For ALL Patients

CLINICAL ASSOCIATES, a professional service of Pathways, Inc.

77 East First Street Corning, NY 14830 ***Phone:*** *(607)936-1771* ***Fax:*** *(607)936-2648* ***email:*** *clinicalassoc@pathwaysforyou.org*

Patient:

Patient Full Name (First and Last) _____ Birthdate _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Employer _____

Insurance Holder (the person who is the primary subscriber):

Insurance Holder Full Name (First and Last) _____ Birthdate _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Employer _____

Responsible Party (person responsible for payment, if different than insurance holder):

Full Name (First and Last) _____ Street Address _____ City _____ State _____ Zip _____

Patient Release:

I certify that the information I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. The Agency will bill insurance as a courtesy. Note Clinical Associates does not participate with Medicaid and cannot bill them for services. Copays and self-pay arrangements are paid at time of service via cash, check made payable to Pathways, Inc., or credit card. Non-sufficient fund checks are held until cash or money order is received by the business office to cover the amount of the check. Patients will pay a $15.00 charge for any returned check to cover the bank's charge to the program. Patients will be notified by telephone, letter or email immediately upon receipt of the non-sufficient fund notice by the business office. Upon receipt of this notification from the business office, patients shall have one week to pay the balance in full, by cash or money order. After three late co-pays or two late self-pay arrangements, a patient will no longer be able to schedule future appointments until the outstanding balance is paid in full. Such delinquent balances will be subject to submission to a Collections Agency. Habitual late payment or no-show to scheduled appointments may result in termination from services. **I understand that if my insurance changes I am to notify Clinical Associates office staff. I am responsible for any amounts not covered by insurance.**

Consent For Treatment:

I give consent for evaluation and treatment to be provided for myself/my child by Clinical Associates staff. I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment. I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.

My signature below shows that I have read and fully understand this Consent for Treatment Form. I agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent. I understand that I may terminate treatment at any time.

I agree to all of the above statements: _____ Date: _____

Signature

****Must be signed by parent or guardian if client is under the age of 18.***

Our scheduling program can send you an email reminder one week prior and one day prior to a scheduled appointment.

May we email you appointment reminder: Yes ☐ No ☐ Email: _____

May we call you for appointment reminders: Yes ☐ No ☐

May we text you for appointment reminders: Yes ☐ No ☐ Number to text: _____

For ALL Patients; complete for Primary Care Provider as the Person/Entity where information should be sent/received

CLINICAL ASSOCIATES, a professional service of Pathways, Inc.

77 East First Street Corning, NY 14830 ***Phone****: (607)-936-1771* ***Fax****: (607)-936-2648* ***email****: clinicalassoc@pathwaysforyou.org*

Consent for Release of Confidential Information

Client's Name: _____ **DOB:** _____

hereby authorize Clinical Associates to (check 1, 2, or 3):

1. ☐ Exchange information between Clinical Associates and the party listed below:
2. ☐ Release information/records of my treatment to:
3. ☐ Obtain information/records from:

Person/Entity where information should be sent to and/or received from:

_____ _____
Name Street Address

_____ _____ _____ _____
City State Zip Code Phone Number

Purpose/Need for information: _____

The specific type of information to be released:

☐ Medical history	☐ Verbal Communication	☐ Diagnosis
☐ Psychosocial evaluation	☐ Education evaluation	☐ Treatment plan
☐ Progress notes	☐ Psychological evaluation	☐ Treatment recommendations
☐ Discharge summary	☐ Psychiatric evaluation	☐ Medication reports
☐ Referral letter	☐ After-care plan	☐ Mental health screenings
☐ Attendance dates	☐ Follow-up letter	☐ Other

For treatment time period of: _____ Or a one-time release _____

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that: 1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION. I specifically authorize release of such information to the person(s) indicated above. 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights. 3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. 5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

_____ _____ _____
Signature Relationship Date

If any person physically unable to provide a signature desires to consent to this release, please print his/her name on the appropriate signature line above and record below the signatures of two (2) responsible persons who witness that such person understands the nature of this release and freely gave his/her consent.

_____ _____
Witness of person unable to sign Date

_____ _____
Witness of person unable to sign Date

Telemedicine Informed Consent Form

I [print client's name] _____ hereby consent to engaging in telemedicine via Doxy.me, or other electronic means with Clinical Associates (provider) as part of my treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my personal medical/mental health information, both orally and visually, through electronic means, to health care practitioners located in New York State or outside of New York State.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. Should I do so, I will not risk the loss or withdrawal of treatment benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to: reporting child, elder, and dependent adult .abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to any other entities shall not occur without my written consent.

(3) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(4) I understand that I have a right to access my mental health information and copies of my mental health records in accordance with New York State law.

(5) I also understand that there are inherent risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information or treatment could be interrupted or accessed by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

(6) I understand that telemedicine based services and care may not be as complete as in-office services in some instances. I understand that if my provider believes I would be better served by another form of mental health services (e.g. in-office services), I will be referred to in-office services when or as needed.

(7) I agree that if I am feeling suicidal, homicidal, or otherwise experiencing a mental health crisis I will call 911, present to the nearest hospital emergency department, or contact the suicide hotline (1-800-273-8255).

(8) I understand that I am responsible to check with my state and with my insurance provider before engaging in telehealth services to be certain that services provided by Clinical Associates will be approved and covered. I agree that I am responsible for all fees associated with these telehealth services.

(9) Finally, I understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and the efforts of my provider, my condition may not immediately improve, and in some cases may even decline. I have read and understand the information provided *above.* I have discussed any and all of my current questions with my provider and they have been answered to my satisfaction.

_____ _____

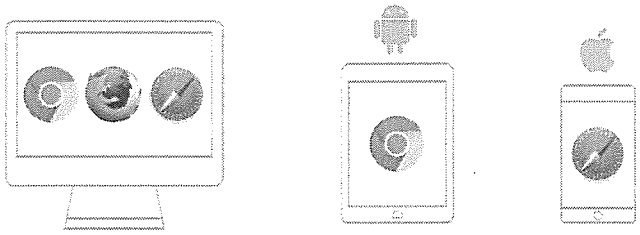
Signature of client/parent/guardian/conservator Date

_____ _____

If signed by other than client indicate relationship Date

How to check in for your video visit

1 Use a computer or device with camera/microphone



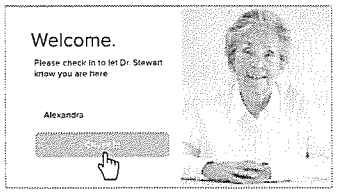
PC and Mac
Chrome | Firefox | Safari

Android
Chrome

iOS
Safari

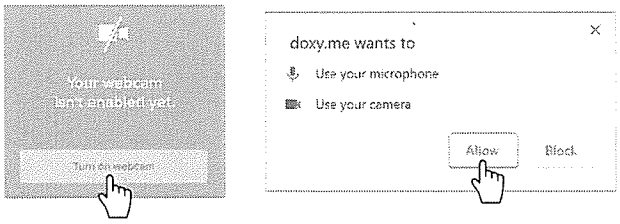
2 Enter your clinician's doxy.me web address into the browser

3 Type in your name and click check in



- ✓ Secure
- ✓ No software to download
- ✓ HIPAA compliant
- ✓ No registration needed

4 Allow your browser to use your webcam and microphone



5 Your care provider will start your visit

Call Tips

- Have a good internet connection
- Restart your device before the visit
- Use the Share Test button in the waiting room
- Need help? Send us a message https://doxy.me

For Patients Age 12+

Name: Date:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
○	○	○	○

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

For Patients Age 18+

CAGE-AID QUESTIONNAIRE

Patient Full Name: Date of Visit:

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	○	○
2. Have people annoyed you by criticizing your drinking or drug use?	○	○
3. Have you ever felt bad or guilty about your drinking or drug use?	○	○
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	○	○

Permission for use granted by Richard Brown, MD.

For Patients Age 12 and older

Patient Full Name: Date of Visit:

GGAD-7 Screen Questions

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T* = + +)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

For Patients age 12-18

Patient Full Name: Date of Visit:

The CRAFFT Screening Questions

Please answer all questions honestly; your answers will be kept confidential.

Part A

During the PAST 12 MONTHS, did you:

	No	Yes
1. Drink any alcohol (more than a few sips)?	○	○
2. Smoke any marijuana or hashish?	○	○
3. Use anything else to get high? "anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"	○	○

If you answered NO to ALL of the questions in Part A, only answer question 1 below. If you answered YES to ANY of the questions in Part A, answer ALL SIX questions below.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	○	○
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	○	○
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	○	○
4. Do you ever FORGET things you did while using alcohol or drugs?	○	○
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	○	○
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	○	○