Path Light Counseling

Client Information

DATE:________/________/________

Please provide the following information about yourself and each person who will be seen. All client information is respected as private and confidential.

CLIENT

NAME: ______________________ ______________________ ______ ☐ ☐
LAST FIRST M.I. **M** **F**

ADDRESS: ______________________ **CITY**: ______________________ **ZIP:**____________

PHONE: HOME: (________)__________________ **WORK**: (________)__________________ **CELL**: (________)____________________

EMPLOYER/BUSINESS: ______________________ **OCCUPATION**:____________________ **SS#:**________-______-________

EMAIL: ______________________ **AGE:** ______ **DATE OF BIRTH:** _____/_____/_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

CLIENT

NAME: ______________________ ______________________ ______ ☐ ☐
LAST FIRST M.I. **M** **F**

ADDRESS: ______________________ **CITY**: ______________________ **ZIP:**____________

PHONE: HOME: (________)__________________ **WORK**: (________)__________________ **CELL**: (________)____________________

EMPLOYER/BUSINESS: ______________________ **OCCUPATION**:____________________ **SS#:**________-______-________

EMAIL: ______________________ **AGE:** ______ **DATE OF BIRTH:** _____/_____/_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

CLIENT

NAME: ______________________ ______________________ ______ ☐ ☐
LAST FIRST M.I. **M** **F**

ADDRESS: ______________________ **CITY**: ______________________ **ZIP:**____________

PHONE: HOME: (________)__________________ **WORK**: (________)__________________ **CELL**: (________)____________________

EMPLOYER/BUSINESS: ______________________ **OCCUPATION**:____________________ **SS#:**________-______-________

EMAIL: ______________________ **AGE:** ______ **DATE OF BIRTH:** _____/_____/_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

WHERE DID YOU HEAR ABOUT BILL SEERY OR PATH LIGHT COUNSELING? ______________________

Please turn to the next page.

WILLIAM L. SEERY, L.M.F.T., PATH LIGHT COUNSELING
INFORMED CONSENT FOR TREATMENT
(AS REQUIRED BY STATE LAW)

THIS *AGREEMENT* CONTAINS IMPORTANT INFORMATION ABOUT THE PROFESSIONAL SERVICES AND BUSINESS POLICIES OF WILLIAM L. SEERY, PATH LIGHT COUNSELING. PLEASE TAKE TIME TO REVIEW THE FOLLOWING POLICIES. FEEL FREE TO ADDRESS ANY QUESTIONS YOU MAY HAVE WITH YOUR COUNSELOR. AS OF JULY 1, 2004 THE ARIZONA STATE LICENSING BOARD OF BEHAVIORAL HEALTH EXAMINERS REQUIRES THAT WE PROVIDE THIS INFORMATION TO OUR CLIENTS, BEFORE SERVICES ARE RENDERED.

PSYCHOLOGICAL SERVICES

With psychotherapy/counseling there are many different approaches and methods that can be used to address problems or concerns. The goal(s) for treatment will be mostly defined by you the client and your therapist can help to identify these. Therapy is most successful, when the client is as much involved as possible both during session and at home.

THERAPUTIC PROCEDURES

Psychotherapy/counseling can have both benefits and risks. Since therapy often involves talking about unpleasant aspects of life, you may experience uncomfortable feelings like sadness, guilt, anger or loneliness. On the other hand, psychotherapy/counseling has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems and significant reductions in feelings of distress. However, there are no absolute guarantees of what you will experience.

Your first few sessions with your counselor will focus on evaluating your needs. By the end of the evaluation, your counselor will be able to offer you some first impressions of what your therapy will include and a suggested treatment plan. You should evaluate this information along with your own opinions and consider whether or not you will feel comfortable working with your counselor. If you have questions about your counselor's approach, you may discuss them whenever they arise. If you wish, your counselor will be happy to recommend another mental health professional for you to see.

REFUSAL OF AND/OR WITHDRAWING FROM TREATMENT

As a client of Path Light Counseling, you may, at some point, decide that the care you are receiving from your counselor is not in your best interest, or that you and your counselor's personalities are not a good match. At any time, for any reason, you may refuse treatment and/or withdraw from treatment. You are encouraged to discuss concerns about therapeutic treatment with your counselor. If you are not comfortable doing this, you may contact the director of Path Light Counseling for assistance (assuming this is not the same person.)

TREATMENT PARTICIPATION AND REVIEW

You are invited to participate in treatment decisions and in the development, review and revision of your treatment plan. The counselor(s) at Path Light Counseling welcomes client participation.

CONFIDENTIALITY OF RECORDS

Special protection is given by the law to psychotherapy / counseling notes (the private notes written by your counselor about the details of each session, documenting and analyzing the conversations between the two of you). In most cases, they may not be released to anyone, unless authorized by you or court ordered by a judge. You may view the HIPAA laws, posted in our office, for further information on the confidentiality of your records. Your records will be kept in complete confidence, with the following exceptions:

1. Consultation with a clinical supervisor or other counseling professionals (these professionals are required to maintain the same level of confidentiality as your own counselor).
2. If you are a danger to yourself or others (i.e., threat of suicide or homicide).
3. Sexual or physical abuse of children or the elderly.

You have the right to look at the information your counselor has about you in their mental health and billing records for as long as the information is kept, which is seven years beyond your last date of service. You may request a copy of this information, but there may be a small printing fee. Contact your counselor to arrange how to review your record.

MINORS

Information regarding any session, including those in which minors are the clients, will be kept confidential and will not be shared with a parent or guardian or any other party without the consent of the minor client, unless the client becomes a threat to him/herself or others. This policy is in accordance with HIPAA law under the Minor and Parent portion:
Patients under 18 years of age, who are not emancipated, and their parents should be aware the law may allow parents to examine their child's records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes the counselor's policy to request an agreement from parents that they consent to give up access to their child's records. If they agree, during treatment the counselor will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. The counselor will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless the counselor feels that the child is in danger or is a danger to someone else, in which case the counselor will notify the parents of the concern. Before giving

parents information, the counselor will discuss the matter with the child, if possible, and do his/her best to handle any objections the child may have.

FEES

Our fee scale is listed on a separate form, called Financial Agreement. Payment is expected at the time of service unless prior arrangements have been made. Cash and personal checks are acceptable forms of payment. If a financial hardship prevents you from paying for each session in full, a payment plan can be arranged. A Partial Payment Agreement must be signed in these circumstances. Client balances over 90 days may be submitted to a collection agency unless arrangements have been made with us to make payments on that balance. We are committed to diligently and respectfully work with you to arrange a payment plan prior to any collection agency being involved.

INSURANCE COVERAGE

Insurance billing can be handled one of two ways:

1. Upon request, we will furnish you with a statement of charges for you to use in filing your own insurance claim.

2. Generally, we do not directly bill third party payers accept by special agreement. In such cases, claims are filed **only as a courtesy to the client; therefore, any follow-up necessary on the claim will be the client's responsibility**. We also only file claims when we are reasonably certain that your insurance company will pay for behavioral health services. In cases where we do directly bill another payer, any and all monies that your insurance company pays on your behalf are applied first toward the balance owed on your account. **However, please keep in mind that ultimately the client is responsible for all charges.** Please feel free to contact us (461-0028) with any questions you may have regarding your statement.

GENERAL POLICIES OF OPERATION

OFFICE HOURS: Office hours vary according to your therapist's schedule. However, the contact information below should be sufficient for any communication that is needed outside of session times. Please feel free to contact your therapist as needed.

NO SHOW POLICY: **IF YOU MUST CANCEL AN APPOINTMENT, PLEASE CALL (520) 461-0028 OR SEND AN EMAIL MESSAGE TO: northlight4@gmail.com AT LEAST 24 HOURS IN ADVANCE.** If you give less than 24 hours notice for a cancellation you will be billed the full amount of the appointment.

APPOINTMENTS: Appointments are typically scheduled weekly or bi-weekly for 50 minutes. Variations from this (i.e. group counseling or extended family sessions) can be discussed with your counselor.

AFTER BUSINESS HOURS: Call **(520) 461-0028.** If there is no answer, leave a message. (i.e., for canceling a session, etc.)

EMERGENCIES: **IF YOU FEEL YOU HAVE A TRUE OR EVEN LIFE THREATENING EMERGENCY AND YOU ARE NOT ABLE TO REACH YOUR THERAPIST, DIAL 911.**

SIGNATURE (S)

I have reviewed the above information and have been given a copy for my own records.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date

Minor Client's Parent or Legal Guardian's Name (s) (Printed) (If Applicable) Date

Minor Client's Parent or Legal Guardian's Signature (s) (If Applicable) Date

PATH LIGHT COUNSELING HIPAA NOTICE
(FEDERAL LAW)

INTRODUCTION

This agreement contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of a patient's Protected Health Information (PHI), used for the purpose of treatment, payment and health care. The Federal Law requires that Path Light Counseling obtain each patient's signature acknowledging that we have provided him/her with this information.

PROTECTED HEALTH INFORMATION (PHI)

PHI includes any information – oral, recorded, written or sent electronically – about a person's physical or mental health, services rendered, or payment for those services, including all personal information connecting the patient to their records. This information can only be used or disclosed if the patient signs a written authorization. There are other situations that require only that the patient provide written, advanced consent. A patient's signature on this agreement provides consent for those activities, as follows:

PROFESSIONAL RECORDS

The law and standards of the counseling profession require that Protected Health Information about a patient be kept in their Clinical Record. Except in unusual circumstances that involve danger to one's self and/or others or where information has been supplied to confidentiality by others, the patient may examine and/or receive a copy of their Clinical Record if they request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that the patient initially view their Clinical Record in the presence of their counselor or have them forwarded to another mental health professional so they can discuss the contents. In most situations, a medical records fee of $35 will be charged. If a counselor refuses their patient's request for access to their records, the patient has a right of review.

PATIENT RIGHTS

HIPAA provides the patient with several new or expanded rights with regard to their Clinical Record and disclosure of Protected Health Information. These rights include requesting that their record be amended, requesting restriction on what information from their Clinical Record is disclosed to others, requesting an accounting of most disclosures of Protected Health Information that the patient has neither consented to nor authorized, determining the location to which protected information disclosures are sent, having any complaints the patient may make about a counselor's policies and procedures recorded in their records, and the right to a paper copy of this agreement, the attached notice form and the counselor's privacy policies and procedures. The counselor will discuss any of these rights with their patients.

MINORS AND PARENTS

Patients under 18 years of age, who are not emancipated, and their parents should be aware the law may allow parents to examine their child's records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes the counselor's policy to request an agreement from parents that they consent to give up access to their child's records. If they agree, during treatment the counselor will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. The counselor will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless the counselor feels that the child is in danger or is a danger to someone else, in which case the counselor will notify the parents of the concern. Before giving parents information, the counselor will discuss the matter with the child, if possible, and do his/her best to handle any objections the child may have.

LIMITS OF CONFIDENTIALITY

- A counselor may occasionally find it helpful to consult with other health and mental professionals about a case. During a consultation, every effort will be made to avoid revealing the identity of a patient. The other professionals are also legally bound to keep the information confidential. If the patient does not object, the counselor will not tell him/her about these consultations unless the counselor feels that it is important. The counselor will note all consultations in the patient's Clinical Report.

- If a government agency is requesting information for health oversight activities, a counselor may be required to provide it for them.

- If a patient files a complaint or a lawsuit against a counselor, relevant information regarding that patient may be disclosed in order to defend against the suit or complaint.

- If a patient files a worker's compensation claim and a counselor is providing services related to that claim, the counselor must, upon appropriate request, provide appropriate reports to the Worker's Compensation Commission or the insurer.

There are some situations in which the counselor is obligated to take actions, which are necessary to attempt to protect others from harm. If so, the counselor may have to reveal some information about a patient's treatment, however, these situations rarely occur.

- If a counselor believes that a child under 18 who has been examined is or has been the victim of injury, sexual abuse, neglect, or deprivation of necessary medical treatment, the law requires that a report with the appropriate government agency, usually the Child Protective Services, be filed. Once such a report is filed, the counselor may be required to provide additional information.

- If the counselor believes that any adult patient who is either vulnerable and/or incapacitated has been the victim of abuse, neglect, or financial exploitation, the law requires that a report with the appropriate state official, usually a protective service worker, be filed. Once such a report is filed, the counselor may be required to provide additional information.

- If a patient communicates an explicit threat of imminent, serious or physical harm, to a clearly identified or identifiable victim, and the counselor believes that the patient has the intent and ability to carry out such a threat, the counselor must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If a patient threatens to harm him/herself the counselor may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

- If the patient is involved in a court proceeding and a request is made for information concerning the professional services provided to them, such information is protected by the counselor-patient privilege law. A counselor cannot provide any information without the patient or their legal representative's written authorization, or a court order. If the patient is involved in or contemplating litigation, he/she should consult with their attorney to determine whether a court would be likely to order such disclosure.

If such a situation arises, the counselor will make every effort to fully discuss it with their patient before taking any action and will limit any disclosure to only what is necessary.

While this written summary of exceptions to the confidentiality should prove helpful in informing the patient about potential problems, it is important that any questions or concerns that the patient may have now or in the future be discussed. The laws governing confidentiality can be quite complex. In any situations where specific advice is required, formal legal advice may be needed.

I have read the HIPAA Notice Form and understand and agree to the stated terms and authorize treatment. (Your signature indicates that you have received a copy of the HIPAA Notice Form if you have requested it.)

_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Printed Name	Signature	Date

PATH LIGHT COUNSELING FEE POLICY

FEES:

Our standard fee is $100 for a 50-minute session. However, that fee may be reduced by mutual agreement in writing after discussing what is mutually affordable at the beginning of treatment. That fee will remain the same during the course of treatment unless it is changed also by mutual agreement in writing.

PAYMENT POLICY:

Payment is required at time of service. Path Light Counseling accepts cash or check as forms of payment. We can also send you a "Pay Pal" receipt via email that can be paid by credit card. Checks are made out to "Path Light Counseling" or if you prefer to, "William Seery, LMFT".

INSURANCE:

While in most cases we don't bill insurance companies, we can supply you with the information needed for you to bill your own insurance for re-imbursement for the fee that you have paid us. In cases that we do bill insurance, you must receive pre-authorization from your insurance company before beginning the billed counseling sessions and we will need to discuss arrangements. We understand how complicated and time consuming receiving authorization for insurance can be. Due to new HIPAA rules (privacy laws), insurance companies must be contacted by the member initially, **NOT** the provider. Please let us know if you have any questions about the insurance form.

PERSON (S) FINANCIALLY RESPONSIBLE FOR THIS THERAPY:

_____/_____

_____

Address (if different from client's address):

_____

_____

FINANCIAL AGREEMENT

I (name) _____ (and) _____
HAVE READ AND UNDERSTAND THE NO SHOW AND CANCELATION POLICIES OF THIS OFFICE (as stated in the Fee section of the Informed Consent Form). In the event of default, I promise to pay my balance, together with all costs of collection.

I hereby agree to pay the fee according to (please mark one below):

☐ Standard Fee: $100.00

☐ Other: $_____

☐ Other payment arrangements

Special Payment or billing arrangements (if applicable): _____

_____

Signature: _____ Date: _____

Signature: _____ Date: _____

Path Light Counseling

STORAGE POLICY FOR CLIENT RECORDS

STORAGE OF WRITTEN RECORDS

Client records are kept and maintained at the Path Light Counseling office and/or branch office(s). All written records will be stored in a secure, locked file cabinet, according to clinical standards prescribed by the state of Arizona. The custodian of records for Path Light Counseling is the Director, William L. Seery, LMFT, who is responsible for the security and access of all records.

All client records are confidential and can only be accessed by the client, who can formally demonstrate that he or she share the privilege. Generally records will be kept for a period of seven years. Clients are entitled to view their records with few exceptions and may do so by contacting the custodian of records and scheduling a time, generally within normal business hoiurs.

DISPOSITION OF WRITTEN RECORDS UPON RELOCATION, TERMINATION OR SALE OF PRACTICE

In the event that the Path Light Counseling practice is relocated, terminated, sold, or a counselor dies, Path Light Counseling will notify each client by phone, email, or postal mail. This will be done within thirty (30) days of the event. Each client will be informed of (1) the future location of each client's written records and (2) how that client can access the written records. Path Light Counseling will respond to client requests for written records within seventy-two (72) hours.

DISPOSITION OF UNCLAIMED CLIENT RECORDS

Path Light Counseling will dispose of (by incineration, shredding, or similar method) all unclaimed client records after one (1) year of the termination of it' practice.

In such cases where the therapist or custodian of records has died, moved away or is for some other reason no longer available, client will be notified as to how arrangements and approval for accessing records may be made.

In the event of the dissolution of Path Light Counseling, announcement will be made by phone, email, or mail regarding the location of the records and how long they will be kept there before being destroyed.

_____

Name (printed)

_____ _____

Signature **Date**

_____

Name (printed)

_____ _____

Signature **Date**

_____

Name (printed)

_____ _____

Signature **Date**

Path Light Counseling

FEE PAYMENT AND LATE CANCELLATION POLICY

FEE PAYMENT:

Payment is due at the time of the session, either at the beginning or end, unless we have made other specific arrangements. Although I generally do not bill insurance companies directly, on your request I can supply you with a statement that includes the information needed for you to bill your insurance for reimbursement.

LATE CANCELLATION POLICY

You are responsible for all appointments that you schedule. If you are unable to keep an appointment, let me know by phone or in person at least one day in advance that you must cancel. PLEASE ASSUME THAT APPOINTMENTS WHICH ARE NOT KEPT OR CANCELLED ONE DAY IN ADVANCE, WILL BE CHARGED. Please feel free to discuss this with me at any time.

Sincerely,

William L. Seery, LMFT

I have read, understand and accept the policies stated above.

(Signature) _____(Date) _____

(Signature) _____(Date) _____

INITIAL THERAPY GOALS

CLIENT NAME: _____DOB: _____

CLIENT NAME: _____DOB: _____

AREA # 1:

Problem: _____

Goal: _____

Objective/Intervention: ❑ Therapy sessions to explore issues and bring new insights or experiences.

❑ Other: _____

AREA # 2:

Problem: _____

Goal: _____

Objective/Intervention: ❑ Therapy sessions to explore issues and bring new insights or experiences.

❑ Other: _____

AREA # 3:

Problem: _____

Goal: _____

Objective/Intervention: ❑ Therapy sessions to explore issues and bring new insights or experiences.

❑ Other: _____

Client Participation Agreement*: I was included in the forming of this treatment plan and I agree that these are my intended goals.*

Client/Guardian Signature: _____ Date_____

Client/Guardian Signature: _____ Date_____

Licensed Behavioral Health Professional signature: _____ Date:_____

Six month review date (if needed): _____