

## 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 questions. 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. Pathways 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 49<sup>th</sup> 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 3<sup>rd</sup> 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                  |        |   | _____ Decision-making, Indecision |   |       |   | _____ Menstrual, PMS, Menopause |   |    |
| _____ Abuse—sexual                    |        |   | _____ Delusions (false ideas)     |   |       |   | _____ Mood Swings               |   |    |
| _____ Abuse—emotional                 |        |   | _____ Depression                  |   |       |   | _____ Obsessions/Compulsions    |   |    |
| _____ Abuse—neglect                   |        |   | _____ Divorce, Separation         |   |       |   | _____ Panic/Anxiety Attacks     |   |    |
| _____ Aggression, violence            |        |   | _____ Drug Use _____              |   |       |   | _____ Parenting                 |   |    |
| _____ Alcohol Use                     |        |   | _____ Eating Problems             |   |       |   | _____ PTSD                      |   |    |
| _____ Anger, Hostility, irritable     |        |   | _____ Financial                   |   |       |   | _____ Sexual Assault            |   |    |
| _____ Anxiety, Nervousness            |        |   | _____ Gambling                    |   |       |   | _____ Self-Esteem               |   |    |
| _____ Appetite/Weight Changes         |        |   | _____ Grieving                    |   |       |   | _____ Sexual Issues             |   |    |
| _____ Attention, Distraction          |        |   | _____ Goals                       |   |       |   | _____ Sleep Problems            |   |    |
| _____ Career concerns, goals, choices |        |   | _____ Guilt                       |   |       |   | _____ Stress                    |   |    |
| _____ Co-dependence                   |        |   | _____ Headaches                   |   |       |   | _____ Suicidal Thoughts         |   |    |
| _____ Confusion                       |        |   | _____ Impulsiveness               |   |       |   | _____ Tobacco Use               |   |    |
| _____ Combat/Combat Exposure          |        |   | _____ Judgment                    |   |       |   | _____ Temper/Low Tolerance      |   |    |
| _____ Cruelty to animals              |        |   | _____ Loss of Control             |   |       |   | _____ Thought Disorganization   |   |    |
| _____ Crying, Sadness                 |        |   | _____ Marital/Partner             |   |       |   | _____ Work Problems             |   |    |
| _____ Custody of Children             |        |   | _____ Memory 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:

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Fears or concerns of counseling: \_\_\_\_\_

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My biggest strength is \_\_\_\_\_

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My biggest weakness is \_\_\_\_\_

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Goal or expectation of counseling: \_\_\_\_\_

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