

CHESTER RIVER BEHAVIORAL HEALTH, LLC
410-778-5550

CLIENT INFORMATION

Name: First _____ MI _____ Last _____

Birth Date: ____ / ____ / ____ Sex: M ____ F ____ SS#:(last 4 digits only) _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (h) _____ (w) _____ (c) _____

Email: _____

Marital Status: single married other

Employment/School Status: employed full-time employed part-time full time student part-time student

Clients' Primary Physician: _____

Address: _____ Phone: _____

In case of emergency, please contact: _____

Emergency Contact Number: _____

INSURANCE COMPANY INFORMATION

Please submit your insurance card at your first appointment so that we may make a copy of it.

Policy Holder Name: _____ DOB: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____

Phone (h) _____ (w) _____

Employer of Policy Holder: _____

Primary Insurance Company Name: _____

Secondary Insurance Company Name: _____

Member ID # _____ Group ID# _____

Maryland Notice Form

This Notice is Required by a New Federal Law, the Health Insurance Portability and Accountability Act (HIPAA). This Notice Describes How Psychological and Medical Information about You May be Used and Disclosed and How You Can Get Access to This Information. Please Review It Carefully.

I. Uses and Disclosures for Treatment, Payment, and Health-Care Operations

We must have your written authorization to *use* or *disclose* your protected health information (PHI) for any reason (with some exceptions discussed in Section III) including for treatment, payment, and health-care operations purposes. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, payment, and health-care operations"
 - Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health-care provider such as your family physician or another therapist.
 - Payment is when we obtain reimbursement for your health-care. For example, when we disclose your PHI to your health insurer to obtain reimbursement for your health-care or to determine eligibility or coverage.
 - Health-Care Operations are activities that relate to the performance and operation of CRBH. Examples of health-care operations are quality assessments and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties.
- "Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health-care operations when you give us permission by signing an authorization form.

You may revoke all authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have acted upon that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances.

- *Child Abuse* - If we have reason to believe that a child has been subjected to abuse or neglect we must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse* - We must disclose protected health information regarding certain handicapped adults who may be victims of abuse, neglect, or self neglect/exploitation.
- *Health Oversight Activities* - If we receive a subpoena from a licensing board because they are investigating our practice, we must disclose any PHI requested by the board.
- *Judicial and Administrative Proceedings* - If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply where the evaluation is court ordered. You will be informed in advance if this is the case.

Maryland Notice Form (Continued)

- *Serious Threat to Health or Safety* - If you communicate a specific threat of imminent harm against another individual or if we believe that there is a clear, imminent risk of physical or mental injury being inflicted against another individual, we must make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself we must make disclosures to protect you from harm.

IV. Patient's Rights and Therapist's Rights

Patient's Rights

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a therapist. On your request, we will send your bills to another address).
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to Accounting* - You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties

- We are required by law to maintain the privacy of PHI and to provide you with the notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice.
- Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise any policies and procedures, we will provide you with a revised notice.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the office's Privacy Officer, Teresa Schaefer. She can be reached at 410-778-5550.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for the PHI that we maintain. If we make any such changes, we will provide you with a new Notice of Privacy Rights.

Print Name _____

Signature _____

Date _____

Chester River Behavioral Health, LLC
FEE AGREEMENT & INSURANCE AUTHORIZATION

Fees for Services

Initial Evaluation	Individual	\$200.00/hr.
	Couples/Families	\$225.00/hr.
Individual Psychotherapy (30 min.)		\$100.00
Individual Psychotherapy (45 min.)		\$125.00
Individual Psychotherapy (60 min.)		\$185.00
Couples/Families (45 min.)		\$150.00
Group Psychotherapy		\$ 50.00
Psychological Testing/Evaluation		\$125.00/hr.
Phone Conversation > (5 min.)		\$185.00/hr.
School Conferences or Meetings		\$185.00/hr.
	(mtg/travel time+mileage @.585 per mi.)	
Court Testimony or Depositions		\$200.00/hr.
	(mtg/travel time+mileage @.585 per mi., retainer required)	
Emergency/Crisis Evaluation (individual)		\$275.00/hr.
Letter Writing		\$185.00 per hr.
Records Fees		\$.85 per page
Preparation Fee		\$ 22.88 + postage
Fail to Keep Appointment		\$125.00
Failure to Provide 24 Hour Notice		\$ 60.00
Return Check Fee		\$ 35.00
Record Review		\$ 60.00 per hr.
Urinalysis		\$ 30.00

I am aware that if I am utilizing my health insurance to pay for any of the above services. I am responsible for any deductible and/or co-payment as outlined in my current policy. I agree to make the required payment at the time of service. I also agree I will pay in full all balances owed to Chester River Behavioral Health & Wellness, LLC should my insurance company not make payment.

Payment for services for minors: the amount due for each session must be paid in full upon arrival. Chester River Behavioral Health & Wellness, LLC will not divide co-payments due to court orders, divorce decrees, or separation agreements. Whoever brings the minor to the appointment is expected to make the payment, or, if minor comes alone, or arrangement for payment must be made in advance.

I am aware that cancellations of appointments (except for situations which would be considered emergencies) must be made with 24 hours advance notice. If I am unable to cancel with adequate notice, I agreed to pay a \$60 fee for that session. If I fail to keep my appointment without any notice, I will be charged \$125 (see 45 min. appointment above). I am aware that my insurance does not cover missed appointments.

I am aware that I may terminate my treatment at any time without consequence and that I will be responsible for payment for the services I have received.

I am aware that failure to meet my financial obligation may result in referral to a collection agency. The patient, and/or guarantor, shall be responsible for and agree to pay all reasonable costs of collection including, but not limited to, reasonable collection agency fees, attorneys fees, and court costs. If any suit must be filed to collect the unpaid balance own accounts, patient, and/or guarantor, agrees that such suit may be brought in courts of Kent or Queen Anne's County, Maryland and waives any objection to jurisdiction or venue.

I am aware that my insurance provider or its agent may request and be provided with information about the type, cost, and date of any treatment I received from Chester River Behavioral Health and Wellness, LLC so that payment may be provided to the therapist. I agree that this information may be released.

I am aware that the development of treatment plans and reviews of progress may be requested by my insurance provider or his agent. I agree to this information being released if my insurance provider or its agent request for authorization of treatment sessions and/or forge payment.

I have been provided a copy, have read, am aware of and agree to the terms described in the Maryland Know This Form Re: be Health Insurance Privacy and Portability Act (HIPPA).

This agreement shall remain in effect for the length of time, I am in treatment or until all financial obligations are met, whichever is longer.

Signature of Client (Parent)

Date

Printed Name

Witness

PLEASE READ EACH SYMPTOM/PROBLEM CAREFULLY AND MARK THE CIRCLE THAT BEST DESCRIBES
HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS, INCLUDING TODAY

NAME: _____ DATE: _____

HOW MUCH WERE YOU DISTRESSED BY:

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	
1	0	①	②	③	④	Nervousness or shakiness inside
2	0	①	②	③	④	Faintness or dizziness
3	0	①	②	③	④	The idea that someone else can control your thoughts
4	0	①	②	③	④	Feeling others are to blame for most of your troubles
5	0	①	②	③	④	Trouble remembering things
6	0	①	②	③	④	Feeling easily annoyed or irritated
7	0	①	②	③	④	Pains in heart or chest
8	0	①	②	③	④	Feeling afraid in open spaces or on the streets
9	0	①	②	③	④	Thoughts of ending your life
10	0	①	②	③	④	Feeling that most people cannot be trusted
11	0	①	②	③	④	Poor appetite
12	0	①	②	③	④	Suddenly scared for no reason
13	0	①	②	③	④	Temper outbursts that you could not control
14	0	①	②	③	④	Feeling lonely even when you are with people
15	0	①	②	③	④	Feeling blocking in getting things done
16	0	①	②	③	④	Feeling lonely
17	0	①	②	③	④	Feeling blue
18	0	①	②	③	④	Feeling no interest in things
19	0	①	②	③	④	Feeling fearful
20	0	①	②	③	④	Your feelings being easily hurt
21	0	①	②	③	④	Feeling that people are unfriendly or dislike you
22	0	①	②	③	④	Feeling inferior to others
23	0	①	②	③	④	Nausea or upset stomach
24	0	①	②	③	④	Feeling that you are watched or talked about by others
25	0	①	②	③	④	Trouble falling asleep
26	0	①	②	③	④	Having to check and double-check what you do
27	0	①	②	③	④	Difficulty making decisions
28	0	①	②	③	④	Feeling afraid to travel on buses, subways, or trains
29	0	①	②	③	④	Trouble getting your breath
30	0	①	②	③	④	Hot or cold spells
31	0	①	②	③	④	Having to avoid certain things, places, or activities because they frighten you
32	0	①	②	③	④	Your mind going blank
33	0	①	②	③	④	Numbness or tingling in parts of your body
34	0	①	②	③	④	The idea that you should be punished for your sins
35	0	①	②	③	④	Feeling hopeless about the future
36	0	①	②	③	④	Trouble concentrating
37	0	①	②	③	④	Feeling weak in parts of your body
38	0	①	②	③	④	Feeling tense or keyed up
39	0	①	②	③	④	Thoughts of death or dying
40	0	①	②	③	④	Having urges to beat, injure, or harm someone
41	0	①	②	③	④	Having urges to break or smash things
42	0	①	②	③	④	Feeling very self-conscious with others
43	0	①	②	③	④	Feeling uneasy in crowds, such as shopping or at a movie
44	0	①	②	③	④	Never feeling close to another person
45	0	①	②	③	④	Spells of terror or panic
46	0	①	②	③	④	Getting into frequent arguments
47	0	①	②	③	④	Feeling nervous when you are left alone
48	0	①	②	③	④	Others not giving you proper credit for your achievements
49	0	①	②	③	④	Feeling so restless you couldn't sit still
50	0	①	②	③	④	Feelings of worthlessness
51	0	①	②	③	④	Feeling that people will take advantage of you if you let them
52	0	①	②	③	④	Feelings of guilt
53	0	①	②	③	④	The idea that something is wrong with your mind

CREDIT CARD AUTHORIZATION FORM

Because there are times that our clients may not pay at the time of sessions (e.g. telehealth, forgotten checkbooks, minors coming to therapy without parents, etc.) we ask that you provide us with a credit card number to keep on file, to which any unpaid balance may be charged at the time of service. If credit card information is not provided, then a deposit equivalent to the charge for a single session will be required prior to the first appointment.

I, _____, authorize Chester River Behavioral Health LLC. to keep my signature on file and to charge my credit card as outlined above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

NAME OF CLIENT: _____

NAME OF CARDHOLDER: _____

RELATIONSHIP TO CLIENT: _____

CARDHOLDER ADDRESS: _____

CARDHOLDER PHONE: _____

___ **VISA** ___ **MASTERCARD**

ID# - - - - - - - - - - - - - - - -

Expiration date: - - / - -

CV code: - - -

___ **ONE TIME ONLY**
___ **UNTIL FURTHER NOTICE**
___ **OTHER:**

Authorized by: _____ **Date** _____

Witness: _____ **Date** _____

CHESTER RIVER BEHAVIORAL HEALTH, LLC
CLIENT RIGHTS AND RESPONSIBILITIES

Statement of Clients' Rights

- Clients have the right to be treated with dignity and respect.
- Clients have the right to fair treatment, regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
- Clients have the right to have their treatment and other client information kept private.
- Only in an emergency, or if required by law, can records be related without Client permission.
- Clients have the right to have an easy to understand explanation of their condition and treatment.
- Clients have the right to know about their treatment choices regardless of cost or insurance coverage.
- Clients have the right to information about providers' professional credentials.
- Clients have the right to know the clinical guidelines used in providing and/or managing their care.
- Clients have the right to provide input on Chester River Behavioral Health's policies and services.
- Clients have the right to know about the complaint grievance and appeal process.
- Clients have the right to know about State and Federal laws that relate to their rights and responsibilities in the treatment process.
- Clients have the right to share in the formation of their treatment plan.

Statement of Clients' Responsibilities

- Clients have the responsibility to give providers the information they need to deliver the best possible care.
- Clients have the responsibility to ask their provider questions about their care, to follow plans and instructions for their treatment, and to let their provider know when their treatment plan no longer works for them.
- Clients have the responsibility to inform their provider about medication and medication changes.
- Clients have the responsibility to keep their appointments. Clients should provide 24 hours notice for any appointment they need to reschedule or cancel.
- Clients should respect the confidentiality of other clients.
- Clients have the responsibility to pay co-payments at the time of service.
- Clients are responsible for the supervision of their children. Children, who are unable to sit quietly in the waiting area, may NOT be left unsupervised.
- I have read and received a copy of my rights and responsibilities.

Signature _____

Dates _____

Informed Consent for Telemedicine Services

Telemedicine involves the use of video conferencing to enable your clinician to provide continued care when face to face contacts are not possible (e.g. illness, injury, childcare, or transportation issues). For the purposes of continued care with CRBH, telemedicine is limited to live two-way audio and/or video contact.

- 1) I understand that my health care provider wishes me to engage in a telemedicine consultation.
- 2) I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
- 3) I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
- 4) I have had the alternatives to a telemedicine consultation explained to me.
- 5) I understand that I or my insurance will be billed for the telemedicine services provided and that I am responsible for the cost of the services not reimbursed by my insurance provider.

By signing this form, I certify:

- That I have read or had this form read and/or explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given the opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient/Parent/Guardian Signature

Date

Witness Signature

Date