PATHWAYS PSYCHOLOGY SERVICES
27 W130 Roosevelt Road, Suite 203 *Phone: (630) 588-8490*
Winfield, IL 60190 *Fax: (630) 588-8491*
www.pathways-psychology.com

INFORMED CONSENT AND CONFIDENTIALITY NOTICE

******PLEASE NOTE: LAST 2 PAGES OF THIS DOCUMENT REQUIRE INITIALS AND SIGNATURES******

For Therapy and Counseling Services:

- Your first appointment will consist of a diagnostic interview in which your clinician will create a diagnostic impression and subsequent treatment plan. Your clinician will communicate this information to you along with recommendations. You have the right to discuss your treatment and progress with your clinician at any time during the course of your counseling/therapy appointments.
- Appointments will last either 53 minutes or 37 minutes pending your insurance benefits or agreement with your provider.
- You are requested to bring your co-pay in the form or a check, cash, or charge that can be applied to your credit/debit card at the time of your appointment.
- Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of you or your child's life, you/your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.
- If you have questions about clinician's procedures, we should discuss them whenever they arise. If your doubts persist, your clinician will be happy to help you set up a meeting with another mental health professional for a second opinion.

For Psychological/Neuropsychological Testing:

- Your first appointment will consist of a diagnostic interview in which your clinician will create a diagnostic impression and make a recommendation regarding testing/evaluation.
- Learning disorder/disability testing is frequently not authorized by insurance and if requested will result in an additional fee based on the scope and magnitude of this additional testing.
- Throughout the assessment process you have the right to inquire about the nature or purpose of all procedures.
- Test administration may be completed by a technician or your psychologist. However, your psychologist will interpret results and write the evaluation.
- When insurance is billed, testing is billed in units that account for the time to administer, score, interpret, and write the evaluation.
- Payment of full balance is required before the report will be released.
- After your clinician has completed testing and received all observational questionnaires, the report (which will include results, interpretation, and recommendations) will typically be completed within 2-3 weeks. You will be contacted to receive the report and have a follow-up feedback appointment.
- A copy of the report will also be forwarded to requested parties if a release of information has been signed.

Confidentiality: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law including:

1. Where there is a reasonable suspicion of child, dependent or elder abuse or neglect.
2. Where a client presents a danger to self or to others.

3. Mandated reporting to state Dept. of Human Service FOID card tracking for individuals who present as a danger to themselves, others, or with intellectual/developmental delay.
4. Court subpoena/order for records.

Family and Couples Therapy Notice: In couples and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Your Pathways Clinician will use his clinical judgment when revealing such information. Your Pathways Clinician will not release records to any outside party unless s/he is authorized to do so by all adult family members who were part of the treatment. *If Pathways is ordered by a court to disclose, Pathways Psychology Services will be required to disclose your records*

Minors: Clients under 12 years of age and their parents should be aware that the law allows parents to examine their child's treatment records. When children between the ages of 12 and 18 are seen alone, the content of these sessions is kept confidential, between therapist and child. Parents of children between 12 and 18 years of age cannot examine their child's records unless their child consents or unless the Pathways Clinician find there is no compelling reason for denying them access to those records. Parents of children between 12 and 18 years of age are entitled to information concerning their child's current physical and mental condition, diagnosis, treatment needs, services provided and services needed. If the Pathways Clinician believes that the child is at imminent risk of harming himself/herself or others, the Pathways Clinician will notify the parents of his/her concern. Before giving parents any information, the Pathways Clinician will discuss the matter with the child, if possible, and do his/her best to handle any objections the child may have with what the Pathways Clinician is prepared to discuss with the parents.

Emergencies: If there is an emergency during our work together, or in the future after termination where Your Pathways Clinician becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, he/she will do whatever he/she can, within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose he/she may also contact the person whose name you have provided on the biographical sheet.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP/WORKERS' COMP in order to process the claims. In order to have appointments authorized, your Pathways Clinician may need to share mental health information including but not limited to: verbal or oral communication of diagnosis, presenting problem, symptoms, progress notes, and treatment plan.

Consultation: Your Pathways Clinician consults regularly with other professionals regarding his/her clients; however, client's identity remains completely anonymous, and confidentiality is fully maintained.

Records and Your Right to Review Them: Both the law and the standards of my profession require that I keep appropriate treatment records. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Your Pathways Clinician assesses that releasing such information might be harmful in any way. In such a case Your Pathways Clinician will provide the records to an appropriate and legitimate mental health professional of your choice. ***** Considering all of the above exclusions, if it is still appropriate, upon your request, Your Pathways Clinician will release information to any agency/person you specify unless Your Pathways Clinician assesses that releasing such information might be harmful in any way. **For this service, Pathways Psychology Services Policy has a $15.00 charge for any record copy services.**

Telephone & Emergency Procedures: If you need to contact Your Pathways Clinician between sessions, please leave a message on the answering service (630) 588-8490 and your call will be returned as soon as possible. Your Pathways Clinician checks his/her messages a few times during the daytime only, unless he is out of town. If an emergency situation arises, you should call 911or have someone take you to the nearest emergency room. Please do not use texting, e-mail or faxes for emergencies. Your Pathways Clinician does not always check his e-mail or faxes daily.

The Process of Therapy/Evaluation and Scope of Practice: Your Pathways Clinician provides neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within his or her scope of practice.

Termination: As set forth above, after the first couple of meetings Your Pathways Clinician will assess if s/he can be of benefit to you or your child. Your Pathways Clinician does not accept clients who, in his/her opinion, he/she cannot help. In such a case he/she will give you a number of referrals, who you can contact. If at any point during psychotherapy, Your Pathways Clinician assesses that s/he is not effective in helping you or your child reach the therapeutic goals, s/he is obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case s/he would give you a number of referrals that may be of help to you or your child.

You have the right to terminate therapy at any time. If you choose to do so, Your Pathways Clinician will offer to provide you with names of other qualified professionals whose services you or your child might prefer.

Payments & Insurance Reimbursement: Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify Your Pathways Clinician if any problems arise during the course of therapy regarding your ability to make timely payments. Not all issues/conditions/problems dealt with in psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. We cannot verify the accuracy of information given by insurance and it remains your responsibility to pay for uncovered, denied, or partially covered services. If your account is overdue (unpaid) and there is no written agreement on a payment plan, Your Pathways Clinician can use legal or other means (courts, collection agencies, temporary suspension of services, etc.) to obtain payment.

INFORMED CONSENT REGARDING EMAIL TRANSMISSION: It is very important to be aware that computers and unencrypted email, texts, and e-fax communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all emails, texts and e-faxes that go through them.

PLEASE IDENTIFY WHAT FORM OF ELECTRONIC TRANSMISSION YOU CONSENT TO:
(Initials Required by parent and child over 12)

_____ _____**I consent to the transmission of unencrypted e-mail from my provider/Pathways Office.**

_____ _____**I consent to the transmission of unencrypted texts from my provider/Pathways Office.**

OR

_____ _____**I ONLY CONSENT TO ELECTRONIC COMMUNICATION THAT IS ENCRYPTED.**

Initials Required by parent and child over 12:

_____ _____**I understand that if I initiate contact with my provider/Pathways staff via their regular e-mail address, I am consenting to transmission of unencrypted e-mail from my provider/Pathways office.**

_____ _____**I understand that if I initiate contact with my provider/Pathways staff via text, I am consenting to transmission of unencrypted text from my provider/Pathways staff.**

Please notify your provider if you decide to avoid or limit, in any way, the use of email, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted email, texts or e-fax or via phone messages, will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and he will honor your desire to communicate on such matters. Please do not use texts, email, voicemail, or faxes for emergencies.

Only parent/adult to initial:

_____ **I understand that I will be directly charged $75.00 if I do not cancel within 24 business hours of my/my child's appointment (weekends do not count).**

_____ **I understand my co-pay/deductible amount will be brought to each appointment.**

_____ **I understand that failure to pay my balance on any/all accounts will result in suspension of services.**

_____ **I am responsible for payment regardless of denial of claims for any reason.**

_____ **It is my responsibility to notify my provider of any changes in insurance.**

_____ **I understand that if I am concerned for my safety or my child's safety or any other situation that may be an emergency, I am to call 911.**

I have read the above Agreement, Informed Consent, Office Policies and General Information carefully, Cancellation Notice (total 4 pages) I understand them and agree to comply with them:

Client name (print)	Date	Signature
Guardian name (print)	Date	Signature
Guardian name (print)	Date	Signature
Clinician	Date	Signature

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BILLING INFORMATION

Type of Service ☐**Individual** ☐**Family** ☐**Group** ☐ **Testing**

Name of Therapist: _____ Date:_____

Client Name: _____ Date of Birth:_____

Parent/Legal Guardian (If Minor):_____

Address: _____

City:_____ State: _____ Zip Code:_____

Home Phone: _____ Work Phone:_____

Cell Phone: _____ Email:_____

Marital Status:_____Employer/School Name:_____

Occupation:_____ Education: _____

Party Responsible for Payment

☐ Mark if same as Client Name.

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Work Phone:_____

Cell Phone: _____ Marital Status:_____

Employer or School Name:_____

It is acceptable to leave messages regarding billing or appointments on my phone at:

___ Home ___ Cell Phone ___ Work

In case of Emergency Contact:

Name:_____

Phone:_____ Cell Phone:_____

INSURANCE INFORMATION

☐ Private Pay $_____ ☐ Bill My Insurance ☐ Workmen's Compensation ☐ EAP

Primary Insurance

Name of Insured: _____ Date of Birth: _____

Insurance Company: _____

Telephone Numbers: _____

Group and other insurance ID #s: _____
Preapproval Needed? _____

Preapproval Company and phone #s: _____

Notes:_____

_____

Secondary Insurance

Name of Insured: _____ Date of Birth: _____

Insurance Company: _____

Telephone Numbers: _____

Group and other insurance ID #s: _____

_____

Preapproval Needed? _____

Preapproval Company and phone #s: _____

Please Read and Sign the Following Agreement.

☐ Yes ☐ No: I am legal guardian to myself/child authorized to provide consent to medical and mental health services.

I give Pathways Psychology Services permission to bill my insurance company for services, and disclose to them sessions, fees, diagnosis, and treatment. I understand that I am responsible for paying my fee, regardless of whether my insurance covers it.

Signed: _____

Date: _____

Witness: _____

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WRITTEN CONSENT & AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

Patient Name: _____ Date of Birth:_____
Address: _____

___I authorize release of mental health information **from** Pathways Psychology Services to:

Individual/Organization:_____
Address: _____
Phone/Fax:
_____

___I authorize _____ **to** release requested information to Pathways Psychology Services.

REQUESTED MEDICAL INFORMATION:

___Histories and Physicals
___Reports of Psychological Testing
___Complete Records
___Oral Communication of Treatment and History
___Psychological Testing Raw Data
___Office Notes
___ Billing Records
___Other:_____
_____

I understand that I may revoke this consent in writing at any time, and that I have the right to inspect and copy the information to be disclosed. This consent is valid until for **one year** unless expiration is specified as:_____.

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences
___ Cannot collaborate on case.
___ Other:_____

I hereby release Pathways Psychology Services, P.C. from any and all legal liability that may arise from the release of the information requested.

Patient (12-years-old and above required) Signature:_____-
_____

Printed Name:_____Date:_____

Parent/Personal Representative Printed Name_____Date_____

Parent/Personal Representative Signature:_____Date_____

Relationship to Patient:_____Date:_____

Witness Signature:_____

NOTICE TO RECEIVING AGENCY/ PERSON: Under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such a re-disclosure. Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records may be further disclosed without specific authorization of such re-disclosure.

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