Pathway Counseling

P.O. Box 620478
Oviedo, FL 32762-0478
Phone: 407-366-5656

CLIENT INTAKE – Child/Teen History Form

Parent/Guardian completes this section: (Pages1-6)

Child/Teen's name: _____ Date:_____

Age:_____ Date of Birth:_____ Gender/Sex_____

Address:_____
Street City/State Zip code

Child/Teen's Mother's Name:_____

May we contact client's mother? Yes___ or No___

Primary Contact Number:_____ Email :_____

May we leave messages for mom? Contact Number: Yes___ No___ Email: Yes___ No___

Address:_____
Street City/State Zip code

Child/Teen's Father's Name:_____

May we contact the client's father? Yes___ or No___

Primary Contact Number:_____ Email :_____

May we leave a messages for dad? Contact Number: Yes___ No___ Email: Yes___ No___

Address:_____
Street City/State Zip code

Child/Teen's Parent's Relationship Status: Single ___ Partnered___ Separated___

Married____ Divorced___ If divorced, when?_____

Mom remarried___ If mom remarried, when?_____

Dad remarried___ If dad remarried, when? _____

Length of Child/Teen's Parent's Relationship _____ year(s) _____ month(s)

Name of Child/Teen's Primary Custodial Parent or Guardian:_____

Relationship to child/teen_____

Contact Number:_____ May we contact this number? Yes___ No___

Address:_____

Street City/State Zip code

Child/Teen's Emergency Contacts:

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

In case of an emergency, please sign below to authorize Pathway Counseling to contact the above emergency contacts._____

Parent/Guardian Signature Date

What has led you to seek counseling for your child/teen at this time? _____

_____

_____

_____

What specific goals do you hope your child/teen will achieve during the counseling experience?

_____

_____

_____

Please place a mark X beside the following areas that pertain to your child/adolescent.

___ Stress	___ Depression	___ Anxiety
___ Fears	___ Panic	___ Hearing voices
___ Seeing things	___ Pregnancy concerns	___ Temper
___ Chronic pain	___ Staying focused	___ Recent death or loss
___ Self-esteem	___ Confidence	___ Racing thoughts
___ Impulsive behavior	___ Defiant behaviors	___ Gender identity
___ Guilt	___ Grief	___ Social problems
___ High risk behaviors	___ Trauma/Disaster	___ Unwanted thoughts
___ Communication	___ Abortion	___ Hopelessness
___ Self-injurious behavior	___ Identity issues	___ Delinquency
___ Family problems	___ Relationship problems	___ Health problems
___ Physical or sexual abuse	___ Verbal abuse	___ Cultural problems
___ Spiritual/moral problems	___ Sexual addiction	___ Eating problems
___ Gambling	___ Pornography	___ Compulsive shopping
___ School problems	___ LGBTQ+	___ Poor concentration
___ Loneliness	___ Indecisiveness	___ Drug use
___ Alcohol misuse/abuse	___ Bad dreams	___ Legal matters
___ Anger	___ Fatigue	___ Other_____

Please list your child/teen's strengths:_____

_____

Family History

Does your child/teen have stepparents? Yes___ No___
If yes, please list their names and ages:

Stepmother/Age_____/_____ Stepfather/Age_____/_____

How would you describe their relationship with their stepparent(s)?

(Stepmom)	Excellent___	Good___	Fair___	Poor___
(Stepdad)	Excellent___	Good___	Fair___	Poor___

Other Important family information:_____

Spiritual/Religious Beliefs:

Are spiritual or religious issues important to you? Yes ___ No ___

What is your religious/spiritual belief? _____

Place of worship, if applicable _____

Does your child/teen share your beliefs? Yes___ No___

If no, please list your child/teen's personal religious/spiritual beliefs and other important information:

_____

Siblings:

____ My child is an only child

How many ***brothers*** does your child have? _____What are their ages? _____

Any important information regarding your child's brother(s) or their relationship with them:

_____

_____

_____

How many ***sisters*** does your child have? _____What are their ages?_____

Any important information regarding your child's sister(s) or their relationship with them:

_____

_____

_____

What is the primary cultural background with which your child/teen most closely identifies?

Caucasian __ Black/ African American __ Hispanic/Latino __ Asian __ Biracial ___

Other: _____

Education:

School Name:_____

School City: _____State:_____Zip Code:_____

Grade of student:_____

Is your child/teen in any special education/exceptional education program? Yes___ No___

If yes, what kind of program is it?_____

Has your child/teen ever had any disciplinary problems in school? Yes___ No___

If yes, check all the following that apply: Suspension___ Expulsion___ Referrals___

Alternative Schools___ Other:_____

Please describe :_____

_____

How would you rate your child/teen's educational experience on a scale from 1-5 where 1 is extremely negative and 5 is extremely positive.

1_____	2_____	3_____	4_____	5_____
Very Negative		Average		Very Positive

Legal History/Social Agency Involvement:

Has your child/teen been involved with the justice system? (arrested, detention, court, etc.)

Yes___ No___ If yes, please describe:_____

_____

Has your child/teen ever had involvement with the Department of Children & Families or a similar agency in Florida or another state?

Yes___ No___ If yes, please describe:_____

_____

Medical History:

Has your child/teen ever had a physical injury, accident, or major illness? Yes____ No_____

If yes, please describe:_____

_____

_____

How would you describe your child/teen's current health?

Excellent___ Good___ Fair___ Poor___

Please describe any current medical problems: _____

_____

Does your child/teen take any prescription medications? Yes ___ No ___

Please list medications: _____

_____

Who prescribed these medications? _____

Does your child/teen take any over-the-counter herbal medication? Yes ___ No ___

Please list: _____

Has your child/teen received outpatient psychiatric/psychological/counseling in the past?

Yes ___ No ___

If Yes, please describe: _____

Have they ever been in the hospital for psychiatric/psychological problems? Yes ___ No ___

If Yes, please describe: _____

Has a physician ever recommended any anti-anxiety, anti-depressant, ADD, ADHD, or anti-psychotic medication for your child/teen? Yes ___ No ___

If Yes, please describe: _____

Has anyone in your family ever been treated or hospitalized for mental health issues, substance abuse, or psychiatric conditions? Yes ___ No ___

If Yes, please describe: _____

Has your child/teen ever been abused or experienced a trauma? Yes ___ No ___

If Yes, please describe: _____

_____

Child/Teen completes this section (pages 7-9)

What has led you to seek counseling at this time?

_____

_____

_____

What specific goals do you hope to achieve during the counseling experience?

_____

_____

_____

Please list your strengths

_____

_____

_____

Family History:

Mother: _____ Age: ____

Deceased? ___ Yes ___ No

If Yes, cause _____

Your age when mom died: _____

How is your relationship with your mom?

__ Excellent __Good __Fair __Poor

Father _____ Age: _____

Deceased ? ___ Yes ___ No

If Yes, cause _____

Your age when dad died: _____

How is your relationship with your dad?

__ Excellent __Good __Fair __Poor

Do you have stepparents? ___ Yes ___ No

Stepmother: _____ Age: ____

How is your relationship with stepmom?

__ Excellent __Good __Fair __Poor

Stepfather: _____ Age: ____

How is your relationship with stepdad?

__ Excellent __Good __Fair __Poor

Other important information about your parents or stepparents: _____

_____

Siblings:
Do you have siblings? Yes___ No___

Any important information regarding your sibling(s) or your relationship with them:

_____

_____

Education:
Rate your educational experience on a scale from 1-5 where 1 is extremely negative and 5 is extremely positive.

1_____	2_____	3_____	4_____	5_____
Very Negative		Average		Very Positive

Substance Usage:
Do you use alcohol, drugs or other substances?

Alcohol ___ Drugs ___ Both ___ I do not use alcohol or drugs ___

If applicable, please list substances:_____

_____

What age did you first use?_____

If you use alcohol or drugs, how often do you use them?
Everyday _____ Several times per week _____ Several times per month _____
Once or twice a month_____ Several times per year _____ Once a year _____
Holidays_____ Weekends_____ Other:_____

Have you ever felt like you should cut down on your alcohol or other drug use (including prescription drugs)? Yes ___ No ___

Do you ever use drugs/alcohol at school? Yes ___ No ___

Do you ever feel pressured to use? Yes___ No___

Have you ever missed school because of substance use? Yes___ No___

Has a friend or relative discussed concerns about your use? Yes ___ No ___

Have you ever felt guilty about your drinking or drug use? Yes ___ No ___

Have you ever had to take a drink or use a drug the next day to steady your nerves? Yes ___ No ___

Are you a recovering alcoholic or recovering drug addict? Yes ___ No ___

Is there a family history of problems with alcohol or drugs? Yes ___ No ___

If so, please explain:_____

Mental Status:

How would you describe yourself?

Happy___ Sad___ Depressed___ Lonely___ Hurt___ Angry___

Other:_____

Suicide Assessment:

Have you attempted suicide? Yes ___ No ___

If Yes, how long ago was your last suicide attempt: Year(s) ago: _____ Month(s) ago: _____

If Yes, how many times have you attempted suicide? 1 ___ 2 ___ 3 ___ 4 ___ If more than 4 times,

how many times: _____

Do you have current thoughts of ending your life? Yes ___ No ___

If Yes, do you have a plan? Yes ___ No ___

If Yes, please describe_____

Do you feel that you have a support system? Yes ___ No ___

If Yes, who are they? _____

If you feel like hurting yourself, who would you tell? _____

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

Pathway Counseling

P.O. Box 620478
Oviedo, FL 32762-0478
Phone: 407-366-5656

INFORMED CONSENT

1. Goals of Treatment: As your therapist, it is my intention to help you in the areas that you would like assistance without creating dependence…Specific goals can be negotiated in the therapy session and revisited on a regular basis to assess the effectiveness of the interventions being utilized.

2. Guarantees: As much as we would like to be able to do so, there are NO GUARANTEES that the counseling sessions will produce the results you are seeking.

3. Risks Associated with Counseling: There are risks associated with being in a therapeutic counseling relationship. During counseling, you will deal with difficult issues in your life that can produce "emotional, behavioral, and relational difficulties." At times, it can make your presenting issues even more difficult than when you first began counseling.

4. Contacting Clients**:** Unless otherwise noted by you to your therapist, each counselor will use the numbers you provide to them in order to reach you.

5. Regarding Text message, Phone Calls, E-mails, and Faxes: While we prioritize confidentiality, it is very important that you are aware that Text messages, Phone Calls, Emails and Faxes can be easily accessed by unauthorized people and therefore, the privacy of such communication can be compromised. If you choose to contact any employee of Pathway Counseling by any method mentioned above, you hereby remove Pathway Counseling and their employees from any form of liability.

6. Client Emergencies: If you are experiencing an emergency, please contact 911 or the Central Florida Hotline. If you choose to call the answering service for Pathway Counseling or an Employee of Pathway Counseling, there is NO GUARANTEE of when we will be able to return your call during this emergency.

7. Therapist vacations: During vacations, you can leave your message with the answering service, BUT there are times in which the messages you leave CANNOT be received by the therapist. Each therapist determines IF and WHEN they are able to return calls left to them while they are on vacation.

8. In cases of emergencies "while in the counseling session:" At times, during a counseling session, a client may become "very depressed or suicidal." At which point a member of Pathway Counseling may need to contact a family member or your emergency contact to provide assistance. It is important for you to provide on your intake form a "list of names: along with "authorization" for your counselor to contact these individuals.

9. Confidentiality and Privilege: The State of Florida, HIPPA, and our Notice of Privacy policy outline your rights to confidentiality and privilege during your counseling sessions. All information being dealt with during the therapy session is considered confidential and privileged UNLESS the information you provide meets the following EXCEPTIONS: (A) Client authorizes release of information in writing and waives privilege, (B) Client reports current abuse of a child, disabled person, elderly individual, or someone who is vulnerable and unable to leave a place of abuse due to institutionalization, (C) Client poses a danger to self or others, (D) Ordered by a "court of law" to make records available, (E) Bill collection/collection agency (as stated in the Notice of Privacy Practices), (F) Parent-child relationship where parent has legal authority over the records.

10. Counseling and Financial Records: All records are maintained as in accordance with HIPPA and the State of Florida guidelines for Mental Health counseling.

11. Ethical Guidelines: Creating a safe therapeutic environment is essential for a healthy relationship to develop between the client and therapist. For this to occur, ethical guidelines are very important. Some of the most significant are: (A) Sexual Contact: There is to be NO FORM of sexual contact between the client and therapist. This includes inappropriate and/or unwanted sexual conversations by text message, phone, e-mail, or personal communication, touch, of private meetings outside of the normal scheduled appointment. (B) Violence/ Harassment if you become violent, threaten verbally or physically, harass me, my coworkers, or my family, Pathway Counseling Therapists reserves the right to immediately terminate the counseling relationship. Should this happen, you will be offered referrals for other sources of care. (C) Dual relationships is best defined as a "relationship which exists both in the therapeutic environment and social or family settings. For example: employer/employee, family members, or close friendships. A "DUAL RELATIONSHIP" decreases the effectiveness of the counseling and puts undue pressure on the client. (C) Fees for service: There is a "fee for service" based upon the "household income" of the individual or family who is seeking therapy. There shall be NO FORM of "bartering" or exchanging of services for the counseling provided.

12. Dispute and complaints: If you have a dispute with one of the therapists at Pathway Counseling, please contact the Director, Charles Wise, in an attempt to have the issue resolved. If there is a need to go beyond the Director, Charles Wise, you may contact the State of Florida Licensing Board for Mental Health Counselors. Clients seeking counseling release, remise, and forever discharge and covenant not to sue or hold legally liable Pathway Counseling or employees from any and all claims, demands, actions, or causes of action related to the counseling process. Clients waive the right to seek the use of clinical records as evidence in any judicial proceeding or to compel the testimony of any employee providing counseling at Pathway Counseling.

13. Licensing Regulations: All therapists of Pathway Counseling are either: Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, Licensed Social Workers, Licensed Clinical Pastoral Counselor, Ordained Ministers, or Registered Interns etc.. All Licensed therapists are required to complete 30 hours of continuing education (CEU) every two years. This is to ensure that you are receiving the best possible care by a qualified professional. For a minimum of 2 years, all Registered Interns meet regularly with a "Clinical Supervisor" to review their "case load" to ensure they are providing the best quality of care for

their clients. Guidelines are used to ensure your "confidentiality" when discussing your counseling sessions. At times when assistance is needed in dealing with a "particular" situation, the staff of Pathway Counseling will use professional colleague consultation to ensure each client receives the best possible care.

14. Fees, charges, and responsibility for payment: Pathway Counseling charges fees for the counseling which is provided to the client. Those fees are based upon a "sliding scale" which is based upon the "household income" of the client. (A) A "fee schedule" is provided by the therapist and is placed in the client file. It is your responsibility to pay for services rendered at the beginning of each session. (B) Based upon the "fee schedule" your counseling fee shall be _____ per session. (C) Payment can be made by: check, cash, credit card and sometimes HSA cards. (D) There are additional charges for which you will be responsible if you choose the other services provided by Pathway Counseling:

    a. Witness fee/ Court Appearance: a fee of $350 per hour which is determined from the time the therapist leaves their home until they return. This fee is to be PAID IN FULL before the court appearance.
    b. Depositions: a fee of $350 per hour which is determined from the time the therapist leaves their home until they return. This fee is to be PAID IN FULL before the date of the deposition and is to be PAID REGARDLESS of whose attorney is requesting the deposition.
    c. Preparation time for Deposition, Witness and Court Appearance, Write up of summaries for record etc.: a fee of $150 per hour and is to be PAID IN FULL along with the payment fees for parts A and B listed above.
    d. Testing and Evaluations for Learning Disabilities, Behavioral, Personality, Career, and ADD/ADHD: Prices vary based upon testing and materials. Cost shall be determined by your therapist.

15. Insurance Policy: Pathway Counseling has chosen the "sliding scale" fee structure since many people do not have mental health insurance benefits. To assist those submitting insurance claims, upon request, we can provide the receipt which you can submit to your medical insurance company.

16. Cancellation Policy: In order to provide the best possible care to you and each of our other clients, Pathway Counseling requires a minimum of 24 hours advanced notice of the cancellation of your scheduled appointment. Please contact your counselor directly or leave a message with Pathway Counseling answering service which is open 24 hours. Based upon the reason for your missed appointment (if no notice is given) you can or will be charged for your missed session at the RATE OF YOUR STANDARD FEE. *** PLEASE NOTE*** By signing the INFORMED CONSENT you are AUTHORIZING Pathway Counseling to charge your credit card for the amount of your standard fee.

Counseling Minor Clients

A minor can enter treatment in ONE of Five ways:

1) Parental Consent
2) Involuntary at a parent's insistence
3) By order of a Court of Law

4) The individual has become an “emancipated minor” as described by the American Bar Association as “living separately from parents and is managing his or her own financial affairs” (ABA, 1980, p. 66)
5) Florida Statute **394.4784.** Minor age 13 years or older may have access to mental health services under the guidelines and circumstance of Florida Law.

In order for Pathway to provide the best possible care of Minor Clients, we require the “consent and involvement” of the parent or legal guardian.

In cases of DIVORCE, Pathway must receive copies of guardianship orders, general and limited power of attorney, custody orders, or letters of authority, showing that you have the authority to provide “CONSENT” for the child to be seen by a therapist.

Also note that in cases of “joint legal custody,” parents have equal legal responsibility of the child and are required to sign the “informed consent” of the minor child to be seen by a counselor at Pathway. Both parents, in this case, shall be responsible for payment of counseling fees as is dictated in the “final divorce decree.” Please note it is the responsibility of the Parent to obtain reimbursement from the EX-SPOUSE for the counseling fees which were paid.

Counseling Families and Couples

In order to provide counseling for either FAMILIES or COUPLES at Pathway Counseling, the following issues are to be agreed upon:

1) Each individual is committed to preserving the “confidentiality” of all information disclosed during the therapy sessions.
2) Although CONFIDENTIALITY is strongly encouraged or even required, the therapist CANNOT GUARANTEE that other family members will not violate this trust.
3) There will also be a “NO SECRET” policy in dealing with family or couples. According to the “no secret” policy, any information obtained by the counselor from one partner can or may be shared with the other partner or family member.
4) The client recognizes the difficulty in maintaining confidentiality and will not hold the counselor “liable” for information which is shared between spouses, partners, or family.

I, the undersigned, agree to the terms of the INFORMED CONSENT and desire to seek counseling at Pathway Counseling Ministry.

Client Name: _____ Date: _____

Signature: _____

Spouse Name: _____ Date: _____

Signature: _____

Parent Name: _____ Date: _____

Signature: _____

Therapist Signature: _____ Date:_____

Pathway Counseling

P.O. Box 620478
Oviedo, FL 32762-0478
Phone: 407-366-5656

NOTICE OF PRIVACY PRACTICES

SUMMARY OF NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY

Federal law, commonly called HIPAA, requires that we describe for you our medical privacy practices and your rights as a practice under the law. If you have any concerns about your medical privacy you can notify us at 407-366-5656.

How we may use your personal medical information.

Pathway Counseling creates and receives medical information about you as part of your care. This information is call Protected Health Information, or PHI. It is personal and private. We may use this information in many ways. We release only the information necessary to accomplish a task.

We use the information when we treat you or refer you for treatment. We may communicate with others professionals and referral agencies.

We may use the information to submit bills for your medical care to insurers, Medicare, or third party payers.

We may use this information for our health care operations. This means the work we must do to provide quality services to you and all of our patients.

We will seek your authorization when state or federal law requires it.

We may use PHI without your permission for the following reasons:

- As required by state or federal law.
- For public health purposes, such as reporting abuse of a child, or vulnerable adult (i.e. people who are elderly or disabled).
- To protect and warn if you disclose a plan or threat to harm yourself. The therapist must attempt to notify your family and legal authority.
- To inform you of alternative treatment.
- When ordered by a regulatory agency, such as Health and Human Services.
- To protect and warn the possible victim of a disclosed plan to threaten or harm another person, and to notify legal authorities.
- To report any admitted prenatal exposure to controlled substances that could be harmful to the mother or child.
- To treat you in an emergency.

- For law enforcement purposes or in response to a court order.
- For agencies involved in a disaster situation.
- For lawsuits and disputes.
- To communicate with coroners, medical examiners, and funeral homes when necessary.
- To communicate with federal officials involved in security activities authorized by law.
- To communicate with correctional officials if you are an inmate.
- To carry out treatment and billing operations through a billing or transcription service.

Your authorization is required for other disclosers.

Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Client Name: _____

Date of Birth: _____

I acknowledge that I have received and have been given an opportunity to read the Notice of Privacy Practices for Pathway Counseling. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Pathway Counseling at 407- 366-5656.

_____

Signature of Client Date

_____

Signature of Parent/Guardian/Personal Representative Date

_____ Initial if you are signing as a representative of the client. Please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

_____

_____

Signature of Staff Date

Pathway Counseling

P.O. Box 620478
Oviedo, FL 32762-0478
Phone: 407-366-5656

50 Minute Counseling Fee is $175.00

Witness Fee / Court Appearance/ Depositions …….. $350.00 per hour (portal to portal)

Preparation for Witness/ Court Appearance / Deposition/ Write up of Summaries of records etc……..…….$175.00 per hour

Professional Counseling Agreement

For the services rendered by _____ at Pathway Counseling, I agree to pay all debts for testing, counseling sessions, and other customary charges in accordance with the terms set below:

1) I acknowledge that each 50-minute counseling session will cost $ _____. The amount is to be determined by the "fee schedule" which is based upon household income.

2) I agree to pay my fee-for-service charge at each appointment by cash, check, or credit card.

3) I understand that if I miss two or more sessions without giving 24 hours notice, Pathway Counseling and my therapist reserve the right to terminate our therapy relationship by letter, text, or phone call.

4) I understand that I must give a "minimum" of 24 hours notice to cancel a scheduled appointment. If a notice is not given, I can or will be charged my standard fee for the missed session.

Credit Card Authorization

I, _____, understand the importance of notifying my therapist at Pathway Counseling in the event of having to re-arrange my counseling session due to an emergency.

I must give 24 hours notice if I am unable to attend my scheduled appointment, and if the notice is not given, I will be charged for my missed session at my standard fee rate.

I, _____, give Pathway Counseling, the authorization to charge my credit card $_____ for each missed counseling appointment. Charge this card for my appointments if this is my preferred method of payment.

Client Name: _____

Client Signature: _____

Date Signed: _____

Therapist Name: _____

Credit Card Number: _____

Expiration Date: _____ Security Code:_____

Zip Code: _____

Name on Card: _____

I have read the above and understand its contents. I agree to abide by the provisions set forth above.

_____ _____ _____

Client Therapist Date