-800-88PMHCA
- Pennsylvania Protection & Advocacy/Disabilities Law Project 1-800-692-7443
- Mental Health Association Pennsylvania 1-866-578-3659

_____ I do not want to complete a Directive for Mental Health

Client's Name: _____
Client's Signature:_____Date:_____

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HIPPA COMPALIANT

Authorization to Obtain or Release Protected Health Information

Client Name:_____ Date of Birth:_____ Age:_____

Adrdess:_____

_____

Home or Cell Number: _____ E-Mail: _____

****If applicable…….***

Parent/Guardian Name: _____ Home or Cell Number: _____

I authorize A Pathway to Healing Counseling Services, LLC to obtain information from and/ or to release Mental Health Records to:

Name of Person or Entity: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone: _____ Fax: _____
E-Mail_____

The purpose for which the information is to be used:

_____Continuing Care _____Employment _____Billing

_____Collateral Contact _____ Disability Benefits _____ School

_____ Personal _____ Legal (given specific reason) _____

****DO NOT RELEASE THE FOLLOWING INFORMATION: _____***

_____

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HIPPA COMPALIANT

Authorization to Obtain or Release Protected Health Information (Page 2)

Authorization:

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This Release of Information demonstrates compliance with HIPPA Standards for privacy, and all Federal and State guidelines. I have been informed to refer to the Notice of Privacy Practices regarding authorized disclosures. I confirm a legible copy of this authorization or my signature thereon may be used with the same effectiveness as an original. "Federal regulation (42 CFR, Part 2) prohibits anyone from making any further disclosure of this information unless it is expressly permitted by my written consent, or as otherwise permitted within such regulations. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client." **(RM 203, 7.2) Rev.4-12-04**. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Revocation must be in writing.

Validation: This Authorization is in effect beginning _____ and

Expires _____ (**not to exceed 180 days**).

Client Signature (including minor client's age 14-17)

_____ Date: _____

Parent/Guardian/Authorized Representative Signature (if applicable)

_____ Date: _____

(**Witness**)

_____ Date: _____

Revocation: I hear by revoke the above authorization.

Signature: _____ Effective Date: _____

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Patient Rights and HIPPA Authorization

The following specifies you rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA")

1. Tell your Mental Health professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit in writing to your Mental Health Professional and your Insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payments, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as their client.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPPA.
5. If this office initiated this authorization, you **must** receive a copy of the signed authorization.
6. ***Special instructions for completing this authorization for the use and disclosure of Psychotherapy Notes:*** HIPPA provides special protections to certain medical records known as "*Psychotherapy Notes".* All *Psychotherapy Notes* recorded on any (i.e. paper, electronic) by a Mental Health Professional (such as a Psychologist or Psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a Mental Health Professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a)medication prescription an monitoring, (b) counseling session start and stop time, (c) the modalities and frequency of treatments furnished, (d) the result of clinical test, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "*Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign authorization to specifically allow for the release Psychotherapy Notes.* Such authorization must be separate from an authorization to release other medical records.

TO BE GIVEN TO CLIENT

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, complete items 9, 9a and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12