PATHWAYS

Patient Information Update/Change

Please take a few minutes to answer the following questions so we can better assist you with your health care.

PATIENT INFORMATION

Last Name:_____ **First Name:**_____ **MI**_____

Name you want us to call you:_____ **Age**_____ **Date of Birth** ____/____/_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer/Student:_____ **Full-time, Part-time, Retired**

Email Address:_____

******Because we respect the confidentiality of communications, please be specific about the following:*****
This will assist us when we are making confirmation calls

PHONE NUMBERS:

	OK To Call	**OK Leave Voice Message**	**OK To Send TEXT MESSAGE**
Home: _____	Yes or No	Yes or No	
Cell : _____	Yes or No	Yes or No	YES_____ NO____

****While we prefer to speak directly with each patient and/or guardian we understand that other individuals or family may have knowledge of and be assisting in your treatment. Please, list the individual (s) who we may leave a message with concerning your appointments, RX refills.**

Name of Person_____ **Relationship**_____
Name of Person_____ **Relationship**_____

For Minor Children-List both Father/Mother, Step Father/Mother or Foster Parents below:

Father/Mother:_____
Step Father/Mother:_____
Foster Parents:_____

RESPONSIBLE PARTY INFORMATION (Person Responsible for Account if a minor)

Responsible Party Name:_____ DOB:____/____/____ ☐ Father ☐ Mother ☐ Other _____

Address: _____ City:_____ State:____ Phone:_____

PRIMARY INSURANCE INFORMATION (We do not bill Secondary Insurance) Provide Copy of Card

Insurance Company:_____ Insurance Phone #:_____
Insured Name:_____ Date of Birth:____/____/____ Relation to Patient:_____
Member ID #:_____ Group #:_____ Employer:_____

Is Patient covered by an EAP? ☐ Yes ☐ No EAP NAME:_____ Employer:_____
Authorization #:_____ Effective Dates:_____

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ (Name of Insurance) and assign directly to my provider/Pathways all insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize Pathways to release all information necessary to secure the payment of benefits.

_____ _____ _____
Responsible Party Signature Relationship Date

PATHWAYS OFFICE POLICIES
CLIENT RIGHTS & RESPONSIBILITES STATEMENT

(Please read these policies carefully, be sure you understand them and keep them for future reference.)

STATEMENT OF PATHWAYS OFFICE POLICIES (Please initial each policy)

♦ _____**Consent for Treatment, Payment, and HealthCare Operations:** Federal regulations allow us to use or disclose protected health information (PHI) from your record in order to provide treatment to you, to obtain payment for services we provide. This may include co-ordination of care with your Primary Physician, another provider or pharmacy personnel in regards to your prescription. It may also include information about your treatment you received here, so that your health plan will pay us or repay you for services rendered. Pathways may also tell your health plan about treatment you are going to receive in order to get authorization or to determine benefits. By initialing and signing this form, you are giving us permission to use or disclose your PHI for these activities. They are described more fully in our Notice of Privacy Practices. This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

♦ _____**I affirm that I have the legal right to consent to treatment:** If you are seeking treatment for a minor child, you may be requested to provide supporting documentation.

♦_____**Appointment Cancellations:** Pathways requires a minimum of 24 hours' notice for rescheduling or cancellation of an appointment. You may call the office during business hours, or leave a message on our Voice Mail. Without such notice, fees will be charged as follows:

**** Late cancellations (less than 24 hours) $80.00***

**** No-shows (no communication prior to missing appointment): $100 up to full fee***

♦ _____**Payment Requirements:** We expect payment at the time of service, including deductible, Co-Pay and/or Co-Insurance amounts. While we do all we can to provide accurate estimates of coverage and benefits, you are ultimately responsible for all charges incurred. It is your responsibility to understand your Outpatient Mental Health Benefits.

We also require a credit or debit card on file for services. We will charge your card in the following cases:
1)Visit Co-Pay and deductible 2) Late Cancels or appointment no-shows

♦ _____**Time of Service Discount (TOS):** In order to receive the TOS discount, payment must be received on the day of service.

♦ _____**Prescription Refills:** We ask for 24-48 hours to process all prescription refills. Contact your pharmacy for all refills. NO refill authorizations will be done after hours or on weekends (Fri/Sat/Sun).

♦ _____**Returned Checks:** Will automatically be sent to PFC Check Solutions.

STATEMENT OF PATIENTS' RIGHTS & RESPONSIBILITIES:

⇒ You have the right to privacy. You will be given our privacy notice to review and sign.
⇒ You have the right to fair treatment. This is regardless of race, religion, gender, ethnicity, age, disability, or source of payment.
⇒ You have the right to a clear explanation of your treatment options and the right to share in developing your plan of care.
⇒ You have the right to ask questions or express concerns about the quality of your care.
⇒ You have the responsibility to treat those giving you care with dignity and respect and to keep scheduled appointments.
⇒ You have the responsibility to give providers information they need, so they can deliver the best possible care.
⇒ You have the responsibility to follow you treatment plan, and to let your provider know when the plan no longer works for you.
⇒ You have the responsibility to not take actions that could harm yourself or others.

- I hereby consent to the use or disclosure of my protected health information as specified above.
- I authorize the release of any medical, behavioral health information necessary to process my insurance claim and authorize payment of Insurance benefits directly to Pathways.
- I also hereby acknowledge and understand the office policies of Pathways as specified above.

_____

Patient Name ***SIGNATURE*** ***DATE***

_____

PARENT or GUARDIAN (If Patient a minor) ***SIGNATURE*** ***DATE***

Staff Initials_____

PATHWAYS CREDIT/DEBIT CARD AUTHORIZATION

PATIENT NAME: _____

Pathways requires a credit or debit card on file for all services.

- _____Appointment Visit Co-ay or deductible
- _____Late Cancellations less than 24 hour notice-Fee of $70.00
- _____Appointment No-show- Full Fee of Services $75-$220 depending on provider

(Please initial each line item-indicating your understanding)

Many times patients prefer to have their credit or debit card on file so we may charge the card automatically for any copayments, co-insurance or balances owed on an ongoing basis for themselves or minor children.

I, _____, authorize Pathways Family Wellness to charge my credit/debit card for all late cancellation and No-Show appointment fees as set forth in Pathways disclosure statement and policies for myself and minor children.

I, _____, authorize Pathways Family Wellness to charge my credit/debit card for all copayments, co-insurance or deductible amounts due after each appointment as set forth in Pathways disclosure statement, policy or self-pay agreement I have signed for myself and minor children.

By signing this authorization form, you agree to notify Pathways Family Wellness of any changes to your credit card information such as a new expiration date or when your credit card has been cancelled, lost, stolen or revoked. A new form must be submitted if information is amended in any way.

CREDIT CARD INFORMATION

_____VISA _____MASTERCARD _____DISCOVER _____AMERICAN EXPRESS ___Debit ___Credit ___Flex Spending/HRA

CARDHOLDER NAME:_____ ___Patient ___Spouse ___Parent/Guardian
(Please Print)

CREDIT CARD NUMBER:_____ EXPIRATION DATE:_____

CV CODE:_____ ZIP CODE ASSOCIATED WITH CARD:_____

I authorize Pathways Family Wellness to keep my Credit Card information and Signature on file and to charge Fees as indicated above. I understand that this authorization is valid until cancelled in writing. I understand that charges for ongoing services will normally be posted to my credit card account the day of services rendered.
I agree that if I have any problems or questions regarding charges to my account, I will contact Pathways Family Wellness for assistance.
I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Pathways Family Wellness and those attempts have failed.

CARDHOLDER SIGNATURE:
_____DATE:_____

Note: Original goes in file located in safe

Staff Initial_____