Healthy Minds LLC
5214 Daybrook Cir
Baltimore, MD 21237
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**_____

GENERAL POLICIES

Professional Fees and Information

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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; I 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, I 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 me to provide them with a clinical assessment. I 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, I 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. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I 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>45 minutes</u>

PRICE LIST

Child Assessment- $150	Adult Assessments- $150
Individual Sessions - $80	Couples/Family Sessions-$100

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.

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Emergencies - I am often not immediately available by telephone. I do not answer my phone when I am with Patients or otherwise unavailable. At these times, you may leave a message on my 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. I 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 therapist.

Paperwork - We DO NOT complete the following paperwork:

1.Disability determination

2 FMLA

3.Social Security , SSI

4.Capacity to manage funds/Payee paperwork

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

PSYCHOTHERAPIST-PATIENT SERVICE AGREEMENT – INFORMED CONSENT

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

Welcome to Healthy Minds LLC. This document contains important information about my 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

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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.

PSYCHOTHERAPY SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a Patient in psychotherapy, 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. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy 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 psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy 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 and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy 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, I 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 initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

PROFESSIONAL RECORDS

I am required to keep appropriate records of mental health services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I 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, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I 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.

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CONFIDENTIALITY

My 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 therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy 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 therapy and about my 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

_____

Printed Name of Patient or Personal Representative

Date _____ Description of Personal Representative's Authority_____

CONFIDENTIALITY AGREEMENT

All information given to or obtained by therapist 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 I am required to report this to victim and legal authorities. If you disclose a plan for suicide, I am 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 I must report this to social services and/or legal authorizes

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_____ ____

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

Parent/ Guardian/Patient Signature _____

Date_____

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.

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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).

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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.

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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

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 14, 2003.

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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 the Practice 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:_____

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Name of Patient (Print) Signature Date

Witness _____ Date _____