PATHWAYS FAMILY WELLNESS
Psychological Testing
2020 New Client Packet

PATIENT INFORMATION

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

Age:____ **Date of Birth**:_____ **Sex:** ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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

Employer/Student:_____ **Occupation/School:**_____

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
Home:	_____	Yes or No	Yes or No
Work :	_____	Yes or No	Yes or No
Cell:	_____	Yes or No	Yes or No

I PREFER TO RECEIVE A TEXT MESSAGE REMINDER FOR MY APPOINTMENTS AT:

_____
(Please sign the attached Text Message Consent)

Schooling and employment history

How many Jobs have you had? ☐ None ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Too many to remember

What is the longest employment position you have held? ☐ 2 weeks – 90 days ☐ 1-2 years ☐ 3-4 years ☐ 5 plus years

What are some of the reasons for leaving previous employment? ☐ Attendance ☐ Fired ☐ Position Terminated ☐ Didn't like ☐ Couldn't do work assigned ☐ Other_____

What occupational/work tasks have been difficult for you? ☐ Customer Service ☐ Computer ☐ Manual Labor ☐ Multi-tasking ☐ Work hours assigned ☐ Other_____

Highest Education Level completed: ☐ Did not finish High School Left @_____grade ☐ High School ☐ GED ☐ Some College

Any history of special education services? If so when:_____

What kind of grades did you typically receive in school? _____

What were some of your strengths in school? _____

What were some of your weaknesses in school? _____

Anything else I should know about your employment or schooling?

_____

_____

REALTIONSHIPS AND FAMILY

Describe your current relational status:

First Name: _____ ☐ Married ☐ Living Together ☐ Partner ☐ Living Together ☐ Engaged

Describe your current living situation; who is living in your home:

First Name: _____ ☐ Spouse ☐ Partner ☐ Child/Step Child ☐ Parent ☐ Foster Child ☐ Other_____

First Name: _____ ☐ Spouse ☐ Partner ☐ Child/Step Child ☐ Parent ☐ Foster Child ☐ Other_____

First Name: _____ ☐ Spouse ☐ Partner ☐ Child/Step Child ☐ Parent ☐ Foster Child ☐ Other_____

First Name: _____ ☐ Spouse ☐ Partner ☐ Child/Step Child ☐ Parent ☐ Foster Child ☐ Other_____

First Name: _____ ☐ Spouse ☐ Partner ☐ Child/Step Child ☐ Parent ☐ Foster Child ☐ Other_____

Where did you grow up? _____Did you move a lot? _____

Parents Relationship: ☐ Married for_____ years ☐ Divorced when I was_____ lived with_____

☐ Parent(s) deceased when I was _____ ☐ Parent(s) remarried_____

Parent(s) Occupation: ☐ Father/Stepfather_____ ☐ Mother/Stepmother_____

Siblings: ☐ Brothers_____ ☐ Sisters_____ ☐ Step Siblings_____ ☐ Your birth order_____

Anger/abuse behaviors: ☐ None ☐ Parent (s) ☐ Sibling(s) ☐ Grandparents ☐ Other

_____

Mental Health Issues: ☐ None ☐ Parent (s) ☐ Sibling(s) ☐ Grandparents ☐ Other

_____

Substance Abuse Issues: ☐ None ☐ Parent (s) ☐ Sibling(s) ☐ Grandparents ☐ Other

_____

Significant Losses or Trauma: ☐ Death ☐ Suicide ☐ Incarceration ☐ Murder ☐ Other

_____

Anything else I should know about your family?

_____

_____

List some positive words you would use to describe yourself._____

What are some of your special interests/hobbies/talents? _____

Who would you identify as people or groups in your support system? _____

_____

What are the biggest or most important problems that you are facing right now?

_____

_____

_____

_____

What goals do you have for psychological testing and evaluation?

_____

_____

_____

_____

 Patient Name: _____

MEDICAL HISTORY

Please indicate if you had any problems with the following-your thoroughness is appreciated!

MENTAL HEALTH HISTORY	NO	YES	DESCRIBE
Have you been hospitalized for mental health issues?			
Have you threatened or attempted suicide?			
Have you worked with a counselor before?			
MEDICAL CONDITION OR PROBLEMS			
Hearts/Lungs			
Nervous System			
Stomach/Intestines			
Bladder/Kidney			
Bones or Joints or Skin			
Reproductive System			
Head Injuries/Serious Accidents/Loss of Consciousness?			
Any surgeries or medical hospitalizations?			
PRIMARY CARE			Please give us the names of Physician , prescription Drugs & herbs
Do you have a Primary Care Physician? (Please sign ROI)			Name: Phone: Date of last visit:
Are you under the care of any other Physicians?			Name(s)
What Prescription Drugs are you currently taking?			
What non-prescription drugs or herbs are you taking?			
HEALTH HABITS			Describe---List Amount and Frequency
Do you Smoke or Chew Tobacco?			
Do you drink alcohol?			
Do you use street drugs?			
Do you use Marijuana?			
Do you use caffeine? (coffee, tea, soda)			
Current Sleep, Diet and exercise habits			
DEVELOPMENTAL MILESTONES			
Any Complications with your delivery or mother's pregnancy?			
Any difficulty meeting developmental milestones? (Walking/talking/eating etc.)			
ADDITIONAL INFORMATION			
Anything else I should know about your medical or mental health history?			

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): $100.00***

♦ _____**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 NOT charge this card without your permission, except in the following cases: 1) Late Cancels or appointment no-shows 2) Your bill is more than 90 days past due, without alternative arrangements.

♦ _____**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: _____

CONSENT and AGREEMENT TO PSYCHOLOGICAL TESTING and EVALUATION

I, _____, agree to allow the evaluator named below to perform the following services:

- ☐ Psychological testing, assessment, or evaluation ☐ Report writing
- ☐ Other (describe):_____

This agreement concerns ☐ myself or ☐ _____

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the evaluator's time required for the reading of records, consultations with other psychologist and professionals, scoring, interpreting the results, and any other activities to support these services.

I understand that the fee for this (these) services(s) is at $180.00 per hour. Though my health insurance may repay me for some of these fees, I understand that I am fully responsible for payment of these services.

I understand that this evaluation is to be done for the purposes(s) of:

_____
_____

I also understand the evaluator agrees to the following:

1. The procedures for selecting, giving, and scoring the tests, interpreting and storing the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association, the Health Insurance Portability and Accountability Act (HIPAA) and other professional organizations.
2. Tests will be chosen that are suitable for the purposes described above. (In psychological terms, their reliability and validity for these purposes and population have been established.) These tests will be given and scored according to the instructions in the tests' manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
3. Tests and test results will be kept in a safe place.

I understand that psychological evaluation is an interactive process between the client and evaluator. It is meant to promote understanding and treatment planning. Sometimes the process can be emotionally painful and other times it may be fulfilling. I have the right to choose my evaluator or to refuse services. If I choose to end services for any reason I understand Nathan Swisher, Psy.D, PLLC will make a list of qualified evaluator available to me. I should question the rationale of treatment if it is unclear to me. While the evaluator has every expectation of helping, they cannot guarantee any specific outcome.

I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate. My signature below confirms that I have read the above and agree to its terms.

_____ _____
Signature of client (or parent/guardian) Date

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

_____ _____
Signature of evaluator Date

PATHWAYS
8217 W 20th Street, Suite A
Greeley, CO 80634
(970) 356-3100 Fax (970) 356-4827

Patient HIPAA Acknowledgment and Consent Form

Patient Name: _____ Date of Birth: _____
(Please print full legal Name)

_____ (Patient Initials) I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures.

_____ (Patient Initials) I agree that the practice may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payer's for treatment purposes.

____ (Patient Initials) **The practice may leave a detailed phone message at the following listed numbers regarding my medical and billing information.**

(_____) _____ and/or (_____) _____

Disclosures to family Members and/or Friends:
I give permission for my Protected Health Information to be disclosed for purposes of billing and payment, communicating results, findings, prescriptions and care decisions to the people designated below. Information will only be released to the parties identified below.

	Name	Relationship	Contact Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I certify that I have read and fully understand all of the above statements and consent fully and voluntarily to all included statements

Print Patient or Responsible Party Name _____ Date _____

Patient or Responsible Party Signature _____ Date _____

Relationship to Patient _____

This consent will remain in effect and grants permission for one year from the time of signing. Permissions may be revoked in writing prior to the expiration.

Staff Initials_____