PATHWAYS
Mental Health Services

Lacey Clinic Phone: 360-799-5782 ~ Fax 360-539-1715 ~ Longview Clinic Phone: 360-799-4556 ~ Fax : 360-846-1722
Website: http://www.pathwaysmhs.org

CHILD & ADOLESCENT PERSONAL INFORMATION:

First Name:

Last Name:

Preferred Name: **Gender Identity:**

Age: **Cell Phone:**

Home Phone: **Date of Birth:**

Address:

City: **State:** **Zip Code:**

Email Address:

Referral Source:

Where would you like to be seen?
___ **Lacey, WA Clinic**
___ **Longview, WA Clinic**
___ **Wellness Program**
___ **Telehealth Clinic**
___ **Telehealth Hawaii**
___ **Telehealth Utah**

Emergency Contact: **Emergency Contact Relationship:**

Emergency Contact Phone/Cell Number:

Current Grade:

Is there a current IEP? ___ Yes ___ No

Is there a current 504 Plan? ___ Yes ___ No

Are biological parents divorced or legally separated? ___ Yes ___ No

If yes, please provide a copy of the parenting plan or court order designating child custody and check one box below:

___ Joint healthcare decision-making
___ Shared healthcare decision-making
___ Sole healthcare decision-making granted to _____ (ex. Mom, Dad, Foster parent, etc.)

Guardian/Parent Name:

Contact Number:

PATHWAYS
Mental Health Services

Lacey Clinic Phone: 360-799-5782 ~ Fax 360-539-1715 ~ Longview Clinic Phone: 360-799-4556 ~ Fax : 360-846-1722
Website: http://www.pathwaysmhs.org

MENTAL HEALTH HISTORY:

Have you been in counseling/therapy before?

Do you prefer a male or female provider?

Have you been diagnosed with any of the following condition/s?

__ Depression	__ ADHD/ADD	__ Personality Disorder
__ Anxiety	__ Bipolar Disorder	__ Schizophrenia
__ PTSD	__ Alcohol Use Disorder	__ Autism Spectrum Disorder
__ OCD	__ Drug Use Disorder	__ Gender Dysphoria
__ Other:		

Please list current medications (prescribed and over-the-counter):

Alcohol & Drug History:

Any mental health hospitalization? ___ Yes ___ No
If Yes, Where (City & State) When was it?

Reason/s for seeking counseling or therapy?

PATHWAYS
Mental Health Services

Lacey Clinic Phone: 360-799-5782 ~ Fax 360-539-1715 ~ Longview Clinic Phone: 360-799-4556 ~ Fax : 360-846-1722
Website: http://www.pathwaysmhs.org

INSURANCE INFORMATION:

ALL APPLICABLE INFORMATION (FOUND ON YOUR CARD) MUST BE COMPLETED

Person financially responsible for account:
Relationship to patient:
Social Security Number of the person responsible for the account:

Primary Insurance:
Patient's Primary Insurance:
Subscriber/Member ID #:
Group ID #:
Primary Insured Name:
Primary Insured DOB:

Required for TRICARE patients ONLY: [write N/A if you do not have Tricare Insurance]
Sponsor's SSN:

Secondary Insurance (if applicable)
Patient's Primary Insurance:
Subscriber/Member ID #:
Group ID #:
Primary Insured Name:
Primary Insured DOB:

Have you contacted your insurance company to verify your eligibility for Mental Health coverage or Telehealth coverage?

Yes: ○ No: ○ *If not, please do so prior to your first appointment.*

TREATMENT CONSENT, FINANCIAL RESPONSIBILITY, AND RELEASE OF INFORMATION

I agree to be financially responsible for no show, last minute and cancelled appointments in accordance with the Pathways MHS cancellation policy as documented by my signature on the Informed Consent. I authorize insurance/EAP benefits to be paid directly to Pathways Mental Health Services, LLC and that Pathways may release any information to my insurance provider required for processing my claims.

Patient Signature: **Date:**

Parent or Guardian Signature: **Date:**