

**ANYONE TAKING PSYCHOTROPIC MEDICATIONS MUST HAVE A SIGNED
RELEASE FORM ON FILE AS WELL AS A LETTER FROM PRESCRIBING
PHYSICIAN LISTING PATIENT'S MEDICATIONS AND DIAGNOSIS.**

PATHWAYS COUNSELING CENTER, INC.
COMPREHENSIVE MENTAL HEALTH ASSESSMENT (CMHA)

Background Information

FIRST CALL:	FIRST SEEN:
	COUNSELOR:
NAME:	PHONE: HOME
ADDRESS:	WORK: _____ CELL: _____
MARITAL STATUS:	MALE FEMALE
EMPLOYMENT:	DATE OF BIRTH: _____ AGE: _____

Email address: _____
**Your email address will be used strictly by Pathways Counseling and will not be sold or shared with anyone else.
 Should you wish to opt out on receiving updated information, please send an email and put unsubscribe in the subject line. Thank you!!**

Person to call in case of emergency: _____ Relationship to Client: _____ Phone: home _____ Phone: work _____ Additional Relative to Contact: Name _____ Relationship to client: _____ Phone: Home _____ Phone: Work _____
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Referral Source: _____

IMMEDIATE FAMILY MEMBERS: CHECK HERE IF MEMBER LIVES WITH YOU:

<u>NAME</u>	<u>AGE</u>	<u>RELATIONSHIP</u>

Any non-family members residing with you? _____ If so, please provide name and age

Is this a stepfamily? Yes _____ No _____

What are the primary issues you wish help with? (Please check using No. 1 as primary issue, 2 as second issue, 3 as third issue, etc.)

- | | | |
|-------------------------------|-----------------|---------------------|
| ___ parent/child relationship | ___ rape | ___ eating disorder |
| ___ husband wife | ___ self esteem | ___ school |
| ___ friendship | ___ depression | ___ parents |
| ___ divorce/separation | ___ mid-life | ___ Other: _____ |
| ___ alcohol/drug abuse | ___ grief | _____ |
| ___ victimof abuse/abusive | ___ phobia | _____ |

CLIENT'S BILL OF RIGHTS AT PATHWAYS COUNSELING CENTER, INC.

- 1. Each client has the right to receive full information from the potential treating professional about that professional's knowledge, skills, preparation, experience and credentials.**
- 2. Each client has the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.**
- 3. Each client has the right to be provided information about the procedures he/she can use to appeal benefit utilization decisions to third party payer systems, to employer or purchasing entities and to external regulatory agencies.**
- 4. Each client shall not be required to disclose confidential, privileged or other information, other than diagnosis, prognosis, type of treatment, time and length of treatment and cost, unless more detailed information is requested and authorized to be released by the client.**
- 5. Each client has the right to choose any duly credentialed professional for mental health.**
- 6. Each client has the right to be free from unnecessary or excessive medication.**
- 7. Each client has the right not to be subjected to non-standard treatment or procedures, experimental procedures or research, psychosurgery, sterilization, electro convulsive therapy or provider demonstration programs, without written informed consent, after consultation with counsel or interested party of the client's choice. (If the client has been adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of N.J.S.A. 30:4-24.2d(2)).**
- 8. Each client has the right to treatment in the least restrictive setting, free from physical restraints and isolation, provided, however that a client in Inpatient Care may be restrained or isolated in an emergency pursuant to the provisions of N.J.S.A. 30:4-24.2d(3).**
- 9. Each client has the right to be free from corporal punishment.**
- 10. Each client has the right to privacy and dignity.**
- 11. Each client has the right to the least restrictive conditions necessary to achieve the goals of treatment/services.**
- 12. Each client has the right to have full information about fees, methods of payment and insurance reimbursement.**
- 13. Each client has the right to refuse a particular intervention strategy.**

Client Signature

Client Printed Name

Date



INTERNAL GRIEVANCE POLICY

Any client who has a grievance should bring this to the attention of his/her counselor. If there is no satisfaction or further action is needed, the client may appeal the counselor's decision in writing to Dr. Mathilda Catarina, Clinical Director. The client shall be given a written notice of the final decision of the appeal from Dr. Catarina. The counselor will also be informed of same decision. Also, the client may direct complaints to any of the following administrators:

Francine Vince, Passaic County Mental Health Administrator
Passaic Mental Health Department, 401 Grand St., 5th Floor, Paterson, NJ 07505 (973) 225-3188

New Jersey Protection and Advocacy
1-800-922-7233 or (609) 292-9742

New Jersey Division of Mental Health Services (DMHS)
1-800-382-6717

DMHS - Northern Regional Office
(973) 977-4397

Division of Youth and Family Services (DYFS)
1-877-652-2873

DYFS-Central Passaic District Office
(973) 977-4525 or 1-800-531-1260

DYFS – North Passaic District Office
(973) 523-6090 or 1-800-847-1743

Passaic County Board of Social Services
(973) 881-0100

Individuals, whose medical, psychiatric or substance abuse presentation is of such a degree that they require in-patient or more extensive treatment than we offer, will be referred to the appropriate agencies.

Client Signature

Client Printed Name

Date



Pathways Counseling Center, Inc.

Phone - 973-835-6337
Fax 973-616-4688

STATEMENT OF UNDERSTANDING

The purpose of this document is to inform you of our policies and to enable our staff to help address your needs as effectively as possible. We thank you for your cooperation so we can work toward that goal.

1. Counseling is a process in which you will need to become actively involved. It is a process that frequently requires time for changes to occur. Often, during the course of counseling, additional problems may become identified which were not known by the counselor or the client at the onset of counseling. As you and your counselor discuss your problems, you may at times experience depression, frustration, fear, anger, uncertainty, guilt, anxiety, confusion, sadness, unpleasant memories, or other painful experiences. However, as you might expect, many clients experience positive outcomes, too. Among them are increased assertiveness, self-confidence, greater job satisfaction, improved interpersonal relationships, enhanced decision making ability, greater self-understanding, independence, and stronger motivation.

2. It is the current policy of Pathways Counseling that the counseling process will take place within a maximum of twelve (12) sessions for most clients. If a counselor and client determine by the end of ten (10) counseling sessions that more than twelve (12) sessions will be needed, the counselor is expected to submit an updated Treatment Plan with a summary of progress made to date and written justification for continued counseling for consideration and approval of the Clinical Director prior to continuing counseling beyond the 12-session limit.

3. If your counselor, after a review of your needs, recommends a medical, psychiatric or psychological evaluation, it is our policy that you comply with this recommendation and provide to your counselor written permission to communicate with these professionals. This will enable your counselor to have important information he/she may need to ensure that you receive quality and necessary care. Non-compliance with this policy will necessitate the discontinuance of services at Pathways Counseling Center, Inc., as could failure to comply with recommendations from these other professionals.

4. Please be aware that we have a professional responsibility to provide the best possible services to you. Therefore, your counselor will be discussing aspects of your case if/when necessary in supervised, confidential consultations.

5. If, during counseling, it is found that the services offered at Pathways Counseling Center, Inc. are not relevant to your needs, it is our policy to recommend other more appropriate facilities and to assist you in any reasonable way to make contact with such services. Your counselor is available to discuss the scope of services offered here as well as the reason for recommending another program. If, for a particular reason, another program or service is recommended by your counselor, Pathways Counseling Center, Inc. then reserves the right to discontinue services to you if you do not accept the recommendation(s).

6. If your counselor spends lengthy periods of time on your case via phone or emergency sessions, it is our policy that such time be billed to you.

7. If the counselor for whom you are waiting has an in-session client crisis, it might necessitate abruptly canceling your appointment. Your counselor will either reschedule an appointment with you or contact you as soon as possible.

8. If you must cancel an appointment, we require that you provide us with a minimum of 24 hours advanced notice. If you notify us in less than 24 hours, or if you fail to call us at all to cancel, you will be charged \$35.00 for

that session. If you miss a session due to an emergency, the fee may be excused. Otherwise, after two “no show” sessions, your relationship with our agency can be discontinued.

9. Your work with us is strictly confidential. With very few exceptions (as required by law)*, if there is ever a need for us to communicate with people outside of this organization, you will need to sign a release of information form. As stated earlier, if your counselor needs to communicate with your family, a medical, mental health or other professional or organization/service, we ask that you grant permission in writing. Failure to cooperate with this policy will result in discontinuance of services from our organization. Additionally, if you are requesting marital or relationship counseling, please be aware that divorce, or the end of a relationship, is still a possible outcome for some couples. Unfortunately, counseling cannot guarantee the expected changes that may or may not occur for individuals, couples, or families. We have a responsibility to make you aware of this information before you begin counseling.

10. A Pathways Counseling Center, Inc. client will be considered active, and the file will remain open for 30 days following the last date of service. If there are no services provided after the 30th day, termination process will begin (with either a phone call or letter from counselor). The client is always welcome to request services from Pathways Counseling Center in the future.

11. Pathways Counseling Center, Inc. retains client files for a period of seven years following the last date of service provided to a client. After that seven-year period, files will be destroyed in a professional and confidential manner (i.e., shredded).

12. As stated earlier, Pathways Counseling Center, Inc. places the utmost importance on the client’s confidentiality. However, if you are using your health insurance to help with the cost of your counseling, it is important to us to make you aware that insurance companies vary in terms of the amount of client information they require when determining reimbursement. We strongly advise that you speak with your insurance company concerning this important matter.

I/we, have read and understand this policy statement or my/our counselor has explained it to me/us. I/we, also certify that I/we am/are voluntarily seeking treatment at Pathways Counseling Center, Inc. or that as the parent/guardian, I/we give my/our consent to treatment of my/our minor child(ren) by Pathways Counseling Center, Inc.

(Client Signature)

(Counselor Signature)

(Client Signature)

(Parent/guardian signature)

(Date)

(Date)

*Under the law, we are required to break confidentiality:

- 1) If a person presents a threat to self or others;
- 2) If there is actual or suspected child abuse or neglect;
- 3) Any other exceptions where a counselor is bound to comply with the law.

16 Pompton Avenue, Pompton Lakes, NJ 07442 (973) 835-6337 FAX (973) 616-4688