PATHWAYS THERAPY AND WELLNESS CENTER

PATIENT REGISTRATION FORM

Patient Name: (Last):_____ **(First) :**_____**(Mid) Initial:** ___

Street Address: _____**Apt #:** _____

City:_____**State:**_____ **Zip:** _____ **Email:**_____

Phone Number: _____**Cell Number:** _____

Marital Status: ☐**Married** ☐**Single** ☐**Divorced** ☐**Widowed**

Birth Date: _____ **Age:** _____ **Gender:** _____ **Social Security #:** _____

Employer: _____ **Work #:** _____ **Retired:** ☐ **Unemployed:** ☐

Emergency Contact: _____ **Relationship:**_____

Emergency Contact Number: _____

Spouse/Responsible Party

Spouse/Responsible Party Name: _____

Date of Birth: _____ **Social Security #:** _____

Employer: _____ **Work #:**_____

PATIENT INSURANCE INFORMATION

Primary Insurance: _____

Address: _____ **City:** _____

State: _____ **Zip code:** _____ **Phone:** _____

Insured Name: _____ **Social Security #** _____

Date of Birth: _____ **Relationship:** _____

Policy #: _____**Group Number:** _____

I hereby consent to treatment conducted by **PATHWAYS THERAPY AND WELLNESS CENTER.** I assign all medical benefits to which I may be entitled directly to **PATHWAYS THERAPY AND WELLNESS CENTER.** I understand that I am ultimately responsible for all charges, regardless of insurance coverage or lack thereof. Should a check be returned due to insufficient funds, a fee of $25.00 will be charged to my account. Checks returned more than once will be assigned to a collection agency. In the event that my account is referred to a collection agency, due to lack of payment on my part, I agree to pay all collection and legal fees that may be added to my account. I agree that there will be a 50% additional fee for all accounts turned over to collections. I hereby authorize the release of any medical information required by my insurance company.

Date:_____ **Patient/Responsible Party Signature:** _____

PATHWAYS THERAPY AND WELLNESS CENTER

2298 W Horizon Ridge Parkway, Suite
201 Henderson, Nevada 89052
(702) 363-7284 Fax (702) 242-5252

DISCLOSURE STATEMENT

Confidentiality:

My professional code of AAMFT ethics prevents me from disclosing information that is shared in therapy or releasing information without your written consent. I cannot guarantee the confidentiality of other participants who are involved in your therapy process. The only exceptions to confidentiality are stated in the family therapy rights section of this disclosure statement.

_____ I understand that case notes are used for clinical purposes only, and are not subject to release for other legal or medical issues. In the event that documentation of therapy attendance, progress, prognosis, diagnosis, is needed, a letter stating these facts may be fashioned by My Therapist/Pathways Therapy and Wellness Center at such time only upon my specific written consent. I will explain during my first session with My Therapist, any pending legal, medical, or otherwise conflicting issues or matters such as mandated therapy, medical disability, custody cases, etc.

_____ If you are participating in couples or family counseling sessions, understand that all information shared in a joint session is open to all participants. Any information shared in an individual session is kept confidential with exception of behaviors that are damaging to the relationship. If this occurs the therapist will address this behavior in the couple's session.

_____ I understand in order for My Therapist to provide optimal therapy, certain cases may be reviewed with other experienced and licensed therapists and trainers/trainees who are furthermore bound to the same provisions of client confidentiality and privacy. In these circumstances, all identifying information is withheld.

_____ I understand that electronic modes of communication with My Therapist cannot, in most instances assure the highest level of confidentiality and may not be HIPPA , or otherwise compliant with state law governing confidentiality. I understand that My Therapist will only initiate phone, e-mail, and text communication per my request which may consist of my initial phone, e-mail, or text communication with her. I understand there may be instances of confidentiality breeches when communicating with My Therapist outside of her office. I will notify My Therapist in writing if I do not wish to receive electronic communication in the future.

_____ I understand that any audio or video taping of the session without prior authorization is strictly prohibited

Fee Schedule and Financial Policy:

Sessions are 45 to 50 minutes long. The charge per session if not through your insurance, will be determined at the time of your initial appointment. Sessions that run over 50 minutes will be billed in 10 minute blocks of time, according to the same rate.

_____ Fees can be paid by cash, check or major credit card. Return check fee is $25.00 Letters or report fees are $60 per request and require 10 business days notice with prepayment of fee. Prepayments are non refundable and are valid for one (1) calendar year of payment. If using health insurance, you are responsible for the knowledge of your benefits and co-pay therein.

Cancellations:

_____ Your appointment time has been reserved for you because your time is valuable. You may call and leave a message on YOUR THERAPIST'S confidential voicemail to cancel prior to your session. **Sessions must be canceled within a minimum of 24 hours prior to your scheduled appointment.** However, if you call on a weekend or holiday this is not considered within regular business hours and will not qualify for the 24 hour policy. **Should you choose to not call within 24 hrs to cancel an appointment and do not show up for your scheduled time, you will be charged in accordance to our fee agreement. *Please note, I do enforce this policy.** *

Your rights as a family therapy consumer are:

To receive information concerning the methods of therapy employed, the techniques used, the duration of therapy (If known), and the fee structure for services provided.

To seek a second opinion, if needed, I can provide you with names of other qualified professionals.

To terminate therapy at any time without any moral, legal, or financial obligations other than those already accrued.

To know our therapeutic relationship is confidential except under the following conditions: a) if you threaten bodily harm or death to yourself or another person; b) If you reveal information about physical abuse, sexual abuse or neglect in regard to a child; c) if you are in court ordered therapy; d) if a court of law issues a legitimate subpoena.

AGREEMENT:

1) **I have read and understand the above policies.**
2) **I have read and understand the financial obligations.**
3) **I have been informed of my rights as a client.**

Signed: _____ Date: _____

Client/Parent/Guardian Signature

Signed: _____ Date: _____

Therapist Signature

Pathways Therapy and Wellness Center

2298 W Horizon Ridge Parkway, #201
Henderson, Nevada 89052
Phone (702) 363-7284 Fax (702) 242-5252

Fee Agreement

Client Name: _____

For cash pay clients: I agree to pay the amount of $_____ per session at the time of the appointment.

For clients using insurance: I agree to pay the insurance deductible, coinsurance or co-payment rates for my insurance plan.

For all clients:
Should I be unable to make my scheduled appointment and fail to give **my therapist** a minimum of 24 hour notice, I understand that **I will be charged the full session fee,** which will be charged to the credit card on file. If you are using your insurance policy, you will be billed a **$100.00** fee for the missed session.

Please note: I do enforce this policy.

Signed:_____ Date:_____
Client or parent/guardian

Signed:_____ Date:_____
Therapist

Credit Card Authorization: 3.9% processing fee applies. For no processing fee, pay via cash or Zelle Pathways Therapy to: pathways@lvcoxmail.com

Cardholder's Name: _____
Credit Card Number: _____
Billing Zip Code:_____ Exp. Date: _____ CVV:_____
Credit Card Authorization Signature: _____

I give Pathways Therapy and Wellness Center LLC full authorization to charge my credit card regarding missed or canceled appointments. I understand that after 60 days from date of service, Pathways Therapy and Wellness Center LLC may charge any outstanding fees including copays, unpaid insurance claims or deductible amounts on the credit card I have given.

Pathways Therapy and Wellness Center
Telehealth Informed Consent Form

Client Name (printed):_____

By signing this form, I understand and agree to the following:

☐ I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies on a HIPAA compliant platform. I agree to participate in teletherapy to include evaluation and on-going treatment. By signing this agreement, I authorize the use of technology assisted media or other electronic means between a clinician and a client who are in two different locations.

☐ I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

☐ I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

☐ I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

☐ I understand that there are risks associated with participating in telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

Emergency Protocols:

☐ I understand that MY THERAPIST will need to know my location in case of an emergency. I agree to inform MY THERAPIST of the address where I am at the beginning of the session **if it is different from the address listed on my contact information**.

☐ I understand that a contact person needs to be listed on my contact information page in the event of a life-threatening emergency. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

IF YOU DECLINE TO PARTICIPATE, PLEASE INITIAL (initials of patient): _____

Client Signature:_____ Date:_____