Behavioral Health Intake Packet

Welcome to Strength for the Journey, LLC! You've taken an important step toward supporting your mental and emotional healing and well-being.

To reserve an initial appointment, please:

- ☐Complete and return this intake packet
- ☐Provide copies of your:
  - ☐Insurance ID(s)
  - ☐Government-issued photo ID

Intake materials can be returned via any of the following methods:

- **Email**: contact@strengthforthejourney.net
- **Fax**: 443-588-1730
- **Secure Upload**: https://bit.ly/SecureMessagingSFTJ
- **Mail**: PO Box 20397, Towson MD 21284

Once we have received your completed intake materials, we will reach out to you to schedule your first appointment.

If you have any questions, please contact Lindsey Lehmuth, Practice Assistant, at 410-384-6287, option 1.

We look forward to supporting you on your wellness journey!

If you are experiencing an urgent crisis or emergency, such as having suicidal or homicidal thoughts, please seek immediate assistance by calling a crisis hotline (9-8-8-), emergency services (9-1-1), or going to your nearest emergency department.

First Appointment Checklist:

_____Intake Packet
(completed and returned)
_____Insurance Card(s)
(prepare to show)
_____Photo ID
(prepare to show)
_____Copay/Coinsurance
(authorize a payment card to keep on file, if applicable)

Wondering what to expect during your first appointment?

- All required paperwork must be reviewed and completed prior to your initial session.
- In your first session, we'll have an initial conversation about your reason(s) for seeking therapy, including your personal history and your treatment goals. Don't worry if you aren't sure of your goals - we'll figure them out together!
- The initial session is about an hour. Subsequent sessions last approximately 45 minutes.
- Note that late arrivals might not be accommodated due to scheduling conflicts. A 24-hour notice for cancellations is required. Late arrivals, no-shows, and cancellations without 24-hour advance notice are subject to a $50 fee. See policy for more details.
- ***Be assured that your sessions are individualized, judgment-free, and completely confidential, with limited exceptions.***

We look forward to talking with you soon!

CLIENT INFORMATION

SECTION I: DEMOGRAPHICS

Name:_____ Preferred Name: _____ DOB: ___/___/____
Address/City/State/Zip:_____
_____
The best time to contact me is (circle): AM PM
Phone: (please circle best contact number):
Cell _____ Okay to leave voicemail messages? ___ Yes ___ No
Home _____ Okay to leave voicemail messages? ___ Yes ___ No
Work _____ Okay to leave voicemail messages? ___ Yes ___ No
Email Address: _____
Gender Identity: _____ Race: _____ Language: _____
Marital Status: _____ Employment Status: _____
Emergency Contact Name:_____Relationship:_____
Emergency Contact Cell:_____ Work:_____ Home:_____

SECTION II: RESPONSIBLE PARTY

Guarantor: _____ Relationship to Patient (if not self):_____
Address/City/State/Zip:_____
_____
Phone: _____ Employer:_____

SECTION III: INSURANCE INFORMATION

Please present ID and insurance card for scanning

Insurance Type: (circle all that apply):
None Medicare Medical Assistance Commercial

PRIMARY INSURANCE

Policy Holder:_____ DOB: ___/___/_____ (Circle): Male Female
Relationship to Patient (Please Circle): Self Spouse Parent Other (Please Specify):
Insurance Company: _____ Ins Co. Phone:_____
Grp#: _____ ID#: _____
Ins Co Address:_____
_____

SECONDARY INSURANCE

Policy Holder:_____ DOB: ___/___/_____ SSN#: _____
Relationship to Patient (Please Circle): Self Spouse Parent Other (Please Specify):
Insurance Company: _____ Ins Co. Phone:_____
Grp#: _____ ID#: _____
Ins Co Address:_____
_____

(Turn Over)

SECTION IV: DISCLOSURE OF MY PROTECTED HEALTH INFORMATION

I authorize Strength for the Journey, LLC to disclose my protected health information either via phone, fax, email or paper copy to (*please check all that apply AND include any applicable phone numbers*):

- My Spouse (Full Name) _____
- My family member (Full Name) _____
- Non-custodial parent (Full Name) _____
- Caretaker (Full Name) _____
- Other (Full Name) _____
- N/A

SECTION V: AUTHORIZATIONS

I authorize permission for treatment of my behavioral health (mental health and/or substance abuse) conditions, and collection of any information necessary for treatment.

I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree that my signature on this document authorizes this provider to submit claims for benefits, for services rendered, without obtaining my signature on each claim to be submitted.

I understand that I am financially responsible for any charges incurred, including any charges not covered by my insurance company.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER: I certify that the information given by me in applying for payment under title XVII of the Social Security Administration or its intermediaries or carriers is the correct information needed for Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for behavioral health services to Leslie Sherrod, LCSW-C DBA Strength for the Journey, LLC, and authorize this provider to submit claims to Medicare for payment.

MEDICAID PATIENT CERTIFICATION: I certify that the information given by me in applying for payment as a recipient of Medical Assistance is correct and request that payment of authorized benefits be made on my behalf. I assign the benefits payable for behavioral health services to Leslie Sherrod, LCSW-C DBA Strength for the Journey, LLC, and authorize this provider to submit claims for payment.

I, _____, acknowledge receipt, review, authorization, and agreement with:

- ✓ Client Information
- ✓ Consent for Services
- ✓ Notice of Privacy Practices
- ✓ No Surprise Act and Good Faith Estimate Notices

Signature:_____ Date:_____

Release of Information Consent Information

Your written consent is needed to allow communication and collaboration with others about your behavioral health treatment with exceptions for extenuating circumstances as detailed in the Notice of Privacy Policies.

If you would like to allow Strength for the Journey to collaborate with your Primary Care Provider, other medical providers (ex. psychiatrist), family members, friends, or any other individual you see as part of your care team, PLEASE COMPLETE THE CONSENT FORM.

This form may be completed multiple times if you have more than one person or organization you are authorizing for disclosure.

If you have any questions, please call 410-384-6287 for assistance.

Release of Information Consent

MedChi CTO Behavioral Health Specialist Referral

I, _____, DOB (___/___/____), authorize Strength for
Patient Name

Journey, LLC, 8415 Bellona Lane, Suite 217, Towson, MD, 410-384-6287, to send and/or receive

the following information:

- Medical history and evaluation(s)
- Mental health evaluations
- Psychosocial history and/or assessments
- Referral status and tracking updates (if applicable)
- Treatment plans and summaries
- Progress, case, contact, and/or termination notes
- Other _____

To / From *(Include name and contact information for whom you are consenting information to be shared):*

The above information may be used for the following purposes:

- Planning appropriate treatment
- Continuing appropriate treatment
- Determining eligibility for benefits or program
- Referral to community or social service resource(s)
- Updating files
- Other_____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. Information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature: _____ Date:_____

My relationship to patient:

____ Self ____Parent/legal guardian ____ Personal representative ____ Other: _____

Patient Name:_____
Date of Birth:_____

INTAKE QUESTIONNAIRE

What brings you to counseling? Is there something specific, such as a particular event?

_____
_____

What are your goals for counseling?

_____
_____

Relationship Status:
☐ Married ☐ Single ☐ Widowed ☐ Other:_____

Living Situation (check all that apply):
☐ Rent ☐ Own
☐ Live alone ☐ Live with family members ☐ Live with friends ☐ Other: _____

Education:
☐ Some high school
☐ High school diploma/GED
☐ Some college
☐ Trade school/vocational training/AA
☐ B.S./B.A
☐ Masters
☐ Doctorate
☐ Other: _____

Have you seen a mental health professional before? ___Yes ____ No
*If yes, when and where?*_____

Have you ever been diagnosed with a mental illness? ___ Yes ___ No
*If yes, what and when?*_____

Specify all medications and supplements you are presently taking and for what reason.

_____
_____
_____

If you are taking any behavioral health prescription medication(s), who is your prescribing provider? Please include their name and phone number.

_____
_____

Have you ever been hospitalized for a psychiatric issue? ___ Yes ___ No
If yes, when and where?_____

Do you now, or have you ever, used alcohol, tobacco, recreational drugs, or prescription medication other than as prescribed? ___ Yes ___ No
If so, which? When did you start, how often did/do you use, and how long did this occur? Please list each substance separately. _____
_____

Please detail any legal history *(arrests, charges, misdemeanors, civil suits, etc.):*

_____

_____

Is there a history of mental illness in your family? If so, who and what illness(es)?

Family Member	Anxiety	Bipolar Disorder	Depression	Schizophrenia	Developmental Disorder	Other (Specifiy)
☐ Mother	☐	☐	☐	☐	☐	☐_____
☐ Father	☐	☐	☐	☐	☐	☐_____
☐ Grandparent	☐	☐	☐	☐	☐	☐_____
☐ Sibling	☐	☐	☐	☐	☐	☐_____
☐ _____	☐	☐	☐	☐	☐	☐_____

What significant educational and work/volunteer experiences have you had? _____

_____

What spiritual practices and cultural influences are important to you? _____

_____

What are your hobbies/interests? What do you enjoy doing when you have free time? _____

_____

Who supports your well-being? _____

_____

Please list any benefits or services from any government or community agencies you are receiving: __

_____

Please check any of the following that apply:

___Frequent headaches
___High blood pressure
___GI concerns
___Hormone problems
___Head injury
___Angina or chest pain
___Irritable bowel
___Chronic pain
___Loss of consciousness
___Heart attack

___Autoimmune disorder
___Seizures
___Kidney-related issues
___Chronic fatigue
___Dizziness
___Faintness
___Heart valve problems
___Urinary tract problems
___Fibromyalgia
___Numbness & tingling

___Shortness of breath
___Diabetes
___Hepatitis
___Asthma
___Arthritis
___Thyroid issues
___HIV/AIDS
___Cancer
___Other (please specify):
_____

What else would you like your therapist to know?

_____

_____

_____

CONSENT FOR SERVICES

This form is called a Consent for Services (the "Consent"). Your therapist ("Provider") has asked you to read and sign this Consent before you start and/or continue therapy. Please review the information. If you have any questions, contact your Provider.

INFORMED CONSENT FOR PSYCHOTHERAPY

General Information:
The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing at the end of this document.

The Therapeutic Process:
You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. We cannot promise that your behavior or circumstance will change. We can promise to support you and do our very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality:
The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client-held privilege of confidentiality exist and are itemized below:

- If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
- If a client threatens grave bodily harm or death to another person.
- If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
- Suspicions as stated above in the case of an elderly person or vulnerable adult who may be subjected to these abuses.
- Suspected neglect of the parties named in items #3 and # 4.
- If a court of law issues a legitimate subpoena for information stated on the subpoena.
- If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally, we may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, we will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to us, and we do not wish to jeopardize your privacy. However, if you acknowledge us first, we will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

INFORMED CONSENT FOR TELEHEALTH SERVICES

Definition of Telehealth: Telehealth involves the use of electronic communications to enable Strength for the Journey, LLC (SFTJ) clinicians to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I, the client, understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information that I have already signed also apply to telehealth. A copy of our Privacy Policies and Informed Consent for Psychotherapy can be provided.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. SFTJ utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth via Backline.

4. SFTJ clinicians follow the State of Maryland COMAR Regulations for Teletherapy: 10.42.10 as well as their respective board regulations (BOPC/ACA or BSWE/NASW) and ethics. They have also received training to provide telehealth services.

5. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services:
Strength for the Journey, LLC will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. The standard copay and/or deductibles would apply. In the event that insurance does not cover telehealth, you may wish to pay out-of-pocket, or when there is no insurance coverage. We can provide you with a statement of service to submit to your insurance company.

Patient Consent to the Use of Telehealth:
I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature, I hereby state that I have read, understood, and agree to the terms of this document.

INFORMED CONSENT FOR IN-PERSON SERVICES DURING THE COVID-19 PANDEMIC

This form contains important information about our decision to conduct in-person services during the COVID19 public health crisis and to set expectations surrounding some corresponding requirements to facilitate health safety for our meetings. Please read this carefully and share any questions you have before signing this document as it will be an official agreement between us.

Decision to Meet In-Person:
We may mutually agree to meet in person for some or all future sessions. Please understand that if there are any future state emergency limits, shelter in place orders or illness impacting our ability to meet, we will develop a reasonable plan to reschedule or meet using telehealth or alternative communication resources that meet the confidentiality requirements necessary to work together.

If you, the client, decide at any time that you would rather move or return to telehealth services, we will outline the plan and confirm that the communication method is clinically appropriate. The plan will include payment/reimbursement for telehealth services as it may vary with your health insurance plan and applicable law.

Risks of Opting for In-Person Services:
Please understand that by coming to the office, and/or meeting for such services in any other venue, you are assuming the risk of exposure to the coronavirus (or any other public health risk); and you agree to waive all rights and claims against my practice and me both jointly and severally for damages arising therefrom. This risk may increase if you travel by public transportation, cab, or ridesharing service.

Waiting Room and Therapy Room Rules:

- Masks are strongly encouraged, though not required, for everyone who enters the office suite. Please note the waiting room is a shared space for multiple health care services.

Practice Steps to Reduce Exposure:
Our practice has taken steps to reduce the risk of spreading the coronavirus within the office. We have implemented guidelines outlined by federal and local health agencies to improve safety from virus contagion.
Although these steps will improve safety, it is impossible to guarantee any outcome with an invisible virus. Please let us know if you have questions about these efforts.

- High touch surfaces are cleaned frequently (ex: doorknobs, bathroom facilities, tea station, etc.).
- Masks are strongly encouraged, though not required.
- Therapists are vaccinated and may wear a mask during sessions.
- Hand sanitizer will be available for use.
- The therapy room utilizes a purifier with a HEPA filter and/or will have a window open (weather permitting) for ventilation.
- The therapy room will be sanitized between patients.

Commitment to Minimize Your Exposure:
To obtain services in person, you agree to take reasonable safety precautions to reduce exposure from any contagious illness. If you do not adhere to these safeguards, it may result in immediate changes in our meeting arrangement.

I, the client, understand and agree to these actions:

- I agree to only come to an appointment when I am symptom-free or when I have been symptom-free for a period of 10 days, with no fever in the past 24 hours, following a COVID-19 diagnoses, per CDC guidelines. (Symptoms include recent onset of one or more of the following: body aches, loss of smell or taste, headache, diarrhea, vomiting, coughing, shortness of breath, difficulty breathing, fever, chills, sore throat or any newly discovered health symptom associated with any contagious virus.) If I am symptomatic, I agree to cancel or request a telehealth appointment, if my insurance plan allows, before the scheduled time.

- I agree to follow the waiting room and therapy room rules and requirements noted above.

- If I have been exposed to or shared a workspace or living arrangement with a person infected by COVID-19, I will immediately disclose this information in advance of our appointment time by phone and we will work together to set up a new meeting time or possible alternative means of communication.

- I understand that if I appear to be physically ill at an appointment, I may be required to leave immediately and understand I will be contacted to reschedule our appointment, possibly temporarily involving another form of communication.

The above precautions will be adjusted if new or additional local, state or federal orders or guidelines are published or required. If that happens, the content may be subject to change, and we will review the changes.

Informed Consent:
This agreement supplements any general informed consent and agreements/acknowledgements that we agreed to at the start of our work together.

Your signature shows that you agree to these terms and conditions.

CANCELLATION, LATE, & NO-SHOW POLICY

A canceled appointment hurts three people: you, your therapist, and another client who could have potentially utilized your time slot. Therapy sessions are scheduled in advance and are a time reserved exclusively for our clients. When a session is canceled without adequate notice, we are unable to fill this time slot by offering it to another current client, a client on the waitlist, or a client with a clinical emergency. In addition, we are unable to bill your insurance company for sessions that are not kept.

APPOINTMENTS THAT ARE MISSED OR CANCELED WITHOUT GIVING 24 HOURS ADVANCE
NOTICE ARE SUBJECT TO A $50 FEE. This means that if an appointment is scheduled for 3:00 pm on a Monday, notice must be given by 3:00 pm on Sunday at the absolute latest. You can cancel your appointment by calling or texting 410-384-6287.

The only time we will waive this fee is in the event of serious or contagious illness, urgent, uncontrollable events, or extreme weather. If you are unsure, please contact your therapist for further guidance. Please note that this fee cannot be applied for clients with Medicaid insurance (Medical Assistance). Thus, clients with Medicaid insurance who have three or more late cancellations or missed sessions will be referred to other providers should there be indication that the pattern will continue.

Also, as each scheduled time slot is designated for a client, if you are 10 or more minutes late, it is possible that you will not be seen to ensure equal respect for all scheduled clients. Late arrival may be counted as a no-show and may be subject to the missed appointment fee.

Additionally, please understand that therapy should be viewed as any other important medical appointment would be viewed. While it is a time commitment, this is for your personal betterment and consistency is key in order to achieve this. That being said, two consecutive missed appointments without first reaching out to the therapist, attempting to reschedule, or otherwise indicating clear commitment to treatment, can result in termination of the therapeutic relationship. If you miss two or more scheduled appointments within a 30-day time period without canceling or rescheduling in accordance with the cancellation policy of 24 hours advance notice, the therapeutic relationship will be terminated. Your case may be reopened at any time should you so choose, however you may be placed on a waiting list if there are other clients waiting to use your time slot. This is standard practice with most therapy agencies and private practice offices.

My signature indicates that I, the client, have read, understand, and agree to this policy.

COMMUNICATION POLICIES

General Information:
Strength for the Journey, LLC is committed to protecting your privacy and maintaining appropriate therapeutic boundaries in accordance with legal and ethical guidelines, expectations, and regulations. These guidelines impact how we will be able to communicate.

Patient Portal:
Patients have the option of having a secure patient portal to access appointments, documents, and other information, such as billing statements, clinical worksheets, etc. The portal does not at this time offer a platform for you to send messages to us and should not be sought for use in emergencies. The portal is not required for you to receive services and you may choose to have documents, worksheets, statements, etc. sent securely via email (please review information about emails below).

The patient portal we use is TherapyPortal through TherapyNotes.com. It requires a password (which you can request to reset as often as needed).

If you are a patient referred by a MedChi CTO participating provider, you can access the patient portal at this link:
https://www.therapyportal.com/p/medchi/

All other patients can access their portals at:
https://www.therapyportal.com/p/strength2020/

If you do not have portal access and would like to have it, please call 410-384-6287 for assistance or simply request at your next appointment.

Emails:
To protect your privacy and comply with federal HIPAA requirements, we will only communicate with you via secure email. This means that you may be prompted to enter a password through the secure email provider MailHIPPO. We primarily send encrypted emails via Google Workspace secured by Paubox. Outside of these secure platforms, you may only receive emails related to appointment reminders, with your consent.

Please note that clinical information and concerns are best discussed within your scheduled therapy appointment time. Email communication is limited to addressing the details and/or logistics of your appointments (ex. confirming or canceling sessions; information about location or address; billing matters; telehealth links, out of office updates, etc.). We will not be able to engage in clinical consultations via email.

On occasion, with your verbal consent, we may email you a worksheet, recommended links, community resource information sheet, etc. to support your treatment goals. This will be discussed in advance and will be sent securely either to your email on file or your patient portal, if you have one.

Text Messaging:
Text messaging, with your permission, is limited to addressing details regarding the logistics of your appointments, such as confirming or canceling sessions, or sharing a telehealth link for you to access. Text messages are not secure or encrypted; therefore, no personal health information may be shared via text. Keep in mind that clinical information and concerns are to be discussed within your scheduled therapy appointment time and we will not be able to engage in a "conversation" or offer clinical consultations via text.

Social Media and the Internet: To maintain appropriate therapeutic boundaries and also protect your privacy, we will not knowingly "friend," like, comment, connect, message, respond, or otherwise engage with you on any social media platforms or internet websites. Please note that we do maintain professional websites, blogs, and have other internet presences but will not interact with you in these spaces to maintain our respective privacies and your confidentiality. Also, on principle and as a core belief of our practice, we do not search for clients on Google, Facebook, or other internet search engines. Your private life is yours and we only discuss what you share and/or present in sessions. Extremely rare exceptions to this general rule may be made, such as during times of crisis, if a safety concern presents and we have no other way to reach you, and/or we feel there is a clinically justified reason or need to do so.

Telephone Availability:
Please note we are unable to directly answer every phone call. We are generally available to respond to messages Mondays-Fridays during business hours and will make every attempt to return your voicemail message within one business day.

***IMPORTANT* As we may not be able to immediately answer or respond to your phone call, if you are experiencing a crisis, please call 2-1-1, option 1, to be connected to your local crisis hotline for help. If you are experiencing an emergency, such as suicidal or homicidal thoughts, please call 9-1-1 or go to your nearest emergency department for immediate assistance.**

Telehealth Links:
We offer three options to access telehealth depending on your internet connectivity needs, requirements, and ease of use. If you are scheduled for a telehealth appointment, you will be using one of these three links:

TherapyPortal via TherapyNotes

Sessions via PsychologyToday.com

Doxy.me

You will be advised of which link to use at the time your appointment is scheduled along with directions on how to access it. If uncertain which to use or if unable to connect, please call or text (410-384-6287) for assistance.

Informed Consent:
Your signature indicates your review, agreement, and adherence of and with these policies. You acknowledge that you may ask questions for clarification and you also understand that these policies are subject to change pending new or additional regulatory, legal, and/or ethical guidance.

SIGNATURE:_____
DATE:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. OUR PLEDGE REGARDING HEALTH INFORMATION:
We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this mental health care practice. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

• Make sure that protected health information ("PHI") that identifies you is kept private.

• Give you this Notice of my legal duties and privacy practices with respect to health information.

• Follow the terms of the Notice that is currently in effect.

• We can change the terms of this Notice and such changes will apply to all information I have about you. The new Notice will be available upon request.

II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment Payment or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. We may also disclose your protected health information for the treatment activities of any health care provider. This, too, can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.
Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. we may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. we do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For our use in treating you.
b. For our use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For our use in defending ourselves in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA
e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As psychotherapists, we will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As psychotherapists, we will not sell your PHI in the regular course of our business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, we can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to

anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although our preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although our preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with us. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and we may say "no" if we believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How We Send PHI to You. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost-based fee for doing so.
5. The Right to Get a List of the Disclosures We Have Made. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost-based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say "no" to your request, but we will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. You are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

SIGNATURE: _____
DATE:_____

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an innetwork facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-ofnetwork provider or facility, the most the provider or facility may bill you is your plan's innetwork cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the federal phone number for information and complaints is 1-800-985-3059. Visit https://www.cms.gov/nosurprises for more information about your rights under federal law. **You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.** Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services. **You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services.** This includes related costs like medical tests, prescription drugs, equipment, and hospital fees. Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059.