Pathway to Wellness
Community Clinic

DATE:

APPT WITH:

PATHWAY TO WELLNESS COMMUNITY CLINIC, LLC

Reminder: If client has a guardian he/she must sign paperwork – Please PRINT Legibly

Last Name: _____ **First Name**: _____**MI**____

Date of Birth ___/___/___ Age: ____ Gender ☐ Male ☐Female ☐Other SS #_____

Street Address: _____Apt or Box #: _____

City_____State_____ZIP_____County_____

Email address: _____ May we send you information at this email? ☐ Yes ☐ No

Primary Phone (_____) _____ Other Phone (_____) _____

Work Phone (_____) _____ May we call or leave a message at this #? ☐ Yes ☐ No

**Would you prefer email, text or call for appointment reminders? _____ (email preferred by clinic)

Briefly describe what brings you to Pathway to Wellness: _____

_____

Referral for: ☐ Mental Health ☐ Substance Abuse ☐ OWI/Zero Tolerance ☐ Domestic Abuse
Referred by: ☐Self ☐Hospital ☐Family/Friend ☐School ☐Court ☐Physician ☐DHS ☐Probation Officer

☐ Other: _____

Name of referral (If applicable, DHS contact, probation officer, doctor): _____

Employment: ☐ Full time ☐ Part time ☐ Unemployed/looking for work ☐ Student ☐Retired ☐ Disabled

☐ Other: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship to Client: _____ Phone: _____

I give consent to contact the above listed person in the event of an emergency ☐ Yes ☐ No
I give consent to contact the above listed person to coordinate my care ☐ Yes ☐ No

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other_____

FAMILY/HOME & SOCIAL INFORMATION

Spouse/Partner's Name: _____ Age: _____ Occupation: _____
My relationship with my spouse/partner is: Poor Fair Average Good Excellent (Circle one)
Mother's Name: _____ Age: _____ Occupation: _____
Father's Name: _____ Age: _____ Occupation: _____
Step-Mother(s)/ Step-Father (s) Name(S): _____
How many siblings do you have? _____ Which number are you: _____
Do you have any children? _____ If so, how many? _____ List their names and ages: _____
_____
List everyone currently living in your household and their relationship to you if not mentioned above: _____
_____
_____
What is the highest level of education completed: _____
Do you have military history: Yes or No (Circle one)?
Have you been or are you currently in the legal system for any reason? _____
_____

MEDICAL/HEALTH INFORMATION

Current Primary Care Physician: _____ Clinic: _____
Have you received mental health treatment before? ☐ Yes ☐ No
If so, Where_____ When: _____
Have you been hospitalized for psychiatric reasons? ☐ Yes ☐ No
If so, Where_____ When: _____
Does anyone in your family have a history of behavioral health issues? If so, please list relationship and issue
_____
_____
What medications do you take? (Include non-prescription, herbal medicines and supplements) (Use back if need)

Medicine	Dose	Frequency	Who prescribes
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any allergies, including medication allergies/sensitivities:

_____

Do you have a history of alcohol use: Y / N
Do you currently drink: Y / N
If yes, please indicate the amount and frequency……
In a day _____ In a week _____ In a month _____

Do you have a history of drug use: Y / N?
Do you currently use any drugs: Y / N
If yes, please indicate the amount and frequency….
In a day _____ In a week _____ In a month _____

Client/Guardian Signature: _____ **Completed on: ___/___/___**

Witnessed by: _____

Symptom Checklist

Please circle any of the following that have been bothering you lately

Abuse	Agoraphobia	Ambition	Anger
Anxiety	Appetite	Bowel Trouble	Career Choices
Children Issues	Compulsive Behaviors	Concentration	Confidence
Depression	Distracted Easily	Divorce	Easily Startled
Eating Problems	Education	Empty Feelings	Energy (Hi/Low)
Extreme Fatigue	Fears	Fetishes	Finances
Friends	Grief/Loss	Guilt	Headaches
Health Problems	Hopelessness	Inferiority Feelings	Insomnia
Irritability	Isolate/Avoid Others	Lack of Interest in Activities	
Learning Disabilities	Legal Issues	Legal Issues due to Anger Management	
Loneliness	Making Decisions	Marriage Issues	Memory Issues
Mood Swings	My Thoughts	Nervousness	Nightmares
Obsessive Thinking	Overweight	Painful Thoughts	Panic Attacks
Parental Responsibilities	Phobias	Relationship Issues	Restless/Fidgety
Ritual Behaviors (Nail Biting, Picking)		Sadness	Self-Esteem
Self-Harm (Cutting, Burning, etc.)		Separation	Sexual Problems
Sexuality Issues	Short Temper	Shyness	Sleep Issues
Stress	Suicidal Thoughts	Tobacco Use	Trauma History
Work Related Issues			

Is there anything else that is important for your therapist to know about and that you have not written about on any of these forms? Please list here and use the back of the paper if needed.

_____

_____

_____

_____

_____

_____

CONSENT FOR TREATMENT

COUNSELING is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY:
All interactions with Pathway to Wellness Community Clinic, LLC including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic, educational, or job placement file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

EXCEPTIONS TO CONFIDENTIALITY:

- The counseling staff works as a team. Your therapist may consult with other counseling staff to provide the best possible care. These consultations are for professional and training purposes.
- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety.
- Wisconsin state law requires that staff of Pathway to Wellness Community Clinic, LLC who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to county child protection services.
- A court order, issued by a judge, may require the Pathway to Wellness Community Clinic, LLC staff to release information contained in records and/or require a therapist to testify in a court hearing.

We appreciate prompt arrival for appointments. Please notify us at 608-643-3663 if you will be late, 24-hour notice of cancellation allows us to use the time for others and avoids you being charged a late cancellation or no show fee.

I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the Pathway to Wellness Community Clinic, LLC.

_____ _____

Print Client Name *Witness*

_____

Signature of client / Parent / Legal Guardian *Date*_____

PATHWAY TO WELLNESS COMMUNITY CLINIC, LLC

RESPONSIBLE PARTY/FEE SCHEDULE

CLIENT: _____ DATE: _____

RESPONSIBLE PARTY: _____
ADDRESS if different from client's_____

As part of receiving services offered at the Pathway to Wellness Community Clinic, LLC, please be aware of the following responsibilities regarding payment of charges of services rendered:

- Patient responsible to know Insurance benefits. Call # on card for out-patient mental health Coverage. Codes: 90791 (Intake) & 90837 (Session) Be sure to ask if Prior Authorization is needed.
- Unless other arrangements are made, full payment is due at the time services are provided. For clients who have insurance, co-payments are due at the time of appointment and deductible will be determined after we receive Ins EOB
- You or whomever signs the "Responsible Party/Fee Schedule" form is financially responsible for all charges, whether or not paid by insurance including any charges for services rendered which are denied, not prior authorized for any reason, not covered by the applicable insurance company. If you are a minor or a student, please make arrangements for a parent of guarantor to sign this form. Please provide the clinic with a complete address for the parent or guarantor for billing purposes.
- To cancel an appointment, you must provide notice 24 hours in advance of your scheduled appointment. If your appointment is on Monday, you must cancel the Friday prior or you will be billed $75 for the 1st appointment, $100 for the 2nd, and $150 After 3rd. Though after your 2 late cancel or no show, you're subject to discharge from the clinic. Please note that insurance companies will not cover this expense.
- Balances over $100 will not be scheduled to be seen until payment is made or have a signed payment plan in place.
- You are responsible for prompt payment of bills for your account. Balances more then 30 days old are subject to interest and penalty fees. If you fail to make a payment within three months of the time charges come due, your balance will be turned over for collections to a collection agency.
- If you have any questions or concerns about billing, please raise these questions to your clinician or the Billing Specialist as soon as possible. We will be happy to assist you

Client or Responsible Party Signature_____

Witness_____

PATHWAY TO WELLNESS COMMUNITY CLINIC, LLC (as of 07/01/2016)

Master Level Therapist	**PhD Level**
$250.00/ Initial Evaluation	$300.00/Initial Evaluation
$200.00/ 60 Min	$210.00/60 Min
$265.00/60 Min Family Session	$275.00 / 60 Min Family Session
$180.00 / 45 Min	$190.00 / 45 Min
$170.00/ 30 Min	$180.00 / 30 Min

Cash Rate

$160.00 / Initial Evaluation	$170.00 / Initial Evaluation	Psychological Testing: $125 Per Unit to Ins
$140.00 / Session	$150.00 / Session	Discuss cash rate with PhD

Pathway to Wellness
Community Clinic

WELCOME TO PATHWAY TO WELLNESS COMMUNITY CLINIC, LLC

This informational packet is designed to help you understand our policies and procedures along with your rights as our client/patient. Please read this packet and if you have questions, feel free to ask. Your signature is requested throughout this packet indicating your understanding and willingness to participate and abide by these policies. We appreciate your trust and confidence in us. We take pride in our training, knowledge, and capabilities, and we want you to know that we are dedicated to giving you quality health care.

OFFICE HOURS: To reach a provider during office hours, or to make or change an appointment, please call:

Pathway to Wellness Community Clinic
(608)643-3663
Monday- Friday (8am-5pm) *Tuesday and Wednesday til 6:30pm

After hours, you can leave a message on our GENERAL voicemail and we will return it on the next business day.
If your call is an emergency, please call "911" or go directly to your local Urgent Care or Emergency Room. Then see our Psychiatric Emergency Policy.

INSURANCE AND BILLING INFORMATION

VERIFICATION OF INSURANCE BENEFITS & PRECERTIFICATION: Your insurance carrier will be contacted to verify outpatient mental health benefits. Many managed care companies require pre-certification, pre-authorization, or a referral prior to treatment. It is your responsibility to obtain the necessary information for treatment at Pathway to Wellness Community Clinic, LLC. You will also be responsible for any deductibles or co-payments not covered by your insurance plan, due at the time of service. Call # on card for your benefits! Also refer to billing sheet.

Insurance claim forms are completed by this office as a courtesy to you. We do not accept responsibility for collecting your claim or negotiating a settlement on a disputed claim.

MONTHLY STATEMENTS: A statement of your account will be sent to you monthly. It is expected that you will make regular payments on any outstanding balance (if any). Any balances more than 30 days past due are subject to interest and penalty fees. Balances more than 90 days past due will be sent to collections. If your balance goes over $100 we will not be able to see you until you make a payment to bring the balance below $100 or set up and adhere to a written payment plan. If you wish to arrange a payment plan, you are encouraged to discuss this with the person in charge of billing. (Note to parents of a minor child: It is this clinic's policy to accept the parent signature on this form as an agreement to be responsible for payment of the minor child's services. If a divorce occurs in the course of your child's treatment, it is still the responsibility of the signing parent to make sure payments are made in a timely manner on your account. It is not the responsibility of Pathway to Wellness Community Clinic, LLC to determine the financial responsibility of the minor child after the divorce has occurred. Therefore, the parent or guardian who signs the responsibility form will remain the responsible party until the bill is paid in full.)

APPOINTMENT POLICY: scheduled appointments can be cancelled up to 24 business hours in advance without penalty. If you do not cancel outside of 24 hours or do not show up you will be charged $75.00 for the first, $100.00 for the second, $ 150.00 for the third occurrence and any others that may follow that. Multiple late cancelations and/or missed appointments can result in termination from the clinic. You will be given 1 verbal warning and a 2nd written warning before you are discharged from the clinic.

(cont. on next page)

CLIENT RIGHTS AND GRIEVANCE PROCEDURE:

As a client at Pathway to Wellness Community Clinic, LLC you have the right to:

- Be treated with dignity
- Have confidentiality of all treatment records
- Review your treatment records
- Prompt and adequate treatment or rehabilitation

If you feel that any of these rights have been abridged or have questions concerning any aspect of treatment, please talk with your therapist. If you are not satisfied, you have the right to submit, in writing, to Pathway to Wellness Community Clinic, LLC, a statement of your concerns or complaints. When received, your statement will be reviewed, and within thirty (30) days you will receive in writing, a response.

You have the right to contact your client rights specialist to file a grievance or to learn more about specific grievance process used by the agency for which you are receiving services, this information is posted in our entry way to the clinic.

Please sign this letter indicating that you have read and understand your rights as a Pathway to Wellness Community Clinic, LLC patient.

_____

Signature/Date