

HEALTHePATH Associates, Inc.
1905 W. 32nd St., Suite 305
Joplin, MO 64804
417-626-7900

Client Name: _____ **Birth date:** ____/____/____

Maiden or other name (if applicable): _____

I acknowledge that HEALTHePATH Associates has a **Notice of Privacy Practices** available to me for review.

Signature (client or authorized representative): _____

Date: ____/____/____

Relationship / Authority (if signed by authorized representative): _____

CONFIDENTIAL REGISTRATION INFORMATION

TODAY'S DATE:		[PLEASE PRINT]				
CLIENT'S NAME Last First MI		CLIENT'S DATE OF BIRTH MO DAY YR		AGE	GENDER Male <input type="checkbox"/> Female <input type="checkbox"/>	CLIENT'S SS# -- --
PARENT/GUARDIAN NAME [IF CLIENT IS A MINOR]		RELATIONSHIP TO CLIENT		DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? YES <input type="checkbox"/> NO <input type="checkbox"/>		
STREET ADDRESS		CITY	STATE	ZIP	HOME TELEPHONE #	
CLIENT'S MARITAL STATUS: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Co-habiting <input type="checkbox"/>						
EMPLOYER		POSITION/JOB TITLE			WORK TELEPHONE #	
LEVEL OF EDUCATION		NAME OF SCHOOL [IF CURRENTLY ATTENDING]				
WHO REFERRED YOU OR SUGGESTED THAT YOU CONTACT US?						
ARE YOU CURRENTLY SEEING A THERAPIST? NO <input type="checkbox"/> YES <input type="checkbox"/> IF "YES", WHO ARE YOU SEEING? HOW LONG HAVING YOU BEEN WORKING WITH THEM?						
PREVIOUS COUNSELING/MENTAL HEALTH SERVICES? YES <input type="checkbox"/> NO <input type="checkbox"/> [IF "YES", PLEASE MARK BELOW AND DESCRIBE]						
OUTPATIENT COUNSELING <input type="checkbox"/> PSYCHIATRIC HOSPITALIZATION <input type="checkbox"/> OUTPATIENT SUBSTANCE ABUSE <input type="checkbox"/> INPATIENT SUBSTANCE ABUSE <input type="checkbox"/>						
NAME & ADDRESS OF YOUR PRIMARY CARE PHYSICIAN				DATE OF LAST PHYSICAL EXAMINATION OR OFFICE VISIT		
PLEASE DESCRIBE ANY MEDICAL CONDITION(S) FOR WHICH YOU ARE RECEIVING TREATMENT						
MEDICATIONS YOU ARE CURRENTLY TAKING [PRESCRIPTION AND/OR OTC]						
Medication		DOSAGE/FREQUENCY		START DATE	PRESCRIBING PHYSICIAN	
_____		_____		_____	_____	
_____		_____		_____	_____	
_____		_____		_____	_____	
NAME OF EMERGENCY CONTACT PERSON			HOME TELEPHONE #		WORK TELEPHONE #	
DO YOU HAVE HEALTH INSURANCE? YES <input type="checkbox"/> NO <input type="checkbox"/>		NAME OF INSURANCE COMPANY			GROUP #	ID#
NAME OF PRIMARY INSURED PERSON [IF DIFFERENT FROM CLIENT]		DATE OF BIRTH OF PRIMARY INSURED PERSON		SOCIAL SECURITY # -- --		RELATIONSHIP TO CLIENT
SECONDARY INSURANCE		DATE OF BIRTH OF INSURED PERSON		SOCIAL SECURITY # -- --		RELATIONSHIP TO CLIENT
Company Name _____						
Group # _____						
ID# _____						

(PLEASE CONTINUE ON NEXT PAGE)

CONFIDENTIAL REGISTRATION INFORMATION

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS OR ISSUES THAT APPLY TO YOU

- | | |
|--|--|
| <input type="checkbox"/> LOSS OF INTEREST OR PLEASURE IN DOING THINGS | <input type="checkbox"/> RACING THOUGHTS |
| <input type="checkbox"/> POOR APPETITE, OVEREATING, WEIGHT GAIN OR LOSS | <input type="checkbox"/> NERVOUSNESS |
| <input type="checkbox"/> TROUBLE FALLING ASLEEP, STAYING ASLEEP, EARLY AWAKENING, OR SLEEPING TOO MUCH | <input type="checkbox"/> SHYNESS |
| <input type="checkbox"/> FEELING TIRED OR HAVING LITTLE ENERGY | <input type="checkbox"/> REPETITIVE OR INTRUSIVE THOUGHTS |
| <input type="checkbox"/> FEELING BAD ABOUT YOURSELF; THAT YOU'RE A FAILURE, OR HAVE LET PEOPLE DOWN | <input type="checkbox"/> SEPARATION |
| <input type="checkbox"/> FEELING DOWN, DEPRESSED OR HOPELESS | <input type="checkbox"/> INFERIORITY FEELINGS |
| <input type="checkbox"/> TROUBLE CONCENTRATING OR EASILY DISTRACTED | <input type="checkbox"/> DRUG USE |
| <input type="checkbox"/> SUICIDAL THOUGHTS THAT YOU WOULD BE BETTER OFF DEAD OR OF HURTING YOURSELF | <input type="checkbox"/> ALCOHOL USE |
| <input type="checkbox"/> LONELINESS | <input type="checkbox"/> LEGAL PROBLEMS |
| <input type="checkbox"/> MOOD SWINGS—UP FOR A FEW DAYS AND THEN WAY DOWN | <input type="checkbox"/> ANGER / TEMPER |
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> SEXUAL PROBLEMS |
| <input type="checkbox"/> HEART RACING, SKIPPING BEATS OR POUNDING | <input type="checkbox"/> SELF-CONTROL |
| <input type="checkbox"/> CHEST PAIN OR PRESSURE | <input type="checkbox"/> NIGHTMARES |
| <input type="checkbox"/> TREMBLING OR SHAKING | <input type="checkbox"/> PHYSICAL HEALTH PROBLEMS |
| <input type="checkbox"/> CHOKING SENSATIONS | <input type="checkbox"/> FINANCIAL PROBLEMS |
| <input type="checkbox"/> HOT FLASHES OR CHILLS | <input type="checkbox"/> PARENTING ISSUES |
| <input type="checkbox"/> NAUSEA, STOMACH UPSET OR STOMACH CRAMPS | <input type="checkbox"/> SELF-CONTROL |
| <input type="checkbox"/> FEELING DIZZY, UNSTEADY OR FAINT | <input type="checkbox"/> RECURRING AND INTRUSIVE MEMORIES OF A TRAUMATIC EVENT |
| <input type="checkbox"/> NUMBNESS OR TINGLING ANYWHERE IN YOUR BODY | <input type="checkbox"/> WORK OR CAREER CHOICE PROBLEMS |
| <input type="checkbox"/> FEAR THAT YOU WERE GOING TO DIE | <input type="checkbox"/> DIVORCE |
| <input type="checkbox"/> SWEATING | <input type="checkbox"/> FRIENDS AND SOCIAL RELATIONSHIPS |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> EDUCATIONAL/SCHOOL PROBLEMS |
| <input type="checkbox"/> FREQUENT HEADACHES | <input type="checkbox"/> FEELING DETACHED OR ESTRANGED FROM OTHER PEOPLE |
| <input type="checkbox"/> DIFFICULTY WITH MEMORY | <input type="checkbox"/> MARRIAGE OR PARTNER RELATIONSHIP |
| <input type="checkbox"/> PROBLEM ADJUSTING TO A MAJOR LIFE EVENT OR CHANGE | <input type="checkbox"/> AMBITION |
| <input type="checkbox"/> OTHER: [PLEASE EXPLAIN BELOW] | |

PLEASE DESCRIBE BRIEFLY YOUR REASON(S) FOR SEEKING HELP AT THIS TIME.

HOW LONG HAVE YOU BEEN EXPERIENCING DIFFICULTIES? LESS THAN 6 MONTHS 6 MTHS TO 1 YEAR 1 TO 5 YRS MORE THAN 5 YRS

HOW MANY SESSIONS DO YOU THINK IT WILL TAKE BEFORE YOU BEGIN TO SEE THE DESIRED CHANGE? (PLEASE CHECK BELOW)

- LESS THAN 5 5 TO 10 10 TO 15 MORE THAN 15

THE INFORMATION YOU HAVE PROVIDED WILL BE TREATED AS CONFIDENTIAL AND WILL NOT BE RELEASED OUTSIDE OUR AGENCY WITHOUT YOUR WRITTEN CONSENT EXCEPT AS PRESCRIBED BY STATE AND FEDERAL LAW.
---THANK YOU---

CLIENT'S SIGNATURE [PARENT/LEGAL GUARDIAN SIGNATURE IF CLIENT IS A MINOR]

RELATIONSHIP TO CLIENT

Do we have your permission to contact you? **PLEASE INITIAL** or provide email address

Appointment reminder: _____ home _____ work _____ cell phone _____ e-mail:

Consent to Treatment and Client Agreement

I acknowledge that I have discussed and understand information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged a \$25 fee for that appointment.

AUTHORIZATION FOR RELEASE OF FINANCIAL INFORMATION AND BILLING PROVISIONS:

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

I authorize my therapist (or their agent) to submit a claim to the insurance carrier with the understanding I will be responsible for the entire unreimbursed balance of the claim to the extent permitted by law. I understand I am responsible for both the insurance and coinsurance deductible.

ASSIGNMENT OF BENEFITS:

I hereby authorize payment directly to HealthPath Associates, Inc. for treatment expense benefits otherwise payable to me, but not to exceed the regular charges for this service/treatment. I understand that I am financially responsible to HealthPath Associates, Inc. for the charges not covered by my insurance plan.

I have been informed & understand that if I am out of network my benefits may be reduced or denied. I understand that I may be responsible for all charges associated with this service.

FINANCIAL RESPONSIBILITY: In consideration for the services rendered, I hereby guarantee payment of all charges for this client. HealthPath's acceptance of insurance assignments does not relieve me from any responsibility concerning payment of this account. The non-insured portion of this client's bill is due at time service is rendered. In the event of collection, the cost of collection, and of reasonable attorney fees shall be included as part of the obligation due HealthPath Associates, Inc.

My signature below shows that I understand and agree with all of these statements.

_____	_____
Signature of client (or person acting for client)	Date
_____	_____
Printed name	Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____	_____
Signature of therapist	Date

Yellow Copy - kept in file White Copy – given to client

This is a strictly confidential patient medical record. Redislosure or transfer is expressly prohibited by law.

Informed Consent and Information You Have a Right to Know

When you come for therapy, you are buying a service to meet your individual needs. You need good information about therapy to make the best choice for yourself and your family. We have written down some questions you might want to ask me about how we do therapy. We may have talked about some of them already. You are free to ask any of these questions, and we will try my best to answer them for you. If the answers are not clear, or if we have left something out, or if you have more questions, just ask again. You have the right to full information about therapy.

A. About Therapy

1. What are the goals of a therapeutic relationship?
2. What will I have to do in therapy? What is expected me as a client?
3. Could anything bad happen because of therapy?
4. What will I notice when I am getting better?
5. About how long will it take for me to see that I am getting better?
6. Will I have to take any tests? What for? What kind? How much will they cost?
7. Will my sessions be recorded with audio and/or video equipment?
8. What is a treatment plan and will I have an opportunity to actively participate in developing and revising the plan?
9. What are the risks and benefits of therapy; including my choice to discontinue therapy?
10. About how long will therapy take?
11. What should I do if I feel therapy isn't working?

B. About Other Therapy and Help

1. What other types of therapy or help are there for my problems?
2. What are the risks and benefits of other methods of treatment for people with problems like mine?
3. Will you assist me by recommending and/or referring me to another qualified professional?

C. About Our Appointments

1. How will we set up our appointments?
2. How long will our sessions last? Do I have to pay more for longer ones?
3. How can I reach you in an emergency?
4. If I can't reach you, to whom can I talk?
5. What happens if the weather is bad or I'm sick and can't come to an appointment?

D. About Confidentiality

1. What kinds of records do you keep about my therapy?
2. Who is allowed to read these records?
3. Are there times when you *have* to tell others about the personal things we might talk about?
4. Are there special limits of confidentiality that apply to couples, family and group therapy that does not apply to individual therapy?

(Continued on other side)

E. About Money

1. What will you charge me for each appointment?
2. When do you want to be paid?
3. Do I need to pay for an appointment if I don't come to it, or if I call you and cancel it?
4. Do I need to pay for telephone calls to you?
5. Will you ever raise the fee that you charge me? When?
6. If I lose some of my income, can my fee be lowered?
7. If I do not pay my bill, what will you do?

F. Other Matters

1. What are your qualifications and credentials?
2. To whom can I talk if I have a complaint about therapy that you and I can't work out?

The list above deals with the most commonly asked questions, but many people want to know more. Feel free to ask any questions you have at any time. The more you know, the better our work will go. You will be offered a copy of this form if you so request. Please read it carefully at home, and if any questions come up, write them on the form or another sheet of paper so we can talk about them when we meet next time. Again, thank you for choosing HealthPath Associates.

I, the client (or his or her parent or guardian), have gone over this list with the therapist, and I understand these questions and the therapist's answers.

Signature of client (or parent/guardian)

Date

Printed name

I, the therapist, have discussed these issues with the client (and/or his or her parent or guardian). I believe this person fully understands the issues, and I find no reason to believe that this person is not fully competent to give informed consent to treatment.

Signature of Therapist

Date

(white) Copy accepted by client

(blue) Copy kept in file

**Emergency Services Information
and
Client NO HARM Agreement**

I, _____ understand that my therapist and/or HealthePath Associates, Inc. does not provide 24 hour emergency services. In crisis situations, every effort will be made by my therapist to schedule an appointment for me within 12 to 36 hours (M-F). As an element of this therapist/client relationship, I agree not to harm myself or anyone else in any way for the duration of my treatment as a client. I further understand that my therapist is a mandated reporter (has a duty to warn) and is required to report to authorities any concerns he/she may have regarding the threat of potential danger to self or others.

If at any time I feel like harming myself or others, I promise I will talk to a trusted family member, friend, responsible person, or one of the emergency numbers listed below. I promise to make contact any time I feel at risk for self-harm or have increasing thoughts which are destructive in nature to others, or self, including altered perceptions of self.

I am aware that the following emergency services are available to me in the event that a family member or other trusted individual is not immediately accessible.

24 hours a day – Seven days a week:

- My local law enforcement agency (911)
 - My local hospital emergency department
 - St. John's Emergency Department – 417.625.2300
 - Freeman Healthcare System Emergency Center – 417.347.6656
-

My signature below indicates I will abide by this agreement, no matter what.

CLIENT SIGNATURE

DATE SIGNED

WITNESS

DATE SIGNED