CARROLL COUNSELING CENTERS
New Patient Instructions and Information

PLEASE READ CAREFULLY AND SIGN WHERE INDICATED

1. Provide your insurance card and photo ID to be copied at (also, secondary if applicable)
2. If you have or share custody of a minor, please provide written proof
3. Contact your insurance company to determine what you are expected to pay at each visit.
4. Make payment for services at the time of each visit (copay/coinsurance and/or deductible if covered by a participating plan). Visa/MasterCard/Discover, check or cash
5. Your insurance company determines the portion of your care that is your responsibility. Therefore after our office submits your claim and receives payment, you may have a balance due which we will collect at your next visit, if you have a credit it will be applied to your next visit.
6. If you cancel an appointment less than 24 hours in advance or miss your appointment, there is a missed appointment charge equal to your insurance allowable or full fee, whichever is less.
7. If you have a change in insurance coverage, please let us know prior to the effective date or you may be responsible for payment in full for visits not covered
8. Please be aware that there are some services not covered by insurance and you will be responsible for payment in full, such as marriage counseling, letters, meetings, consults with schools, educational testing, legal depositions, court appearances, medical records, telephone consults and review of outside reports
9. In the event an insurance company denies payment to Carroll Counseling Center you will be responsible for payment in full.
10. All medication requests should be made at least one week prior to your need. If the request is through your pharmacy, please ask that your request be faxed to 410-549-5182. Some medications require a visit prior to the refill.
11. All returned checks are subject to a $30 charge for each incident and future payments will be asked to be made by credit card or cash.
12. Accounts over 60 days past due are subject to collection activities.

Patient's Name:_____ Date of Birth:_____
Last First Middle Initial

Address:_____
Street City State Zip

Phones: _____
Home Cell Work

Responsible Party:_____ Relationship:_____
Last First Middle Initial

SS#_____ Email_____

Patient's Primary Care Physician:_____ Phone:_____

How did you learn about our services?_____

I have read the above policies of Carroll Counseling Center and I authorize the release of any medical information necessary to process claims for services rendered and request that payment of benefits be made to Carroll Counseling Centers, LLC.

_____ _____
Patient (or financially responsible party if patient is a minor) Date

INFORMED CONSENT FOR
PSYCHOTHERAPY AND/OR MEDICATION MANAGEMENT

Please review this material carefully so that you and your provider of care may discuss any questions or concerns of yours the next time you meet. Some important issues regarding confidentiality need to be understood as you begin your work together.

In general, the confidentiality of all communications between a patient and psychologist or psychiatrist is protected by law, and your doctor can only release information about your work together to others with your written permission. There are a few exceptions, however.

In most judicial proceedings you have the right to prevent your doctor from testifying. However, in child custody proceedings, adoption proceedings, and proceedings in which your emotional condition is an important element, a judge may require your doctor's testimony if it is determined that resolution of the issues before the court requires it. If you are involved in litigation, or are anticipating litigation, and you choose to include your mental or emotional state as part of the litigation, your doctor may have to reveal part or all of your treatment or evaluation records.

If you are called as a witness in criminal proceedings, opposing counsel may have some limited access to your treatment records. Testimony may also be ordered in (a) legal proceeding relating to psychiatric hospitalization; (b) in malpractice and disciplinary proceedings brought against a psychologist; (c) court-ordered psychological evaluations; and (d) certain legal cases where the client has died.

In addition, there are some circumstances when your doctor is required to breach confidentiality without a patient's permission. This occurs if the doctor suspects the neglect or abuse of a minor, in which case the doctor must file a report with the appropriate state agency. If, in your doctor's professional judgment, he/she believes that a patient is threatening serious harm to another, he/she is required to take protective action which may include notifying the police, warning the intended victim, or seeking the client's hospitalization. If a client threatens to harm him/herself, your doctor may be required to seek hospitalization for you.

The clear intent of these requirements is that your doctor has both a legal and ethical responsibility to take action to protect endangered individuals from harm when his/her professional judgment indicates that such a danger exists. Fortunately, these situations rarely arise in our practice.

There are several other matters concerning confidentiality:

1. Our doctors may occasionally find it helpful or necessary to consult about a case with another professional. In these consultations your doctor makes every effort to avoid revealing the identity of the client. The consultant is, of course, also legally bound to maintain confidentiality. If he/she feels that it would be helpful to refer you to another professional for consultation then, of course, with your authorization, he/she will discuss your case with her or him.

2. Our doctors are required to maintain complete treatment records. Patients are entitled to receive a copy of these records, unless the doctor believes the information would be emotionally damaging and, in such cases, the records must be made available to the patient's appropriate designee. Patients will be charged an appropriate fee for preparation.

3. If you use third party reimbursement, our office is required to provide the insurer with a clinical diagnosis and sometimes a treatment plan or summary. If you request it, our office will provide you with a copy of any report which the doctor submits.

4. If you are under eighteen years of age, please be aware that while the specific content of your communication is confidential, your parents have a right to receive general information on the progress of the treatment.

5. Under current Maryland law, in group and family therapy and in marital therapy all participants are required to consent to the release of information. One marital partner may not waive privilege for another. In cases of marital therapy, therefore, the record may be released only if both parties waive privilege or release of the record is court ordered.

While this summary of exceptions to confidentiality should prove helpful in informing you about potential problems, you should be aware that the laws governing these issues are often complex. We encourage your active discussion of these issues. However, if you need more specific advice, formal legal consultation may be desirable. If you request, our office will provide you with relevant portions or summaries of the applicable State laws governing these issues.

I have read the above and fully understand the diagnosis, the nature of treatment, the alternatives to this treatment, the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached. . I understand I may withdraw from treatment at any time but if I decide to do this I will discuss my plan with my provider before acting on it.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Witness Date

carroll COUNSELING center

Consent to use and disclose your health information

This form is an agreement between you, _____ and Carroll Counseling Center and your doctor (we). When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____ .

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions. By signing this form you are agreeing to let us use your information here and send to others for those purposes. The **Notice of Privacy Practices** explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from by calling us at 410-549-5181, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client

Description of personal representative's authority

Effective 4/14/03
Documents
HIPAA Consent
11/17/09