Date:

SCREENING FORM/APPLICATION

<table>
<tr><td colspan="3">Client Name:
Last First Middle</td></tr>
<tr><td colspan="3">Address:
Street City State ZIP</td></tr>
<tr><td colspan="2">DOB:</td><td>Age:</td></tr>
<tr><td colspan="2">Phone:</td><td>Alternate:</td></tr>
<tr><td>Sex: ☐ Male ☐ Female</td><td></td><td>Referral Source:</td></tr>
</table>

<table>
<tr><td colspan="3">Acceptable methods of communication regarding appointments/scheduling:

☐ Phone ☐ Email List preferred email:______________________________ ☐ Text

If I have elected to receive communication via electronic methods, I acknowledge that Pathways cannot guarantee complete privacy of the information exchange..</td></tr>
<tr><td>Primary Care Physician</td><td>PCP Contact Phone:</td><td>Health/Medical Conditions:</td></tr>
<tr><td colspan="3">PCP Address:
Street City State ZIP</td></tr>
<tr><td colspan="2">Medications/Dosages:</td><td>Allergies:</td></tr>
<tr><td colspan="3">Previous counseling services? (If so, where/when/focus of tx)</td></tr>
</table>

Social History

Age	Event	Age	Event
	Death of sibling/parent		Murder of a significant person
	Death of partner/spouse		Neglect
	Divorce of parents		Physical abuse
	Separation of parents		Sexual abuse
	Desertion of parent		Sexual assault
	Mental Illness/Hospitalization of family member		Pregnancy
	Long-term physical illness of family member		Abortion
	Suicide of a significant person		Trouble with the law

Other notable information:____

____

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____

Professional Disclosure Statement and Consent to Treatment

Welcome to Pathways Counseling Center! We are committed to providing you with exceptional services. Please take a minute to read over the office policies. If you have any questions and/or concerns, please do not hesitate to address them with your therapist.

CREDENTIALS / SCOPE OF PRACTICE

Jennifer Zare, LISW-CP
Masters of Social Work (MSW) - University of Wisconsin-Madison (2003)
B.A. – Psychology, University of Notre Dame (2002)
Licensed Independent Social Worker – Clinical Practice (LISW-CP) License # 8403

Elizabeth Saraswat, LISW-CP
Masters of Social Work (MSW) – Fordham University (2009)
Bachelor of Social Work – James Madison University (2007)
Licensed Independent Social Worker – Clinical Practice (LISW-CP) License # 12301

∫Joel Burke, LPC, NBCC
Master's of Professional Counseling – Liberty University (2016)
Doctorate of Ministry – Southern Baptist Seminary (1988)
Master's of Divinity – Southern Baptist Seminary (1980)
Licensed Professional Counselor (LPC) – License # 7123
Adheres to the code of ethics of the American Counseling Association

Donna Metta, MA, LPC
Master's in Creative Arts Therapy – Hofstra University (1997)
BA Psychology – SUNY Stony Brook (1993)
Licensed Professional Counselor (LPC) – License # 5001
Adheres to the code of ethics of the American Counseling Association

Our therapists provide a number of psychotherapeutic services that include: individual, group, and family therapy with children, adolescents, adults, and families facing a range of behavioral, emotional, and social challenges.

Appointments/Scheduling

- Appointments are provided on a first-come, first-serve basis
- Online scheduling is available at www.pathwaysofgreenville.com to enable clients with more flexibility and control over their own appointments. You may schedule up to three appointments to guarantee a preferred time slot; however, if an appointment is broken, remaining appointments will be cancelled. No show fees will apply.
- After hours appointments are available (after 5pm on weekdays, and weekends) with a modest convenience surcharge of $25 per hour. This surcharge is not covered by insurance or EAP programs.
- A client will be moved to inactive status after 3 months of no contact with the therapist. At this time the client will have to reapply to be reinstated as an active client

Client Rights

- **Compassionate and Sensitive Treatment –** You will be treated with respect and dignity by all staff members
- **Appropriate treatment** – Your therapist will work with you to determine the most effective treatment for the challenges you are experiencing. This includes: developing a treatment plan, providing the most effective psychotherapy, consulting with other experts/professionals when needed, and/or referring to another professional with the appropriate expertise.
- **Informed consent** – you will be informed of the benefits and risks of therapy
- **Discontinuation of Treatment** – you may opt to stop treatment or request a referral to another therapist at any time.
- **Confidentiality –** the psychotherapy relationship is confidential. Every effort is made to protect and maintain your privacy and confidentiality. However, there are some limitations to your confidentiality:
    - All therapist are mandated by standards – through Duties to Warn – to breach confidentiality if they discover:
        1) A client is threatening self-harm or suicide
        2) A client is threatening to harm another or homicide
        3) A child has been or is being abused or neglected
        4) A vulnerable adult has been or is being abused or neglected

    Therapy files may be subpoenaed in South Carolina through a court order (signed by a judge).

    If you wish for your information to be released to another party, you must sign a specific release of information.

    Routine case consultation with other professionals is done to ensure high quality and coordinated care. No identifying information is shared unless a written consent is signed.

Please respect the privacy of all individuals you see entering, leaving, or in the waiting area. Do not hesitate to let your therapist know if you have concerns about your privacy.

Client Responsibilities

- Payment for services (See Financial Responsibilities form for details)
- Remembering and attending all scheduled appointments
  *Automated reminders are provided as a courtesy but cannot be guaranteed.
- Arriving on time for scheduled appointments
- Providing 24 hour notice for cancellations
- Rescheduling cancelled appointments
- Notifying your therapist when you are ready to discontinue services

Missed Appointments/Late Cancellations

24 hour notice is required for all cancellations. A $50 fee will be automatically charged to the card you place on file. If we are able to fill your appointment slot with another client, the fee will be waived. In the case of illness and you provide a doctor's note, the fee will be waived.

How to Communicate with Your Therapist

The preferred method of communication with your therapist is face-to-face during sessions. If you need to reach your therapist outside of scheduled sessions, contact them through their direct line and voicemail. Text and email are not secure methods of communication and are not recommended. Messages sent through the online portal are secure and acceptable for brief non-emergent communications.

Social Media

We invite you to like our Facebook Page to stay up to date on the latest research, therapy methods, and information regarding our services. Therapist's are not permitted to accept personal requests to be "connected" on social networking sites. This can compromise your confidentiality, our therapist's respective privacy, and may blur the boundaries of the therapeutic relationship.

Emergency Procedures

A confidential voicemail is available to you at all times. A diligent effort is made to return all calls within 24 hours. If you are in an immediate crisis please contact 911 or the Crisis Line at 864-271-8888. When your therapist is unavailable due to vacation or illness, a professional colleague is available to assist in emergent/life-threatening situations.

If your therapist is unavailable due to a personal emergency, a professional colleague may contact you to inform you of any pertinent information.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996
(HIPAA CERTIFICATE)

This notice describes how medical information about you may be used and disclosed about you as well as how you may obtain access to this information. Please review it each time you visit. Please keep this certificate copy for your records.

All information revealed by you in a counseling/therapy session and most information placed in your counseling/therapy file (all medical records or other individually identifiable health information held or disclosed in any form – electronic, paper, or oral) is considered "protected health information" by HIPAA. As such, your protected health information cannot be distributed to anyone else without your express informed and voluntary authorization. Your records will be kept secure and viewed only by your Therapist. The exceptions to this are defined below. Additional information regarding your rights as a client can by found in the Professional Disclosure Statement.

USE OR DISCLOSURE OF THE FOLLOWING PROTECTED HEALTH INFORMATION THAT DOES NOT REQUIRE YOUR CONSENT OR AUTHORIZATION:

1. Uses and disclosure required by law. For example, files subpoenaed by a Judge.
2. Uses and disclosures about victims of abuse, neglect, or domestic violence – like the duties to warn (explained in the Professional Disclosure Statement).
3. Uses of disclosures for health and oversight activities – such as correcting records or correcting records already disclosed.
4. Uses and disclosures for judicial and administrative proceedings – such as in cases of malpractice or breach of ethics.
5. Uses and disclosures for law enforcement purposes – such as when you claim mental health issues as a defense in a civil or criminal case.
6. Uses and disclosures for research purposes – using client information in research; always maintaining confidentiality.
7. Uses and disclosures to avert serious threat to health or safety – for example, Probate Court for a commitment hearing.
8. Uses and disclosures for Worker's Compensation – basic information in your records as a result of your Worker's Compensation claim.

AS A CLIENT YOU HAVE A RIGHT TO:

1. See and receive a copy of your counseling/therapy file. Psychotherapy notes afforded special privacy protection under the HIPAA regulations and are excluded from this right. You will be required to pay copying fees of $.20 per page.
2. Request amendments to your counseling/therapy file.

3. Receive a history of all disclosures of protected health information. You will be required to pay coping fees of $.20/page.
4. Restrict the disclosure of your protected health information for the purpose of treatment, payment and operations. If you chose to release any protected health information, you will be required to sign a release of information form detailing exactly to whom and what information you wish to disclose.
5. Register a complaint with the Secretary of Health and Human Services OR The South Carolina Licensing and Regulations Board if you feel your rights, herein explained, have been violated. Telephone numbers are available at: http://www.llr.state.sc.us

You have a right to a personal copy of these documents or view them on the website: www.pathwaysofgreenville.com. (1) The HIPAA Certificate (2) The Professional Disclosure Statement and Consent for Treatment Form. It will be necessary for you to sign indicating that you have received, read, and understand any part of your client rights under HIPAA or the Professional Disclosure Statement and Consent for Treatment. Your therapist will be happy to explain these documents.

Jennifer Zare is the designated “Privacy Officer” for Pathways Counseling Center, LLC. Please discuss complaints related to privacy directly with the Privacy Officer. You can also directly file a complaint with the LLR Board and Department of Health and Human Services.

FINANCIAL POLICIES FORM

Please initial each item below to acknowledge that you understand and agree to Pathways Counseling Center's financial policies.

_____ Each client is responsible for the payment of therapy services provided. Payment is due at the conclusion of each session in full. Cash, check, or credit cards are acceptable payment methods. Please make any checks payable to: Pathways Counseling Center.

____ An active credit card must be retained on file. Every attempt will be made to notify you of any upcoming charges to your account; however, in the event of an overdue balance and reasonable effort to contact you for settlement, the card on file will be charged to settle the outstanding balance.

____ Pathways Counseling Center agrees to file insurance claims as a courtesy to all clients. In the event that an insurance company declines payment for any reason, it is the clients' responsibility to pay for services in full.

____ Insurance companies or other third party payers do not cover "no show" or late cancellation fees. Clients are responsible for settling payment ($50) prior to the next session.

____ Some insurance companies require authorization prior to, and throughout, treatment. It is the client's responsibility to obtain and maintain any authorizations required by their insurance.

____ Pathways offers a $20 discount off of each therapy service for clients that do not file with insurance / third party payer and pay cash on the day of service.

____ After hours appointments are available for a modest convenience surcharge of $25 per hour. Surcharges are not covered by insurance or EAP programs.

____ There is a $25 fee for all returned checks.

____ Should an account be placed with collections, it is the client's responsibility to cover any additional costs (i.e. agency fees, legal fees, court costs, etc.,).

____ ____________________________
Signature (responsible party) Date

PAYMENT RESPONSIBILITY FORM

As the financially responsible party, I authorize the associates of PATHWAYS COUNSELING CENTER, LLC to charge the card listed for fees associated with outpatient therapy, including: fees for late cancellations, missed appointments, and returned checks.. I agree to pay for services at the time rendered or to discuss other specific payment arrangements with my therapist, and to pay, in good faith, any charges accrued. If this card expires and there is another active card listed on file, I accept that charges will be filed to the active card.

Card Type	
Cardholder Name	
Billing Street Address	
Billing Zip Code	
Card Number	
Expiration	
Security Code	

Signature ______________________ Date ______________

THIRD PARTY PAYER FORM

☐ **I will be utilizing my Employee Assistance Program (EAP).**

Please contact your EAP and attain the following information prior to your first session.

COMPANY:____

POLICY HOLDER:____

EMPLOYER;____

AUTHORIZATION #:______________________________________

OF SESSIONS AUTHORIZED:______________________________

START DATE OF AUTHORIZATION:___________________________

☐

_______________________________________ _______________________

Signature of Client (Responsible party) Date

☐ **I will have Pathways file my insurance claims for me.**

Pathways will file insurance claims for you as a courtesy. Our therapists are networked with many insurance companies, but not all. Please be well informed of your insurance benefits prior to your first session. Please call your insurance company and fill in the information below to assure coverage is provided accurately. Any insurance balance that is not paid within 30 days becomes the responsibility of the client.

Client seeking services:______________________________ Date of birth:____________

Insurance company:__________________________________ Phone:_________________

Claims Address:____

Policy Holder:____ Date of birth:_____________

Policy Holder's Address:____

Policy Holder's Relationship to Client:____

Insurance ID #:______________________________________Group #:________________________

Effective Date of Coverage:___________________________

Services covered by insurance : (Circle all that apply)

INDIVIDUAL Tx FAMILY Tx COUPLES Tx GROUP Tx

Do you have a deductible? YES NO If yes, what is the amount?:_____________

Has the deductible been met?: YES NO

Do you have a copayment? YES NO If yes, what is the amount?:____________

Do you have coinsurance? YES NO If yes, what is the amount?:____________

Does your insurance require pre-authorization?:_ YES NO

If Yes, please list the Authorization #:____

How many sessions have been authorized?:__________________________________

Other notable information:____

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____ _________________________

Signature of Client (Responsible party) Date

CONSENT TO TREATMENT

I acknowledge that I have read and received Pathways Counseling Center's

- Professional Disclosure Statement
- HIPPA Privacy Practices Certificate

I have thoroughly completed and understand Pathways Counseling Center's

- Financial Policies Form
- Payment Responsibility Form

My signature below indicates that I understand and accept the information in these documents and will comply with the outlined policies and procedures. I further consent to psychotherapy treatment. I understand that my participation in counseling is voluntary and I may terminate services at any time. If I do decide to terminate services I will notify my therapist. Although I expect to benefit from counseling, I acknowledge that success is dependent upon all participants involved in the therapeutic process, and cannot be guaranteed. I understand that I am financially responsible for treatment and any portion of fees that my insurance or third party payer does not cover.

__________________________________ ______________________
Signature of Client/Authorized Person Date

If more than one individual is seeking therapy, please have all sign below:

__________________________________ ______________________
Signature of Client/Authorized Person Date

__________________________________ ______________________
Signature of Client/Authorized Person Date