

Metro Maryland Counseling Center

Welcome to Metro Maryland Counseling Center (MMCC). MMCC provides a full range of professional psychological services for children, adolescents and adults, including individual, couples, family and group psychotherapy, psychological testing, psycho-educational assessments and appropriate and appropriate referrals to medical and social agencies, if needed. We hope that your involvement with us will be of benefit to you during this period in your life. It is our desire that you will experience the growth and resolution of your conflicts and concerns. We are committed to helping you reach those goals.

Identifying Information

Acct # _____

Therapist _____

DSM _____

___ / ___ / ___
(Date)

Client Name _____

Parent's Name (if client is a child) _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex (Circle): M F Date of Birth: ___/___/___

S.S.#: _____ - _____ - _____

___ No calls to home

___ No calls to office

___ No mail to home

Insurance Information

Insurance Co.: _____ Subscriber's Name: _____

Claims Address & Phone Number _____

Subscriber's SS # / Policy #: _____ Group #: _____

Subscriber's Date of Birth: ___/___/___ Subscriber's Employer: _____

Relationship to Subscriber (check one): ___ Self ___ Spouse ___ Child

In case of emergency, contact: Name: _____ Phone #: _____

Relationship: _____

**** Attached to this sheet is additional information needed and the terms and policies of our services to you.**

Client Acknowledgement and Agreement:

- I have read, understood and received a copy of the information on pages 2 through 6 of this document.
- I have had the opportunity to ask questions and have any questions answered.
- I understand and agree to abide by the contents and terms of this Agreement, and I consent to participate in treatment.
- I accept full responsibility for the financial obligations incurred for all services rendered on my behalf.

Signed: _____ Date: ___/___/___ Printed name: _____

Signed: _____ Date: ___/___/___ Printed name: _____

MMCC's Policies, Practices and Client Agreement for Treatment

THE PROCESS: Your overall involvement in treatment will depend on the nature of the issues being addressed. Your self-exploration, learning new ways of coping and problem solving, with guidance and feedback from your therapist (counselor, social worker, nurse psychotherapist, psychologist, or psychiatrist), are likely to result you feeling better.

However, there are times in the process when feelings such as unhappiness, anger, anxiety, guilt, frustration or others may increase. In couples, family, or group work some interpersonal tension or conflict may occur. This is a normal part of the process.

If you are in another recovery program, please inform your therapist. Exploring and working on issues in treatment may sometimes result in greater struggles to remain abstinent, clean or sober.

It is your therapist's commitment to offer you care and trained expertise, to give constructive feedback, to offer any necessary referrals, and to maintain confidentiality (some exceptions to confidentiality are listed below).

It is your commitment as a client to attend scheduled appointments, to be active and open in treatment, to reflect upon and practice new skills, to take any prescribed medications, and to pay all fees owed.

CONTACT WITH YOUR THERAPIST: Most sessions will be scheduled weekly. Individual, conjoint, and family sessions are 45 or 50 minutes in length; group sessions are usually 90 min. in length. Medication follow-up sessions are usually 30 min. in length.

If you need to speak to your therapist between scheduled appointments, call either office (Timonium at 410-561-9584 or Ellicott City at 410-750-3330) and leave a message on his/her Voice Mail, or inform the secretary, who will try to reach him/her. There will be a charge for this contact with your therapist: for calls 10 – 30 min. in duration, one-half session fee; for calls 30-50 min., a full session fee.

EMERGENCIES: In an emergency, express the urgency of your need to the secretary, who will try to reach your therapist. If your therapist is unavailable, another therapist may be able to speak to you. If in immediate danger, you or someone you love would be encouraged to go directly to the nearest hospital Emergency Room which would provide an evaluation and contact your therapist.

For an emergency during non-business hours, you can contact the Answering Service (410-288-8270), which will attempt to reach your therapist. If s/he cannot be reached, an on-call therapist will call you back. The charge for this contact will be: for calls 10-30 min., one-half session fee; for calls 30-50 min., a full-session fee.

CONFIDENTIALITY: Information you share with your therapist is generally confidential and will not be revealed to anyone without your written permission except in these cases:

- 1 If you are a danger to yourself or someone else, the law requires that potential helpers or victims be notified.
- 2 If there is suspicion of abuse of a child, elder or dependent or disabled adult, by law this must be reported to the authorities.
- 3 If insurance is used, your insurance company could require your therapist to provide information about your diagnosis and treatment.
- 4 If for some reason your therapist and/or your records are subpoenaed in a court case, your therapist may have to comply by law, after discussing the matter with you.
- 5 If you are under 18 years of age, your parents or guardians have a legal right to be informed of your general progress.
- 6 If you are in group therapy, group members will be urged to keep confidentiality; however, your therapist cannot guarantee that all members will do so.
- 7 If your therapist seeks supervision/consultation for your case, s/he will share only essential and anonymous information with the supervisor/consultant.

PAYMENT FOR SERVICES: You are to pay all fees owed at the time of the scheduled service. We accept cash, check and credit cards.

MMCC will provide an insurance-ready claim form for you to submit to your insurance company for reimbursement. Your insurance policy is a contract between you, your employer, and your insurance company. For this reason, you are expected to interact with your insurance company to pre-authorize treatment (if needed) and to initiate and maintain reimbursement.

Please discuss with your therapist whether he/she participates with your insurance company, and what procedures may be involved in utilizing the insurance. Our Administrative Staff can answer any questions you may have about submitting claims for reimbursement.

MMCC Fee Information:

Metro Maryland clinicians include both MMCC employees and Independent Contractors. Interns are supervised by licensed therapists.

Our services include psychotherapy and counseling for individuals, couples, and families; and psychological, educational, vocational, and addictions assessment.

Fees for these services are based on the therapist's education, experience, and licensure/certification [as psychologist, clinical professional counselor (LCPC), and clinical social worker (LCSW-C)].

Fees for psychological and psychoeducational testing will depend on the instrument being used. For other services such as report writing, authorized consultations, preparation of records or treatment summaries, telephone contact longer than ten minutes (or of unusual frequency), or other services you may request are billed on a prorated basis.

Please discuss fee and payment arrangements with your therapist. The administrative staff can provide additional information.

Your therapist and MMCC retain the right to submit past due accounts to attorney, collection agency, or court for collection.

CANCELLATION POLICY

We require 24-hour advance notice for cancelled appointments. You may leave your cancellation on the Voice Mail if the secretary is not available to take your message. Sessions missed without this cancellation will be charged at full fee. Insurance companies do not reimburse for charged missed appointments.

INFORMED CONSENT: I have reviewed the information in the Agreement, and have had my questions answered. I understand and agree to abide by the contents and terms of this Agreement and I consent to participate in treatment.

Signature of Client, Parent or Guardian _____

Printed Name: _____ Date: _____

Additional Signature: _____

Printed Name: _____ Date: _____

Witness Signature: _____

Printed Name: _____ Date: _____

Metro Maryland Counseling Center

NOTICE OF PRIVACY PRACTICES (SHORT VERSION)

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

Our commitment to your privacy.

Our practice is dedicated to maintaining the privacy of your personal health information. We are also required to do this by law. These laws are complicated, but we must provide you with important information. This explanation is a shorter version of the full, legally required Notice of Privacy Practices (NPP), which is available from our Administrative staff in the Timonium office. However, we can't cover all possible situations, so please contact our [Privacy Officer](#) (see the end of this document) about any questions or problems.

We will use the information about your health, which we get from you or from others mainly to provide you with treatment, to arrange payment for your services or for some other business activities, which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we /you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign and Authorization to allow this.

Of course, we will keep your health information private, but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these which may occur less frequently. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to respond according to your request.
2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records, but we may charge you. Contact our [Privacy Officer](#) to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our [Privacy Officer](#). You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can always get a copy of the NPP from the [Privacy Officer](#) or from our administrative staff.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our [Privacy Officer](#) and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Privacy Officer

If you have any questions regarding this notice or our health information privacy policies, please contact our **Privacy Officer who is Dr. Doris Morgan and can be reached by phone at 410561-9584.**

The effective date of this notice is April 14, 2003.

Metro Maryland Counseling Center

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____ and Metro Maryland Counseling Center. When we use the word “you” below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read The Notice of Privacy Practices before you sign this Consent form.

IF YOU DO NOT SIGN THIS CONSENT FORM AGREEING TO WHAT IS IN OUR NOTICE OF PRIVACY PRACTICES WE CANNOT TREAT YOU.

In the future w may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our website, www.metromarylandcounseling.com or by calling us at 410-561-9584 or from our Privacy Officer.

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

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

Signature of client or his/her personal representative

Date

Printed name of client or personal representative

Relationship to client

Description of personal representative’s authority

Date of NPP _____

Copy given to the client/personal representative