Pathway
Caring for Children

FOSTER CARE • COUNSELING • POST-ADOPTION SUPPORT

4895 Dressler Rd NW Ste. A, Canton, OH 44718 • 330-493-0083 • www.pathwaycfc.org

Client ID: _____

Client Name: _____ **DOB:** _____ **SSN:** _____

Legal Guardian: _____ **Relationship:** _____ **Phone #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

School: _____ **E-mail Address:** _____ **Gender:** _____

Who referred you to Pathway? _____ **Is there a current connection with Children Services?** ☐ Yes ☐ No

Is there a formal custody agreement? **(Provide copy if yes)** ☐ Yes ☐ No **Is the client under court supervision?** ☐ Yes ☐ No

Client's Marital Status

☐ Married
☐ Widowed
☐ Single (Never Married)
☐ Divorced
☐ Separated

Client's Race (check all that apply)

☐ Asian
☐ African American
☐ Alaskan Native
☐ Native American
☐ Hispanic
☐ Native Hawaiian
☐ Pacific Islander
☐ White
☐ Other

Client's Primary Source of Income/Support

☐ None
☐ Other/Unknown
☐ Wages/Salary
☐ Disability
☐ Family/Relative
☐ Retirement
☐ Public Assistance

Client's Current Educational Enrollment

☐ Pre-School
☐ K-12th Grade
☐ GED Classes
☐ College
☐ Vocational
☐ Is not attending school

If K-12th Grade: IEP ☐ Yes ☐ No

Client's Highest Education Level Completed

☐ None
☐ Elementary 1st-5th Grade
☐ Middle 6th-8th Grade
☐ High 9th-12th Grade/GED
☐ Technical School
☐ Some College
☐ 2 Yr Associate Degree
☐ 4 Yr Bachelor Degree
☐ Graduate Degree

Client's Current Living Arrangement

☐ Private Residence
☐ Perm. Supportive Housing
☐ Residential/Group Home
☐ Community Residence
☐ Temporary Housing
☐ Foster Care
☐ Homeless
☐ DD Facility
☐ Correctional Facility
☐ Other

Client's Employment at Admission

☐ Full Time
☐ Part Time
☐ Unemployed
☐ Disabled
☐ Homemaker
☐ Retired
☐ Student
☐ Volunteer Worker
☐ Engaged in Residential/Hospitalization

Has your child experienced any of the following recently?

☐ Family issues: divorce/blended family
☐ Crisis/trauma issues (grief)
☐ Change in job/schedule
☐ Changes in school or grades
☐ Family accident or illness
☐ Death of family or friend
☐ Financial stress
☐ Legal Stress
☐ Family moved
☐ New baby in the home
☐ Adoption

Current Signs/Symptoms of the Child (check all that apply)

☐ Social Concerns/Anxiety / Worry
☐ Suicidal Thoughts/Behaviors
☐ Depression / Sadness
☐ Excessive fearfulness
☐ Excessive energy
☐ Self-Injurious behaviors
☐ Hears or sees things others do not
☐ Acts without thinking
☐ Angry outbursts/ Mood swings
☐ Behavior problems
☐ School Adjustments
☐ Changes in eating or sleeping
☐ Abuse (physical / emotional / sexual)
☐ Dangerous behaviors (running away, drug use)

1. **How is your child's physical health?** ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good
2. **Is your child currently experiencing suicidal or homicidal thoughts and/or behaviors?** ☐ Current ☐ Past ☐ No
3. **Have MH services been provided elsewhere?** ☐ Yes ☐ No **Date of last service** **Agency/Contact:** _____
4. **Has your child ever been hospitalized for psychiatric care?** ☐ Yes ☐ No
5. **Is there a previous diagnosis?** ☐ Yes ☐ No If yes, Diagnosis : _____

What is bringing you in for services? _____

_____

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Client ID:

Financial Payer Information- **Primary** Insurance	Financial Payer Information- **Secondary** Insurance
☐ **Insurance** ☐ **Medicaid** ☐ **Self-Pay**	☐ **Insurance** ☐ **Medicaid** ☐ **Self-Pay**
INSURANCE COMPANY:	INSURANCE COMPANY:
Name of Card Holder:	Name of Card Holder :
Phone #:	**Phone #:**
Relationship to client:	**Relationship to client:**
Address of Card Holder:	**Address of Card Holder:**
Card Holder Date of Birth:	**Card Holder Date of Birth:**
Card Holder SSN#:	**Card Holder SSN#:**
Card Holder's Employer:	**Card Holder's Employer:**
Group #:	**Group #:**
Billing/Policy Number:	**Billing/Policy Number:**
Billing Mailing Address:	**Billing Mailing Address:**
Provider Phone Number on Card for Verification of Coverage:	**Provider Phone Number on Card for Verification of Coverage:**

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION: I hereby authorize and direct payment of my medical benefits to Pathway Caring for Children, for any services furnished to the client named above by any authorized Pathway service provider. I authorize the Pathway service provider to release any information, including diagnosis and the records of any treatment or examination rendered to the client named above.

AUTHORIZATION OF PAYMENTS: I understand that Pathway Caring for Children will assist me in submitting my claim to my insurance carrier. I agree to complete all required paperwork that would authorize any and all third party payers to release payment to Pathway for approved services. I hereby authorize payment directly to Pathway Caring for Children and its service providers. My signature acknowledges this statement.

MEDICAL EMERGENCIES

Emergency Contact 1: **Phone:** **Relationship**:

Emergency Contact 2: **Phone:** **Relationship**:

Preferred Doctor: **Preferred Hospital:**

X _____

Signature of Client or Legal Parent/Guardian **Date**

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Client ID:

Client Orientation and Consent for Mental Health Services Pathway Caring for Children is committed to providing individualized mental health services to clients. Services are provided by qualified professionals in a variety of settings to accommodate client needs in the best possible manner. One or more of the services offered by Pathway Caring for Children may be recommended for you or your child. An Individualized Treatment Plan will be developed with you to identify recommended services and goals for improvement. All mental health services have potential benefits and risks. A description of each service is outlined below along with the potential benefits and risks associated with each service. In the case of divorce or separation, by law, the nonresidential parent has the right to progress of treatment if requested unless there is court order restricting access. Providers do not assess custody and visitation.

☒ **I hereby authorize Pathway Caring for Children to provide Mental Health Services: Diagnostic Assessment-** a comprehensive assessment of client's needs and level of mental health functioning to identify presenting problems as well as client strengths in order to determine a course of treatment for the individual. A diagnostic impression a treatment plan developed to address identified needs. All mental health clients will receive a Diagnostic Assessment prior to any other mental health services, UNLESS one has been completed recently by another qualified provider, and it has been provided to Pathway Caring for Children staff. Potential benefits of the Diagnostic Assessment are that mental health conditions may be accurately diagnosed, and service plans for relieving these conditions can be developed. Potential risks may include temporary increases in stress associated with the focus on identifying problem areas

☒ **Counseling and Psychotherapy-**- assist the client in addressing specific issues impacting his or her mental health functioning. A qualified therapist will meet with the client (and with significant family members or other individuals, if indicated) in structured therapeutic sessions. Depending upon client need, services can be provided within individual and group formats. Potential benefits of Counseling and Psychotherapy services are an increased understanding of one's emotional well-being and better interpersonal functioning. Potential risks include temporary increases in stress associated with an in-depth focus on the client's personal concerns.

☒ **Therapeutic Behavioral Services (TBS)** – are goal directed supports intended to achieve identified goals set forth in the treatment plan and includes solution focused interventions, emotional and behavioral management, problem behavior analysis, treatment planning, identification of strategies or treatment options, restoration of social skills, restoration of daily functioning, crisis prevention and improvement. Potential benefit of TBS is increased opportunities for improved mental health functioning within a variety of areas of the client's life. Potential risks include temporary increases in stress associated with a more comprehensive approach to addressing identified problem areas.natural environment that are designed to facilitate improved functioning in the community. This may include: linking with and coordinating services

☒ **Community Psychiatric Supportive Treatment (CPST)-** designed to assist the client in improving his or her level of functioning in a variety of areas. CPST professionals provide an array of services within the client's with other agencies that are involved with the client; advocating for the client's needs with schools, courts, child protective agencies, etc.; monitoring mental health symptoms and providing important information to counselors, doctors, case workers, etc.; providing education regarding the client's mental health needs to parents, foster parents, teachers, etc.; and skill building activities with the client to aid in self-management of mental health conditions. Potential benefits of CPST services are increased opportunities for improved mental health functioning within a variety of areas of the client's life. Potential risks include temporary increases in stress associated with a more comprehensive approach to addressing identified problem areas.

I understand that each service received has potential benefits and risks associated with it, and I am entitled to an explanation of these risks and benefits. I further understand that I have the right to refuse this service, and that I have the right to withdraw consent for any service at any time.

X _____

Signature of Client or Legal Parent/Guardian

X _____

Relationship to Client **Date**

Privacy Practices Policy

I understand that Pathway Caring for Children may use my/my child's health information for treatment, billing and health care operations. I have been given a copy of Pathway's Notice of Privacy Practices to read that describes how my/my child's health information is used and shared. I understand that Pathway Caring for Children has the right to change this notice at any time. I may request and receive a paper or electronic copy by contacting Pathway's Privacy Officer at Pathway Caring for Children 4895 Dressler Rd. NW, Canton OH 44718. My signature below constitutes my acknowledgement that I have been provided a paper copy of the Notice of Privacy Practices.

X _____

Signature of Client or Legal Parent/Guardian **Date**

Medical Emergencies

In the event that an emergency contact can't be reached, I grant permission to appropriate Pathway Staff to obtain emergency medical treatment for which expenses I agree to be responsible or provide child's medical/insurance card for payment of expenses. The bill for such treatment should be sent to me at my address:

X _____

Signature of Client or Legal Parent/Guardian **Date**

Client Rights and Grievance Procedures: Client Rights and Grievance Procedures for Mental Health Services are posted in the waiting areas of each office location and on our website at www.pathwaycfc.org. I have been provided with a copy of the Client Rights and Grievance Procedure.

Signature of Client or Legal Parent/Guardian _____ **Date** _____

HIPAA REQUIREMENT: DOCUMENTATION OF SPECIAL CONTACT REQUEST

Request for Special Contact Procedures: (Check all that apply)

☐ **Normal Phone Contact:** Permission to leave message on voice mail or with anyone answering.

Special Phone Contact: ☐ Leave no messages ☐ Leave message only with client/parent-guardian ☐ Do NOT contact me by phone

☐ **Text Communications**: I consent to receiving text communications at the phone number I provided, including updates, reminders, and other relevant information. Message and data rates may apply. Msg Frequency varies. Reply STOP to opt-out. See www.pathwaycfc.org for Terms & Privacy Policy

Mail/Address: _____ Email: _____

Signature of Client or Legal Parent/Guardian _____ Date _____

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Financial Agreement for Mental Health Services

Client Name:

Pathway Caring for Children will bill your insurance as a courtesy to you. It is your responsibility to advise Pathway of all insurance coverage, including changes, and provide us with a photocopy of the insurance card at the time of enrollment or coverage change.

If you have financial assistance through the State of Ohio under Medicaid, it is your responsibility to inform the Enrollment staff if the client is covered through other insurance plans. **Be advised**: Not reporting other insurance coverage may invalidate your financial assistance through the State of Ohio.

Insurance providers will not guarantee coverage until the bill is received by the insurance company. Pathway will bill the insurance and attempt to collect the costs of service. **As the signer of this Statement of Financial Responsibility** you will receive an invoice which will include an amount owed by you and an amount potentially approved by the insurance company. Your insurance may determine a service to be "not covered" therefore, **you will be responsible** for the agreed upon portion of the costs of service. If Pathway does not receive reimbursement from the payer within *45 days*, you will assume responsibility for payment of the agreed upon portion of the costs of services provided by Pathway Caring for Children. **SPECIAL NOTE**: In situation of divorce, separation, court orders, etc., the party initiating treatment will be financially responsible for the account including administrative fees or penalties.

A current copy of any insurance card is required to be presented at the time of enrollment and provided to Pathway Caring for Children upon any changes to insurance payers.

Any client with an outstanding balance is required to immediately set up a payment plan with the Accounts Receivable Specialist.

If the payment plan is not followed, services may be *terminated and* collection may be forwarded to legal counsel.

I have read and understand the above policy for my account with Pathway Caring for Children. I agree to follow the payment guidelines as stated above.

I understand that failure to follow this guideline may result in termination of my services and negatively affect my credit history with this and other agencies.

X _____

Print name of Client or Legal Parent/Guardian

X _____

Signature of Client or Legal Parent/Guardian **Date**

X _____

Full Mailing Address– Street or PO Box, City, State and Zip

There will be a $25.00 charge for any checks returned from the bank marked "non-sufficient funds." Should this occur twice Pathway Caring for Children will no longer accept personal checks as payment. The client will then be required to use money orders or cash as payment for services.

Pathway Caring for Children Consent for Interactive Videoconferencing

CLIENT NAME:_____ EMAIL ADDRESS:_____

Pathway Caring for Children has made available an interactive videoconferencing option for those clients and their parents and legal guardians who wish to receive services via the internet.

☒I understand that consent to participate in interactive videoconferencing is separate from giving consent to participate in mental health services. Consent to participate in interactive videoconferencing addresses only those conditions related to receiving mental health services via an electronic format.

☒I understand that interactive videoconferencing is not appropriate for all clients and that Pathway providers will evaluate both my mental health needs/my child's mental health needs as well as technological capabilities before recommending, commencing, and continuing the service.

☒I understand that interactive videoconferencing is provided through scheduled appointments, during Pathway business hours only, and is not available on demand. I understand that the Pathway cancellation policy also applies to interactive videoconferencing.

☒I understand that interactive videoconferencing may not be a covered service by my insurance company. I understand that I will be financially responsible for the costs associated for those sessions should I/my child choose to continue to receive sessions electronically. I understand that I am responsible for knowing the limits of my insurance coverage.

☒I understand that Pathway Caring for Children has contracted with a vendor to provide an encrypted, confidential, HIPAA compliant platform for which to provide interactive videoconferencing. Pathway offices are considered "originating sites", and Pathway staff are responsible for ensuring equipment standards and confidentiality at originating sites only. Pathway is not responsible for managing equipment used by the client in their home (client site) such as a smart phone, tablet or personal computer. Pathway is also not responsible for ensuring confidentiality at the "client site" (client home, family or friend home, etc.).

☒I understand that interactive videoconferencing is only available via the vendor secured by Pathway. Face Time, Skype, and other social media platforms are not permitted to be used for therapy sessions. I may not be eligible to participate if I/my child does not have access to a computer, smart phone, or tablet with the capability to participate via the vendor. I acknowledge that I/my child must have access to the Internet at the "client site" in order to participate. I understand that email, texts, instant messages and chats are not considered interactive videoconferencing, and that I/my child and Pathway staff must be able to "see" each other via videoconference.

☒I understand that any interaction conducted over the Internet increases the risk of a breach of confidentiality.

☒I understand that Pathway staff may not be able to address a mental health crisis as effectively when services are offered via the Internet versus the office setting or in-person meetings. I understand that crisis resources have been made available to me via the client portal. I understand that Pathway staff may contact emergency services in my community to perform a wellness check for me/my child, if necessary.

☒I acknowledge that I have been provided instructions on equipment failure, interruptions in service, and how to log-in, schedule, and reschedule interactive videoconferencing appointments. I understand I have the right to ask questions and receive instruction from Pathway staff should I experience difficulties accessing the service.

☐**By agreeing to this consent for the treatment and services listed above, via the checking of this box, I understand that this acts as an electronic signature and I am the client/guardian of the client named above**.

_____

Client/Guardian Name Date

_____

Pathway Staff Date

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Authorization to Release Information: FOR MEDICAID MEMBERS ONLY

This release will expire: ☒ Three hundred and sixty five days (365) for Mental Health
□ Ninety days (90) for Foster Care □ Other specific date: _____

_____

Client Name **Date of Birth**

The purpose of this authorization is to assist in assessment, treatment planning, and coordination of care for the person listed above. I hereby authorize Pathway Caring for Children to (check all that apply) □**Obtain from** □ **Release to** ☒**Exchange with** the Authorized Organization or Individual noted below:

Ohio Department of Mental Health & Addiction Services
(Name of Authorized Organization or Individual to whom disclosure is made)

30 East Broad Street 36th Floor Columbus, OH 43215-3430
(Address, phone number of Authorized Organization or Individual)

Dates of Service to Release (From):_____ (To): _____ or ☒ All dates of Service/Episodes

Information to be disclosed (check all that apply):

□ Diagnosis/Assessment
□ Symptoms
□ Employment
□ Education Records/IEP/MFE/Behavior/Attendance
□ Recommendations
□ Discharge Summary
□ Individual Treatment Plan/ITP Updates
□ Legal History
□ Income
□ Medical History
□ Intake/Admission
☒Other (specify) demographic information, diagnosis, high risk behaviors for the purpose of outcomes reporting, substance abuse records (if any)

Authorization may be revoked by client or legal custodian at any time by notifying Pathway Caring for Children in writing. Once revoked, the Agency will not release any information, except to the extent the provider or person who is to make the disclosure has already acted in reliance on it. **Authorized period may be shortened per client/guardian at any time.**

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV) , Acquired Immune Deficiency Syndrome (AIDS) test results or diagnosis (ORC3701.24.3).

***Prohibition on redisclosure*:** The records which have been disclosed to you are protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of these records unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. **42 CFR part 2 prohibits unauthorized disclosure of these records.**

_____
Signature of Client or Parent/Guardian Date

_____
Witness Date

_____
Signature of Pathway Staff Making Request Date

I, _____ hereby revoke this consent for the above information effective _____ (date).

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Authorization to Release Information

This release will expire: ☒ Three hundred and sixty five days (365) for Mental Health

☐ Ninety days (90) for Foster Care ☐ other specific date: _____

Client Name **Date of Birth**

The purpose of this authorization is to assist in assessment, treatment planning, and coordination of care for the person listed above. I hereby authorize Pathway Caring for Children to (check all that apply) ☐**Obtain from** ☐**Release to** ☒**Exchange with** the Authorized Organization or Individual noted below:

(Name of Authorized Organization or Individual to whom disclosure is made)

(Address, phone number of Authorized Organization or Individual)

Dates of Service to Release (From):_____ (To):_____ or ☒ All dates of Service/Episodes

Information to be disclosed (check all that apply):

☒Diagnosis/Assessment
☒Individual Treatment Plan
☒Symptoms
☐Employment
☒ Education Records/IEP/MFE/Behavior/Attendance
☒ Recommendations
☒Discharge Summary
☐Legal History
☐Income
☐ Medical History
☐ Intake/Admission
☒ Other (specify) client account information

Auuthorization may be revoked by client or legal custodian at any time by notifying Pathway Caring for Children in writing. Once revoked, the Agency will not release any information, except to the extent the provider or person who is to make the disclosure has already acted in reliance on it. **Authorized period may be shortened per client/guardian at any time.**

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV) , Acquired Immune Deficiency Syndrome (AIDS) test results or diagnosis (ORC3701.24.3).

Prohibition on redisclosure: "This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client."

_____
Signature of Client or Parent/Guardian Date

_____
Witness Date

_____
Signature of Pathway Staff Making Request Date

I, _____ hereby revoke this consent for the above information effective _____ (date).

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Cancellation Policy

Community Clients

In order to make progress in treatment, it is important that you regularly schedule and attend your sessions. When you schedule an appointment, you are reserving your Service Provider's time and you have a responsibility to honor that commitment, or if needed, to cancel in a timely manner.

We require **at least 24 hours advance notice** for all cancellations. This allows the Provider time to fill the time slot with another person who may be waiting to receive services.

If you cancel with less than 24 hours notice, it will be considered a "late cancel." If you do not call or attend it will be considered a "no-show."

All late cancels and no-shows will be addressed with you immediately in order to avoid lapses in your treatment, and to ensure that others waiting for services will be able to schedule in a timely manner.

We track all no-shows, late cancels and cancellations.

A 2nd no-show or late cancel during a sixty day period will result in being placed on "Standby" status. This means you may call the Centralized Scheduling Manager in the morning to determine if there are available appointment times for that day.

In cases of repeated attendance problems, your Provider will discuss your situation with you and make a decision about your ability to continue with treatment.

Please arrive 5-10 minutes before your appointment so that we can begin promptly. Those who are late will have a shorter session so the next client won't have to wait.

Please understand the following:

- If I need to cancel my appointment, I must give at least 24 hours notice.
- If I late cancel or no-show more than twice in sixty days, I will be placed on Standby status, meaning that I will be able to schedule appointments the day of.
- If I attend 2 consecutive sessions while on Standby status, I will again be permitted to schedule sessions in advance.
- If I continue to have attendance issues, including no-shows, late cancels or excessive cancellations of any type, I may be discharged from treatment due to noncompliance.

Child's Name: **DOB:**

Parent/Guardian/Custodial Agent Signature **Date**