Authentic Pathways
Counseling & Consulting

4773 Carroll Cemetery Rd, Carroll, Ohio 43112

PATIENT DEMOGRAPHIC FORM
(TO BE UPDATED ANNUALLY OR WITH ANY CHANGES)

Patient Name:_____ Date of Birth: _____
First MI Last

Social Security #: _____-_____-_____ Marial Status: S M W D

Mailing Address: _____ City/State: _____

Zip: _____ Email: _____

Home Phone #: (_____)_____ Cell Phone #: (_____)_____

Employer: _____ Work Phone #: (____)_____

Referring Physician: _____ Practice: _____

Spouse Name: _____ Date of Birth: _____

Employer: _____ Work Phone #: (____)_____

Emergency Contact & Relationship: _____ Phone (____)_____

Please list individual(s) we are authorized to speak with regarding your care/account:

_____

INSURANCE INFORMATION Please provide insurance card for us to copy.

Insurance Co.:_____ Policyholder: _____

Policyholder's Date of Birth: _____ Social Security #:_____-_____-_____

Member ID #:_____ Group #: _____

Patient/Parent Signature _____

Authentic Pathways
Counseling & Consulting

TREATMENT CONSENT
AUTHORIZATION FOR DISCLOSURE

Name _____

1. Consent for treatment

   I, the undersigned, do hereby voluntarily consent to and authorize such outpatient treatment as judged to be necessary by my clinician. Such treatment may include psychotherapy and diagnosis/assessment. I understand that this consent authorizes the use of standard and customary treatment for psychiatric and/or substance abuse conditions and does NOT authorize the use of unusually hazardous, experimental, or investigative treatment procedures. Though I expect the care given to meet customary community standards, and I have been advised of the potential risks and benefits associated with treatment, I understand the practice of mental health disciplines is not an exact science, and I acknowledge that no guarantees have been made to me concerning my care. Because psychotherapy is a cooperative effort between client and therapist, I will work with my therapist in a cooperative manner to resolve my difficulties. If I refuse the treatment that is suggested for me or if I discontinue treatment, I will not hold my therapist responsible for any consequences resulting from my decision. I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults. Furthermore, I understand that state and local laws require that my therapist report all cases in which there exists a specific potential to harm others.

2. Authorization for Disclosure of Information

   The undersigned hereby authorize Joshua Culbertson, LLC and/or Authentic Pathways Counseling & Consulting to release or disclose information in the medical, business, or clinical record of the client to the following:

   Any private or public entity with which a claim is being filed for all or part of the client's charges, including any insurance carrier or compensation carrier or any of their respective agents, representatives, and claims processing personnel.

   Any attorney, collection agency, or other persons or entities engaged in the collection of any debt the client, or responsible party to Joshua Culbertson, LLC and/or Authentic Pathways Counseling & Consulting.

   Any person, corporation, public or private agency to the extent necessary for your clinician to obtain and/or maintain licensure, accreditation, federal and/or state reimbursement for provisions of health care services, or certification.

   Any public or private utilization review organization needing information by telephone or writing to certify the medical necessity or appropriateness of treatment services under review

   Your name, phone number and address for educational outreach and fundraising activities at Joshua Culbertson, LLC and/or Authentic Pathways Counseling & Consulting.

   For any release beyond the scope of this consent, the client will be asked to sign a Release of Information form.

The information released may include diagnoses and treatment including, but not limited to, mental and physical condition, drug/alcohol, and any other information requested to determine coverage, medical necessity, or other benefits determination. This release does NOT include information on HIV/AIDS or ARC-related information.

This authorization may be revoked at any time except to the extent that actions have already been taken. To cancel this authorization the client and/or responsible party realizes that they must do so in writing and send it to the clinician. Otherwise, this authorization for disclosure of information shall expire at the termination

of therapy, 180 days from last visit or at settlement of claims which are payable to Joshua Culbertson, LLC and/or Authentic Pathways Counseling & Consulting. Your name will be kept on the educational and fundraising list indefinitely unless you notify The Center otherwise.

3. Drug/Alcohol Confidentiality Regulation

   The undersigned hereby understands that minors age 14 and above have the right to confidentiality regarding treatment for drug and alcohol abuse or dependence.

4. Medicare Client Certification

   I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a Medicare claim. I request the payment of authorized benefits be made on my behalf for professional services only.

Appointments/Cancellations Policy

Individual appointments must be cancelled 24 hours in advance. You will be charged a late fee of half the session charge if you cancel an appointment without 24-hour notice. We have 24 hour voice mail to take messages (614-706-0975).

Late cancellations and no-show charges noted on your bill are not legally reimbursable by insurances; therefore those charges are your responsibility.

My signature below represents that I have read and understand the information described above.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Responsible Person if other than Client Date

_____ _____
Witness Date

Authentic Pathways
Counseling & Consulting

Patient Rights & Responsibilities

- Patients have the right to be treated with personal dignity and respect.
- Patients have the right to care that is considerate and respects member's personal values and belief system.
- Patients have the right to personal privacy and confidentiality of information.
- Patients have the right to receive information about managed care company's services, practitioners, clinical guidelines, and patient rights and responsibilities.
- Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Patients have the right to participate in an informed way in the decision making process regarding their treatment planning.
- Patients have the right to discuss with their providers the medically necessary treatment options for their condition regardless of cost or benefit coverage.
- Patients have the right of members' families to participate in treatment planning as well as the right of member over 12 years old to participate in such planning.
- Patients have the right to individualized treatment, including
    - Adequate and humane services regardless of the source(s) of financial support,
    - Provision of services within the least restrictive environment possible,
    - An individualized treatment or program plan,
    - Periodic review of the treatment or program plan, and
    - An adequate number of competent, qualified, and experienced professional clinical staff to supervise and carry out the treatment plan.
- Patients have the right to participate in the consideration of ethical issues that arise in the provision of care and services, including
    - Resolving conflict
    - Withholding resuscitative services,
    - Forgoing or withdrawing life-sustaining treatment, and
    - Participating in investigational studies or clinical trials.
- Patients have the right to designate a surrogate decision-maker if the member is incapable of understanding a proposed treatment or procedure or unable to communicate his or her wishes regarding care.
- Patients and their families have the right to be informed of their rights in a language they understand.
- Patients have the right to voice complaints or appeals about managed care companies or the care provider.
- Patients have the right to make recommendations regarding managed care company rights and responsibilities policies.
- Patients have the right to be informed of rules and regulations concerning patients' conduct.
- Patients have the responsibility to give their provider and managed care company information needed in order to receive care.
- Patients have the responsibility to follow their agreed upon treatment plan and instructions for care.
- Patients have the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing with their provider mutually agreed upon treatment goals.
-

Patient Signature_____ **Date**_____

Clinician Signature_____ **Date**_____

Authentic Pathways
Counseling & Consulting

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

NOTICE OF PRIVACY PRACTICES

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

Authentic Pathways
Counseling & Consulting

NOTICE OF PRIVACY PRACTICES

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date of this Notice August 1, 2017

This Notice of Privacy Practices applies to the following organizations.

Authentic Pathways Counseling & Consulting

4773 Carroll Cemetery Rd.

Carroll, OH 43112

614-7060975

740-422-1548 (f)

joshua.culbertson@gmail.com

Authentic Pathways
Counseling & Consulting

NOTICE OF PRIVACY PRACTICES

I _____ (print name) have read, understand and been provided the chance to ask questions about this Notice of Privacy Practices.

_____ _____

Client Signature Date

PROFESSIONAL DISCLOSURE STATEMENT

Joshua Culbertson, Licensed Professional Counselor (LPC) License C.1700654
Under Supervision of David Dagg-Murry, LPCC-S, LICDC-S
Joshua Culbertson, LLC DBA Authentic Pathways Counseling & Consulting
4773 Carroll Cemetery Road
Carroll, OH 43112
T: 614.706.0975
F: 740.422.1548
joshua.culbertson@gmail.com

FORMAL PROFESSIONAL EDUCATION

University	Degree Received	Dates Attended
Zane State	Assoc. in Business Admin.	1997
Ohio University	Bachelor's of Spec Studies in Business & Communications	2008
MTSO	Masters of Arts in Counseling	2017

PROFESSIONAL EMPLOYMENT

Employer	Title	Dates Employed
APDS	Counselor	2016 - 2017
Wexner Medical Center	Psychiatric Counselor	2017 - Present

AREAS OF COMPETENCE:
Personal and social counseling, mental health counseling, chemical dependency counseling, addictions counseling, LGBTQ-related concerns, consultation.

Licensure is granted by:

The State of Ohio Counselor, Social Worker,
and Marriage & Family Therapist Board
77 South High Street, 16th Floor
Columbus, OH 43215-6108
614/466-0912

Authentic Pathways
Counseling & Consulting

Authorization to Disclose Protected Health Information to Primary Care Physician

Section 1. Client

Client Name		Date of Birth	

Section 2. Behavioral Health Provider

Section 3. Primary Care Physician

Name:	Authentic Pathways Counseling & Consulting, LLC Joshua Culbertson, LPC			**Name:**			
Address:	4773 Carroll Cemetery Road			**Address:**			
City:	Carroll			**City:**			
State:	OH	**Zip:**	43112	**State:**		**Zip:**	
Phone:	614.706.0975	**Fax:**	740.422.1548	**Phone:**		**Fax:**	

☐ Client does not have a primary care physician

Section 4: Client Authorization

I, the undersigned understand that I may revoke this consent at any time to the extent that action has been taken in reliance upon it and that in any event this consent shall *expire 1 year from the date of signature below* unless revoked prior to that date. I can end this authorization at any time by contacting Authentic Pathways, 614.706.0975. Information disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law. I have read and understand the above information and give my authorization:

Please check **ONE**

☐ I **DO** authorize any information on my care to be shared between the providers listed above to facilitate my treatment.

☐ I **DO** authorize information on my care to be shared *with the following limitations* (check any):
☐ Medication Only ☐ Other _____

☐ I **DO NOT** authorize any information on my care to be shared between my behavioral health clinician and my primary care physician.

_____ _____

Client Signature Date Authorized Representative Signature Date

If authorized representative, describe relationship to client (required) _____

Section 5. Clinician Information *(to be completed by clinician)*

Presenting Problem/Chief Complaint/Diagnosis:		
Treatment plan/recommendations:		
Current psychotropic medications:		
Signature:	Phone:	Date:

Please feel free to contact me if you have information that you believe would be beneficial to our combined care of this client

Authentic Pathways Counseling & Consulting
4773 Carroll Cemetery Rd. ~ Carroll, OH 43112 ~ (614)-706-0975

Credit Card Authorization Form

Client Name: _____

Payment Method: (_) VISA (_) MasterCard (_) American Express (_)Discover
Account Number:

_____ Expires _____/_____ Code:_____

Cardholder Name (as it appears on card):

_____

Cardholder Address: (include street, city, state and zip)

_____

Phone Number (including area code) : (_____) -_____ -_____ Home Cell

Email: _____

I _____ authorize this card to be used for payment for
(Card Holder)

(Client's Name) **_____ appointments** (including co-payments and balance of appointments applied to my deductable not reimbursed to provider by my insurance company) **/cancellations.**

My (Card Holder's) below signature on file authorizes Joshua Culbertson, LLC and/or Authentic Pathways Counseling & Consulting to charge the credit card listed on this form. I understand my card will be charged (via Square) with the information I have provided. A receipt will be emailed to me at the email I have provided. I understand my card will also be charged for any missed appointments, which fall within the cancellation policy guidelines.

_____ _____/_____/_____
Signature on file ***Date***

The above credit card information will be shredded within 30 days of the termination of counseling services