PATHWAYS COUNSELING

FIRST NAME		MIDDLE INITIAL		LAST NAME	
STREET ADDRESS			CITY, STATE, ZIP		
GENDER		D.O.B.		AGE	

SS #

CONTACT INFORMATION:		MAY WE CONTACT YOU HERE?	LEAVE A MESSAGE?
MOBILE PHONE			
OTHER PHONE			
EMAIL			

Primary Insurance

Policyholder Name	
Relationship to Patient	
Policyholder Employer	
Policyholder SS#	
Policyholder DOB	

Are you covered on a secondary insurance? NO YES
(if "yes" fill out below)

Policyholder Name	
Relationship to Patient	
Policyholder Employer	
Policyholder SS#	
Policyholder DOB	

How did you hear about Pathways/Dr. Salituro? _____

May we contact this person to send a thank you note? Yes No

Please list medications, dosage, and condition they are prescribed for below:

Please list dates and details of any psychiatric hospitalizations or partial hospitalizations/IOP below (use back if necessary):

Thank you for choosing Pathways Counseling P.C. We realize that starting counseling is an important decision, and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have questions about your treatment, or these policies, please don't hesitate to ask. From here forward, any field requiring a signature or initials refers to the patient and the parent/guardian if the patient is a minor.

INFORMED CONSENT TO TREATMENT: Dr. Alli Glore Salituro has earned a Ph.D. from the University of Tennessee-Knoxville. She is licensed in Illinois as a Clinical Psychologist. She has over 20 years of experience providing therapy to adolescents and adults. I consent to have Dr. Salituro perform evaluation, psychotherapy and mental health treatment.

Signature(s)_____ **Date:**_____

CONFIDENTIALITY: Your verbal communication and clinical records are strictly confidential except for: a) information (e.g., diagnosis and dates of service) shared with your insurance company to process your claims, b) information you report about physical, sexual abuse or elder abuse, which therapists are mandated to report to the Department of Children and Family Services in accordance with Illinois law, c) when you sign a release of information, consenting to have specific information shared with a third party, d) if you provide information that indicates you are in danger of harming yourself or others, and/or e) if a subpoena is issued in a court case or otherwise required by law. To be most effective and for the purposes of further learning, Dr. Salituro consults regularly about cases. In these instances, colleagues providing consultation are bound by the same ethical principles, and every effort is made to conceal clients' identifying information. By signing, I agree that I understand the policies regarding confidentiality, including that I consent to have Pathways Counseling release information to my insurance company for billing and coordination of care.

Signature(s)_____ **Date:**_____

CONTACTING YOUR THERAPIST: The office number is (630) 209-7359, and Dr. Salituro's voicemail is handled keeping confidentiality in mind. Voicemails are not transcribed, will be discarded as soon as they are heard, and your phone number will not be stored. This mobile device is password protected as is the voicemail associated with it. Please be advised that—though this is a mobile number—texting is discouraged. If this mobile phone were ever to become stolen or lost, there is no way to guarantee your messages would not be accessed by a third party. If you choose to text, please consider omitting identifying data and limiting its use to simple matters like "I'm running 5 minutes late to my appointment." If you are interested in using email to communicate, please sign the **Email policy**. E-mail and text messages are not appropriate ways to contact Dr. Salituro for emergency situations. If an emergency situation arises, call me. If no call is received within 15 minutes, contact 911.

Initials _____

FINANCIAL/INSURANCE ISSUES: As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. The full fee is due at each session unless we have a contract with your insurance company. In that case, we ask that at each session you pay your co-pay/coinsurance. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300.00, we will ask that you sign a payment plan contract. If your account is overdue, and we are unable to reach you to address the matter of payment, it may be turned over to our collection agency; the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We accept cash, checks, and credit cards. Checks can be made out to **Pathways Counseling P.C.** We charge a $25 service fee for any returned check.

Initials _____

Lastly, if you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise you will be billed at the hourly rate. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.

Initials _____

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. If you prefer to decline consent no information will be shared.

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME: _____
CLINIC: _____
ADDRESS: _____
PHONE: _____

Signature(s)_____**Date:**_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.

Signature(s)_____**Date:**_____