



PATHWAYS FAMILY WELLNESS

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: _____

****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)

MINOR CHILDREN

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

Father/Mother: _____ Phone Number: _____

Step-Father/Mother: _____ Phone Number: _____

Foster Parents: _____ Phone Number: _____

*Note: If minor child does not live with both biological parents you must complete the 'Minor Child Consent Packet'
Whoever brings the child to the appointment is responsible for the Co-Pay, Co-Insurance and/or Deductible or Self Pay Payment

PRIMARY INSURANCE INFORMATION (We do not bill Secondary Insurance)

Insurance Company: _____ Insurance Phone #: _____

Insured Name: _____ Date of Birth: ____/____/____ Relation to Patient: _____

Member ID #: _____ Group #: _____ Employer: _____

Does your Employer provide an Employee Assistance Program (EAP) benefits? Yes No EAP NAME: _____

Authorization #: _____ Effective Dates: _____ # Sessions: _____

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 _____

If you are not using your health Insurance or have a Health Insurance we are not contracted with you must complete the Self Pay Agreement form. We will be glad to provide a billing statement if you wish to submit a claim on your own. The exception is Medicare and Medicaid.

MEDICAL HISTORY

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

MENTAL HEALTH HISTORY	NO	YES	DESCRIBE
Primary Reason for your Visit			
Any previous/current Mental Health or Substance Abuse Treatment?			
Family history of mood, anxiety Attention or substance abuse problems?			
MEDICAL CONDITION OR PROBLEMS			
Hearts/Lungs			
Nervous System			
Stomach/Intestines			
Bladder/Kidney			
Bones or Joints or Skin			
Reproductive System			
Head Injuries or Serious Accidents			
Any known drug allergies?			
PRIMARY CARE			Please give us the names of Physician , prescription Drugs & herbs
Do you have a Primary Care Physician? (Please sign ROI)			
Are you under the care of any other Physicians?			
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)			
Any Problems with sleep?			Hours of sleep per night:
Height: _____ Weight: _____			

FOR FEMALES ONLY: Many medications, which are used routinely in women of childbearing age, may not be entirely safe during pregnancy. Anyone who may be pregnant or may become pregnant should inform her physician before taking any prescription medication. If you are on any medication including over the counter medication-and may become pregnant during treatment, tell your physician.

Are you pregnant? Y N Could you become pregnant while in treatment? Y N

Patient Name: _____

PATHWAYS OFFICE POLICIES & CLIENT RIGHTS & RESPONSIBILITIES STATEMENT

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

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 coordination 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.

◆ **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 request a credit or debit card be on file. This will be used for appointments, Late Cancellation Fee, No-Show Fee or for balances 90 days past due.

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

◆ **Prescription Refills:** Please allow 24-48 hours to process all prescription 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 your 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.

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.

Patient Name

SIGNATURE (12 and older)

DATE

PARENT or GUARDIAN (If Patient a minor)

SIGNATURE

DATE

PATIENT NAME: _____

PATHWAYS CREDIT/DEBIT CARD AUTHORIZATION

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

We will NOT charge this card without your permission, except in the following cases:

- Late Cancellations -day of your appointment-Fee of \$80.00
- Appointment No-show- Full Fee of Services \$100-\$220 depending on provider

Often 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: _____ (Please Print) ___ Patient ___ Spouse ___ Parent/Guardian

CREDIT CARD NUMBER: _____ EXPIRATION DATE: _____

ZIP CODE ASSOCIATED WITH CARD: _____

___ I do not wish to keep my Credit Card information on file; however, I will provide my Credit Card information to Pathways for any late cancellations, no-shows or balances due on my account.

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 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.

PATIENT or GUARDIAN SIGNATURE: _____ DATE: _____



8217 W 20th Street, Suite A
Greeley, CO 80634

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. I also understand the practice may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors 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 acknowledge that I have read and fully understand all of the above statements and consent fully and voluntarily to all included statements

Patient Signature (12 and older) _____ Date _____

Parent/Responsible Party Signature _____ Date _____

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.