flourish
COUNSELING + WELLNESS CENTER

Patient Information:

Name:_____Email:_____
Address:_____
City/State/Zip_____
Phone:_____Cell_____May we leave a message? Y or N Email? Y or N
DOB:_____(MM/DD/YYYY) Circle: *Male or Female*

Insurance/Insurer Information:

Insurance Co:_____ID # of Policy Holder:_____Group #:_____
Policy Holder's Name:_____Circle M or F DOB: _____
Relationship to Patient:_____SS # of Policy Holder: _____
Mental Health Benefits # (on back of card)_____Employer's Name: _____
2nd Insurance Co:_____ID # of Policy Holder:_____Group #:_____
Policy Holder's Name:_____Circle M or F DOB: _____
Relationship to Patient:_____SS # of Policy Holder: _____
Mental Health Benefits # (on back of card)_____Employer's Name: _____

If your insurance requires an authorization to pay for your visits, **PLEASE** call your insurance company to request an authorization and an authorization number. Therefore, if your visits are not authorized **PRIOR** to your visit and the insurance refuses to pay, you will be responsible for the full fee. See Financial Policy.
Authorization #:_____# of visits authorized:_____Date Authorization starts and ends: _____

Consent for Treatment:

I do hereby express my understanding that patient will receive psychological and/or psychotherapy and/or pharmacotherapy services provided by a clinician at the center. I understand the purpose of the service to be one or a combination of individual therapy, group therapy, and family therapy.

I acknowledge that my therapist is not available 24 hours a day via any communications method (phone, texts, email, and website). I understand for emergencies, I should contact my therapist and contact emergency services by calling 911.

I have read this Consent for Treatment and I understand it fully, and voluntarily sign:

Client, Parent, or Managing Conservator Date

_____ _____

Limits of Confidentiality:

I further understand that my privilege of confidential communication will be maintained by the therapist with the *following exceptions*:

- Should there be an allegation of child or elder abuse or neglect, the treating clinician has an obligation to report any pertinent information to the proper authorities, and may be asked to testify in court regarding that information, and will, if subpoenaed to do so.
- Should there be any expressed intention to harm another or oneself, the treating clinician has an obligation to report this information to the appropriate authorities and to make a reasonable effort to prevent such action and will do so.

I have read this Confidentiality Agreement and I understand it fully, and voluntarily sign:

_____

Client, Parent, or Managing Conservator Date

Financial Agreement:

I understand that I am fully responsible for payment at time of service of entire fee or insurance copay/coinsurance for services. I acknowledge it is my responsibility to determine whether treatment services are covered by my insurance company and if needed, to obtain pre-authorization of services. If pre-authorization is not obtained, or there is a deductible which has not yet been satisfied, I understand I am responsible for the entire bill.

Once pre-authorization has been obtained, Flourish Counseling and Wellness will be responsible for submitting claims to the specific insurance companies whom they are credentialed. It is the patient's responsibility to submit claims to insurances Flourish does not participate with.

Minor Clients

The adult accompanying a minor or the parents (or guardians of the minor) are responsible for full payment. This office is not a party to any divorce decree. Adult clients are responsible for the bill, and the responsibility of the minor rests with the accompanying adult. If subpoenaed patient or guardian is responsible for fees from the Olney Center to appear and consult.

I understand that there is a $75.00 charge for no shows, and $75 charge for cancelling without 24 hours' notice, not reimbursable by insurance. I understand web & phone sessions may not be covered by insurance and I am responsible.

I have read this Financial Agreement and I understand it fully, and voluntarily sign:

_____

Client, Parent, or Managing Conservator Date

Credit Card on File (Optional)

I authorize Flourish Counseling and Wellness Center, LLC to charge my credit card for all services provided for the above patient.

Client, Parent, or Managing Conservator_____ Date _____

Card Type:_MC_VISA__DISCOVER Card Holder Name: _____

Billing Address: _____

Card #_____ Exp._____ CVV_____

HIPAA PRIVACY NOTICE of Flourish Counseling & Wellness Center, LLC Policies and Practices to Protect the Privacy of Your Health Information *(Effective Date February, 2009)*

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

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

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

"*PHI*" refers to information in your health record that could identify you.

"*Treatment, Payment and Health Care Operations*"

– *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

- *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

- *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

"*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. I retain the option of preparing separate Psychotherapy Notes or including such information in your PHI Progress Notes on a case by case basis. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Maryland Department of Child and Family Services.

Adult and Domestic Abuse: If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

Health Oversight: If a complaint is filed against me with the Maryland Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The

privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

Worker's Compensation: If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice and to make the new notice provisions effective for all PHI that I maintain.. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will provide with a copy of the policies and procedures at your next treatment contact or by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Andrea Lopes or Kimberly Wells at 3011-570-7500.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, S.W., Atlanta, GA 30303-8909.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on 1 January, 2014.

Flourish Counseling and Wellness, Center

3430 North High Street
Olney, MD 20832
Phone: 301-570-7500

Acknowledgement:

Patient or Guardian Signature Date

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Care Provider to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and medication if necessary.

I, the undersigned, understand that I may revoke this consent at any time. I have read and understand the information and give my authorization:

Patient Authorization

I agree to release any applicable mental health/substance abuse information to my PCP.

My Primary Care Physician is _____
Address _____
Phone Number_____

____I agree to release medication information only.

____I WAIVE NOTIFICATION of my PCP that I am seeking/receiving mental health services and direct you NOT to notify him/her.

____I do not have a PCP and do not wish to consult with one. I therefore waive notification of a PCP that I am seeking/receiving mental health services.

_____
Patient Signature Date

Patient Rights:

- You can end this Authorization to Disclose PHI to PCP at any time by contacting our office.
- If you make a request to end this Authorization, it will not include information already disclosed based on your previous permission.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed Authorization. Please keep a copy for your records.
- You do not have to agree to this request to use of disclose information.

Information to be completed by Behavioral Health Provider

I saw_____(Patient Name) on_____(Date)
for_____(Reason/Diagnosis)

Summary:

_____
_____
_____
_____

(Clinician/Credentials)_____Date_____

Authorization for Electronic Communication

As a convenience to me, I hereby request that Flourish Counseling and Wellness Center communicate with me regarding my treatment with her via electronic communications (e-mail or text message). I understand that this means Flourish Counseling will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, <<Organization>> shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Flourish Counseling to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Flourish Counseling and Wellness Center to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Flourish Counseling and Wellness Center, I may revoke this authorization by providing written notice to Flourish Counseling and Wellness Center at 3430 N High St Olney, MD 20832 or fax at 301-570-7515.

I agree that Flourish Counseling may communicate with me electronically unless and until I revoke this authorization by submitting notice to Flourish Counseling in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically as described above.

_____

Patient Name

_____ _____

Signature of Patient/Guardian Date