~ A Path with Heart Counseling~

Professional Counseling for Individuals, Couples and Families

Legal Name:_____ DOB: _____Phone # _____
Mailing Address: _____
E-mail:_____

Your Primary Insurance Plan

☐ **Presbyterian** ☐ **Pres Cent (Medicaid).** ☐ **Pres. Medicare (Senior Plan)** ☐ **BCBS** ☐ **BCBS Cent.(Medicaid)** ☐ **BCBS Medicare (Senior Plan)**
☐ **Molina** ☐ **United** ☐ **Western Sky** ☐ **Friday Health** ☐ **Aetna** ☐ **Medicare** ☐ **Other**_____ ☐ **Self-Pay**

Member ID#: Group #:
Co-pay Amount: _____
Deductible Amount: _____

In case of emergency?

Contact Person _____ Phone_____
Primary Care Physician_____ Phone_____

Please List Current Medications, Vitamins, Herbs, and Dosages:

_____

Please List Allergies/Reactions to drugs and/or foods. _____

Would you describe yourself as happy and at peace most of the time? **Yes** ☐ **No** ☐

Do you engage in regular exercise of physical activity? **Yes** ☐ **No** ☐

How would you rate your eating habits? ☐ **Healthy** ☐ **Fair** ☐ **Unhealthy**

What is your occupation? _____ Most of the time do you find your work fulfilling? ☐ **Yes** ☐ **No**

On average, how many hours do you devote to work weekly? _____

What are your greatest challenges?_____

What are your greatest strengths?_____

How do you take care of yourself (how do you relieve stress)?_____

Do you have any addictions or Unhealthy Habits you would like to change? Please explain:

_____

When you were growing up, did you have any Adverse Childhood Experiences (Abuse, Neglect, Difficulties)? Please explain: _____

Have you ever worked with a counselor before? **Yes** **No** When?_____
Was it helpful or not helpful? _____

What would be most helpful to address in your counseling sessions? (What would you like to accomplish in our work together). _____

_____

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Quality of Life Self-Assessment

(1 is the Lowest and 10 is the Highest)

- Your current levels of Inner Peace and Emotional Wellbeing:

1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

What do you think interfering with your current levels of inner peace and emotional wellbeing?

- Your satisfaction and fulfillment with your current Habits, Behaviors, Lifestyle and Quality of Life:

1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

What Habits and Behaviors do you think you need to change to improve your Quality of Life?

- Your current levels of Health, Energy and Vitality:

1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

What is interfering with your current levels of Health, Energy and Vitality?

- Your current levels of satisfaction with your Physical Fitness, Eating Habits and Body Weight:

1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

What is interfering with your satisfaction with your Physical Fitness, Eating Habits and Body Weight?

- Your current relationship with yourself **(Self-Confidence, Self-Esteem, Self-Care):**

1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

What is interfering with the quality of your relationship with yourself?

- Your current levels of Happiness, Fun, Inspiration, Passion and Enriching Growth in your Life:

1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

What is getting in the way of your experience of Happiness, Fun, Inspiration, Passion and Enriching Growth in your Life?

- Your current levels of satisfaction and fulfillment in your current Career:

1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

What is interfering with your levels of satisfaction and fulfillment in your current Career?

- Your level of satisfaction and fulfillment with your current Financial Situation:

1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

What do you think is interfering with your levels of satisfaction and fulfillment with your current Financial Situation?

- Your current levels of Happiness, Fulfillment and Healthy Connection in your most important relationships:

1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

What is getting in the way of your levels of Happiness, Fulfillment and Healthy Connection in your most important relationships?

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Please check all that apply to you:

Past	Current		Past	Current	
☐	☐	Physical Challenges/Pain	☐	☐	Healing from Trauma
☐	☐	Anxiety	☐	☐	Eating Challenges
☐	☐	Depression/Unhappiness	☐	☐	Relationships Challenges
☐	☐	Gambling Challenges	☐	☐	Grief or Significant Loss
☐	☐	Alcohol or Drug Challenges	☐	☐	Health Challenges
☐	☐	Financial Challenges	☐	☐	Suicidal Thoughts or Attempts
☐	☐	Feelings of Overwhelm	☐	☐	Homicidal Thoughts

Please check all that apply to you:

☐ Heart Attack/Stroke	☐ Low Blood Pressure	☐ Serious Injuries
☐ High Cholesterol	☐ Fainting/Dizziness	☐ Sports Injuries
☐ High Blood Pressure	☐ Surgeries	☐ Arthritis
☐ Blood Clots	☐ Back Pain	☐ Auto-Immune Disease
☐ Chest Pain	☐ Smoking	☐ Pre-Diabetes or Diabetes

☐ Other_____

Have you been approved by your medical doctor for moderate physical activity? ☐ ***Yes*** ☐ ***No***

Do you have a mental health advance directive? ☐ **Yes** ☐ **No** (If no, we are required to provide you with information about mental health advanced directives if you would like that information.)

Informed Consent and Consent for Treatment: All information on this form and throughout counseling and coaching is confidential. The exception to this confidentiality agreement is for insurance billing purposes and/or when there is an imminent danger to self or others, as in cases of abuse, clear neglect, and suicide risk; we must break confidentiality to alert the appropriate authorities in those situations. By signing this form you are consenting to receive behavioral health counseling.

Philosophy Statement: A Path with Heart is a supportive and heart-centered counseling practice. Our intention is to support you in becoming the person you want to become, helping you to take action toward creating a better quality of life for yourself and those you love.

Signature_____ **Date**_____

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Patient Bill of Rights and Responsibilities and Our Privacy Practices (HIPAA) and Social Media Policy (SMP)

You have a Right To:

- Be treated with courtesy and respect and with protection of privacy.
- Receive prompt and reasonable responses to questions and requests.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive health care treatment, regardless of race, national origin, religion, disabilities, or source of payment.
- To participate in all decisions regarding your health care, including refusal of care.
- Express complaints regarding any violation of your rights.

You are Responsible for:

- Giving your healthcare provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about your health.
- Reporting unexpected changes in your condition to the health care provider.
- Keeping appointments and, when unable to do so, notifying your health care provider or facility with 24-hour advance notice.
- Taking positive action towards changing your life for the better and following through with agreed-upon therapeutic homework.
- Making sure financial responsibilities are carried out.

OUR PRIVACY PRACTICES AND YOUR RIGHTS: JOINT NOTICE OF PRIVACY PRACTICESTHIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The privacy practices of A Path with Heart and certain organizations that participate in an organized health care arrangement ("OHCA") with A Path with Heart are described in this Joint Notice of Privacy Practices ("Notice"). Health information about you is contained in our records, but the information in those records belongs to you. This Notice will help you understand how we protect the privacy of your health information and how to complain if you believe your privacy rights have been violated. The terms "we" and "our" used in this Notice refer to A Path with Heart and the members of our OHCA that share this Notice and agree to abide by its terms.

HOW WE PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

Whenever possible, A Path with Heart uses or shares health information that doesn't identify you. We have policies and procedures to protect the privacy of health information that does identify you. We have a training program to educate our employees and others about our privacy policies. Your health information is only used or shared for our business purposes or as otherwise required or allowed by law.

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OUR RESPONSIBILITIES

- We are required by law to maintain the privacy of your health information.
- We are required to provide patients with this Notice that describes our legal duties and privacy practices regarding protected health information.
- We have a legal duty to notify you, and you have a right to know when your protected health information has been inappropriately accessed, used, or disclosed as a result of a breach.
- We must follow the terms of the most current Joint Notice of Privacy Practice and are required to ask you for a written acknowledgment that you received and reviewed a copy.

YOUR HEALTH INFORMATION RIGHTS

You have rights with respect to your protected health information. For more information on how to exercise these rights, see the How to Make a Request section of this Notice. The health information rights described in this Notice also apply to a person with legal authority to make health care decisions for a child or other person (for example, a parent or legal guardian). There are exceptions. For example, in New Mexico, some health care services can be provided to a minor without the consent of a parent, guardian or other person. In these cases, the minor has the rights described in this Notice for health information related to the health care service provided. Some of the rights described below are subject to certain limitations and conditions.

Right to Get a Copy of Health Information. You have the right to get a copy of your health information. Usually, this information is contained in medical and billing records. You must make a request in writing to get a copy of your health information.

Right to Amend Incorrect or Incomplete Health Information. We strive to ensure that the health information kept in our records is accurate and complete. However, occasionally a mistake can occur. You have the right to request that we change incorrect or incomplete health information in our records. We may deny your request if appropriate.

Right to Request Confidential Communications. You have the right to request that we deliver health information to you in a certain way or at a certain location. We must agree to a reasonable request or may deny your request if it is against the law or our policies.

Right to Request Restrictions of the Use or Disclosure of Your Health Information. You have the right to request that your health information is not used or shared for certain purposes. We are not required to agree to your request except if required by law, or if you request restriction to disclosure of your protected health information to the health plan and you pay A Path with Heart for those services or health care items in full. We must tell you if we cannot agree to your request.

Right to Request an Accounting of Disclosures. You have the right to request an Accounting of Disclosures. This report will show when your health information was shared by us outside of our organization without your written authorization.

Right to Receive a Paper Copy of this Notice. You have a right to receive a paper copy of this Notice, even if you also agreed to receive it electronically.

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OUR SOCIAL MEDIAL POLICY

We will not communicate with current or former clients on Social Media. Privacy and confidentiality cannot be protected on Social Media. Therefore, we cannot "Friend" "Follow" or Interact with our clients on Social Media. If one of our therapists discovers that they have inadvertently or accidently established a social media communication or contact with you, they will cancel that social media relationship due to the security risk these types of casual contacts with clients can create.

WHEN HEALTH INFORMATION CAN BE SHARED WITHOUT A WRITTEN AUTHORIZATION

For Treatment or Payment: <u>We are required by law to coordinate care.</u> We may share your health information, with your primary care physician and/or other important health care providers you notify us about in order to coordinate your health care. We also use and share your health information in order to receive or facilitate payment for the treatment and services provided to you.

For Health Care Operations and Compliance with Insurance Companies: We use and share health information in order to operate our business and deliver quality care and services to our patients and we are required to make records available to health insurance companies for quality management reviews and audits.

Required by Law: We will use and share your health information when required by federal, state, or local law.

Legal and Administrative Proceedings. Your health information may be shared as part of an administrative or legal proceeding if your records are subpoenaed.

Emergency Situations: We will use professional judgment to decide if sharing your health information is in your best interest during a health emergency or if you are incapacitated.

Public Safety. Your health information may be shared to prevent or lessen a serious and immediate threat to yourself or to the health or safety of anyone or the general public.

Release of Medical Records (ROI)

A SEPARATE WRITTEN AUTHORIZATION (ROI) IS REQUIRED TO RELEASE YOUR MEDICAL RECORDS: We will not use or share your health information, without your written authorization unless required by law or as described in this Joint Notice of Privacy Practices. You may cancel an authorization in writing at any time, except to the extent we have already taken action according to the authorization.

x_____ x_____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE **DATE OF SIGNATURE**

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Billing and Financial Policy Statement

A Path with Heart is committed to providing you with high-quality medical care in a cost-effective manner. In order to accomplish this, we depend upon you to promptly pay for the services you receive and provide us with proof of insurance.

Payment Expectation:

- The fee for service charge for counseling sessions is $160 per session. We have a sliding scale available for patients with financial needs. At the time of service, it is your responsibility to pay your deductible, co-payment, or co-insurance amount specified by your insurance plan.
- Any medical services not covered by your insurance plan are your responsibility. We require payment in full for these services at the time of the visit unless other arrangements have been made.
- If your insurance company denies a claim, you are fully responsible for paying for the charges within 30 days of receiving our statement.

If You Have Health Insurance: We encourage you to read your insurance policy and attempt to understand your benefits and payment obligations. Please contact your insurance carrier to discuss any questions you might have about your coverage and about the best way to use your insurance benefits. For example, many insurance plans limit you to certain physicians or facilities and many require referrals or authorizations for receiving certain services. You should also understand the amount you will generally pay for services (your deductible, copayments, or co-insurance, if applicable).

Self-Pay Clients and Good Faith Estimates: Patients without insurance coverage, or proof of coverage, are expected to pay in full at the time of service. **The Good Faith estimate** is not a present or future bill. The good faith estimate shows a list of expected charges for items or services from your healthcare provider. The good faith estimate must include expected charges for the service you are provided, specifying the health care service and the charge for that service. Because the good faith estimate is based on information known at the time your provider creates the estimate, your good faith estimate won't include any unknown or unexpected future costs that your healthcare provider is not aware of at the time. At A Path With Heart Counseling our fees are clear, transparent, and easy to understand. **The charge for self-pay patients is $160 per counseling session. Each counseling session you attend will cost you $160 at the conclusion of that session. We estimate that the total cost of your counseling sessions at A Path With Heart will be $160 per session, multiplied by however many sessions you decide to attend in the future.**

At A Path With Heart, our patients self-refer to our counseling practice. The patients we serve seek our services voluntarily, of their own free will, and as such, our patients determine their own frequency and duration of sessions. It is not possible for us to reliably or ethically predict how many counseling sessions you will decide to attend in the future. Nor is it appropriate for us to unduly influence your decisions in this regard. As a patient, it is your right to determine your own frequency of counseling sessions as well as the duration of counseling treatment. Your health care decisions are personal and should be based upon your own health care wants and needs and your budget. It would be inappropriate and unethical for us to decide for you, how many counseling sessions you should attend in the future. It is your right to determine and have control over your healthcare decisions. We charge $160 per counseling session, for each counseling session you attend. The total cost of your health care with us will be $160 multiplied by however many sessions you attend. We cannot accept advance payments for future sessions. Payment for each session is due at the conclusion of the counseling session.

Please sign below indicating that you have read and understand our Billing and Financial Policy Statement and have received a good faith estimate.

Sign:_____ **Date:**_____

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Medical Records, Requested Letters, Consultations with Professionals, and Court and Legal Matters: There is an administrative charge of $30 for the duplication and sending of medical records that must be paid in advance. There is a charge of $160 per hour for requested letters (reading and writing), requested consultations, and communications with other professionals, with a minimum charge of $160.

Clients are discouraged from having therapists subpoenaed, deposed, or providing records for the purpose of litigation. Even though clients are responsible for all fees, it does not mean that your therapist's testimony will be solely in your favor. Therapists can only testify to the facts and to our professional opinion. When it comes to Court or Legal Matters the following fees are in effect:

1) Preparation time $160 per hour with a minimum of 1 hour charge.
2) Phone calls with Attorneys, Guardian Ad Litems, Parenting Coordinators, CYFD, and Court Appointed Professionals, $160 per hour with a minimum charge of 1 hour.
3) Deposition or giving testimony, $160 per hour, including drive time, with a minimum charge of 3 hours, $480.
5) All attorneys' fees and costs that are incurred by the therapist as a result of the legal action.
6) The minimum charge for a Court Appearance is $1,200.

A Retainer of $1,200 is due at least 72 business hours before the scheduled deposition or court appearance. The remainder of the costs will be billed after the court appearance and will be due upon receipt. If we are subpoenaed and the case is continued with less than 72 hours notice, prior to the beginning of the day of the scheduled court appearance, and testimony is not given, then the client will be charged for preparation time and $500 for therapist taking the time off of work to appear in Court. All fees listed above are doubled if the therapist is scheduled to be going out of town at the date and time of the subpoena, or if the therapist is given less than 72 hours' notice on a subpoena.

Patient Acknowledgement: I have read and understand this explanation of my financial responsibility for services I receive from A Path with Heart:

Sign:_____ **Date:**_____

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Coordination of Care with Your Primary Care Physician and other Health Care Providers

We are required to coordinate with your primary care physician and any other health care provider you feel is important for us to coordinate with.

Primary Care Physician: _____ Phone_____

Other Health Care Providers: _____ Phone_____

Signature_____ **Date**_____

We Have a 24-hour Notice Cancellation Requirement Policy

If you need to reschedule or cancel an appointment, please call 24 Hours before your appointment time to provide adequate notice.

***There will be a $50 charge for all appointments that are rescheduled, canceled, or missed, without 24-hour notice.**

***(There will be no charge to Medicaid patients).**

Signature_____ **Date**_____