# Healing Path Counseling

Name: Date of Birth: Race/Gender/Pronouns Social Security #:

Home Address: Email

Voice, Text, Email Phone #

Y or N Other Phone #

Referred by: Social media Website Internet

Friend Family Doctor Attorney

Marital Status: Educational Level School? Y N Employed? Y N School/Employer Name:

Partner Name: Partner Address: Partner Phone #

Emergency Contact Name: Emergency Contact Address: Emergency Contact Phone #

**If Client is Under 18:**

Parent/Legal Guardian Name: Parent/Legal Guardian Address: Parent/Legal Guardian Phone #

Other Parent Name: Other Parent Address: Other Parent Phone #

**Medical Information**

Primary Care Physician Name: PCP Phone #

Drug Allergies:

Current Medications:

Employee Assistance Program Name: Policy/Auth #

By signing below, I AUTHORIZE THE RELEASE OF INFORMATION necessary to process my EAP/ out of network claim forms, to the referral source if applicable, and, in case of emergency, to release information which is essential to handle the emergency.

Client signature: Parent/Guardian/Legal Representative Signature: Date:

PRINT NAME:

Staff Signature: Date:

HP Healing Path Counseling

## Consent to Treatment

Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, or course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

Our current fee is $120 per session. Payment for your session is due at the time of service. We accept cash, personal checks, Health Savings Account cards, and credit cards. We work with several Employee Assistance Program companies and we are responsible for filing claims for our services.

Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your therapist. If you must cancel or reschedule your appointment, we ask that you call our office at least 24 hours in advance. This will free your appointment time for another client. If you cancel an appointment after 24-hour notice, there is a $30 fee.

We also charge for our time when you require written correspondence. This is billed according to the amount of time utilized with a minimum fee of $50. This would include correspondence such as letters to other practitioners, disability applications, etc.

**If you are in a life and death emergency dial 911 for assistance or go immediately to your local emergency department.**

Although the client-therapist sessions will be intimate psychologically, it is important for you to understand that the client-therapist relationship is professional and not social. All contact will be limited to sessions you arrange with your therapist. Sessions are usually held in one of our offices. If you should encounter your therapist outside of the office, the therapist will speak with you only if you initiate the contact; this allows you to maintain the privacy of your psychotherapeutic relationship. Please do not invite your therapist to social gatherings (including, but not limited to, parties, weddings, business meetings, etc.), offer gifts, or ask them to relate to you in any way other than the professional context of our therapy sessions. Although this may seem artificial and/or awkward, it is the best way to promote a good psychotherapeutic relationship.

Your sessions should focus on your concerns exclusively. You will learn a great deal about your therapist the longer you work together; our therapist may occasionally share experiences and struggles with some regularity as models for clients. Nonetheless, you will still be experiencing the therapist in a professional role solely.

Our therapists follow all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Privacy Policy and Authorization for Release of Information, which are both provided to you.

Discussions between a therapist and client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and client; a negligence suit brought by the client

against the therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist. By signing this Consent to Treatment, you are giving consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

In the event of the death or incapacitation of the undersigned therapist, it will be necessary to assign your case to another therapist and for that therapist to have possession of your treatment records. By signing below, you are giving consent to another licensed mental health professional, selected by undersigned therapist, to take possession of records, provide records at your request, and/or deliver those records to another therapist of your choosing in the event that the undersigned therapist becomes incapacitated. This is required by Arkansas State Law.

Our therapists attend peer consultation with colleagues occasionally. They may discuss the work occurring in your session in these sessions while maintaining your anonymity.

I do hereby seek and consent to take part in the treatment provided by this agency. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward 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 (or my child) may stop treatment with this therapist at any time. 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 am aware that an agent of my insurance company or other third-party may be given information about the types, costs, and providers of any services I receive. I understand that if payment for the services I receive here is not made, the therapist may stop treatment. My signature below shows that I understand and agree with all these statements. I

have been given the opportunity to ask questions regarding this information.

_____ _____

Signature of Client (legal representative) Date

_____

Relationship to Client

I, Wendy Blackwood, M.S, LPC-S, TA-S, EMDR ICT, NCC, DCC, 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

**Privacy Policy: Your Information. Your Rights. Our Responsibilities.**

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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.**

## HEALING PATH COUNSELING FEES, CREDIT CARD AUTHORIZATION, AND OFFICE POLICIES

### APPOINTMENTS

- Appointments are typically scheduled on a weekly basis and are approximately 45 minutes long.
- More frequent sessions or an intensive outpatient schedule are available if determined appropriate by you and your therapist. For progress to be made in counseling, it is crucial that you attend appointments consistently.
- Please notify us within 24 hours of scheduled appointment, if you will be unable to attend (see fee schedule for late and reschedule fees)

### OFFICE POLICIES

- Prior to entering counselor's office, please silence your cell phones, and please turn off all electronic devices.
- Please plan for your appointment, and make appropriate arrangements for children, pets, and travel to and from the office.

### FEE SCHEDULE:

| | |
|---|---|
| • Diagnostic & Evaluation Session (1st visit) ($60.00 to hold the appointment, $60.00 due at scheduled time) | $120.00 |
| • Regular Office Visits (45 minutes) | $120.00 |
| • Outside Office Work (inpatient visits, court, collaboration with other professionals, academic, phone/video meetings) | $150.00hr |
| • **Court appearances-requires a 4-hour minimum retainer due the week of court** $150 per hour thereafter. No refund will be given, if less than 48 hours' notice of cancelling court. | $600.00 |
| • Written Reports (insurance companies, supervisors, etc) | Minimum $25.00 |
| • Returned check fee per check | $50.00 |
| • Cancelled or Rescheduled Appointment without 24 hr. notice | $30.00 |
| • 2nd Cancelled or Rescheduled Appointment without 24 hr. notice | $60.00 |
| • No Show Appointment | $70.00 |
| • 2nd No Show Appointment plus all no shows thereafter | $120.00 |
| • Late Fee for Outstanding Balances (applied monthly) | 10%of total bill |
| • A reasonable fee will be charged for copies of any records requested by the client | |

### INSURANCE/EMPLOYEE ASSISTANCE PROGRAMS (EAP) /WORKER'S COMPENSATION

- Clients are responsible for full payment at time of services.
- We do not bill insurance, but we will provide, at your request a 1500 form to submit to your insurance on a monthly basis.
- It is your responsibility to obtain the address for the MENTAL HEALTH DEPT of your insurance, and to follow-up regarding processing with your insurance.
- It is your responsibility to contact your human resource department to find out if you have an employee assistance program, and to inform them that you would like to take advantage of the program.
- We must be notified by the EAP that they are covering your sessions prior to your counseling session, or you will be responsible for payment for that session.
- If your appointments are being covered by an Employee Assistance Program, Worker's Compensation, or insurance they may require medical records in order to approve payment. For Healing Path Counseling to release those records, permission needs to be given on the HIPPA form.

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered. I understand that if I chose to end services, I am still responsible for any outstanding balance.

By signing below, you hereby authorize Healing Path Counseling to maintain your credit card on file in the event that there is a later charge to your account. You will be notified via email/telephone prior to any subsequent charges.

Signature-Client/Parent _____ Date _____

Signature-Parent/Guardian _____ Date _____

## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests. **Ask us to limit what we use or share**
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* In these cases, we never share your information unless you give us written permission: • Marketing purposes

- Sale of your information
- Most sharing of psychotherapy notes In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you.
*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.
*Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual die.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena. Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. Changes to the Terms of this Notice

**We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.**

## Other Instructions for Notice

- Effective April 15, 2020
- You may contact Wendy Blackwood, MS, LPC-S, TA-S, EMDR CIT, NCC, DCC with any questions regarding this notice: Healing Path Counseling, 1422 Caldwell Street, Suite N & O, Conway, AR 72034, (501) 327-7224, wendy@healingpathcounseling.com.
- We never market or sell personal information.

HP Healing Path Counseling

A copy of the document entitled **Privacy Policy: Your Information. Your Rights. Our Responsibilities.**, which outlines HIPAA privacy laws, has been made available for me to review.

_____ _____

Client signature Date

_____

Print Client Name

_____ _____

Witness Date

# AUTHORIZATION FOR RELEASE OF INFORMATION

**Name:** _____ **Date of Birth:** _____

## Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected. **Patient Authorization**

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

☐ **I hereby authorize Healing Path Counseling to RELEASE my protected health information (PHI) to:**

_____

☐ **I hereby authorize Healing Path Counseling to OBTAIN my protected health information (PHI) from:**

_____

### Disclosure Scope for PHI Release:

Disclosure may include the following verbal or written information: (check all that apply)

☐ Face sheet ☐ History & physical
☐ Laboratory/diagnostic testing results ☐ School ☐ information ☐ Discharge
☐ summary ☐ Medication records
☐ Behavioral health/psychological consult ☐ Psychosocial ☐ assessment/Family history
☐ ER record report ☐ Psychiatric evaluation
☐ Substance abuse treatment records ☐ HIV/AIDS lab results ☐ & treatment history
☐ Progress & Case Notes ☐ Summary of treatment ☐ records & contact dates
☐ Psychological evaluation/testing results ☐ Other: _____
☐ Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be released by Healing Path Counseling, without my written consent. I understand that this authorization will remain in effect for:

☐ The period necessary to complete all transactions on accounts related to services provided to me.
☐ One (1) year
☐ Other: _____

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian/custodian of this child.

_____ _____

*Signature of Client/Legal Guardian or Legally Authorized Representative* *Date*

_____ _____

*Witness* *Date*

# HEALING PATH COUNSELING
# ADOLESCENT INFORMATION FORM

ADOLESCENT'S NAME_____ DATE _____

Please check your therapy goals:

Anxiety___ Anger___ Depression___ Education___ Family___ Grief/Loss___ Physical Health___

PTSD/Trauma___ Stress___ Substance Use___ Other_____

## MEDICAL HISTORY

Name of Primary Care Physician: _____ Physician's Phone: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Current medications take:

1. _____ Dosage/Freq. _____
2. _____ Dosage/Freq. _____
3. _____ Dosage/Freq. _____
4. _____ Dosage/Freq. _____

Prescribed by: _____

Has your child been hospitalized for medical or psychiatric reasons? Yes____ No____

| Hospital | Mo/Yr | Reason |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Describe any important medical history, chronic ailments, or other health problems experienced by your or any other family members:

_____

Do you have any close relatives (father, mother, brother, sister, grandparents) who have experienced depression, anxiety, or other emotional difficulties? Please list:

_____

## SCHOOL AND FAMILY HISTORY

Do you experience any academic problems while in school? Yes ____ No ____
If yes, please explain: _____
What grade of school are you currently in? _____ What school are you currently attending? _____
How would you describe your current support network? (friends, relatives, etc.):
Poor___ Fair___ Good___ Excellent___

# HEALING PATH COUNSELING
# ADOLESCENT INFORMATION FORM

Please check all information which applies to your child's biological parents:
Mother: Living___ Divorced___ Deceased___ Married___ Remarried____ # of times____

Father: Living___ Divorced___ Deceased___ Married___ Remarried____ # of times____

With whom does your child live? Mother___ Father___ Stepmother___ Stepfather___ Guardian___ Grandparent___

Do you consider someone else (stepparent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

---

List first names and ages of your brothers & sisters:

| Name | Age | Relationship (biological, step, half, etc.) | Lives with: |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Others living in the home with you:

| Name | Age | Relationship | Grade/Occupation |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Check next to the word that best deprescribes your relationship with the following:

Your Mother: Poor___ Fair___ Good___ Excellent___

Your Stepmother: Poor___ Fair___ Good___ Excellent___

Your Father: Poor___ Fair___ Good___ Excellent___

Your Stepfather: Poor___ Fair___ Good___ Excellent___

Other (grandmother, etc.) Poor___ Fair___ Good___ Excellent___

Are there any problems that have occurred in your family relating to:

Alcohol abuse___ Drug abuse___ Sexual abuse___ Physical abuse___ Emotional abuse___

Traumatic event (natural disaster, fire, car wreck, death) ___

# HEALING PATH COUNSELING
# ADOLESCENT INFORMATION FORM

## MENTAL STATUS

**Please check any of the following that describes how you have been feeling lately:**

Sad__ Anxious__ Depressed__ Frightened__ Guilty__ Angry__ Ashamed__ Aggressive__ Resentful__

Worthless__ Tearful__ Irritable__ Confused__ Jealous__ Hopeless__ Extreme ups/downs__

**Please check any of the following risk-taking behaviors you have engaged in:**

Gang involvement__ Skip school__ Dropped out__ Dangerous dieting__ Cutting__ Stealing__

Unprotected sex__ Running away__ Bullying others__ Fire starting__ Hurt animals__

Restrict or restricted food intake__ Over exercise__

Please check yes or no to the questions below and explain any yes answers below.

| | Yes | No |
|---|---|---|
| 1. Have you had any changes in eating or sleep pattern? | ___ | ___ |
| 2. Have you ever considered suicide in connection to your current problem? | ___ | ___ |
| 3. Have you ever considered suicide in the past? | ___ | ___ |
| 4. Have you attempted suicide recently or in the past? | ___ | ___ |
| 5. Have you had any homicidal thoughts recently or in regard of problem? | ___ | ___ |
| 6. Have you ever considered homicide in the past? | ___ | ___ |

Please explain any yes answers in the space below.

_____

_____

_____

## LEVEL OF FUNCTIONING

Do you currently have concerns in any of the following: (Check all that apply)

Self-Esteem___ Getting along with friends___ Getting along with family___ Parent's recent divorce___

Problems complete daily tasks___ Work problems___ Other_____

What activities or hobbies do you participate in? _____

# HEALING PATH COUNSELING
# ADOLESCENT INFORMATION FORM

Please indicate how much time you spend doing the following: (Check all that apply)

Watching TV: 0 hours__ 1+hours__ 1-3 hours__ 3-5 hours__ 5+hours__

Engaging in physical activity: 0 hours__ 1+hours__ 1-3 hours__ 3-5 hours__ 5+hours__

Playing video games: 0 hours__ 1+hours__ 1-3 hours__ 3-5 hours__ 5+hours__

Is there any other information regarding you and your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____