PATIENT FORMS

Pathways Family Wellness

BASIC INFORMATION

Full Name____

First Middle Last Suffix

What name do you prefer to be called ______________________________

Date of Birth________________ Age _____

Phone Number ___________________ Landline or Mobile:___________________

May we leave a voice message or send a text message to the mobile # listed? _______Yes _______No

Address _____________________________________ City ___________State ___ Zip _________

Driver's License State _____________ Driver's License # ____________________

Email Address ____

Sexual Orientation _________________ Gender Identity____________________

EMERGENCY CONTACT AND DISCLOSURES TO FAMILY AND/OR FRIENDS:

While we prefer to speak directly with each patient and/or guardian we understand that other individuals or family may have knowledge of and be assisting in your treatment. Please list the individual (s) who we may leave a message with concerning your appointments, billing and payment inquiries, medical findings, RX refills and care decisions. (Protected Health Information)

Full Name _______________________Relationship ______________ Phone #_________________

Full Name _______________________Relationship ______________ Phone #_________________

FINANCIAL INFORMATION

Who will be financially responsible for you? ___ Myself ___Parent ___Someone else

Full Name ____________________________Relationship ____________Phone # _______________

ADDITONAL INFORMATION

Please list your preferred pharmacy

Pharmacy Name ____________________________________ Phone # _______________________

Address __________________________________City ______________ State ___ Zip _________

INSURANCE INFORMATION

Primary Insurance Company____________________________________ Phone # ________________________

Policy Number/Member ID # ____________________________________ Group # ________________________

Primary Policy Holder ________________________________ Relationship to Patient _____________________

Sex (Male/Female)_____________________ Date of Birth ___________________

*Secondary Insurance (Only Medicare Supplements)____

Policy Number _______________________ Group # _______________ Phone # ___________________

Does your Employer provide an EAP (Employee Assistance Program) benefit? __________________(yes/no)

Employer Name:_________________________________

EAP NAME:________________________________ Phone # ____________________________________

Authorization #:________________________ __________ # Visits authorized: _____________

__________ I certify that I and/or my dependents have insurance coverage with the Insurance listed above and assign directly to my provider/Pathways all insurance benefits otherwise payable to me for services rendered. I understand that I am responsible for all charges accumulated. I hereby authorize Pathways to release all information necessary to secure the payment of benefits.

Patient HIPAA Acknowledgment and Consent Form

______________I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I also understand the practice may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

_______________I also understand that in the state of Colorado, any patient 12 and older has the right to seek treatment on their own. Any patient 12 and older must sign all forms along with their parents and /or guardian.

PATHWAYS FAMILY WELLNESS TERMS OF SERVICE

Thank you for choosing Pathways Family Wellness as your mental health care provider! Our goal is that by providing you with the best possible care, you will be successful, and you will thrive. Please read the following. If you have questions, please contact one of our Patient Representatives.

Appointment Scheduling and Cancellations:

- To schedule or reschedule an appointment please call the office direct at 970-356-3100.
- Appointments must be cancelled or rescheduled more than 24 hours prior to your appointment to avoid an $80 fee.
- If a follow-up appointment is a no-show, you will be charged a $100 fee per missed visit.
- Late cancel or no-show fees are not reimbursed by insurance. Must be paid prior to the next appointment.
- After 2 No Shows the provider may discharge you from the practice.
- Clients arriving more than 10 minutes late will be considered a late cancel, charged $80 and will need to reschedule.
- New patients must fill out the New Patient Packet before their first appointment, or the appointment will be cancelled.
- A photo ID of the patient, or the guardian in the case of minors must be on file.

Fees, Payments, and Insurance Requirements:

- We expect payment at the time of service. While we do all we can to provide accurate estimates of coverage and benefits, you are responsible for all charges incurred. It is your responsibility to verify your mental health coverage.
- PFW requires that you have a valid credit card on file in your patient portal prior to your visit.
- Your card will be charged the day of your appointment for all charges due. (deductible, copays, late or no-show fees)
- PFW will submit claims to your insurance company on your behalf if we are a participating provider . If we are not in-network, we will provide a HCFA so you can submit a claim for reimbursement.
- Requests for medical records, written letters are not included in the cost of your session. A separate fee is charged for these requests. Medical records fees are governed by the state. Letters and reports are billed at $50 per half hour. Expect a seven-to-10-day turn-a-round for these requests.

Prescription Refills:

- Please allow 24-48 hours to process all prescription refills. NO refill authorizations will be done after hours or on weekends (Fri/Sat/Sun). It is your responsibility to make sure you do not run out.
- Medication will NOT be prescribed if you missed your last appointment and have not rescheduled.
- A controlled substance agreement must be on file to receive this type of medication.
- If you lose your controlled medication (Adderall, Vyvanse, Ritalin) you must file a police report and provide us with a copy for us to prescribe an early refill.

Other information:

- **We do not do paperwork for service animals.**
- **An appointment is required to complete disability paperwork, which is not reimbursable by insurance. An hour's appointment is needed.**
- **If you are seeking treatment for a minor child and you have joint custody, both parents must consent to treatment.**

CONSENT AND AUTHORIZATION

I affirm that I have the legal right to consent to treatment: If you are seeking treatment for a minor child, you may be requested to provide supporting documentation.

- **I hereby consent to the use or disclosure of my protected health information as specified above.**
- **I authorize the release of any medical, behavioral health information necessary to process my insurance claim and authorize payment of Insurance benefits directly to Pathways.**
- **I also hereby acknowledge and understand the office policies of Pathways Family Wellness as specified above.**

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Patient Name *SIGNATURE (12 and older)* *DATE*

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PARENT or GUARDIAN (If Patient a minor) *SIGNATURE* *DATE*

MEDICAL HISTORY

Please Complete providing as much detail as possible.

MENTAL HEALTH HISTORY	NO	YES	DESCRIBE
Primary Reason for your Visit			
Any previous/current Mental Health or Substance Abuse Treatment?			
Family history of mood, anxiety Attention or substance abuse problems?			
MEDICAL CONDITION OR PROBLEMS			
Hearts/Lungs			
Nervous System			
Stomach/Intestines			
Bladder/Kidney			
Bones or Joints or Skin			
Reproductive System			
Head Injuries or Serious Accidents			
Any known drug allergies?			
PRIMARY CARE			Please give us the names of Physician , prescription Drugs & herbs
Do you have a Primary Care Physician?			
Are you under the care of any other Physicians?			
What Prescription Drugs are you currently taking?			
What non-prescription drugs or herbs are you taking?			
HEALTH HABITS			Describe---List Amount and Frequency
Do you Smoke or Chew Tobacco?			
Do you drink alcohol?			
Do you use Marijuana?			
Do you use caffeine? (coffee, tea, soda)			
Any Problems with sleep?			Hours of sleep per night:
FEMALES ONLY: Are you pregnant?			Please notify your physician if you become pregnant during your course of treatment.
Height:_________________________________ Weight:_____________________________			