WORCESTER YOUTH & FAMILY COUNSELING SERVICES, INC.

Client Information – Medicaid Insurance
(Please Print)

Patient's full name:_____SS# _____

Home Address:_____City:_____State:_____Zip:_____

Home/Cell Phone:_____Sex:_____Age:_____DOB:____/____/_____

Patient Employer:_____Work #:_____

Family Physician:_____Referred By:_____

Person to Contact in Emergency:_____Phone:_____

For Grant Purposes: ____ African American ___ Caucasian _____Hispanic ____ Asian _____ Other _____Income

Insured/Responsible Party Information
Please complete this section regardless of insurance coverage.

Name of Insured/
Responsible Party:_____ Relationship:_____

Home Address:_____ Home/Cell Phone:_____

Employer & Address:_____ Phone:_____

Insured's DOB: _____ Insured's SS#: _____

Insured's Primary Ins. Co:_____ID#:_____Group#:_____

Secondary Ins.Co?___No___Yes Company:_____Policy #:_____

Job Related Injury-Workmen's Comp. Co:___No___Yes; Company:_____

Please Continue to Next Page

Date:_____
Therapist: _____
DSS (check one) Yes _____ No _____

WORCESTER YOUTH AND FAMILY COUNSELING SERVICES, INC.

OUTPATIENT THERAPY SERVICES AGREEMENT

Welcome to Worcester Youth and Family Counseling. This document contains important information about our professional services and business policies. Please read it carefully and write down any questions you might have so that you can discuss them with your therapist during your meeting today. When you sign this document, it will represent an agreement between you and Worcester Youth and Family Counseling Services, Inc.

COUNSELING SERVICES

Therapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you bring forward. There are many different methods that may be used to deal with the problems that you hope to address. Counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things you and your counselor talk about both during sessions and at home.

Counseling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, your counselor will be able to offer you some first impressions of what your work will include and a treatment plan. You should evaluate this information along with your own opinions of whether you feel comfortable. Counseling involves a large commitment, so you should be very careful about the therapist you select. If you have questions about procedures or treatment, you should discuss them with your therapist whenever they arise. If your doubts persist, your counselor will be happy to help you set up a meeting with another mental health professional for a second opinion.

If you are going through a legal dispute regarding custody or visitation of your minor child, please be advised of the following: A therapist may NOT make recommendations regarding custody or visitation unless properly trained and certified in such practices (see COMAR 10.36.09.00—10.36.09.05). None of the therapists here at Worcester Youth and Family Counseling Services, Inc. are trained or certified in forensic practices and CANNOT make such recommendations. Furthermore, a treating therapist CANNOT have a dual relationship as a therapist (providing treatment) and evaluator (evaluating and making court recommendations). If you need such services, your therapist would be happy to assist you with a referral.

MEETINGS

The evaluation process typically lasts from 2 to 4 sessions. During this time, you can decide if your counselor is the best person to provide the services you need in order to meet your treatment goals. If counseling begins, you will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time you and your therapist agree on. As you are feeling better and making progress, you will not have to meet as frequently. Once you and your counselor agree that you have fully met your goals, then therapy will terminate. Please provide at least 24 hours advance notice of cancellation. If you consistently cancel appointments (2 or more cancellations without 24 hr notice), you will not be guaranteed your time slot and your therapist will discuss this with you. If you are a no-show for your appointment 2 times, then you will not be allowed to schedule another appointment.

Please be aware that your sessions are confidential and may not be audio or video taped by any media device. The consumer has the right to decline treatment, if part or all of the treatment is to be recorded for research or review by another person

PROFESSIONAL FEES/ BILLING POLICY

Our hourly fee is $200.00 for the initial visit and $150.00 for follow up visits. You will be expected to pay for each session at the time it is held, unless you have insurance coverage which requires another arrangement. In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan. If there is a situation where your therapist needs to appear in court on your behalf, the fees are $150.00 per hour. You will be charged this fee for preparation time, driving time, and time spent in court. Insurance will not cover this type of service and payment in full is expected prior to the court date.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. All services rendered by Medicaid will not be the consumers responsibility.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Your clinician will fill out forms and provide you with whatever assistance necessary to help you receive your benefits. However, you (not your insurance company) are responsible for full payment fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. You should be aware that most insurance companies require a clinical diagnosis and treatment plan in order to cover services. Insurance companies claim to keep such information confidential and private.

CONTACTING YOUR THERAPIST

Therapists are often not immediately available by telephone. While your therapist is usually in the office during business hours, he/she will probably not answer the phone when with a client. Counselors do not conduct therapy on the phone, however they can answer questions, give general information, or give feedback if you are in crisis. If you need assistance, you may speak to the communications coordinator or leave a message on your counselor's voice mail. If you are in distress after hours, calls are directed to the Life Crisis Center which can be accessed by pressing "0" or remaining on the line on our voice mail system. At any time, however, if you are experiencing a life threatening emergency, please call 911 or go to your nearest emergency room.

PROFESSIONAL RECORDS

The laws and standards of this profession require that your counselor keep treatment records. You are entitled to have access to your records unless your therapist believes that seeing them would be emotionally damaging. In this case, your therapist would be happy to review them with you together in session or provide a summary.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. Your counselor will discuss the limits of privacy with you and your parents. In most cases, parents are provided with general information about your treatment. However, if your therapist believes there is a high risk that you will seriously harm yourself or someone else, he/she will immediately notify your parents of this concern.

CONFIDENTIALITY

The relationship between Worcester Youth & Family Counseling Services, Inc. (WYFCS) and its clients is confidential. We will not release information without written permission except under the following conditions:

1. The client threatens harm to self or others.
2. The client is a minor (under 18) and there is suspected child abuse and/or neglect.
3. In cases where a WYFCS staff member (typically your therapist) is subpoenaed to appear in court and privilege is waived.

4. When an adult client states that she/he was sexually abused as a child and this abuse has not previously been reported.
5. The client has been referred by the Department of Juvenile Services as a condition of probation.
6. The client seeks treatment to avoid detection or apprehension or enable anyone to commit a crime.
7. Contact with a therapist is for the purpose of determining sanity in a criminal proceeding.
8. Contact is for the purpose of establishing competence to stand trial in court.
9. Contact is one in which your therapist must file a report to a public employer or information required to be recorded in a public office, if such report or record is open to public inspection.
10. The client is under the age of 16 years and the victim of a crime.
11. The client is over the age of 65 and the therapist believes he/she is the victim of abuse.
12. A client is deceased and the communication is important to decide an issue concerning a deed or conveyance, will, or other writing executed by the client affecting interest in property.
13. The client files suit against his/her therapist for breach of duty or a therapist files suit against a client.
14. The client has filed suit against anyone and has claimed mental/emotional damages as part of the suit.
15. A client waives rights to privilege or gives consent to limited disclosure by his/her therapist.
16. Insurance companies paying for services have the right to review all records.

WORCESTER YOUTH & FAMILY COUNSELING SERVICES, INC.

CONSENT FOR TREATMENT

I, _____, acknowledge that I have read and understand all of the information described in the Outpatient Therapy Services Agreement, including confidentiality.

I authorize Worcester Youth and Family Counseling Services, Inc. to provide adequate care for my mental health needs. I understand that participation in therapy is voluntary and I freely consent without undue influence. I understand that I may withdraw this consent in writing and terminate treatment at any time. I acknowledge that I have the capacity to consent to treatment for myself or my minor child.

Client Name (please print): _____

Client Signature: _____ Date_____

If applicable:

Parent/Guardian Name (please print):_____

Parent/Guardian Signature:_____

Relationship to Client: _____ Date _____

WORCESTER YOUTH & FAMILY COUNSELING SERVICES, INC.

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I authorize direct payment to my service provider.
4. I have fully disclosed all of my insurance information; including any secondary or tertiary insurance policies. I understand that I am responsible for any charges that accrue if all of my insurance information is not disclosed.
5. I understand that I am responsible for notifying Worcester Youth and Family Counseling Services for any and all insurance changes. Including but not limited to; policy changes, receiving of new cards, additional policies, etc.
6. I hereby permit a copy of this to be used in place of an original.

Client Name (Please Print):_____

Client Signature:_____ Date_____

If applicable:

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____

Relationship to client: _____ Date: _____

WORCESTER YOUTH & FAMILY COUNSELING SERVICES, INC.

NOTICE OF PRIVACY PRACTICES

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.

Understanding your health record:
A record is made each time your visit a hospital, physician or other health care provider. Your symptoms, examination and test results, diagnoses, treatment and a plan for future care are recorded. This information is most often referred to as your "health or medical record," and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy and enable you to relate to who, when, where, and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure, such as releasing or providing access to medical information about you to other parties. Use or disclosure of your health information will follow the more stringent of State or Federal laws.

Uses and Disclosures for Treatment, Payment, and Health Care Operations:

Your protected health information, or PHI, refers to the information in your health record that could identify you. It may be used for *treatment, payment, and health care operation* purposes with your written authorization.

Treatment –When your therapist provides, coordinates, or manages your health care and other services related to your health care. The sharing of your health information may progress to others involved in your care. For example, your therapist may consultant with another health care provider, such as your family physician or another therapist.

Payment – Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to either you or a third party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

Health Care Operations – The clinical staff in this office will use your health information to assess the care you received. Your information may be reviewed by the Clinical Director in our efforts to continually improve the quality and effectiveness of the care and services we provide.

Other Uses and Disclosures Requiring Authorization:
Your PHI may be used or disclosed for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances, when your therapist is asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. An authorization will also be needed before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes compiled about conversations during a private, joint, or family counseling session, which are separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

Understanding our office policy for specific authorized disclosures
We cannot release any of this information unless authorized:

- **Business Associates** – Some or all of your health care information may be subject to disclosure through contracts for services to assist this office in providing health care. For example, it may be necessary to obtain specialized assistance to process certain laboratory tests or radiology images. To protect your health information, we require these business associates to follow the same standards held by this office through terms detailed in a written agreement.

- **Notification** – Your health record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well being or your whereabouts.
- **Communications with family –** Using best judgment, a family member, or close person friend, identified by you, may be given information relevant to your care and/or recovery.
- **Marketing** – This office reserves the right to contact you with appointment reminders or information about treatment alternatives and other health related benefits that may be appropriate to you.

Uses and Disclosures without Authorization

Your PHI may be used or disclosed without your consent or authorization in the following circumstances:

- **Child Abuse** – If there is reason to believe that a child has been subject to abuse or neglect, the belief must be reported to the appropriate authorities.
- **Adult and Domestic Abuse** – PHI may be disclosed if there is belief that you are a victim of abuse, neglect, self-neglector exploitation.
- **Health Oversight Activities** – If a subpoena is issued from the Maryland Board of Examiners of Psychologist because they are investigating the practice, any PHI requested by the Board must be disclosed.
- **Judicial and Administrative Proceedings** – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and information will not be released without authorization or a court order. The privilege does not apply when you are being evaluated or a third part, or where the evaluation is court ordered.
- **Serious Threat to Health or Safety** – If you communicate a specific threat of imminent harm against another individual or there is belief that there is clear, imminent risk of physical or mental injury being inflicted against another individual, disclosures may be made to protect that individual from harm. If there is belief that you present an imminent, serious risk of physical or mental injury or death to yourself, disclosures may be made to protect you from harm.
- **Worker's Compensation** – This office will release information to the extent authorized by law in matters of worker's compensation.
- **Public Health** – This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth or morbidity. This office is further required by law to report communicable disease, injury, or disability.
- **Correctional Facilities** – This office will release medical information on incarcerated individuals to correctional agents or institutions for the necessary welfare of the individual or for the health and safety of other individuals. The rights outlined in this Notice of Privacy Practices will not be extended to incarcerated individuals.
- **Law Enforcement** – (1) Your health information will be disclosed for law enforcement purposes as required under state law or in response to a valid subpoena. (2) Provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of this office believes in good faith that there has been unlawful conduct or violations or professional or clinical standards that may endanger one or more patients, workers, or the general public.

Understanding your health information rights:

Your health record is the physical property of the health care practitioner or facility that compiled it, but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request that amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your PHI, and to receive an accounting of the disclosures we have made of your PHI for most purposes other than treatment, payment or health care operations. Other disclosures excluded are direct disclosures to yourself, family or friends involved in your case. Other than activity that has already occurred you may revoke any further authorization to use or disclose your health

information. You may also request communications of your health information to be made by alternative means or to alternative locations.

Our responsibilities:
This office is required to maintain the privacy of your health care information and to provide you with notice of legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations.

This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient information. In the event that changes are made, this office will notify you at the current address provided on your medical file.
Other than for reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

To receive additional information or report a problem:
For further explanation of this notice you may contact our office at 410-641-4598. If you believe your privacy rights have been violated, you have the right to file a complaint with this office by contacting the individual listed above, or by contacting the Secretary of Health and Human Services, with no fear of retaliation by this office.

Notice of Privacy Practices Availability:

The terms described in this notice will be posted where registration occurs. All individuals receiving care will be given a hard copy.

_____ _____
Client Signature Date

If applicable:

_____
Parent/Guardian Signature (if minor child)

_____
Relationship to Client

WORCESTER YOUTH & FAMILY COUNSELING SERVICES, INC.

PATIENT GRIEVANCE PROCEDURE

It is the intent of Worcester Youth & Family Counseling Services, Inc. to provide each client with the most professional services possible. However, there may be times when those we serve have questions or concerns regarding the services they receive. In such instances the grievance procedure will be to:

1. Discuss your issues with the professional assigned to assist you.
2. If after discussing the situation you are dissatisfied, arrange an interview with the Executive Director of Worcester Youth & Family Counseling Services, Inc. to discuss your concerns. The Executive Director may be reached at 410-641-4598, or in writing WYFCS
   P.O. Box 925
   Berlin, MD 21811

I have read and understand the grievance procedures discussed above.

_____
Client Name (please print)

_____ _____
Client Signature Date

If applicable:

_____ _____
Parent/Guardian Signature (if minor child) Date

_____
Relationship to Client

WORCESTER YOUTH & FAMILY COUNSELING SERVICES, INC.

OFFICE CLOSINGS POLICY

DURING INCLEMENT WEATHER OR OTHER EMERGENCIES

Worcester Youth & Family Counseling Services, Inc. wants all clients and their families to be safe during inclement/extreme weather and other unforeseen emergencies. Therefore, in the event of extreme weather, civil disorder, or other unforeseen community emergencies, Worcester Youth & Family Counseling Services, Inc. will make a determination about changing operational hours and a message will be placed on our **voicemail** system that morning before business hours begin. Please call our office at **410-641-4598** to ensure that the agency is open. Even if **Worcester County Schools are closed, we may be open.** Again, please call our office to ensure that the agency is open.

I have read and understand the Office Closings Policy discussed above.

_____
Client Name (please print)

_____ _____
Client Signature Date

If applicable:

_____ _____
Parent/Guardian Signature (if minor child) Date

_____
Relationship to Client

WORCESTER YOUTH & FAMILY COUNSELING SERVICES, INC.

ADVANCED DIRECTIVE FOR MENTAL HEALTH

Maryland law gives the right to anyone 16 years of age and over to be involved in decisions about their mental health treatment. The law states that individuals have the right to make decisions in advance, including mental health treatment decisions, through a process called advanced directive. The advanced directive is designed to assist with pre planning should an individual become unable to make informed decisions.

Are you 16 years old or older?

_____ yes _____ no

Do you have an advanced directive?

_____ yes _____ no

Would you like to receive an information package regarding advanced directives?

_____ yes _____ no

_____ _____

Client signature Date

_____ _____

Parent/Guardian signature Date

Disclaimer:
Advanced Directives are important legal documents. Individuals are advised to seek legal advice should clarification of laws be needed. Please note, Worcester Youth and Family Counseling Services can provide you with an information based packet only: however we can **not** provide legal advice.

Worcester Youth and Family Counseling Services, Inc
Cancellation/No Show Policy

Thank you for trusting your care to Worcester Youth and Family Counseling Services, Inc. (WYFCS). When you schedule an appointment with WYFCS, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and at least within the guidelines set below. Advance notification of cancellation gives us time to schedule other patients who need care and are waiting for an appointment opening. Please see our Appointment Cancellation/No Show Policy below:

1. Please call us at (410) 641-4598 no later than 3:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 12:01 p.m. on Friday.
2. Reminder calls go out 2 days prior to your appointment if you or your clinician have requested that we contact you prior to the appointment. This is the perfect time to check your schedule to ensure your appointment availability and contact us if there is a conflict.
3. Ultimately, it is your responsibility to arrive for your appointments with or without a reminder call.
4. If you arrive 15 minutes after the scheduled start time for your appointment, we may need to reschedule your appointment.
5. After the 2nd appointment that is noncompliant with this policy, or if you fail to show for your appointment, we will no longer schedule you with our agency.
6. We understand that emergencies do arise, and they will be reviewed on a case-by-case basis.

Thank you for your consideration. Please sign below indicating that you have read and understand our Cancellation/No Show Policy.

Client Name (Print)

Client or Responsible Party Signature Date

Updated 7/26/18