PATHWAYS COUNSELING

Welcome to Pathways Counseling
Client Information and Informed Consent for Services

Welcome and thank you for choosing Pathways Counseling for your counseling services. Today's appointment will take approximately 50 minutes. I understand beginning a process of counseling may be a major decision and you may have many question. This document is intended to inform you of Pathways Counseling policies, state and federal laws, and your rights and responsibilities. If you have any questions or concerns, please ask and I will do my best to provide you all of the information you need.

Pathways Counseling offers a wide array of counseling services, including individual, family, couples, and group services. Effective counseling and psychotherapy is founded on mutual understanding and good rapport between client and therapist. Pathway Counseling's goal is to create a supportive environment in which clients can explore emotional needs and overcome barriers that limit their full potential. I take an open-minded approach to client wellness and consider how each individual's mental, physical, emotional, social and spiritual health impacts their specific situation.

PROVIDER: Susan Dalrymple holds a Master's Degree in Social Work from UT Arlington, completed 3,000 supervised hours, and passed all required exams to be independently licensed as a Clinical Social Worker through the Texas State Board of Social Work Examiners. Additionally she is a Board Approved Supervisor. If you have questions, concerns or complaints, I hope you feel free to raise concerns with me so we can work to resolve concerns together. If we are unable to reach a satisfactory solution you can direct inquiries and complaints to the Texas State Board of Social Work Examiners at 1100 West 49th Street, Austin, TX 78756-3183 or 800-232-3162.

PSYCHOLOGICAL SERVICES: Psychotherapy is not easily described in general statements. It varies depending on the personality of the psychotherapist and the client and the specific issues you bring. There are many different methods for addressing issues you hope to resolve. Psychotherapy calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we discuss both during our sessions and at home, in the community, in relationships, or where ever the issues reside.

While beneficial, Psychotherapy can also have risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Psychotherapy has also shown to have great benefits for people who go through the process. Therapy often leads to an improved relationship, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience. Each person is unique.

The first session involves an evaluation of your needs. At your next session, Mrs. Dalrymple will be able to offer you some first impression of what the work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with Mrs. Dalrymple. If you have questions about the procedures, we should discuss them as they arise. If your doubts persist, Pathways Counseling can link you to another mental health provider for a second opinion.

SESSIONS: Appointments last 50 minutes, and a full evaluation may take up to two sessions. During this time, you and Mrs. Dalrymple both decide whether this is the best therapeutic fit for your needs and to best meet your treatment goals. If a treatment plan is agreed upon, sessions are typically one 50 minute session weekly, or according to your needs.

COURT APPEARANCES: It is the policy of Mrs. Dalrymple to avoid court appearances whenever possible. As mental health professionals, we view our role in an individual's or family's life to be one of assessment and treatment, not to provide testimony in a legal setting. Please be advised that the only time a professional from Pathways Counseling appears in court is when required by court and issued a subpoena. Attending and preparing for court hearings is time consuming and costly, not only to Mrs. Dalrymple, but to other clients as well.

Attending court requires that all clients be cancelled and re-scheduled during that time, which may delay, inconvenience or prohibit their ability to receive needed services. This time demand directly impacts Mrs. Dalrymple's ability to maintain her commitment and service to all of her clients. It is important that client understand that testimony in court may or many not help your case.

If required to testify, the only information that will be provided is any truth of which there is firsthand knowledge. Fees for court testimony are: $300.00 per hour, beginning from the time of departure from the office until return to the same location, with a minimum of three hours billed. Fees are also required for copying of records ore creating summaries or documents for court. Fees are due 24 hours prior to any court appearance.

Initial _____

CONFIDENTIALITY & LIMITATIONS: All communication with your counselor is confidential and will not, except under circumstances explained below, be disclosed to anyone outside of Counseling Services unless you give written authorization to release information (or in the case of a minor the parent or legal guardian).

A record is kept of your work with Pathways Counseling. It contains information you have provided in writing, as well as counseling notes of your sessions. The record remains with Pathways Counseling for a period of seven years following your last visit; at that time, it is destroyed. Your record does not leave the possession of Pathways Counseling.

It is important you understand all identifying information about your therapeutic treatment is kept confidential. Information solicited by phone, written, or in person about clients is not provided. You will need to sign consent to release information before any information is provided to a 3rd party outside of this office. This condition applies to cases where coordination of treatment is necessary with another health professional (e.g. physician, psychiatrist). However, there are exceptions and/or limitations to confidentiality. The following are some exceptions that allow or require the release of confidential information, without client consent. Examples include:

- In cases of immediate risk/threat of suicide or homicide on the part of the client.
- In cases of child or elderly abuse or neglect.
- In cases required by law or court subpoena.
- In case consultation. As professionals, we do consult with one another from time to time. Any clinical material is conveyed without identification whenever possible. At other times, it will be necessary (for example, if another therapist is covering calls during a vacation).
- Case material is sometimes used in training, research, writing, etc. This is always done with identifying information removed and with great care and respect for privacy.

Initial _____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of Mrs. Dalrymple, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my initials on this form, I hereby consent to another licensed mental health professional, selected by Mrs. Dalrymple, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

Initial _____

EMERGENCY SITUATIONS: Pathways Counseling not provide emergency services, though Mrs. Dalrymple desire to be as available as is reasonably possible. You may call the office number at any time and leave a message if no one can answer. During the business day, Mrs. Dalrymple can often, though not always, return calls fairly quickly. Nighttime and weekend calls are usually returned the following business day. If you find yourself in an urgent situation, you will need to make a judgment about the prudence of waiting for a return call, versus calling your physician, 911 or seeking care in the nearest emergency room for immediate care, asking for the clinician/psychologist/psychiatrist on call. If Mrs. Dalrymple is away for an extended period of time, voice mail will indicate that, with an expected date of return.

Initial _____

Professional Fees & Fee Agreement

Session Fee Schedule is as follows:

Initial Diagnostic & Evaluation Session (1st Visit)—$120.00
Regular Office Visits (50 minutes) Individuals–100.00
Regular Office Visits (80 minutes) –150.00

The following is a fee agreement between you and Pathways Counseling. You are expected to pay for each session in the amount of $_____ at the beginning of each session.

INSURANCE: Fees and/or co-payments vary according to insurance companies. I authorize the release of any medical or other information necessary to process an insurance claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to **Pathways Counseling**.

Insurance company: _____ ID # _____
Group#:_____ Insurance Provider phone#: _____
Policy Holder: _____ Relation: _____ Policy Holder Date of Birth: _____

Secondary Insurance: _____ ID # _____
Group#:_____ Insurance Provider phone#: _____
Policy Holder: _____ Relation: _____ Policy Holder Date of Birth: _____

Initials _____

Financial Consent & Accountability Statement

I am aware that I must call to cancel an appointment within 24 hours of that appointment in order to avoid full financial responsibility for that session. It is my responsibility to call my counselor (day/night/weekend) to cancel my appointment.

Furthermore, I agree to the one time charge or debit to my credit/debit card in the amount of my regular appointment fee plus the service charge, following any missed session or appointment cancelled with less than 24 hours notice. **Pathways Counseling** is not required to notify me of this charge.

I am aware that payment is due at the beginning of each session. All checks should be made out to **Pathways Counseling**. If paying by cash, only exact amounts will be accepted. If you do not bring exact cash, your counselor will not be able to make change and the excess will be applied to your next session. If you choose to pay ahead for sessions, please be aware that we do not provide refunds for unused sessions.

If my check is returned for insufficient funds I agree to bring cash payment for the session and the NSF bank charge before my next scheduled appointment. If no cash payment is made, I agree to a one-time credit/debit charge to my account plus the NSF fee and the service charge to be made. **Pathways Counseling** is not required to notify me of this charge.

Credit /Debit Card Information:
Name as it appears on the card_____
Credit/Debit Card #_____ Expiration Date_____ CCV _____
Cardholder's Zip Code _____

_____ _____
Signature – Client Date

APPOINTMENT REMINDER NOTIFICATION:
Would you like to receive an appointment reminder 24 hours prior to your visit? Yes ☐ No ☐
Do you prefer to be reminded via email? Yes ☐ No ☐ Email: _____
Do you prefer to be reminded via text? Yes ☐ No ☐ Cell phone#: _____
Do you prefer to be reminded via automated message? Yes ☐ No☐ Phone Number: _____

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION: Although your health record is the property of the entity that created it, you have the right to:

- Request a restriction, in writing, on certain uses or disclosures of your medical information for treatment, payment, or health care operations, with the exception of emergency operations. Will consider your request *but are not legally required to agree to a requested restriction.* We will inform you of our decision on your request.
- Obtain a paper copy of this notice of our privacy practices upon request.
- Inspect and obtain a copy of your medical information, in most cases.
- Request in writing, an amendment to your records if you believe the information in your record is incorrect or important information was not created by us, maintained by us, or if we determined the record is accurate. You may appeal in writing our decision to not amend a record.
- Obtain an accounting of disclosure stating who and where your health information has been disclosed for purposes other than treatment, payment, health care operations (TPO) or where you specifically authorized a use or disclosure in the past (6) years, but not prior to April 14, 2003. The request must be in writing and state the time period desired for the accounting. After the first request, there may be a charge.
- Request that medical information about you be communicated to you in a confidential way or at an alternative location, but you must specify how or where you wish to be contacted.

By signing this form, I am consenting for Susan Dalrymple and Pathways Counseling to use and disclose my medical information as disclosed in this Privacy Information Document.

LIMITS OF THE COUNSELING RELATIONSHIP

Although sessions with your counselor may be very intimate psychologically and interpersonally, the relationship is a professional relationship rather than a social one. Contact must be limited to sessions you arrange with your counselor.

Due to ethical guidelines, you are asked not to invite your counselor to social gatherings, offer gifts, ask your counselor to write references for you or relate to you in any way other than the professional context of the counseling sessions (this includes any interaction involving social networking sites).

Your counselor is required to keep the identity of clients confidential. Therefore, your counselor cannot and will not acknowledge you outside of counseling sessions unless you first acknowledge them.

Again, in order to maintain proper ethical standards, when the counseling relationship ends, the limitations of contact with your counselor must remain the same.

I have read and understand the Limits of the Counseling Relationship. Initials _____

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

While it is generally expected that you will benefit from therapy, there may be periods of feeling worse before feeling better and there is no guarantee of success in therapy. There may be alternative treatments or modes of therapy to consider. I will encourage you to become aware of these factors and to ask any questions you may have at any time during our work together.

_____ _____

Signature – Client Date

_____ _____

Therapist Date

Pathways Counseling

Adult Personal Information

Name _____ Date _____

Address _____ Apt _____

City _____ State _____ Zip _____

E-mail _____ Okay to contact? ☐ Yes ☐ No

Home Phone _____ Okay to contact? ☐ Yes ☐ No

Cell Phone _____ Okay to contact? ☐ Yes ☐ No

Work Number _____ Okay to contact? ☐ Yes ☐ No

Date of Birth _____/_____/_____ Age _____ Gender: ☐ Male ☐ Female

Driver's License# _____ State _____

Employer _____ Occupation _____

Number of different jobs in past 3 years: _____ Highest Schooling Completed: _____

Mental Health Coursework: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

If married, partnered, separated, divorced, or widowed, how long: _____

Name of Spouse/Partner: _____ Date of Birth _____/_____/_____

Have Children? ☐ Yes ☐ No If yes, how many? _____

Name of Children/Other in Household	Relationship	Date of Birth	Age	Lives with You?
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No

Physician Name _____ Date of last physical: _____/_____/_____

What medications are you taking? _____

_____

Current health issues: _____

Past, Chronic, or Significant Health Issues/Surgeries: _____

_____

In Case of Emergency, I authorize Pathways Counseling to contact _____

Relationship _____ Phone Number _____ Alternate Number _____

How did you hear about us? Please circle: Friend/Family Pathway's Website Psychology Today

Insurance/EAP Referral _____ Other _____

PATHWAYS COUNSELING ASSESSMENT and HISTORY INFORMATION

This information will help you & your therapist begin to clarify your therapy goals.

Name _____ Date _____

☐ Yes ☐ No Have you ever been treated by a psychiatrist?
☐ Yes ☐ No Have you ever been hospitalized for mental or chemical dependency treatment?
☐ Yes ☐ No Have you ever been to counseling before? If yes, when? _____
☐ Yes ☐ No Have you seen another therapist in the **past 24 months**?
If yes, whom did you see? _____
☐ Yes ☐ No Have you ever attempted suicide?
If yes, when? _____
Briefly describe your reasons for seeking counseling services: _____

_____

_____

What have you tried so far to handle this situation? _____

_____

_____

Please place a number that best corresponds to issues listed below that are currently issues. For issues were in the past, please mark "P" for past, with a number to indicate how long ago it was an issue. For example, if you had an issue with prescription drug use 10 years ago, mark "P-10" next to "Drug Use."

Rarely			Sometimes			Often			Always
0-1	2	3	4	5	6	7	8	9	10

_____ Abuse—physical
_____ Abuse—sexual
_____ Abuse—emotional
_____ Abuse—neglect
_____ Aggression, violence
_____ Alcohol Use
_____ Anger, Hostility, irritable
_____ Anxiety, Nervousness
_____ Appetite/Weight Changes
_____ Attention, Distraction
_____ Career concerns, goals, choices
_____ Co-dependence
_____ Confusion
_____ Combat/Combat Exposure
_____ Cruelty to animals
_____ Crying, Sadness
_____ Custody of Children

_____ Decision-making, Indecision
_____ Delusions (false ideas)
_____ Depression
_____ Divorce, Separation
_____ Drug Use _____
_____ Eating Problems
_____ Financial
_____ Gambling
_____ Grieving
_____ Goals
_____ Guilt
_____ Headaches
_____ Impulsiveness
_____ Judgment
_____ Loss of Control
_____ Marital/Partner
_____ Memory Problems

_____ Menstrual, PMS, Menopause
_____ Mood Swings
_____ Obsessions/Compulsions
_____ Panic/Anxiety Attacks
_____ Parenting
_____ PTSD
_____ Sexual Assault
_____ Self-Esteem
_____ Sexual Issues
_____ Sleep Problems
_____ Stress
_____ Suicidal Thoughts
_____ Tobacco Use
_____ Temper/Low Tolerance
_____ Thought Disorganization
_____ Work Problems
_____ Worry

Other _____ Other _____

Pathways Counseling

In the past 36 months has there been a death of a family member or someone close to you? ☐Yes ☐No
If yes, who? _____ When? _____ Relationship? _____

Prior to the 36 month, has there been a death of someone that was close to you? ☐ Yes ☐ No
If yes, who? _____ When? _____ Relationship? _____

Please rate below on a scale of 1 through 10, 1 = not at all and 10 = very much so:

_____ I was very close and had a good relationship with my father.
_____ I was very close and had a good relationship with my mother.
_____ I was very close and had a good relationship with my siblings.
_____ I have several good friends.
_____ I often have nightmares.
_____ I enjoy spending time alone.
_____ I have a tendency of agreeing with other people to avoid confrontations.
_____ I don't like being around other people, I want to be alone.
_____ I like myself.
_____ I have a healthy interest in sex.
_____ I sometimes am confused with my identity.
_____ I put the needs and wishes of others first before myself even if I'm not comfortable with it.
_____ I think I am responsible for the way others feel and their behaviors.
_____ I drink alcoholic beverages at least 3 times per week.
_____ I have a problem saying "no."
_____ Others make me mad, disappointed, or sad easily.

Any Current Legal Issues? _____
Any Past Legal Issues? _____
Have you ever filed a complaint against a professional? Yes ☐ No ☐ If yes, please explain: _____
_____

Spiritual/Religious identity growing up: _____ Now: _____
Describe your spiritual and religious practice today: _____
_____
_____

Mother's Occupation _____ Her age _____ Age at Death _____

Cause of death _____

Father's Occupation _____ His age _____ Age at Death _____

Cause of death _____

How would you rate your parent's marriage/relationship? Very happy☐ Happy☐ Ave☐ Unhappy☐

If divorced, what was your age when this occurred? _____

Number of Brothers _____ Number of Sisters _____ You are the _____ child.

Number of previous marriages/partners _____ First names of previous mates, years together, and children from that relationship:

_____

_____

_____

_____

Fears or concerns of counseling: _____

_____

My biggest strength is _____

_____

My biggest weakness is _____

_____

Goal or expectation of counseling: _____

_____

_____