Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

PATIENT INFORMATION

Patient Name_____ **D.O.B**_____

Address_____ **SS#**_____

City_____ **State**_____ **Zip code**_____

Phone Number_____

Guardian Name *(if applicable)* _____

Marital Status_____

Ethnicity_____

School Name_____ **Highest level of Education**_____

Physician Name, address & number _____

_____

Insurance Information

Insurance Type_____

Insurance number_____

Referral Information:

Referral Source_____

Presenting Concerns _____

_____

Emergency Contact

#1 Name _____ **Relationship to patient**_____

Phone Number_____ **Alt Number**_____

#2 Name _____ **Relationship to patient**_____

Phone Number_____ **Alt Number**_____

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

GENERAL POLICIES

Professional Fees and Information

Self Pay Patients – Fees vary depending on services provided. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check or cash; we am not able to process credit card charges as payment. Any checks returned to my office are subject to an additional fee of up to $35.00 to cover the bank fee that I incur. If you refuse to pay your debt, we reserve the right to use an attorney or collection agency to secure payment.

Insured Patients-You are responsible for paying your copayment for each session.

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical assessment. We have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier if you plan to pay with insurance.

Additional fees - In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me (Cash Patients only). If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify these fees start at $350.

Cancellation Policy - Cancellations must be made 24 hours before scheduled time. If you miss a session without canceling, or cancel with less than 24 hour notice you will forfeit your set appointment times.

Active Case - In order to remain an active Patient you must attend appointments a minimum of 2x a month. If you fall under the minimum, you will be discharged from services.

Assessments are <u>60 minutes</u>

Individual and Family sessions are <u>30-60 minutes</u>

No-Show - If you No Call No Show 2x during our treatment process, you will be discharged from services.

Lateness - You are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

Emergencies - We often not immediately available by telephone. We do not answer our phone when we are with Patients or otherwise unavailable. At these times, you may leave a message on our confidential voice mail and your call will be returned as soon as possible. If you are in need of immediate assistance please call 911, go to the neatest hospital or call 24- hour

Baltimore City Crisis Response 410 433 5175

Baltimore County Crisis Hotline 410 931 2214

Termination- It is important to provide sufficient time before termination to review therapeutic process and therapeutic relationship. We recommend at least one session to complete this work with you.

Court Appearances or Letters- We do not attend court or write letters to the court or behalf of Patients. This includes custody proceedings, criminal proceedings etc. If this is something you need you will need to work with another rehabilitation program.

Paperwork - We DO NOT complete the following paperwork:

1.Disability determination

2 FMLA

3.Social Security, SSI

4.Capacity to manage funds/Payee paperwork

If assistance is needed with filing out the above paperwork, needs will be address in your Individual Rehabilitation Plan.

Your signature below indicates that you have read and received a copy of General Policies and agree to their terms.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

PSYCHIATRIC REHABILITATION PROGRAM - PATIENT SERVICE AGREEMENT – INFORMED CONSENT

Patient Name:_____ **D.O.B**_____

Welcome to Healthy Minds LLC. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHIATRIC REHABILITATION SERVICES

Psychiatric Rehabilitation is the process of changing mental, emotional, and behavioral responses. Psychiatric Rehabilitative care is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a Patient in a Psychiatric Rehabilitation Program, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. We, as your Psychiatric Rehabilitative Provider, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychiatric Rehabilitation has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of Psychiatric Rehabilitation often requires discussing the unpleasant aspects of your life. However, Psychiatric Rehabilitation has been shown to have benefits for individuals who embark on the process. Psychiatric Rehabilitation often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, increase function of daily living activities and resolutions to specific problems. But, there are no guarantees about what will happen. Psychiatric Rehabilitation requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 1-3 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, we will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an individual rehabilitation plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with us. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

PROFESSIONAL RECORDS

We are required to keep appropriate records of mental health services that we provide. Your records are maintained in a secure location in the office. We keep brief records noting that you were here, your reasons for seeking psychiatric rehabilitation, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, we recommend that you initially review them with us, or have them forwarded to another mental health professional to discuss the contents. If we refuse your request for access to your records, you have a right to have our decision reviewed by another mental health professional, which we will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Confidentiality Agreement. You have been provided with a copy of that document and we have discussed those issues.

OTHER RIGHTS

If you are unhappy with what is happening in psychiatric rehabilitation, I hope you will talk with us so that we can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that we refer you to another psychiatric rehabilitation program and are free to end services at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of psychiatric rehabilitation and about our specific training and experience.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read and received a copy of Informed Consent and agree to their terms.

_____

Signature of Patient or Personal Representative

_____ Date _____

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority_____

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

CONFIDENTIALITY AGREEMENT

All information given to or obtained by psychiatric rehabilitation program staff will be used only for therapeutic services and are considered confidential. Information requested about you for any other purpose can only be released by your written consent. Information may be released without your request if required by Federal Law or in response to legal investigations and court order. There are a few exceptions to this law:

- **Duty to Warn and Protect-**If you disclose intentions to harm another person psychiatric rehabilitation program staff are required to report this to victim and legal authorities. If you disclose a plan for suicide, we are required to notify legal authorizes and inform family.

- **Abuse of Children and Vulnerable Patients-**If you disclose that you are abusing a child or vulnerable adults or child is in danger of abuse we must report this to social services and/or legal authorizes.

- **Insurance Providers-**We may be required to release mental health information to insurance companies regarding services provided to you.

Parent/ Guardian/Patient Signature _____

Date_____

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

HEALTHY MINDS LLC- PATIENT COPY

NOTICE OF PRIVACY RIGHTS

This Notice Describes How Medical Including Mental Health Information About You May Be Used And Disclosed And How You Can Get Access To This Information. **Please Review It Carefully.** During the process of providing services to you, Healthy Minds LLC will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily that information is confidential and will not be used or disclosed, except as described below.

I. USES AND DISCLOSURES OF PROTECTED INFORMATION

A. General Uses and Disclosures Not Requiring the Patient's Consent: Healthy Minds LLC will use and disclose protected health information in the following ways.

1. *Treatment*. Treatment refers to the provision, coordination, or management of healthcare [including mental health care] and related services by one or more health care providers. For example, Healthy Minds LLC staff involved with your care may use your information to plan your course of treatment and consult with other staff to ensure the most appropriate methods are being used to assist you.

2. *Payment*. Payment refers to the activities undertaken by a health care provider [including a mental health provider] to obtain or provide reimbursement for the provision of health care. For example, Healthy Minds LLC will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company for services provided. The information provided to insurers and other third party payors may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment. If you are covered by Medicaid, information will be provided to the State of Maryland's Medicaid program, including but not limited to your treatment, condition, diagnosis, and services received.

3. *Health Care Operations*. Health Care Operations refers to activities undertaken by Healthy Minds LLC that are regular functions of management and administrative activities. For example, Healthy Minds LLC may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning, and accreditation, certification, licensing and credentialing activities.

4. *Contacting the Patient*. Healthy Minds LLC may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

5. *Required by Law*. Healthy Minds LLC will disclose protected health information when required by law or necessary for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when the

Patient is a danger to self or others or gravely disabled; (e) when required to report certain communicable diseases and certain injuries; and (f) when a Coroner is investigating the Patient's death.

6. *Health Oversight Activities*. Healthy Minds LLC will disclose protected health information to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, regulatory programs or determining compliance with program standards.

7. *Crimes on the premises or observed by Healthy Minds LLC personnel.* Crimes that are observed by Healthy Minds LLC staff, that are directed toward staff, or occur on Healthy Minds LLC's premises will be reported to law enforcement.

8. *Business Associates*. Some of the functions of Healthy Minds LLC are provided by contracts with business associates. For example, some administrative, clinical, quality assurance, billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

9. *Research*. Healthy Minds LLC may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulation are followed.45 CFR § 164.512(i).

10. *Involuntary Patients*. Information regarding Patients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payors and others, as necessary to provide the care and management coordination needed.

11. *Family Members*. Except for certain minors, incompetent Patients, or involuntary Patients, protected health information cannot be provided to family members without the Patient's consent. In situations where family members are present during a discussion with the Patient, and it can be reasonably inferred from the circumstances that the Patient does not object, information may be disclosed in the course of that discussion. However, if the Patient objects, protected health information will not be disclosed.

12. *Fund Raising*. Healthy Minds LLC, or its fund raising Foundation, may contact Patients as a part of its fund raising activities.

13. *Emergencies*. In life threatening emergencies Healthy Minds LLC staff will disclose information necessary to avoid serious harm or death.

B. Patient Authorization or Release of Information. Healthy Minds LLC may not use or disclose protected health information in any other way without a signed authorization or release of information. When you sign an authorization, or a release of

information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent Healthy Minds LLC has already taken action in reliance thereon.

II. YOUR PRIVACY RIGHTS AS A PATIENT

A. Access to Protected Health Information. You have the right to inspect and obtain a copy of the protected health information Healthy Minds LLC has regarding you, in the designated record set. There are some limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask Healthy Minds LLC staff for the appropriate request form.

B. Amendment of Your Record. You have the right to request that Healthy Minds LLC amend your protected health information. Healthy Minds LLC is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask Healthy Minds LLC staff for the appropriate request form.

C. Accounting of Disclosures. You have the right to receive an accounting of certain disclosures Healthy Minds LLC has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you request an accounting. To make a request, ask Healthy Minds LLC staff for the appropriate request form.

D. Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health information. Healthy Minds LLC does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To make a request, ask Healthy Minds LLC staff for the appropriate request form.

E. Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information from Healthy Minds LLC by alternative means or at alternative locations. For example, if you do not want Healthy Minds LLC to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask Healthy Minds LLC staff for the appropriate request form.

F. Copy of this Notice. You have a right to obtain another copy of this Notice upon request.

III. ADDITIONAL INFORMATION

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

A. Privacy Laws. Healthy Minds LLC is required by State and Federal law to maintain the privacy of protected health information. In addition, Healthy Minds LLC is required by law to provide Patients with notice of its legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.

B. Terms of the Notice and Changes to the Notice. Healthy Minds LLC is required to abide by the terms of this Notice, or any amended Notice that may follow. Healthy Minds LLC reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted in Healthy Minds LLC's service delivery sites and will be available upon request.

C. Complaints Regarding Privacy Rights. If you believe Healthy Minds LLC has violated your privacy rights, you have the right to complain to Healthy Minds LLC management. To file your complaint, call Healthy Minds LLC at 240 468 8476. It is the policy of Healthy Minds LLC that there will be no retaliation for your filing of such complaints. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 1961 Stout Street – Room 1426, Denver, CO 80294; (303) 844-2024; (303) 844-3439 (TDD); (303) 844-2025 FAX

D. Additional Information. If you desire additional information about your privacy rights at Healthy Minds LLC, please call Healthy Minds LLC's Privacy Office at 240 468 8476

E. Effective Date. This Notice is effective April 1, 2020.

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

PATIENT HIPAA ACKNOWLEDGEMENT

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices(NPP) and agree to its terms.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that Healthy Minds Psychiatric Rehabilitation Program make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

_____

_____OK to leave message with detailed information
_____Leave message with call back numbers only

Written Communication Address:

_____

_____OK to mail to address listed above
_____E-mail me at:_____

Work Telephone Number:

_____

_____OK to leave message with detailed information
_____Leave message with call back numbers only

Fax Communication:

_____OK to Fax at the number listed above

Cell Number:

_____

____ I give permission to text my cell number
____ I do not give permission to text cell number

Email Address:

_____

____ I give permission to send documents to email address
____ I do not give permission to send documents to email

Other:_____

Name of Patient (Print)	Signature	Date

Witness _____ Date _____

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

HEALTHY MINDS LLC
DEMOGRAPHICS QUESTIONNAIRE

Information will be kept confidential; it will not be used to discriminate, rather it is used to ensure you receive the highest quality care and services.

Name:_____ Date:_____

What is your age?	**Highest Level of Education:**	**Occupation**	**Citizenship**	**Religion**
☐0–18 years ☐19–24 years ☐25–34 years ☐35–44 years ☐45–54 years ☐55–64 years ☐65+ years ☐Prefer not to say	☐8th ☐9th ☐10th ☐11th ☐12th ☐Some College ☐Associates Degree ☐Masters Degree ☐Doctoral Degree ☐I prefer not to answer	___ Student ___ Full-time employment ___ Part-time employment ___ Unemployed ___ Disabled	☐Birth ☐Naturalization ☐Not a Citizen ☐Prefer not to answer	☐Christian ☐Buddhist ☐Hindu ☐Jewish ☐Muslim ☐Sikh ☐Prefer not to say ☐Any other religion, write

What is your ethnicity? **Choose one section from A to G, then tick the appropriate box to indicate your ethnic group.**					
A: White ☐British, English, ☐Northern Irish, ☐Scottish or Welsh ☐Irish ☐Gypsy or Irish ☐Any other white background, please specify ☐Prefer not to say	**B: Mixed or multiple ethnic groups** ☐White and Black Caribbean ☐White and Black African ☐White and Asian ☐Any other mixed or multiple ethnic background, please specify ☐Prefer not to say	**C: Asian or Asian-American** ☐British ☐American ☐Indian ☐Pakistani ☐Bangladeshi ☐Chinese ☐Any other Asian background, please specify ☐Prefer not to say	**D: African-American, African, Caribbean or black British** ☐Caribbean ☐American ☐African ☐Any other black British, African or Caribbean background, please specify ☐Prefer not to say	**E: Latina, Latino, Hispanic** ☐Mexican ☐Puerto Rican ☐Cuban ☐Dominican ☐Any other Hispanic background, please specify ☐ Prefer not to say	**G: Other ethnic group** ☐Arab ☐Any other ethnic group

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

Disability Status	
Do you have a disability, long-term illness or health condition? ☐Yes ☐No ☐Prefer not to say	**Please place an X in the relevant box or boxes if any of the below apply to you.** ☐Blind or sight loss ☐Deaf or hearing loss ☐Mobility – e.g., difficulty walking short distances or climbing stairs ☐Learning disability, where a person learns in adifferent way – eg dyslexia ☐Mental illness – e.g., schizophrenia, depression, bipolar ☐Speech impairment ☐Cognitive disability – e.g., brain injury, autism, attention-deficit hyperactivity disorder, and/or Asperger's syndrome ☐Other impairment – e.g., epilepsy, cardiovascular conditions, asthma, cancer, facial disfigurement, sickle cell anemia, or progressive condition such as motor neuron disease ☐Prefer not to say ☐Other (please specify)
Primary Language ☐English ☐Spanish ☐German ☐French ☐Creole ☐Russian ☐Arabic ☐Yoruba ☐Other:_____ ☐I prefer not to answer	**Please identify languages spoken:** **Please identify your preferred language:**

Sexual orientation ☐Straight ☐Heterosexual ☐Gay or Lesbian ☐Bisexual ☐Prefer to self-describe _____ ☐Prefer not to say	**Gender** ☐Female ☐Male ☐Non-binary ☐third gender ☐Prefer to self-describe_____ ☐Prefer not to say
Income	☐<$10,000$10,000–$14,999 ☐$15,000–$24,999 ☐$25,000–$34,999 ☐$35,000–$49,999 ☐$50,000–$74,999 ☐$75,000–$99,999 ☐$100,000–$149,999 ☐$150,000–$199,999

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

Completed By:_____Date:_____

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

PATIENT ACKNOWLEDGEMENT OF RECEIPT

I, _____, agree to participate in the Psychiatric Rehabilitation Program and will participate in the development of the Individual Rehabilitation Plan (IRP) for the Psychiatric Rehabilitation Program services. I hereby give consent for the services to be provided.

I, _____, understand that I have choices when deciding which Psychiatric Rehabilitation Program provider to use. Options include:

_____ Mosaic Community Services
6501 N. Charles Street
Baltimore, MD 21204

_____ Changing Turn
3006 Hamilton Ave
Baltimore, MD 21214

_____ Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204

_____ _____
Client (16 years of age and over) Date

_____ _____
Parent/Guardian Date

_____ _____
HM PRP Staff Person Date

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

PRP SERVICE DELIVERY

- Healthy Minds LLC provides respectful, compassionate and professional care to our clients. Treatment at Healthy Minds psychiatric rehabilitation program entails a minimum of 3 visits per month.
- Our goal is to help you be healthy and as safe as you possibly can. The most effective way to treat mental illness is through consistent rehabilitation appointments where you can discuss difficult experiences and symptoms, and learn ways to cope with the feelings associated with them.
- Healthy Minds does not treat mental illness with medication. We treat mental illness with rehabilitative care and monitor compliance with medication management as prescribed by a provider of your choice.
- You must keep your appointment with the Rehabilitation Counselor.
- Tampering with prescriptions, being dishonest about past or present medications prescribed elsewhere, or being dishonest about your participation with other treatment providers (e.g., Methadone program, Substance Abuse program, etc.) will result in immediate discharge from the program.
- We strive to minimize waiting time, however occasional delays are possible.
- If you are more than 15 minutes late for your appointment, you will be rescheduled. If you are early for an appointment, you will have to wait until your scheduled time. If you miss an appointment, you will be given the next available appointment.
- You will be discharged from treatment if you miss three (3) appointments in 90 days or 90 days of inactivity. If you are discharged due to noncompliance with treatment, you must wait 1 month before re-admission and re-evaluation into the program.
- Assistance with applications for SSI, SSDI, etc. will not be completed until you have been in active treatment for a minimum of three (3) months and have kept all scheduled appointments.
- If you are enrolled in our program and you are in a true crisis, please call 911 or visit your nearest emergency room.

I have read, been informed of, understand and agree with the Treatment policy explained above.

_____ _____

Client (16 years of age and over) Date

_____ _____

Parent/Guardian Date

_____ _____

HM PRP Staff Person Date

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

TRANSPORTATION RELEASE OF LIABILITY

Please read this form carefully and be aware that in consideration for the Heathy Minds LLC staff and volunteers Transportation Services (hereinafter referred to as the "Party"), you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you might sustain as a result of said services, including but not limited to, vehicle operations and boarding and exiting the vehicle.

I recognize and acknowledge that "Party" is neither a common carrier nor in the business of providing transportation services to the public. I further recognize and acknowledge that there are certain risks of physical injury to vehicle passengers, and I voluntarily agree to assume that full risk or any injuries, damages or loss, regardless of severity, that I may sustain as a result of participating in any and all activities connected with or associated with receiving transportation services, including, but not limited to, injuries, damages, and loss arising out of negligent operation or supervision of the vehicle. I further agree to waive and relinquish all claims I may have (or accrue to me) against "Party" including its respective officials, agents, volunteers, employees, and independent contractors.

I do hereby fully release and forever discharge "Party" from any and all claims for injuries, damages or loss that I may have or which may accrue to me and arising out of, connected with, or in any way associated with said transportation services.

I further agree that this agreement shall be governed by the laws of the State of Maryland.

I have read and fully understand the abuse waiver and release of all claims.

_____	_____	_____
Participant Print Name	Participant Signature	Date
_____	_____	_____
Guardian (if participant is a minor) Print Name	Guardian Signature	Date

PARTICIPATION WILL BE DENIED if the signature of adult participant or guardian and date are not on this waiver.

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

MEDICAL EVALUATION FORM

Patient's Name:. _____ Date: _____

Please check if you have experienced any of the following: (explain below)

_Asthma _Abdominal pains _Allergies/other than meds _Bedwetting _Blackouts _Blood pressure problems _Blurred vision _Cancer _Convulsions _Diabetes _Dietary problems _Dizziness _Fainting spells _Frequent illness	_Head injuries _Headaches _Heart problems _High Fever _Hysterical attacks _Incoordination _Injuries/accidents _Insomnia _Kidney problems _Loss of consciousness _Menstrual problems _Muscular /skeletal abnor. _Nausea	_Nightmares _Nosebleeds _Paralysis, Numbness, Weakness _Peptic Ulcer _Ringing in ears _Serious illness _Sexual Problems _Sleepwalking _Strange odor _Thyroid _Unexplained crying _Weight problems _ Other (explain)

Explanation: _____

_____

_____

Allergic to: _____

_____

Medications: _____

_____

Immunizations: _____

_____

Other recommendations: _____

Signature of person completing form: _____

HMPRP Staff signature: _____ Date: _____

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

ENTITLEMENT FEES

Entitlement	Date of Award	Amount of Award	Frequency of Receipt
MA			
SSI/SSDI			
SNAP			

AUTHORIZATION TO RELEASE PHOTO, VIDEO OR WRITTEN TESTIMONIAL

I, _____, hereby authorize Healthy Minds Psychiatric Rehabilitation Program to use my photo, video, or written testimonial for professional purposes in the office, social media platforms, marketing events, etc. It is my understanding that Healthy Minds will use professional discretion when posting my photo, video, or written testimonial.

_____

Client name (print)

_____ _____

Client (Guardian if minor client) signature Date

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

ADVANCED MENTAL HEALTH DIRECTIVES
(Applicable if Age 16 or Older)

I,_____, have received information regarding

Advanced Mental Health Directives.

Please Check One:

I currently have an Advanced Mental Health Directive and have given LRS a copy.

☐ Yes ☐ No

I have ☐ accepted ☐ declined assistance with making an advanced directive.

_____ _____
Parent/Guardian signature Date

_____ _____
Client (Age 16 or older) Date

_____ _____
Healthy Minds PRP Staff Person Date

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

AUTHORIZATION-RELEASE OF MEDICAL INFORMATION – MENTAL

Print Patient's Name: Birth date (Month/Day/Year):

Home Address: City, State, Zip code:

Phone Number:

I hereby authorize Healthy Minds LLC to (circle one or both) **Receive from** **Send to**

Name (Physician, Hospital, Agency, etc.):

Street Address: City, State, Zip code:

Phone Number: Fax #/Email address:

Purpose of the use or disclosure?

My individually identifiable health information described below. I understand that this authorization is voluntary. I understand that I may cancel its request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider; the release information man no longer be protected by HIPAA (Federal Register Vol.65, No. 250, Part II 45 CFR, Parts 160 and 164) privacy regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization. The following information I am consenting to be released/received:

__ Discharge Summary

__Pathology Reports

__Emergency Reports

__History and Physical Laboratory Reports

__Other: any and all counselor, psychological progress notes or mental health evaluations

__Other:_____

I do I do NOT authorize release of information related to HIV (Human Immunodeficiency Virus) infection

This authorization expires on _____

_____ _____

Signature of Individual or Guardian or Personal Representative of Patients Estate Date

_____

Staff Witness Date

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

AUTHORIZATION-RELEASE OF MEDICAL INFORMATION – MEDICAL

Print Patient's Name: Birth date (Month/Day/Year):

Home Address: City, State, Zip code:

Phone Number:

I hereby authorize Healthy Minds LLC to (circle one or both) **Receive from**
Send to

Name (Physician, Hospital, Agency, etc.):

Street Address: City, State, Zip code:

Phone Number: Fax #/Email address:

Purpose of the use or disclosure?

My individually identifiable health information described below. I understand that this authorization is voluntary. I understand that I may cancel its request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider; the release information man no longer be protected by HIPAA (Federal Register Vol.65, No. 250, Part II 45 CFR, Parts 160 and 164) privacy regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization. The following information I am consenting to be released/received:

__ Discharge Summary

__Pathology Reports

__Emergency Reports

__History and Physical Laboratory Reports

__Other: any and all counselor, psychological progress notes or mental health evaluations

__Other:_____

I do I do NOT authorize release of information related to HIV (Human Immunodeficiency Virus) infection

This authorization expires on _____

_____ _____

Signature of Individual or Guardian or Personal Representative of Patients Estate Date

_____

Staff Witness Date

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This is an agreement between you, _____ and

(**Print Client Name**)

Healthy Minds LLC

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this inf01mation to decide on what treatment is best for you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information.

If you are concerned about some of your inf01mation, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. Though we will try to respect your wishes we may not be able to agree to these limitations. However, if we do agree, we promise to comply with your wishes. This consent may be revoked with a written request to which we will comply from the time the written request is received.

_____ _____
Signature of client or personal representative Date

_____ _____
Printed name of client or personal representative Relationship to client

_____ _____
Rehabilitation Specialist or Program Director Date

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

CLIENT/PATIENT CODE OF CONDUCT ACKNOWLEDGMENT

Clients/Patients will:

1. Treat staff & volunteers with respect & honesty.
2. Refrain from discriminatory comments or actions in regards to sexism, racism, ableism, classism, homophobia, biphobia, transphobia and any other behavior that is derogatory to a marginalized person(s) in our community.
3. Inform staff of needs and changes in circumstances in order to receive relevant services.
4. Give advance notice of their need to access services in order to ensure the services can be provided in a timely manner.
5. Be prepared to work with other Rehabilitation Counselor & Healthy Minds staff when your usual counselor or support staff is not available, or be willing to wait until they are available.
6. Understand that Healthy Minds LLC works with many individuals with many levels of needs, and staff may need to prioritize their time to deal with emergency or high need situations.
7. Maintain confidentiality of other clients, patients and staff.
8. Understand that Healthy Minds LLC and its staff has limitations in regards to the services they provide.
9. Realize that access to services may have limits and eligibility does not automatically ensure services.
10. Understand that staff/volunteers may not be available on a drop in basis, an appointment may be necessary.
11. Deal with problems and concerns in a mature manner according to Healthy Minds LLC Policies and Procedures.
12. Understand that posting comments on social media that harass, bully or defame a rehabilitation counselor, Healthy Minds LLC staff, patients or clients is unacceptable and could result in immediate dismissal from program and services.

Refusal of Service: Service users have a responsibility to be respectful and considerate of other service users, employees, independent contractors, and volunteers of Healthy Minds LLC. The decision to refuse service is usually made by the rehabilitation counselor in consultation with the Executive Director. Wherever possible, if a client/patient is refused service, that service user is provided with a referral to other Psychiatric Rehabilitation services and / or other appropriate agencies.

Individuals may be refused service:

1. Where a manager and an employee/contractor agree that a client/patient has contravened the above responsibility.
2. Where a client/patient is or is perceived to be threatening, harmful, sexually inappropriate or sexually harassing to fellow group members/clients, staff or volunteers, is disruptive to the group's ability to function, or breaches the group confidentiality requirement.
3. Where a client/patient behaves violently in any real or perceived manner.
4. Where a client/patient is or is perceived to be threatening or obscene in interaction with employees, volunteers or other service users.

I have read, been informed of, understand and agree with the Code of Conduct explained above.

_____ _____
Client (16 years of age and over) Date

_____ _____
Parent/Guardian Date

_____ _____
Healthy Minds PRP Staff Person Date

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

GRIEVANCE/COMPLAINT POLICY

Healthy Minds Psychiatric Rehabilitation Program process for addressing a complaint is as follows:

- Consumers/families are encouraged to address complaints with their staff and attempt to work out the perceived problem in an informal manner.
- If the informal attempt to address the complaint does not result in a satisfactory outcome for the consumer/family, a formal complaint may be initiated.
    - To file a formal complaint, a compliant form can be obtained from your staff, the Program Director, Executive Director, or in the agency suggestion box located on the door of the agency's administrative office.
    - Complete the complaint form and submit it to the Executive Director.
    - Upon receipt of the complaint form, the Executive Director will begin an investigation of the complaint, which may include interviews with the person submitting the complaint, and other persons noted on the form and/or within the agency that may offer relevant information in resolving the complaint.
    - Within 5 working days of receiving the complaint, the Program Director will respond, in writing to the person who submitted the complaint, noting the result of the investigation. The written response will be provided during a meeting between the Program Director and the consumer/family, in which the outcome of the investigation will be discussed.
- Should the client/family be dissatisfied with the result of the response to the complaint, an appeal can be made to the Governing Board by indicating to the Program Director that an appeal of the outcome is requested.
    - Within 5 working days, the Governing Board will respond in writing to the consumer as to the outcome of the appeal review.
- At any time in the process, from the initial informal attempt to resolve the complaint to the receipt of the written response from the Corporate Compliance Officer, the consumer has the right to seek assistance from an advocate outside of the organization. Available advocate for consumers/families: Behavioral Health Systems Baltimore: 410- 837-2467.

I have read, been informed of, understand and agree with the Grievance/Complaint policy explained above.

Client (16 years of age and over)	Date
Parent/Guardian	Date
HM PRP Staff Person	Date

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

TEMPORARY USE OF TELEHEALTH SERVICES TO MITIGATE POSSIBLE SPREAD OF NOVEL CORONAVIRUS ("COVID-19")

BACKGROUND

On March 5, 2020, Governor Lawrence J. Hogan, Jr., declared a state of emergency due to disease ("COVID-19") caused by the novel coronavirus. COVID-19 is a severe respiratory disease, resulting in illness or death, caused by person-to-person spread of the novel coronavirus.

Commonly reported symptoms of COVID-19 infection include fever, cough, shortness of breath, and pneumonia. While the exact incubation period for this coronavirus has not yet been determined, it is believed that most infected people will develop symptoms 2-14 days after they were exposed. There is no vaccine available for COVID-19. Prevention measures center on frequent hand washing, covering coughs and sneezes, and separating people who have respiratory symptoms. Treatment for COVID-19, as with any coronavirus infection like the common cold, includes the use of over-the-counter fever-relievers, drinking plenty of fluids and resting at home to help relieve symptoms. Those with more severe symptoms may be hospitalized to provide additional support.

TEMPORARY USE OF MEDICAID TELEHEALTH SERVICES WITH THE HOME AS AN ORIGINATING SITE

Maryland Department of Health issued a notice to providers on March 11, 2020 granting temporary expansion of telehealth services. This includes, but is not limited to, temporary expanding the definition of a Telehealth originating site under COMAR 10.09.49.06 to include a patient's home or any other secure location as approved by the patient and the therapist for purpose of delivery of Medicaid-covered services. The purpose of this expansion of regulatory authority is to ensure individuals can access certain health care services in their own home while mitigating possible risk for transmission of COVID-19. This expansion will remain in place until further notice by Maryland Department of Health.

Effective Monday, March 16, 2020 Healthy Minds LLC will render **ALL** Behavioral Health Rehabilitation Sessions via Telehealth. The delivery of Telehealth services to the home is an effort to mitigate possible spread of the novel coronavirus (COVID-19). Telehealth uses two-way audio-visual technology assisted communication. The services will be provided via Doxy.me. Doxy.me offer a HIPAA compliant platform for audio/visual meetings. However, there will be times when Non-HIPAA compliant platforms will be utilize when accessibility to Doxy.me is not available. Non-HIPAA compliant platforms include Zoom, Whatsapp, Duo, and Facetime. *Please be advised that the use of Non-HIPAA complaint platforms may limit the confidentiality of your information.*

Appointments must be confirmed no later than 1-hour prior to the appointment time. After an appointment is confirmed, your Rehabilitation Counselor will send a text to those using a smartphone or an email to those using a computer with a link to the Doxy.me waiting room. Patients can use smart phones or computers for the session. The meeting will start once the rehabilitation counselor and patient have entered the waiting room. Appropriate attire is required when using telehealth services.

Healthy Minds LLC will maintain the applicable standards of COMAR 10.09.49 Telehealth Services. Participants must provide verbal consent to use Telehealth Services at Healthy Minds LLC prior to their first audio/visual session. Please contact Jacquette Jacobs, LCPC for further information on Telehealth services at (240) 468-8476 or by email at jjacobs@hmllc.org.

_____ _____

Client (Guardian) Signature Date

Healthy Minds LLC
100 West Road Suite 300
Towson, MD 21204
Phone: (240) 468-8476 Fax: (443) 378-8983
Email: jjacobs@hmllc.org

Discharge/Termination & Transfer Policy

All services provided at Healthy Minds LLC is voluntary. When services are no longer necessary or required, or when the Rehabilitation Specialist feels that treatment should be discontinued due to non-compliance or other reasons, our policy is as follows:

---Termination of services will, whenever possible, be a collaborative effort between the client and the Rehabilitation Specialist and based on completion of treatment goals. When this decision is made, the Rehabilitation Specialist and client develop a discharge plan formulating continued service needs. The Rehabilitation Specialist will also assist the client with the necessary referrals for treatment, rehabilitation, or community support.

---A client may be discharged from services if he/she has cancelled more than three consecutive appointments or not shown up after a phone call. A client may also be discharged if he/she has not participated in services for a period of 90 days and has made no indication that he/she will return to treatment. If a client is unable to attend due to hospitalization or other temporary reasons, the chart will remain open until the client chooses to return.

---A decision to terminate services may be recommended if the client fails to comply with the treatment goals that have been discussed and agreed upon between the client and Rehabilitation Specialist.

---Treatment may also be terminated if the client presents a threat to the health or safety of the clinic staff o other patients.

---If a Rehabilitation Counselor is leaving the agency, all efforts will be made by the Rehabilitation Counselor and the agency to make sure that sufficient time is provided for appropriate termination and/or transition to a new Rehabilitation
Counselor. In some circumstances a client may request to transfer to another Rehabilitation Counselor or a Rehabilitation Counselor may feel that he/she cannot effectively work with a particular client. In these situations, all efforts will be made to involve the client and his/her family in the decision and transfer. The Rehabilitation Counselor/Rehabilitation Specialist will document in a transfer summary the reasons for transfer and other relevant information. The client's record will also be transferred to the new Rehabilitation Counselor, following the client's signed release of information.

_____ _____

Client (Guardian) Signature Date

_____ _____

Rehabilitation Specialist Signature Date

Leave Blank