

**WORCESTER YOUTH & FAMILY COUNSELING SERVICES, INC.**

**Client Information – Sliding Scale**

**Client Name:** \_\_\_\_\_

**If Minor, Parent/Guardian:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Client's Social Security #:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**For Grant Purposes:** \_\_\_\_\_ **African American** \_\_\_\_\_ **Caucasian** \_\_\_\_\_ **Hispanic**  
\_\_\_\_\_ **Asian** \_\_\_\_\_ **Other**  
\_\_\_\_\_ **Income**

**Marital Status:** \_\_\_\_\_ **Gender: Male** \_\_\_\_\_ **Female** \_\_\_\_\_

**Home Telephone #:** \_\_\_\_\_ **Other #:** \_\_\_\_\_

**Referred by:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Telephone #:** \_\_\_\_\_ **May we call you at work?:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Person to Contact in Emergency:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Payment Information**

Please read and sign below

I have discussed the rate per session with my counselor or other staff member and I agree to pay the per session rate specified. Fees are payable at the time of service.

To better serve our clients, 24 hours notice of the cancellation of an appointment is required. Without notice a \$25.00 charge will incur immediately and possibly forfeiture of any specific appointment time slot.

\_\_\_\_\_  
**Client or Guardian Signature**

\_\_\_\_\_  
**Date**

**Per-Session Rate:** \$ \_\_\_\_\_ **Authorized Signature:** \_\_\_\_\_

**Therapist:** \_\_\_\_\_

**WORCESTER YOUTH & 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 try to provide at least 24 hours advance notice of cancellation. If you consistently cancel appointments (3 or more cancellations in a row), you will not be guaranteed your time slot and therapist will discuss this with you. If you no-show your counselor 3 times in a row, 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.

## **PROFESSIONAL FEES/ BILLING POLICY**

Our hourly fee is \$150.00 for the initial visit and \$100.00 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 \$100.00 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.

## **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.  
Financial Agreement**

Patient/Client Name: \_\_\_\_\_

Self-Pay/No insurance:

Payment is due in full at the time services are rendered, unless special arrangements have been approved by our business office.

IF YOU HAVE MEDICAL INSURANCE:

We will file claims to your medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information that is provided to our office on the patient information form is accurate and current. If there is a change in insurance information please let us know immediately. You will be financially responsible for any charges incurred due to not informing us of a change in insurance. We will submit to secondary insurance as long as we are given the correct information and we are notified that you would like this service done.

Deductibles, Co-Payments, and Coinsurance:

Co-payments are constant and due at the time the service is rendered. Coinsurance and deductibles vary for each insurance policy and we can only approximate the percentages covered by each plan. Payment of the estimated portion is due at the time of service. The remainder will be billed after we receive notification from your insurance and will be due upon receipt of your statement.

Authorizations:

A copy of your insurance card is required at the time of the initial service. The card is descriptive and indicates whether an authorization is needed. Oftentimes, the behavioral health benefits are under a separate company and we must contact them to verify the necessity of an authorization. **If a copy of the card is not on the file at the initial service and the claim is denied for “no authorization,” you will be responsible for the payment.**

Primary Care Physician Referral(s):

In the event that your insurance company requires a referral from your primary care physician, you agree that you are responsible for providing this office with the original referral within five (5) days of your first office visit. If the referral condition is not met, you agree to pay in full for all services provided to you upon receipt of your statement.

Provider Coverage:

We are able to provide you with our list of providers who participate with your insurance company. However, we are not responsible for ensuring that our provider is covered under your particular plan provision. Each insurance company has multiple plans. The provider may participate with the insurance company, but not your particular plan. Please contact your insurance company to verify that the provider you are seeing is appropriately covered. **It is ultimately your responsibility to verify coverage for your particular plan. If the insurance company denies the claim for a plan provision, you will be responsible for the balance.**

**Medical insurance coverage is a contract between you and your insurance company.**

WE ARE NOT a party to this contract. We will not be involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “usual and customary” charges, etc., other than to supply factual information as necessary. **You are ultimately responsible for the timely payment of your account.**

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portions of all charges for professional services are immediately due and payable to this office. All services rendered by this office are charged directly to you, and you ultimately, will be personally responsible for payment, regardless of your insurance coverage.

PAYMENT METHODS AND OTHER INFORMATION:

- We accept check, Visa, MasterCard, Discover, and most health savings cards.
- Accounts can be set up on payment plans if necessary at no additional cost.
- Accounts that are past due will be turned over to our collection agency and reported to the Credit Bureau.
- In the event that your account goes to collections, there will be a 20% collection fee added to your account balance. The agency may recover all reasonable costs incurred in collecting any delinquent balances, including reasonable attorney’s fees.
- Accounts that have statements returned with no forwarding address will be charged \$10 and turned over to a collection agency.
- **All late cancellations and no-shows will be billed \$25 automatically.** (We require 24-hour notice in advance to avoid charges.)

**A SPEICAL NOTE: In situations of divorce, separation, court orders, etc., the party initiating treatment will be financially responsible for the account (including no-shows and late cancels).**

We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

I acknowledge that I have read and agree to the Financial Policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**WORCESTER YOUTH & FAMILY COUNSELING SERVICES, INC.**

**CONSENT FOR TREATMENT**

I, \_\_\_\_\_ acknowledge that I have read and understand all of the information described in the corresponding packet. I have thoroughly read the confidentiality statement and understand that there are specific exceptions in which confidentiality will be broken.

These exceptions are:

1. A risk of imminent danger to myself or to another person.
2. Suspicion that a child or elder is being physically abused, sexually abused or neglected.
3. When there is a valid court order issued for medical records.

I authorize Worcester Youth and Family Counseling Services, Inc. to provide adequate care for my mental health needs. I understand that I may withdraw this consent in writing and terminate treatment at any time.

Client Name (please print): \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date \_\_\_\_\_

If applicable:

Parent/Guardian Name (please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

## 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 you 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 consult 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 of 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.

**Patient Comments:**

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\_\_\_\_\_  
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.**

**Cancellation / Missed Appointment Policy**

Dear Valued Client:

Due to decreases in funding, increases in client cancellation and demand for our services, Worcester Youth & Family Counseling Services, Inc. has instituted the following mandatory policy.

In the event of a missed or cancelled appointment all clients will incur the following charge which will be payable immediately:

- Missed scheduled appointments - \$25.00
- Cancellation of scheduled appointments - \$25.00

Worcester Youth & Family Counseling Services, Inc. understands that at times circumstances occur making it difficult to keep scheduled appointments therefore, we will waive the fee above if 24 hours notice is given. Your cooperation is appreciated.

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I have read and understand Worcester Youth & Family Counseling Services, Inc.'s Cancellation Policy. I also understand that I will automatically be charged in accordance with this policy in the event I miss or cancel a scheduled appointment.

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Client Signature (parent/guardian if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## 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.