Welcome to our Practice!

First, let us thank you for choosing Mid-Atlantic Behavioral Health to provide your behavioral health services. Our mission is to empower positive mental health change in individuals, families and their communities. We combine a safe caring place with the expertise needed for people to get better.

As a convenience to our patients we offer the opportunity for you to review our policies and complete new patient paperwork at home and bring it with you to your scheduled appointment. This information may be downloaded at www.midatlanticbh.com under New Patient Paperwork. It can also be printed from the patient portal using the menu on the left. At your first appointment, our staff will answer any questions you may have regarding this information and review the completed paperwork with you.

All patients should review the:
- Notice of Privacy Practices
- Provider-Patient Services Agreement
- Credit Card on File FAQ

Patients should complete, sign, and bring with you the following:
- All forms on the patient portal (or arrive 20 minutes early to complete in our office)
- Key Policies Summary Statement
- Release of Information forms for your Primary Care Physician and any other individuals or providers you would like us to obtain or release information to/from (Family members, previous mental health treatment providers and/or facilities)
- Agreement Services for a Minor in Joint Custody Cases
- Medication Reconciliation
- Credit Card on File Authorization
- Acknowledgement of Receipt of New Patient Paperwork

At your first appointment you will also be asked to fill out patient registration and medication reconciliation forms and get your photo taken. Please also remember to bring your insurance card, photo identification, and any copays, co-insurance or deductible payments.

What to expect:
It is common for those new to treatment to feel both eager to get going and uncomfortable about starting the process. Do not let some awkwardness keep you from beginning what you know will be in your long-term best interest. If you have some questions and you feel you need
answers before your appointment, please call and let us discuss these. We hope that, as in most situations in life, you will find that if you forge ahead, your worries will lessen rapidly.

Over the years, our clients have found it very helpful to think about what they want to get from treatment or therapy. Please make some notes about your goals and what is most important to you, so that we can discuss these when we meet.

If you are requesting therapy:
Your first appointment/s will include a diagnostic/evaluation period to determine your treatment needs and whether the provider you are meeting with can meet those needs. If psychotherapy begins, your clinician will usually schedule one session per week, or every other week. The length of each appointment and the total length of your treatment may vary based on your clinical needs and scheduling constraints. *Please note that once you begin therapy your day and time will remain the same so make sure you schedule at a time you will be able to make consistently.*

If you are requesting medication management services:
Currently, medication management services are typically only provided to patients in therapy at our practice. If you begin medication management services as well, you will be scheduled with a licensed psychiatrist and/or advance practice registered nurse with a psychiatric specialty for a diagnostic interview. During this session, you and the provider will identify the services you need in order to meet your treatment goals and determine whether he/she is the correct provider to help you meet these goals. Ongoing psychiatric services vary in length and frequency and are based on your needs and the prescriber’s recommendation. They may be scheduled weekly, bi-weekly, monthly or quarterly. Your sessions may include medication evaluation/monitoring and/or psychotherapy. Please note that Urine Drug Screens are routinely ordered prior to beginning and during use of controlled substances. Our practice takes a very conservative approach to the use of Benzodiazepines in treatment.

If you are requesting neuropsychological testing:
Psychological testing appointments typically being with a 45 minute intake appointment during which the psychologist will interview you. If the patient is a child or adolescent his/her parents/caregivers will be interviewed alone as well as with the child. Please provide activities for your child to keep busy within the waiting room during this time as only a limited number of toys are available. Though a receptionist is nearby, if your child requires direct supervision at all times, it is recommended that another adult be present to supervise them in the waiting room during this interview. For adult patients undergoing testing, you will be interviewed and may chose to have other adults present if you feel they would provide valuable information to the psychologist. At the end of that session the next steps will be outlined. Typically testing takes place in one visit (1-5 hours) during which the psychologist or an assessment technician will administer one or more tests that measure various areas of functioning based on the concerns shared on the phone or raised in interview. Parents/caregivers or adult interview participants may be asked to complete rating scales as well. Breaks may be required so it is recommended that you bring a drink and/or snack. After testing has been completed, a
feedback session will be scheduled, usually in about 3 weeks. At this time, we will go over the results of the evaluation and provide you with a written report.

Payment and Billing:
If you plan on using your insurance benefits for your treatment we request that you verify your benefits by calling your insurance company and obtaining any necessary authorizations prior to scheduling your first appointment. Please note that as covered in the Key Policies Summary, you will be billed separately and held responsible for any portion of the treatment that you receive and your third party payment does not cover, regardless of the reason for denial. If you have a co-payment, coinsurance, or deductible with your insurance company, please be prepared to pay this amount in full at the time of your appointment. We accept cash, checks, flexible spending, debit and credit cards. We require a credit or debit card be held on file by our billing company for all patient responsible balances that exceed 60 days past due. Details are provided in additional documents.

How to reach us:
If you have any questions prior to your appointment, please call (302) 224-1400 or e-mail us at info@midatlanticbh.com. If you must cancel your appointment, please notify us at least 24 business hours (72 for testing) prior to the scheduled appointment time. Failure to provide adequate notice will result in a missed appointment charge per our fee schedule, which is not typically a benefit of most insurance policies.

We look forward to working with you---
The providers and staff at Mid-Atlantic Behavioral Health, LLC
Welcome to Mid-Atlantic Behavioral Health. This document (the Agreement) contains important information about our professional services and business policies. The law requires that we obtain your signature acknowledging that we have provided you with this information which was done when you checked in for your first visit.

It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protection and patients’ rights with regard to the security and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practice (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which was also made available to you, explains HIPAA and its application to your PHI in greater detail.

Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about procedures at any time. When you sign the accompanying acknowledgement of new patient paperwork it will represent an agreement between us. According to this document, you may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

**PSYCHOLOGICAL SERVICES**

**Psychotherapy:** We provide psychotherapy services. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the clinician and the client and the particular problems you are experiencing. There are many different methods your clinician may use to you cope with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for very active participation on your part. In order for the therapy to be most successful, you will have to work on things talked about both during our sessions and at home.

Psychotherapy 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, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific
problems, and significant reductions in feelings of distress. Thus, it is possible that you may experience both 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 clinician will be able to offer you some first impressions of what your work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with the clinician. Therapy involves a large commitment of time, money, and energy, so you should be mindful of the therapist you select. If you have questions about procedures, you should discuss them whenever they arise. If your doubts persist, your clinician will be happy to help you set up a meeting with another mental health professional for a second opinion.

**Psychiatric evaluation and medication management:** Mid-Atlantic Behavioral Health also provides psychotherapy, psychiatric evaluation and medication management services by a licensed psychiatrist and/or advanced practice registered nurses with a psychiatric specialty. You will first be scheduled for an initial diagnostic interview. At the end of this session the psychiatrist will offer their impressions and psychiatric treatment recommendations. You should evaluate this information along with your opinion of whether you feel comfortable working with the psychiatrist then together you will decide how to proceed. This evaluation period can last anywhere form 1-4 sessions. If medication is recommended, you will be offered information regarding its risks, benefits side effects and possible alternatives. You may be asked to sign an informed consent for each medication prescribed.

**Psychological Assessment and Other Testing Services:** Portions of the referrals to our practice involve requests for psychological assessment and other testing services. Testing services are provided when the use of psychometric instruments is necessary to determine a psychological diagnosis and to determine treatment needs accordingly. Psychological assessment is the process of collecting data from interviews and instruments and then placing this data in a wide perspective, with its main focus being problem solving and decision-making. Those seeking psychological assessment services will discuss the structure, cost potential benefits and risks during the initial intake.

**APPOINTMENTS**
Since we offer a variety of services you may be scheduled for one or more type of service.

**Initial Diagnostic Interviews:** This is your first appointment with any of our providers and offers the opportunity for you and the provider to decide what if any treatment is recommended and whether they are the appropriate provider to meet your treatment needs.

**Therapy Sessions:** When psychotherapy begins, your clinician will schedule session based on what is needed to meet your need. Appointment blocks may be every other week, or every other week. It is possible some sessions may be longer, shorter, or more/less frequent. You and the provider will establish your treatment goals.
**Psychological Testing:** Psychological testing appointments typically include an initial diagnostic interview and follow up testing appointments (typically with an assessment technician) that usually take place over 1-2 half day sessions. You will be billed for face-to-face time with the providers as well as the amount of time it takes to score and interpret your data and write the report.

**Psychiatric Services:** Psychiatric services vary in length and frequency and are based on your needs and the prescriber’s recommendation. They may be scheduled weekly, bi-weekly, monthly or quarterly. Your session may include medication evaluation/monitoring and/or psychotherapy.

**PROFESSIONAL FEES**

Our fees vary based on the professional delivering the services and services delivered (a fee schedule is available upon request). In addition to scheduled appointments, we charge a set amount for other professional services you may need, and will break down the hourly cost if the activity is a period of less than one hour. Other services include but are not limited to:

1. Report writing,
2. Completion of FMLA and/or Disability Paperwork
3. Telephone conversations lasting longer than 10 minutes
4. Repeated crisis calls after hours
5. Attendance at meetings, consulting with other professionals with your permission
6. Preparation of records or treatment summaries

If you become involved in legal proceedings that require Mid-Atlantic Behavioral Health’s participation, unless payment arrangements are made with your attorney, you will be expected to pay for all our professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the complexity of legal involvement, we charge $150 - $250 per hour for preparation and $250 - $350 per hour for attendance at any legal proceedings. Participation by phone is charged at the same rate however, the provider may offer this option at a reduced rate. Prior to being involved in legal issues, an estimate of time and cost will be provided to you. A minimum of half of this amount is due prior to participation and the balance is due at the close of each legal proceeding.

**Other Fees:**

- Returned checks: $40 service fee per returned item.
- Additional statement fees: receipts are provided with no charge at the time of service and patients with outstanding balances will be mailed a statement monthly. All requests for additional statements may incur a $2 charge.
- Medical Records: TMP Solutions handles all of Mid-Atlantic Behavioral Health’s records requests. Requests by you or anyone other than your medical insurance company for your records may incur a minimum $25 per patient or .50 cents (existing patients) or $1.00 (discharged patients) per page charge and payment may be required prior to the release of records. Records requests typically take at least 10 business days.
**MISSED APPOINTMENTS**

Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 business hours (72 hours for testing appointments) notice of cancellation or unless we both agree that you were unable to attend due to circumstances beyond your control. **It is important to note that insurance companies do not provide reimbursement for cancelled sessions. You will be responsible for any missed appointment fees incurred and these will need to be paid prior to your next date of service.** If it is possible we will try to find another time to reschedule your missed appointment.

Missed appointments are billed at a flat fee based on the provider you were scheduled with and the service that was to be delivered. Missed appointments are billed at the following rate and due prior to your next date of service:

- **All appointments with a psychologist-$75 per appointment** (testing is usually scheduled for several hours)
- **All appointments with a master’s level therapist-$50 per appointment**
- **Initial evaluations or therapy appointments with a prescriber - $85 - $100 per appointment**
- **Medication Monitoring appointments - $45 - $50**
- **Group Therapy sessions - $30 per appointment**

Sometimes when a patient misses an appointment without giving notice or cancels frequently we are unclear whether they wish to continue treatment or not. If you miss or cancel an appointment and do not have a future one scheduled you will need to contact the office to indicate you would like to continue treatment. If we do not hear from you, we will assume you would like to terminate and you will be discharged from treatment. If you cancel or miss 2 or more appointments in a 60 day period you may receive a letter indicating that we would like to review your treatment commitment and will wait to hear from you before scheduling you another appointment. Again, if we do not hear from you, we will assume that you wish to terminate treatment and you will be discharged. **Please be aware in all these cases we are not able to continue to reserve your appointment time for you.**

**MEDICATION MANAGEMENT ISSUES**

If you are experiencing an issue with your medication or require a refill an office visit is typically required. Refills will only be given without an appointment and/or fee in special circumstances. If your prescriber agrees to authorize a refill this may take up to 72 business hours (does not include weekends or holidays). Prior authorizations for medications also take a minimum of 72 hours. Many of our prescribers do not work every day and will only be contacted on their day off for life threatening emergencies. Therefore, some refill requests may take longer based on your doctor’s schedule. **Medication refills must be requested through our website (www.midatlanticbh.com) or left on the medication support line for a specific prescriber. Please also be advised that as part of your treatment plan Urine Drug Screens are routinely ordered prior to and during treatment especially if controlled substances are prescribed.**
TERMINATING TREATMENT
All relationships have a beginning, middle and end. This is true in treatment relationships as well. In treatment, ideally the patient and provider should mutually agree that it is time to terminate the therapeutic alliance when the patient’s treatment goals have been achieved and there is a reasonable expectation that the gains will be maintained. There are, however, circumstances in which there is not mutual agreement. MABH acknowledges that the patient may choose to terminate treatment at any time. If you choose to terminate and request it, your provider will supply you with a referral to another provider. You will remain obligated for any unpaid balances and other contractual agreements.

Though it is rare, providers may also initiate termination without your consent under the following conditions:

- The goals of treatment have been met and treatment is no longer needed
- There is noncompliance with the structure of treatment (canceling or missing appointments, failure to pay fees, failure to follow through with recommendations, etc.)
- There is lack of progress despite appropriate treatment
- A conflict of interest arises
- Illness or disability of the provider or family member requiring a significant reduction in or absence from work
- Termination of the provider’s work with this practice

CONTACTING US
On most weekdays, the receptionist will be available during normal business hours (8:00 am – 8:00 pm Monday through Thursday and 8:00 am – 4:00 pm on Friday) to answer phone calls. If no one is available, the phone system will permit you to leave a message in the general office mailbox, which is monitored frequently during office hours. We make every effort to return all calls within one business day. You are also welcome to leave a voicemail on your clinician’s confidential voicemail. If you are difficult to reach, please inform us of some times when you will be available.

If you experience a life threatening emergency outside of business hours or receive the office voicemail you will be provided instructions for contacting the on-call clinician. **Please note that this service is only to be used to true life threatening emergencies and only so that the clinician may direct you to the most appropriate crisis facility. Extended phone calls (more than 10 minutes), calls deemed to be not of a life threatening nature, and or repeated crisis calls may result in additional charges which may not be paid by your insurance company.**

Medication refills or issues other than serious side effects cannot be handled through the on-call phone line.
If you leave a message and feel that you can’t wait for us to return your call, contact your family physician or proceed to the nearest emergency room and ask for the psychologist or psychiatrist on call.

If your clinician will be unavailable for an extended time, Mid-Atlantic Behavioral Health will provide you with the name of another Mid-Atlantic Behavioral Health clinician to contact, if necessary.

LIMITS ON CONFIDENTIALITY
In general, the law protects the privacy of all communications between a patient and mental health professionals. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written advance consent. Your signature on this Agreement provides consent for those activities as follows:

- We may occasionally find it helpful to consult with other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. If you do not object, we will not tell you about these consultations unless we feel it is important to our work together. I will write all consultations in your Clinical Record (which is called “PHI” in my Notice of Providers’ Policies and Practices to Protect the Privacy of Your Health Information).
- If you treat with more than one provider at MABH (therapist, psychiatrist, evaluator) your medical information will be available to all and they will consult without additional consents.
- We have contracts with other businesses that provide mental health and other business support services. As required by HIPAA, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of the data except as specifically allowed in the contract or otherwise by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient seriously threatens harm to himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who could help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services we provided to you, such information is protected by the doctor-patient privilege law. We cannot provide any information without your
written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information. We strongly discourage this as it is often nonproductive to the therapeutic relationship.

- If a government is requesting the information for health oversight activities we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If we are treating a patient who files a worker’s compensation claim, we may, upon appropriate request, be required to provide otherwise confidential information to your employer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about the patient’s treatment. These situations are unusual in our practice but include:

- If we have reason to believe that a child who we are evaluating or treating is an abused child and/or an adult was an abused child in the past, the law requires that we file a report with the appropriate government agency, usually the Division of Family Services. Once such a report is filed, we may be required to provide additional information.
- If we have reason to believe that an elderly person or other adult is in need of protective services (regarding abuse, neglect, exploitation, or abandonment), the law allows us to report this to the appropriate authorities, usually the Department of Aging, in the case of an elderly person. Once such a report is filed, we may be required to provide additional information.
- If we believe that a patient presents a specific and immediate threat of serious bodily injury regarding a specifically identified or reasonably identifiable victim and he/she is likely to carry out the threat or intent, we may be required to take protective actions, such as warning the potential victim, contacting the police, or initiating proceedings for hospitalization.

If any of the above situations arise, we will make every effort to fully discuss it with you before taking any action and we will limit my disclosure to what is necessary; however, our first priority will be to ensure the safety of the victim.

While this written summary of exceptions of confidentiality should prove helpful in informing you of potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not an attorney. In situations where specific advice is required, formal legal advice may be needed.
PROFESSIONAL RECORDS
You should be aware that, pursuant to HIPAA, we may keep Protected Health Information about you. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals we set for treatment, your progress toward those goals, your medical and social history, your treatment history, any past treatment records we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance company.

Except in unusual circumstances that involve danger to yourself or others where information has been supplied to us confidentially, or the record makes reference to another person (unless such other person is a health care provider) and we believe that access is reasonably likely to cause substantial harm to such person, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. We are sometimes willing to conduct this review meeting without charge. In most circumstances, we are allowed to charge a copying fee of $1 per page (and certain other expenses). MABH contracts with a third party vendor to fulfill all records requests on our behalf. Please note that requests may take up to 10 business days to fulfill. The exceptions to this policy are contained in the attached Notice form.

At Mid-Atlantic Behavioral Health your clinical record is part of an electronic medical record (EMR). All information is password protected to prevent unauthorized parties from viewing records. Back-up data is stored on and off site to prevent any loss of data. Any paper records that relate to you are stored in secure area.

NEW PATIENT RIGHTS
HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected health information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to have a paper copy of this Agreement, the attached Notice Form, and our privacy policies and procedures. We are happy to discuss these rights with you.

MINORS AND PARENTS
Patients under 18 years of age who are not emancipated and their parents should be made aware that the law may allow parents to examine their child’s treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child’s records. If they agree, during treatment, we will provide them only with

Revised 1-5-2017
general information about the progress of the child’s treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child’s treatment when it is complete. Any other communication will require the child’s authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parent of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

Both parents have the right to participate in their child’s treatment and must agree to the treatment plan unless a sole legal (not physical) custody agreement is on file. Additional consents must be signed in these cases to release information to the non-custodial parent. Our goal is to provide therapy services for your child and not be involved in custody issues. We expect that you will help ensure that we do not become involved. If however our involvement is requested and/or mandated professional fees outlined will apply regardless of who mandates our participation.

BILLING AND PAYMENT
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If you are using your insurance benefits it is your responsibility to know your coverage, copays, and any authorization requirements. Copays, coinsurance or deductible amounts are due at the time of service. Any outstanding balances for which we send you a bill are subject to additional service and interest charges. Current fees for this may be obtained from the front office. Please note that you may also be asked to reschedule appointments and will not receive written reports if you have an outstanding balance for monies owed by you until payment or payment arrangements are made.

If you have agreed to assume financial responsibility for services provided (i.e., without third party payment), you will not be provided services or written or verbal feedback regarding evaluation results until the balance of the amount due is paid in full. (In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan.)
All co-payments, coinsurance, deductible and self-pay amounts are due at the time of service. If your account has an outstanding balance, you are expected to pay your account in full before seeing the provider. MABH reserves the right to cancel all appointments if full payment is not received at time of service. If you cannot pay a balance in full within 30 days, please contact our billing department to see if you qualify for special payment options. We accept cash, personal checks, flexible spending, debit and credit cards.

If at any time you have a balance due exceeding 60 days past due and have not made appropriate payment arrangements with our billing department your account will be subject to collection by MABH using your credit card on file. Your account may also be referred to an outside collection agency and you agree to pay for all collection costs incurred. Further, you understand that if your account is referred to a collection agency, or if your past due status is
reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon or kept, we have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient’s treatment is his/her name, demographic information, the nature of the services provided, and the amount due. If additional legal action is necessary, its costs will be included in the claim. Currently our collection fee is 37%.

**INSURANCE REIMBURSEMENT**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers and verify this with your carrier prior to beginning treatment.

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. If it is necessary to clear confusion, we may be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plan such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work on specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval prior to beginning therapy or for more therapy after a certain number of sessions. **It is your responsibility to know if this is required and inform the office of such prior to beginning treatment.** While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed care plans will not allow us to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your psychotherapy. Others will allow you to continue as a private pay client.

You should also be aware that your contract with your health insurance companies requires that we provide it with information relevant to the services we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical
information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical databank. We will provide you with a copy of any report we submit, if you request it. By signing the Acknowledgement of Receipt of New Patient Paperwork you agree that we can provide requested information to your carrier.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above (unless prohibited by contract).

Your signature on the Acknowledgement of Acknowledgement of Receipt of New Patient Paperwork indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.
NOTICE OF PROVIDER’S POLICIES AND PRACTICES
TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations
We are permitted to use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could be identified as relating to you.
- “Treatment, Payment, and Health Care Operations”
  *Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician.
  *Payment* is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  *Health Care Operations* are activities that relate to the performance and operation of our practice, including, without limitation, improving your care and contacting you when necessary. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination
- “Use” applies only to activities within our practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization
We may use or disclose PHI for purposes outside of treatment, payment, and health care operations other than those listed in Section III only when your appropriate authorization is obtained. An “authorization” is your written permission for specific disclosures. In those instances, when you are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes your clinician has made about your conversation during an interview or a private, group, joint, or family counseling session, which they have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI, although disclosure without your authorization is permitted under certain limited circumstances, including some of the circumstances listed in Section III.
You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. Any such revocation will be effective, except for (1) any prior actions that we have undertaken in reliance on that authorization, or (2) circumstances when the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under policy.

I will also obtain an authorization from you being using or disclosing PHI in a way that is not described in this notice.

III. Further Uses and Disclosures Not Requiring Authorization
We may use or disclose PHI for purposes outside of treatment, payment, and health care operations without your consent or authorization in certain ways that contribute to the public good. We have to meet many conditions in the law before we can share your PHI for these purposes. These purposes include the following circumstances:

- **Child Abuse:** If we have reason to believe that a patient who we are evaluating or treating is an abused child, and/or was an abused child in the past, the law requires that we file a report with the Division of Family Services. Once such a report is filed, we may be required to provide additional information.

- **Adult and Domestic Abuse:** If we have reasonable cause to believe that an older adult is in need of protective service (regarding abuse, neglect, exploitation, or abandonment), we may report such to the local agency which provides protective services.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release the information without your written consent, or a court order. The privilege does **not** apply when you are being evaluated for a third party or where the evaluation is court ordered or in certain other circumstances when satisfactory assurances are received from the party seeking disclosure.

- **Serious Threat to Health or Safety:** If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and we determine that you are likely to carry out that threat, we must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent or notifying the police.

- **Individuals Involved in Your Care or Payment:** When appropriate, we may share PHI with a person, such as a family member or close friend, who is involved in your health care or in making payment for such health care. We also may notify your family members about your location or general condition.

- **Worker’s Compensation:** If you file a worker’s compensation claim, we will be required to file periodic reports with your employer which shall include, where pertinent history, diagnosis, treatment, and prognosis.

- **Otherwise Allowed by Law:** When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state’s confidentiality law. This includes certain narrowly-defined disclosures required or authorized by law enforcement agencies or by a health oversight agency (such as the Department of Health and Human Services or a state department of health); to an entity assisting in a disaster relief effort; to a coroner, medical examiner, or funeral director when an individual dies; to an organ or tissue
procurement organization; for public health purposes relating to disease, reactions to medication, or FDA-regulated products; for health research purposes; or for specialized government functions such as fitness or military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient’s Rights and Provider’s Duties

Patient’s Rights
- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of PHI about you or the amount or types of PHI to be disclosed to someone, such as a family member or close friend, involved in your health care or in making payment for such health care. We will consider your request, but in most cases are not legally required to agree to a restriction you request.

- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request we will send your bills to another address or contact you at an alternate phone number.)

- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in our mental health billing records used to make decisions about you for as long as the PHI is maintained in the record, provided that we may charge a reasonable, cost-based fee for the production of any copies. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request under certain circumstances, subject to your ability to file a statement of disagreement with the denial that will be included in future disclosures of the subject PHI. On your request, we will discuss with you the details of the amendment process.

- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI that we have made for six years prior to the date you ask, except for those made in the course of treatment, payment, or health care operation or to which you provided authorization (as described in Section II of this Notice), who we shared the PHI with, and why, provided that we may charge a reasonable, cost-based fee for any accounting you request in excess of one such accounting per year. On your request, we will discuss with you the details of the accounting process.

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

- **Right to Restrict Disclosures When you Have Paid for Your Care Out-of-Pocket.** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.

Provider’s Duties
- We are required by law to maintain the privacy and security of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

- We will let you know promptly if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI, or that your PHI has not been encrypted in accordance with government standards; and (b) our risk assessment fails to determine that there is a low probability that your PHI has been compromised.
- We reserve the right to change the privacy policies and practices described in this notice and to make the changes apply to all PHI that we maintain. Unless we notify you of such changes, however, I am required to abide by the terms currently in effect.
- If we revise policies and procedures, I will notify you by mail with a revised notice.

V. Confidentiality of Alcohol and Drug Abuse Information

Alcohol and drug abuse information has special privacy protections under Federal law and regulations. Generally, we will not disclose any mental health or medical information that pertains to the treatment or diagnosis of drug abuse or alcohol abuse or a referral for such treatment or diagnosis, and which would identify a patient as an alcohol or drug abuser, unless:

1. The patient consents in writing:

2. The disclosure is allowed by a court order; or

3. The disclosure is made (i) to medical personnel in a medical emergency, (ii) to qualified personnel for research, management, audit, or program evaluation, or (iii) to a qualified service organization that provides data processing, bill collecting, dosage preparation, laboratory analysis, or legal, medical, accounting, or other professional services for us or service to prevent or treat child abuse or neglect, provided that such qualified service organization enters into a written agreement with us acknowledging its privacy obligations with respect to such information.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

VI. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about your access to your records, you may contact the managing director, Dr. Traci Bolander at 302-224-1400.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. For more information, visit www.hhs.gov/ocr/privacy/hipaa/complaints/.

VII. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect June 23, 2014.
Key Policies Summary Statement

Thank you for choosing Mid-Atlantic Behavioral Health to provide your mental health care. We are committed to providing you with quality care. The following is a summary of our most important policies. Details are provided in the Provider-Patient Services Agreement. We ask that you review and sign both documents before beginning treatment. Your signature indicates that you understand and agree to follow all of our policies. All patients must agree to and are held responsible for all policies. If you have a question or concern, please discuss this with the practice administrator prior to engaging in treatment.

Insurance Coverage:
Your health insurance is a contract between you and your insurance carrier. It is your responsibility to know the terms contained in your policy regarding coverage, co-payments, co-insurance, deductibles and noncovered services. If you have any questions about your insurance, you will need to contact your carrier directly. Current insurance cards and identification must be presented at every appointment. **You are responsible for all costs not covered by your insurance carrier regardless of the reason for denial.**

Initial: _______

Missed Appointments:
Most cancelled appointments require **24 business hours notice (72 hours required for testing appointments).** Without 24 business hours notice, you may be charged as follows:

- All appointments with a psychologist-$75 per appointment (testing is usually scheduled for several hours)
- All appointments with a masters’ level therapist - $50 per appointment
- Initial evaluations or therapy appointments with a prescriber - $85 - $100 per appointment
- Medication Monitoring appointments with a prescriber - $45 - $50
- Group therapy session - $30 per appointment

Patients with two or more missed appointments in a 60 day period may be discharged from the practice.

Initial: _______

Co-payments, Self-Pays, Deductibles & Outstanding Balances:
ALL co-payments, coinsurance, deductible and self-pay amounts are due at the time of service. If your account has an outstanding balance, you are expected to pay your account in full before seeing the provider. MABH reserves the right to cancel all appointments if full payment is not received at time of service. If you cannot pay a balance in full within 30 days, please contact our billing department to see if you qualify for special payment options. We accept cash, personal checks, flexible spending, debit and credit cards. If at any time you have a balance due exceeding 60 days past due and have not made appropriate payment arrangements with our billing department your account will be subject to collection by MABH using your credit card on file. Your account may also be referred to an outside collection agency and you agree to pay for all collection costs incurred. Further, you understand that if your account is referred to a collection agency, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Initial: _______
Medication Management Issues:
If you are experiencing an issue with your medication or require a refill an office visit is typically required. Refills will only be given without an appointment and/or fee in special circumstances. If your prescriber agrees to authorize a refill this may take up to 72 business hours (does not include weekends or holidays). Prior authorizations for medications also take a minimum of 72 hours. Many of our prescribers do not work every day and will only be contacted on their day off for life threatening emergencies. Therefore, some refill requests may take longer based on your doctor’s schedule. Medication refills must be requested through our website (www.midatlanticbh.com) or left on the medication support line for a specific prescriber. Please also be advised that as part of your treatment plan Urine Drug Screens are routinely ordered prior to and during treatment especially if controlled substances are prescribed. Initial:______

Consenting to Treatment of Minors:
In order to ensure parents/guardians consent to and have the opportunity to participate in treatment, we must understand any custody issues. Please initial the appropriate statement:

- Both parents live together and agree to this treatment – Initial:______
- There is a formal or informal custody agreement in place and we understand that we must provide a copy of the agreement and sign a consent for treatment in joint custody cases – Initial:______
- The parent/guardian signing has sole legal custody and will provide that paperwork – Initial:_______

Communication from the Office:
Please be advised that we use an automated calling and text messaging system to remind you of appointments and other healthcare communications. This system will call the primary number you provided to us 48 hours before your appointment. A text message will be sent 24 hours before your appointment to the cell number provided. Please answer this call and follow the prompts by pressing 1 to confirm your appointment and respond to the text message. If you do not wish to receive reminder calls, have messages left or receive SMS/text messages, please advise the front desk. Otherwise this document will serve as your consent for messages to be left at any phone number we have on file for you. You also agree to allow the office to contact you about non-medically relevant information. Initial:______

Miscellaneous Fees:
If your provider is required to complete forms on your behalf, all attempts should be made to do this as part of your scheduled appointment. If this is not possible or you prefer that they be completed outside of your scheduled time, a charge will be incurred and will not be covered by your insurance company. The charge for completing forms including but not limited to leave of absence, FMLA, and Short/Long Term Disability or medical letters is a minimum of $25 or a prorated amount of the provider’s normal hourly fee. We may require that you be seen at least three times prior to completing any disability forms. All forms will normally be completed within one week.

Other Fees:
- Returned checks: $40 service fee per returned item.
- Additional statement fees: receipts are provided with no charge at the time of service and patients with outstanding balances will be mailed a statement monthly. All requests for additional statements may incur a $2 charge.
- Medical Records: TMP Solutions handles all of Mid-Atlantic Behavioral Health’s records requests. Requests by you or anyone other than your medical insurance company for your records may incur a minimum $25 per patient or .50 cents (existing patients) or $1.00 (discharged patients) per page charge and payment may be required prior to the release of records. Records requests typically take at least 10 business days. Initial:______
My signature indicates that I have read this policy, and that I understand and agree to all of Mid-Atlantic Behavioral Health’s Policies provided in the Key Policies Summary Statement and as detailed in the Provider-Patient Services Agreement.

Print patient name: ____________________________________________

Patient’s signature (if over 14): ________________________________ Date: ________________
(For minors over 14 consenting to voluntary treatment for substance abuse)

Parent/Guardian’s signature (if patient under 18): __________________________ Date: ________________

*If the authorization is signed by a personal representative of the patient, a description of such representative’s authority to act for the patient must be provided.

**If you have any questions regarding these financial policies please call our Practice Administrator at 302-224-1400 extension 317.
Authorization for Release of Information with Primary Care Physician (PCP)

___ MABH is SENDING records
___ MABH is REQUESTING records
___ MABH to keep request on FILE

This form when completed and signed by you, authorizes Mid-Atlantic Behavioral Health, LLC to release protected information from your clinical record to the person you designate.

I, __________________________ authorize: Mid-Atlantic Behavioral Health, LLC to release to and/or obtain from the following information noted regarding my medical, mental health and substance abuse (if applicable) records for myself DOB: ___________ or my minor child: ______________________ DOB: ___________

_____ Letter advising of treatment participation and treatment plan, mental health diagnosis, medications, including alcohol/drug treatment & HIV related information and updates on treatment, if requested by PCP.
_____ Other Reports as requested

This information should only be released to/received from: PCP

Name: ___________________________ Phone: ___________________ Fax: __________________
Address: ________________________

For the purpose of: Background Information Evaluation Continuity of Care At the request of individual Other __________________________

(“at the request of the individual” is all that is required if you are the patient and you do not desire to state a specific purpose.)

This Authorization is valid until you are discharged from this incident of care or until retracted in writing.

You have the right to revoke this Authorization, in writing, at any time by sending such written notification to the office address listed below. However, your revocation will not be effective to the extent that Mid-Atlantic Behavioral Health, LLC has taken action in reliance on this Authorization or if this Authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Mid-Atlantic Behavioral Health, LLC generally may not condition behavioral health services upon my signing an authorization unless the psychological services are (i) research-related; or (ii) provided to me for the purpose of creating health information for disclosure to a third party.
I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of my information and no longer protected by federal privacy regulations. However, any disclosure of information that pertains to the treatment or diagnosis of drug abuse or alcohol abuse or a referral for such treatment or diagnosis, and which would identify a patient as an alcohol or drug abuser, permitted hereunder shall be accompanied by the following written statement: “This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.”

Any facsimile, copy, or photocopy of this Authorization shall have the same effect as the original.

Patient’s signature (if over 14): ____________________________ Date: ____________
(For minors over 14 consenting to voluntary treatment for substance abuse)

Parent/Guardian’s signature (if patient under 18): ____________________________ Date: ____________

**If the authorization is signed by a personal representative of the patient, a description of such representative’s authority to act for the patient must be provided.**
Authorization for Release of Information

This form when completed and signed by you, authorizes Mid-Atlantic Behavioral Health, LLC to release protected information from your clinical record to the person you designate.

I, _____________________ authorize: Mid-Atlantic Behavioral Health, LLC to release to and/or obtain from the following information noted regarding my medical, mental health and substance abuse (if applicable) records for myself DOB: ______________ or my minor child: _____________________ DOB: _____________

This information should only be released to/obtained from (circle one):
- Psychiatrist
- Therapist
- School
- Family Member
- Hospital
- Other

Select type of information to be released to/obtained from the above:
- All medical information including mental health diagnosis, notes, reports, labs, medications, alcohol/drug treatment and HIV related information
  OR (if not all records should be released/obtained, select records below to be released to/obtained from the above party.
- Psychological Evaluations/Reports
- Educational Reports
- Current Functioning Information
- Billing/Attendance Information

Information may be released to/obtained from:
Name: _______________________________ Phone: ___________________ Fax: __________________
Address: ________________________________

For the purpose of: Background Information   Evaluation   Continuity of Care   At the request of individual
Other ________________________________

(“at the request of the individual” is all that is required if you are the patient and you do not desire to state a specific purpose.)

This Authorization is valid until you are discharged from this incident of care or until retracted in writing.

You have the right to revoke this Authorization, in writing, at any time by sending such written notification to the office address listed below. However, your revocation will not be effective to the extent that Mid-Atlantic Behavioral Health, LLC has already released any information to the person you designated.

910 S. Chapel Street Suite 102 • Newark, DE 19713 • P: 302.224.1400 • F: 302.224.1402 • www.midatlanticbh.com
Behavioral Health, LLC has taken action in reliance on this Authorization or if this Authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Mid-Atlantic Behavioral Health, LLC generally may not condition behavioral health services upon my signing an authorization unless the psychological services are (i) research-related; or (ii) provided to me for the purpose of creating health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of my information and no longer protected by federal privacy regulations. However, any disclosure of information that pertains to the treatment or diagnosis of drug abuse or alcohol abuse or a referral for such treatment or diagnosis, and which would identify a patient as an alcohol or drug abuser, permitted hereunder shall be accompanied by the following written statement: “This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.”

Any facsimile, copy, or photocopy of this Authorization shall have the same effect as the original.

Patient’s signature (if over 14): ____________________________ Date: ________________
(For minors over 14 consenting to voluntary treatment for substance abuse)

Parent/Guardian’s signature (if patient under 18): ____________________________ Date: ________________

**If the authorization is signed by a personal representative of the patient, a description of such representative’s authority to act for the patient must be provided.
Agreement for Services for a Minor in Joint Custody Cases

We acknowledge that we have discussed our child’s situation with the provider signing below and agree that our child, ________________________, would benefit from one or more of the behavioral health services provided by Mid-Atlantic Behavioral Health, LLC.

We have had the chance to discuss any issues we have/had related to the evaluation/treatment to be provided, have had our questions answered and understand the services being offered.

By signing below, we, the parents/legal guardians of, ______________________________, give our permission for him/her to participate in outpatient mental health services at Mid-Atlantic Behavioral Health, LLC. We understand that the plan is for ______________________________ to receive the following services:

- Diagnostic interview
- Psychological testing (tests to be determined at interview)
- Individual therapy
- Family therapy
- Group therapy
- Medication Management
- Other ________________________________________________

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your child __________________. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court or produce records, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony or records, even though I will work to prevent such an event. If I am required to testify or to produce records, I am ethically bound not to give my opinion about either parent’s custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $250 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs and $1 per page for all records.
Detailed descriptions of our services and policies, procedures, risks, and benefits of services are provided in the provider-client agreement, which you acknowledge that you have received.

By signing below, you acknowledge that you have read, understand and agree to all of the points above.

Parent/Guardian’s signature: _____________________________ Date: ______________

Parent/Guardian’s signature: _____________________________ Date: ______________

*In joint custody cases both parents must consent*

I have discussed this evaluation/treatment plan with the above-signed parents and we have all agreed to proceed.

Signature of provider: _____________________________ Date: ______________

This authorization is valid until retracted in writing.
Name:________________________________________

Medication Reconciliation

To all of our Clients/Patients:

To ensure that our patients receive the best integrated care as well as meet the U.S. Department of Health and Human Services, Federal Meaningful Use Standards, we gather data regarding your recent and current medications. We ask that you complete this form as well as give us permission to review your prescription history in our electronic prescribing system.

**Please list all prescribed medications that you are currently taking for health conditions:**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Prescriber</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please list all mental health medications you have been prescribed in the past, whether they were helpful or not, and side effects:**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Helpful/Not Helpful</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Helpful</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Helpful</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Helpful</td>
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<td>Not Helpful</td>
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<tr>
<td></td>
<td></td>
<td>Helpful</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Helpful</td>
<td></td>
</tr>
</tbody>
</table>

**Please list all food and drug allergies, indicate the severity, and explain the symptoms/reaction you experienced:**

<table>
<thead>
<tr>
<th>Allergen (food/drug)</th>
<th>Severity</th>
<th>Symptoms/Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
</tr>
<tr>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
</tr>
<tr>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
</tr>
<tr>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
</tr>
</tbody>
</table>

**Pharmacy Name**

**Pharmacy Phone Number**

**Pharmacy Fax Number**

Patients Signature:________________________________________

Date:___________________
Credit Card on File Authorization

Mid-Atlantic Behavioral Health, LLC is committed to making our billing process simple and easy. We require that you keep a credit or debit card on file as a convenient method of payment for the portion of services not covered by your insurance carrier and you are responsible for.

I, __________________________________________, authorize Mid-Atlantic Behavioral Health, LLC to automatically charge patient responsible balances that exceed 60 days past due for services rendered to me or any other patient(s) listed on this form to the following credit card (expires after 1 year).

Check one:  ☐ Visa  ☐ Mastercard  ☐ Discover

Credit card #: XXXX-XXXX-XXXX-____________________

Exp date (mm/yy): ________________________________

I agree that it is my responsibility to ensure the credit card on file is active and has an appropriate amount of available credit. Please call our office to update your credit card on file information.

Relationship to patient (circle one):  Self  Parent/Guardian  Other

Patient Full Name: _______________________________  DOB: ___ / ___ / ___

Patient Full Name: _______________________________  DOB: ___ / ___ / ___

Patient Full Name: _______________________________  DOB: ___ / ___ / ___

I understand that once the insurance carrier has paid their portion of my care, I will receive an explanation of benefits (EOB) from them. This EOB will show the patient responsibility amount balance remaining. Mid-Atlantic Behavioral Health LLC, will notify you via billing statement mailed to your address on record.

Declined transaction/closed account:

- You will be notified by our billing department to provide alternate card for payment.
- A $50 declined payment fee will be added to all accounts if no alternative payment is provided.
- A letter will be sent to you notifying you of the declined payment. If no response is received within 30 days of the date of the letter, your account will be sent to our collection agency and you agree to pay all collection costs incurred.

Print name: ______________________________________

Signature: ______________________________________  Date: ________________
ACKNOWLEDGEMENT OF RECEIPT OF NEW PATIENT PAPERWORK

I certify that I have been given the opportunity to read or review and agree to the terms set forth in the following documents:

- Key Policy Summary Statement
- Notice of Privacy Practices
- Provider-Patient Services Agreement
- Credit Card on File Agreement
- Agreement for Services for a Minor in Joint Custody Cases, if applicable (Both parents must consent in joint custody cases and custody agreement is required to be on file with our office)

This acknowledgement serves as my informed consent for treatment for myself or my child. I also understand that the practice has the right to change these documents from time to time and that I may contact the practice at any time at the address listed to obtain a current copy of these documents.

Print Patient Name: ________________________________

Patient Signature: ________________________________

Parent/Guardian Name (if applicable): ________________________________

Parent/Guardian Signature (if applicable): ________________________________

Date: ________________________________

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our new patient paperwork, but acknowledgment could not be obtained because:

Date: ________________  Initials: ________________  Reason: ________________

Revised 1/1/2017