- Pathways, Inc. welcomes all new patients! To assist us in making your initial visit as smooth and efficient as possible, we ask you to download, print, and fill out the forms on this page. Please bring them with you to give to the receptionist upon your arrival.

- In addition, please bring the following information to your first appointment:

    1. Two forms of identification: One must be a picture Identification with your current address.

    2. If you do not have a current address on your identification, please bring proof of residency. Examples: a lease agreement, or a utility bill with your name on it.

    3. Your insurance card(s).

    4. Your co-payment: We accept cash, check, Visa, MasterCard, Discover, or Amex?

    5. Referral information: If your are referred by an outside agency such as Department for Community Based Services (DCBS), Department of Corrections (DOC), Probation and Parole, or any other agency, please bring any documentation from that referral.

    6. Proof of family income: (Acceptable income verification outlined below.)
        - Wages: Copy of current pay stubs for a one-month period.
        - SNAP: Benefit letter; Copy of bank statement showing deposit; letter of action.
        - TANF (Temporary Assistance for Needy Families): Benefit letter; bank statements.
        - SSI or SSA: Letter of action; Copy of bank statement showing deposit.
        - Pension and Annuities: Copy of current payment; annual statement.
        - Disability Compensation: Copy of current payment; letter of verification.
        - Unemployment Benefits; Copy of current payment; letter of verification.
        - Child and/or Spousal Support: Copy of current payment.
        - Support from an Individual: Copy of current payment and statement signed by person.
        - Student Aid: Financial Aid statement from College or University.
        - Veteran's Benefits; Copy of current payment; copy of verification letter.
        - Signed Federal Tax Return: Copy of most recent tax return.

    7. Any legal documentation regarding custody, guardianship, Powers of Attorney, etc.

Admission Information for New Consumer

Full Name: *Last* *First* *Middle*			SS#: – –	Age:
Date of Birth:	Gender: ❑M or ❑F	If under age 18, parent/guardian:		Any Custody/Guardian issues?
Street Address:		City:	County: State:	Zip:
Home Phone #:		Work Phone#:		Cell Phone #:
Communication Preference: ❑Cell Phone ❑Home Phone ❑Work Phone ❑US Mail ❑Do Not Contact			Primary Language:	
Race: ❑Caucasian/White ❑African American ❑Native American ❑Asian ❑Hispanic ❑Bi-racial				Ethnic Origin:
Marital Status: ❑Single ❑Married ❑Divorced ❑Widow ❑Co-habitating ❑Separated			Highest Level of Education:	Years
Employment Status: ❑Work Full-time ❑Work ❑Laid-Off ❑Student ❑Retired ❑Homemaker ❑Legally Disabled				Occupation:
Housing: ❑Own/Buying ❑Rent ❑Live with Family ❑Live in Shelter ❑Other:				Number in house (household size):

Do you smoke? ❑No ❑Yes If yes: ❑Current every day smoker ❑Current some day smoker ❑Current status unknown ❑Former smoker ❑Never smoked ❑Smoker ❑Unknown if ever smoked	Insurance Information: Medical Card ❑Yes ❑No Medicare? ❑Yes ❑No Private Insurance? ❑Yes ❑No Name of Insurance: _____
Any military Service: ❑No ❑Yes What branch of service?	Card holder's Name: _____ Card holder's date of birth:_____ Card holder's SS#: – –
Is your visit related to an automobile accident? ❑Yes ❑No	Is your visit related to a Worker's Compensation Issue? ❑Yes ❑No
Person to contact in case of emergency:	Relationship: Phone #:
Parent/Guardian Information: Name: _____ SS#: ____–____–_____ Date of Birth: _____ Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____	Foster Parent Information: Name: _____ SS#: ____–____–_____ Date of Birth: _____ Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Primary Care Provider(s) (outside providers):	Legal Status:
Have you ever received Pathways services before? ❑No ❑Yes If yes, What year:	What county:
Household income: $ ❑Monthly ❑Annually	Source of Income:
Who referred you to Pathways?	Pharmacy of Choice:
Allergies to medications:	Other allergies

Comments: _____
_____

_____ _____
Staff Completing Form Date

CONSUMER CONFIDENTIALITY STATEMENT

As a consumer of services provided by Pathways, Inc., I understand that the identity of other consumers is confidential. I understand that Federal Law and regulations protect the confidentiality of each individual who receives services from Pathways, Inc.

I will respect other consumers' confidentiality. I understand that if I obtain information regarding another consumer, including but not limited to, the fact that an individual is being treated at Pathways; and/or, if while attending a group service, should I learn any additional information regarding an individual, I cannot discuss this outside of the program.

I understand that there could be penalties for failure to comply with the above statements, including possible civil penalties.

_____ _____

Consumer's Signature Date

_____ _____

Witness's Signature Date