"Making Individuals' Lives Better"

Patient Information

Patient Information

Patient Name:_____ **DOB:**_____ **Sex:**_____

Driver's License:_____ SSN:_____

Home Phone:_____ **Cell:**_____

Address:_____

Employer:_____ Position:_____

Employer Address:_____ Phone No._____

Emergency Contact Information:

Dependent?_____ If yes, Guardian's Name:_____

Guardian's Phone:_____ Cell:_____

Marital Status:_____ Spouse's Name:_____

Spouse's Employer:_____ Work Phone No._____

Emergency Contact:_____ Relationship:_____

Home Phone:_____ Cell:_____

Emergency Contact:_____ Relationship:_____

Home Phone:_____ Cell:_____

Insurance

Insured Party:_____ Relationship to Patient:_____

Insurance Company:_____ Phone No._____

Address:_____

Policy No._____ **Group No.**_____

Dual Coverage?_____ 2nd Insurance Company:_____

Insured Party:_____ Relationship to Patient:_____

Phone No._____ Address:_____

Policy No._____ Group No._____

Payment Method:_____ Card/Check No._____

I Verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-rays,photographs,anesthetics,medicines,surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize Kirstin Care, LLC to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

Telehealth Services Informed Consent

Definition of Telehealth

Telehealth involves the use of electronic communications to enable professionals to connect with individuals using 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 understand that I have the rights with respect to telehealth:

1. I understand privacy and the confidentiality laws apply to telehealth, and that no information obtained using telehealth services will be disclosed to researchers or other entities without my written consent.
2. My health care provider has explained how the videoconferencing technology will be used to conduct a telehealth session, that unlike a direct patient/provider in person, I will not be in the same room as my health care provider.
3. I understand the potential risks to technology including interruptions, unauthorized access, and technical difficulties. I understand my health care provider, or I can discontinue the videoconference consult/visit if it is believed videoconferencing technologies are not adequate for the situation.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment.
5. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be in other areas, including out of state.
6. I understand that no results for anticipated benefits can be guaranteed or assured by my provider.
7. I understand my healthcare information may be shared with other individuals for purposes of scheduling and billing. Individuals other than my healthcare provider may be present during the session to operate video conferencing equipment. I further understand that I will be informed of their presence, and that such individuals will maintain confidentiality on information obtained during the session. Furthermore, I have the right to request the following:
    a. Ask non-medical personal to leave the telehealth examination room; and/or
    b. Terminate the consultation at any time.
8. I agree certain situations – such as 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 911 or seek help from a hospital or crisis-oriented healthcare facility in my immediate area.

Consent to the Use of Telehealth:

By signing this form, I certify:

- That I have read or had this form read and/ or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client Name (Print)	Client Signature	Date

Informed Consent For Mental Health Treatment

Welcome to Kirstin Care OMHC. We hope that your experience with us will be positive and that our assistance will be beneficial to your mental health. Your counselor/Psychiatric Nurse Practitioner/Psychiatrist is _____ and has the following credentials:

_____

The purpose of KIRSTIN CARE mental health treatment is for our counselors to help you achieve your goals and overcome any obstacles that led you to seek services with KIRSTIN CARE . This treatment will include various mental health treatments and/or Medication Management. You are encouraged to work with your provider in the development of your treatment plan and you should be informed of the process of any new modes used within your treatment process. The associated risks of mental health treatment are limited; you may experience some emotional difficulty, which your counselor/Nurse Practitioner will do their best to help you work through. The benefits to be gained from your visits are vast; some potential benefits of counseling/medication management are an improved outlook on life, more effective coping skills, greater understanding of self, and better communication tools that will not only have positive effects on your relationships, but through many spheres of your life.

As a client of KIRSTIN CARE , you are not required to accept treatment from KIRSTIN CARE at any time, and you have the right to decline part or all of your treatment, including withdrawal from our services should you not be willing to participate.

____Medication Management
____Child/Adolescent Therapy
____Family Therapy
____Individual Therapy
____IOP (Intensive Outpatient)
____Group Therapy

_____ _____
Client Name (Print) Client Signature Date

Informed Consent for One Medical Record

I understand and consent to Kirstin Care OMHC (KIRSTIN CARE) having one medical record for me. I understand that every counselor/Nurse Practitioner that provides treatment for me at KIRSTIN CARE will have access to all clinical notes in my clinical record.

_____ _____

Client Name (Print) Client Signature Date

Consent for Treatment of a Minor

I, _____, give Kirstin Care OMHC and

_____
Parent/Guardian Counselor/Nurse Practitioner/Psychiatrist

permission to provide treatment for _____.

Confidentiality Statement

I, _____, and _____ understand limits to confidentiality and have
Parent/Guardian Child

been provided with a copy of this statement.

For the Parent/Guardian: The right to confidentiality is maintained with two exceptions:

1. The professional has reason to believe that you will harm yourself.
2. The professional has reason to believe that you will harm others, including your child.

For the Child: The right to confidentiality is maintained with three exceptions:

1. The professional has reason to believe that you will harm yourself.
2. The professional has reason to believe that you will harm others.
3. The professional has reason to believe that someone or something is harming you, including your parents.

Additional Disclosures at the Parent's Request:

_____
_____
_____
_____
_____
_____

_____

_____

_____

_____

_____ _____

_____

Counselor/Nurse Practitioner/Psychiatrist Parent/Guardian Date

Policies and Procedures

Welcome to Kirstin Care OMHC. Please read all documents thoroughly and complete them where necessary, so that you are prepared to discuss any questions with your counselor during your first session.

_____ **1. CONFIDENTIALITY**

(Initial)

All information obtained/derived by the course of treatment is fully confidential. Exceptions to this guideline include instances when (a) the patient is a clear danger to themselves or others; (b) the patient is a minor (under the age of 18) and reports that he or she is or has been a victim of physical or sexual abuse; and (c) there is any suspected abuse to a child or elder abuse.

If you desire Kirstin Care OMHC to release or obtain information from a specific individual or agency, ask your counselor for an "Authorization to Release Information" form.

I understand that cases are occasionally discussed between Kirstin Care OMHC counselors and supervisors to provide the best clinical treatment possible.

_____ **2. TELEPHONE CALLS**

(Initial)

Occasions may arise when you need to talk to your counselor in between normally scheduled sessions.

If you leave a message with your counselor, they will make every effort to respond in a timely manner. Any consultation by telephone made between scheduled sessions will incur a charge to the patient. If there is a life-threatening emergency, call 911 or go immediately to your local Emergency Room.

_____ **3. LENGTH OF SESSION**

(Initial)

Depending on what your insurance allows and authorizes, the psychotherapy session is 38 minutes in length or 53 minutes in length, beginning at your appointed time and

concluding about 38 minutes or 53 minutes after. Therefore, it is to your benefit to arrive a few minutes in advance of the appointment time. Since your counselor has sessions scheduled after yours, the sessions must end 38/53 minutes after the appointment time regardless of your arrival time. If client's lateness precludes the scheduled session length, a late fee may be assessed in addition to the copay.

_____ **4. FEES AND PAYMENT***

(Initial) ***Does not apply to Medicaid clients***

All payment is due at the time services are rendered. Payment may be made in the form of cash, check, or credit. If you choose to pay by check, please be prepared to supply a form of ID (e.g.
driver's license) and make the check payable to Kirstin Care OMHC. A $25.00 service charge will be levied on all checks returned by a bank for insufficient funds. If you choose to pay by credit card, please use the "Credit Card Authorization" form contained in this packet.**(cont'd on next page)**

Our current fee per session (per a max of 55 minutes) is $100-$150 depending on the Current Procedural Terminology (CPT) code. If any or all outstanding balances are not paid, Kirstin Care OMHC reserves the right to release a client's name and address to a collection agency. Also, a monthly interest fee of 2% will be charged for these balances until they are paid in full.

_____ **5. INSURANCE**

(Initial)

Kirstin Care OMHC will bill your insurance company for all sessions unless otherwise agreed upon. You are responsible for any balance that insurance does not cover and agree to pay any unpaid balance on your account in a prompt manner. ***This does not apply to active Medicaid clients.***

All balances on accounts will be collected from clients 90 days after insurance has been billed. This means that Kirstin Care OMHC is giving your insurance company 90 days to pay the claim. The law states that it must be processed within 30 days of receipt. After 90 days, you are responsible to pay Kirstin Care OMHC directly. We will give you a receipt, which you can use to try to get your insurance company to reimburse you.

If your insurance changes or is terminated, please call the Kirstin Care OMHC administrative office as soon as possible to provide the office staff with your new information. Check the benefits as your coverage has likely changed from your old policy. If the insurance changes and you fail to notify us, this will result in the claim being denied from the insurance company and you will be held responsible for the entire fee.

6. CANCELLATIONS AND MISSED APPOINTMENTS

_____ (Initial)

_____: **No-show/No Call/Missed Appt:** Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show" and recorded in your file. After the third rescheduled appt, we will be unable to put you on the schedule. ***Please keep in mind that it may be a few weeks before an appointment becomes available to see the Psychiatrist.***

1. _____: **Late Arrivals:** We provide you with a grace period of 15 minutes. If you arrive late for your appointment, it may be rescheduled on a case by case basis. Out of respect and consideration to the doctor and therapist, **please** plan accordingly and be on time.

2. _____: **Appointment Confirmation:** We do provide courtesy calls but ultimately, it is your responsibility to remember your scheduled appointments. If we are unable to reach you to confirm your appointment, we have the right to cancel it and put another client in that time slot.

3. _____: **Therapy Services:** If three consecutive "no-shows/missed appt" are documented in your file, an intent to discharge letter will be sent out. If we do not hear back from you in a stated time period, you will be discharged from the program.

7. INCLEMENT WEATHER POLICY

_____ (Initial) The Mental Health Provider is responsible for determining if the weather is too hazardous to commute to your practice location. If your provider decides to hold the session as originally scheduled, you are expected to show and will be charged a cancellation fee for missed appointments. If your provider decides to cancel your session, they will contact you to inform you of the change.

We trust that your experience with Kirstin Care OMHC will be helpful and profitable to you. If you have any questions regarding these policies or other aspects of your relationship with us, please discuss them with your counselor or his/her clinical supervisor.

My signature certifies that I have read, understand, and have been given a copy of the Policies and Procedures document.

Client's Signature _____ Date _____

Privacy Notice of Kirstin Care OMHC

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

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of your individual identifiable health information; this is, *Protected Health Information (PHI)*, as that term is defined in the HIPAA under *Information*.

THE EFFECTIVE DATE OF THIS NOTICE IS MAY 8th, 2018. KIRSTIN CARE OMHC is required to follow the terms of this Notice until it is replaced. KIRSTIN CARE OMHC may make changes to the terms of this Notice at any time. **Upon your request**, we will provide you with a copy of the current Notice. KIRSTIN CARE OMHC reserves the right to make the changes apply to your *Information* maintained in our files before, and after, the effective date of the new Notice. The following is a general description of how Federal and State law permits us to use and disclose your *Information*. ***Purposes for which KIRSTIN CARE OMHC May Use or Disclose Your Mental Health Information with your Consent to Treatment***

KIRSTIN CARE OMHC may request your consent for the use and/or disclosure of your *Information* for *treatment, payment,* or *health care operations* as described below:

- *Treatment*. KIRSTIN CARE OMHC will use and disclose your *Information* to provide, coordinate, or manage your mental health care and any related services. KIRSTIN CARE OMHC may disclose your *Information* to physicians, therapists, other mental health providers, or other health care providers who are treating you or assisting in your diagnosis, treatment, or recovery.

- *Payment*. Your *Information* will be used and disclosed, as needed, to obtain payment for your mental health care services. This may include certain activities that your health insurance plan undertakes before it approves or pays for the mental health care services that may we recommend for you; such as eligibility determination or coverage for insurance benefits, reviewing services provided to you for medical necessity, and utilization review activities. If more than one third-party payer is responsible for payment for your health care, KIRSTIN CARE OMHC may disclose your *Information* to more than one health plan and those health plans may share your *Information* with each other. Your *Information* may also be used and disclosed as needed to obtain payment for mental health care services rendered to you by other providers.

- *Mental Health Care Operations. KIRSTIN CARE OMHC may use or disclose, as needed, your Information in order to support delivery of mental health care services. KIRSTIN CARE OMHC may call you by name in the waiting room area. KIRSTIN CARE OMHC may use or disclose your Information, as necessary, to contact you to schedule an appointment or remind you of your appointment.*

- *KIRSTIN CARE OMHC* may share your *Information* with third party Business Associates who perform various administrative services; for example, those within KIRSTIN CARE OMHC, or with whom KIRSTIN CARE OMHC contracts, who perform billing services, transcription services, record retention, or other professional consultants. Whenever an arrangement between us and a Business Associate involves the use or disclosure of your *Information*, we will have a written contract that contains terms that will protect the privacy of your *Information*.

- *Health Care Services*. Your *Information* may be used and disclosed to contact you and to give you information about treatment alternatives or other health benefits and services that may be of interest to you.

Uses and Disclosures with Your Verbal Consent

Your *Information* may be disclosed to a family member, friend, or other person selected by you or as designated by the law, if you verbally agree.

Uses and Disclosures With Your Written Authorization

Except as provided below, your information will not be used for any non-routine purposes unless you give your written authorization to do so. If you give written authorization to use or disclose your *Information* for a purpose that is not described in this Notice, then, with certain exception, you may revoke it in writing at any time. Your revocation will be effective for the information *KIRSTIN CARE OMHC* maintains, unless *KIRSTIN CARE OMHC* has acted in reliance on your authorization.

Uses and Disclosures Without Your Consent

- As required by law;
- To comply with legal proceedings, such as a court or administrative order or subpoena;
- To law enforcement officials for limited law enforcement purposes;
- To a coroner, medical examiner, or funeral director about a deceased person;
- To avert a serious threat to your health or safety or the health or safety of others;
- To a governmental agency authorized to oversee the mental health care system or government programs; · To federal officials for lawful intelligence, counterintelligence, and other national security purposes; and
- To public mental health authorities for public health purposes.

Your Rights

You may make a written request to us to do one or more of the following concerning your *Information*:

- Put additional restrictions on use and disclosure of your *Information*.
- Communicate with you in confidence about your *Information* by a different means than KIRSTIN CARE OMHC is currently doing.
- See and get copies of your *Information*.
- Receive a list of disclosures of your *Information* that KIRSTIN CARE OMHC has made for certain purposes for six (6) years prior to your request, with certain exceptions permitted by law, which includes exceptions for disclosure made directly to you or made pursuant to your authorization.

If you want to exercise any of these rights or require further information about privacy practices, please contact us at the address below. In certain instances, KIRSTIN CARE OMHC is not required to agree to your request. KIRSTIN CARE OMHC will give you necessary information and forms for you to complete and return to request your *Information*. KIRSTIN CARE OMHC is permitted, by law, to charge you a fee for copying any documents requested in accordance with your rights as listed above. (Fee $1.00 per page.)

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Complaints

If you believe that KIRSTIN CARE OMHC violated your privacy rights, you have the right to complain to us or to the Secretary of the U.S. Department of Health and Human Services (DHHS). You may file a written complaint with us at the address below. An individual must file a complaint within 180 days of when he/she knew or should have known that the act or omission occurred, unless the time limit is waived by the Secretary of DHHS. KIRSTIN CARE OMHC will not retaliate against you if you choose to file a complaint.

Contact Address:
Kirstin Care OMHC
5801 Allentown Road Suite 310, Camp Springs, Maryland, 20746

Privacy Notice Acknowledgement

As a client of Kirstin Care OMHC, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by Kirstin Care OMHC.

Client Name or Guardian (Print): _____

_____ _____
Client Signature Date

Kirstin Care OMHC Disclosure

(to be completed at the first session with your provider)

I, _____, am glad that you have chosen to begin a wellness relationship with me. I am committed to providing the best possible care to promote your wellbeing and growth. My credentials are _____.

To contact me, please call _____. Messages received after 6 p.m. may not be heard until the next day. Messages received over the weekend may not be heard until the next working day. While your call is very important to me, I am often in session and may not immediately return your call. However, I will make every attempt to return it within 24 hours. If you have a clinical emergency, please do not call me first. Instead, please call 911 or go to the nearest emergency room while you attempt to reach me.

Sincerely,

Provider Signature_____ Date _____

This is to certify that I have read, understand, and have received a copy of this disclosure form:

Client Signature_____ Date_____

HIPAA ACKNOWLEDGEMENT

Client Name: _____

The Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology of Economic and Clinical Act (the HITECH Act) are regulatory standards for privacy and security. KC PRP is committed to maintaining the privacy and integrity of privileged information and complying with all the requirements of HIPPA and the HITECH Act.

The American Recovery and Reinvestment Act of 2009 contains significant changes to the HTPAA Act of 1996. Security Breach notifications, applications to Business Associate Agreements, and improved enforcement are areas that have been incorporated into the American Recovery and Reinvestment Act of 2009.

An important part of HIPPA, known as the Privacy Rule, was developed to address the electronic transfer of private client information. The Privacy Rule seeks to prevent dissemination of protected health information (PHI), i.e., that sort of information that a client might have an expectation will not be shared without his or her permission. Enumerated in 45 C.F.R. § 164.514, an individual's PHI includes information that could identify and/or reveal medical information about the person.

If you believe your privacy rights have been violated, you can file a complaint, or to receive more information about our privacy practices, please contact:

Corporate Office
5801 Allentown Road
Suite, 310
Suitland, MD 20746
Phone Number: 301.636.4001

One has the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event one feels privacy rights have been violated. **We will not retaliate against one for filing a complaint.**

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 877.696.6775

I have received a copy of the Privacy Practices/HIPAA forms. I understand the above information regarding protected health information (PHI).

Client Signature:_____ Date:_____

Staff Signature: _____ Date: _____

ADVANCE DIRECTIVE ACKNOWLEDGEMENT FORM

Client Name:_____

Date:_____

I, _____, acknowledge that Kirstin Care OMHC (KIRSTIN CARE) has provided me with a copy of the Maryland Department of Mental Health and Hygiene Advance Directive for Mental Health Treatment. I acknowledge that I have read and understand the notice and my rights contained within. _____Yes _____No

I have an Advance Directive (if yes, a copy must be provided) _____Yes _____No

I choose to decline the Advance Directive _____Yes _____No

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

COMAR 10.21.17.04 C

Revised 5/09/19

"Making Individuals' Lives Better"

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, _____ fully authorize KC OMHC to release/receive information regarding my Healthcare to:

Name/Agency: _____ Relationship to Client: _____

Address: _____

City, State, Zip: _____ Phone# _____ Fax # _____

For the following purposes:

- ☐ Psychological Evaluation
- ☐ Psychological History
- ☐ Treatment Planning
- ☐ Diagnostic Testing
- ☐ Medical Test Results
- ☐ Medical Advance Directive
- ☐ Living will, durable power of attorney
- ☐ Vocational/Educational Information
- ☐ Necessary Rehabilitation Information
- ☐ Medication Information
- ☐ Financial, Entitlements/Benefits Information
- ☐ Job Placement Information
- ☐ Discharge/Follow-up Care
- ☐ Other/ Any Relevant Information

The information will be communicated via:

☐ Telephone ☐ Fax ☐ Email

Correspondence and is authorized to be communicated both ways:

☐ Yes ☐ No

The requested information will be used to help:

☐ formulate OMHC goals ☐ Coordinate treatment across my healthcare team.

I know that this authorization is voluntary, and will not affect my healthcare and payment if I refuse to sign it.

I understand that I may review the requested information, request and keep upon receipt, a copy of this authorization after I sign it.

I understand that the information provided by this request will be held in the strictest of confidence and is to be used only by the professionals on my healthcare team.

This authorization can be cancelled by me at any time, unless a process has already started and its completion depends on this authorization.

Signature: _____ Date: _____

Last Four: _____ Date of Birth: _____

Witness: _____ Date: _____

5801 Allentown Road Suite 310 Camp Springs, MD 20746 *www.kirstincare.com*
Office: 240-392-2876 Fax: 240-838-3015

Client Preference Sheet

Do you have a strong preference for:

1. A therapist of a particular gender, race/ethnicity, sexual orientation, religion, or other personal characteristic?

2. A therapist/counsellor who speaks a specific language that is most comfortable for you?

3. Modality of therapy: such as individual, couple, family, or group therapy?

4. Length of therapy sessions: such as 30min, 45min, 60min?

5. Frequency of therapy: such as twice weekly, weekly, monthly, ad hoc or other?

6. Medication, psychotherapy, or both in combination?

7. Preferred days and times of appointments. Mornings, Afternoons, Weekdays, Saturday (Weekdays M-F First appointment 9am, Last appointment 5pm)

8. Are there any techniques/strategies that you would like us to try?

AUTHORIZATION FOR THE RELEASE OF INFORMATION