Access Behavioral Health

2324 N Rolling Road
Windsor Mill, MD 21244
Tel 410-744-1089 Fax 410-298-1932
www.accessbevioralclinic.com

CONSENT FOR TREATMENT

Welcome to our practice. This information sheet covers important issues related to your treatment. Please read it and acknowledge receipt by signing the intake form.

CONFIDENTIALITY

1. **HIPPA compliance –** Our practice safely stores your protected health information. Our electronic charting and email system are securely encrypted to maintain your confidentiality.
2. **Release of information –** Our providers must have your permission to reveal any information about you. In order to provide you with excellent medical care, we may ask for your consent to speak with your primary care provider, therapist, family members, or others.
3. **Exceptions –** Under specific legal circumstances, information may be releases without your permission. We are obligated by law to disclose information if:
    - **You are an imminent danger to yourself or others**
    - You tell us about an incident of child abuse
    - You tell us about an incident of abuse of someone over age 65 or a disabled adult
    - You are unable to provide food, clothing, or shelter for yourself
    - The court orders a release of information
4. **Insurance companies –** If we are contracted with your insurance panel or you submit invoices to your insurance company, be aware that the company may request certain information from us as a requirement of your reimbursement. This information could include dates of appointments, diagnoses, medications prescribed, and treatment summaries.
5. **Emergencies –** We keep an emergency contact on record to be used only in the case of an emergency.

PROVIDER AVAILABILITY

1. **Phone calls –** Our administrative staff is available during work hours to answer your calls about scheduling or billing. If you prefer, you may leave a message on your provider's voicemail that will be returned as soon as possible. We do not charge for phone calls with your provider of less than five minutes. Fees for longer provider calls, either with you or to coordinate care with other providers, are prorated and not covered by insurance: patients may be responsible for these charges.
2. **After-hours access –** If you are having clinically urgent situation during evenings, weekends, or holidays, you can contact your provider by following the instructions given through the voicemail system. If you are having a medical or psychiatric emergency, do not wait for a call back; call 911 or to your nearest emergency room.
3. **Email –** Administrative staff and providers can communicate with you about non-urgent matters by out HIPPA-compliant, secure email system. When you received an encrypted email from our practice, you will be asked to create a password and sign in to read it. Please keep in mind that emails you send originating from your server may not be secure.

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4. **Text –** Texting is not a secure form of communication. Our providers will not return test messages but will respond by secure email instead.
5. **Medications refill requests –** Please allow two days for refill orders to be sent to your pharmacy. In order to receive refills, you must have a future appointment scheduled.

SCHEDULING

1. **Length of sessions –** Initial assessment are 60 minutes, psychotherapy sessions are 45 minutes, and medication management appointments are 25 minutes. Our providers start and sessions on time.
2. **Appointment reminders –** Our office sends emails or phone reminders two days prior to your scheduled appointment. If you receive an appointment reminder in error, please email or call the office to clarify or cancel.
3. **Missed appointments –** We ask for two full business days' notice for any cancellations. For example, if your appointment were on Monday at 10a.m., you will need to cancel by Thursday at 10a.m. to avoid charges. *Please be aware that insurance companies do not cover missed sessions, so cancellation fees will be charged directly to your account.*
4. **Holidays and vacations – ABH** observes holiday, and our clinicians take about three weeks of vacation each year

BILLING

1. **Payment -** Payment is collected at the time of service by cash, credit card, or check made out to Access Behavioral Health.
2. **Insurance billing –** We are contracted with Beacons (Maryland Medicaid), Medicare, Magellan, and Carefirst/Blue cross Blue shield. *Please call your insurance company to verify your benefits before your initial appointment.* Our staff checks insurance benefits for all new and returning patients. However, information given to us can be unreliable and is not a guarantee of coverage. Please present your insurance card at your first appointment. If we are not on your insurance panel, you are responsible for submitting your claims and collecting reimbursement.
3. **Insurance changes –** Please inform out office promptly of any insurance changes. Without timely notification, your insurance may deny coverage, and you may incur full financial responsibility.
4. **Statements –** If you are paying out of pocket for your visits, statements are mailed upon request at any time.

Please keep a copy of this for your records and sign the intake form to acknowledge receipt of this consent.

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DISCONTINUATION OF TREATMENT POLICY NO SHOW POLICY

All new and follow up appointments must be cancelled at least two days prior to the appointment time.
Cancellation or reschedule requests on the day of the appointment are considered NO SHOW appointments.
Please be aware that Access Behavioral Health may discontinue your treatment for any of the following reasons

1. **Achievement of treatment goals.**
2. **Failure to appear for two or more appointments within a two-month period, without at least a 24-hour notification.**
3. **Being consistently late for appointments or consistently cancelling appointments.**
4. **Not participating in treatment for a period of 90 consecutive days.**

I hereby certify that I have been informed of my rights and responsibilities and of the grievance procedures as a client of Access Behavioral Health

Print Patient or Guardian Name _____ _____

Patient or Guardian Signature and Date _____ _____

We look forward to working with you.

Access Behavioral Health **Patient Demographic Sheet**

PATIENT'S NAME:	PATIENT DATE OF BIRTH:	SEX:
ADDRESS:		
CELL NUMBER:	HOME TELEPHONE:	
RACE:	EMAIL ADDRESS:	

REASON FOR SEEKING MENTAL HEALTH SERVICES (check all that apply)

□ Behavior Problems	□ Psychological/Educational Testing
□ Attention Deficit/Hyperactivity Disorder	□ Psychosis
□ Depression	□ Custody/Court/Legal
□ Anxiety	□ Suicidal Ideation
□ Autism	□ Other

WHO REFERRED YOU TO ABH?

□ PCP _____	□ General Hospital Discharge _____
□ Pediatrician _____	□ Psychiatric Hospital Discharge _____
□ Specialist (indicate specialty) _____	□ Social Worker/Counselor _____
□ School _____	□ Psychiatrist _____
□ Emergency Department _____	□ Self-referred

INSURANCE INFORMATION (no information will be treated as self-pay)

Primary Insurance Co. _____	Secondary Insurance Co: _____
Policy/Identification Number: _____	Policy/Identification Number: _____
Insurance Telephone Number: _____	Insurance Telephone Number: _____
Subscriber's/Policy Holder's Name: _____	Subscriber's/Policy Holder's Name: _____

FINANCIALLY RESPONSIBLE PARTIES (GUARANTORS)

Primary Guarantor's Name: _____	Secondary Guarantor's Name: _____
Relationship to Patient: _____	Relationship to Patient: _____
Address (if different from patient):	Address (if different from patient):
Address: _____	Address: _____
Home#_____ Cell#_____	Home# _____ Cell#_____
Work#_____ Email_____	Work# _____ Email: _____
Social Security Number_____	Social Security Number_____
DOB:_____ Marital Status_____	DOB _____ Marital Status_____
Name of School the Child Attends and Address: _____	