HIGHTOWER BEHAVIORAL HEALTH

PATIENT **INTAKE** FORM

Patient Name: (First & Last)_____ Middle Name: _____

Date of Birth:_____ Social Security Number_____ Sex: _____

Home Address:_____

City:_____ State:_____ Zip Code: _____

Home #:_____ Cell #:_____ Work #: _____

Preferred method of contact: (circle one) Phone Email Letter

Marital Status: Married_____ Single_____ Divorced_____ Separated_____ Widowed _____

Language (otherthan English):_____ **Race:**_____ Ethnicity: _____

Email address:_____ Employer: _____

Spouse/Parent:_____ Phone #: _____

Emergency Contact:_____ Phone #: _____

How did you hear about us? _____

INSURANCE I N F O R M A T 1 0 N

Ins Co Name:_____ Policy/ Member ID #: _____

Patient Relation to Insured: Self:_____ Spouse:_____ Child:_____ Other: _____

Policy Holder:_____ Sex: _____

Address:_____ City:_____ Zip Code: _____

Home #:_____ Date of Birth: _____

Employer: _____

SECONDARY I N S U R A N C E

Ins Co Name:_____ Policy/ Member ID#: _____

Patient Relation to Insured: Self:_____ Spouse:_____ Child:_____ Other: _____

Policy Holder:_____ Sex: _____

Address:_____ City:_____ Zip Code: _____

Home #:_____ Date of Birth: _____

Employer: _____

HIGHTOWER BEHAVIORAL HEALTH. 420 Crain Highway, Unit 3, Glen Burnie MD 21061. 0: 410 595 6199. F: 410 684 5334 info@hightowersvc.com; www.hightowerbh.com

HIGHTOWER BEHAVIORAL HEALTH

Financial Policy: To ensure accurate claim filing, please give your most current insurance card to our receptionist to be copied. If we are unable to verify your insurance, you will be responsible for payment at the time of service. Hightower Behavioral Health participates with Medicare/Medicaid and most managed care plans. We will bill your insurance company in compliance with the guidelines of our contract.

All co-payments, deductibles, and co-insurance as applicable are due at the time of service.
Payment in full is due at the time of treatment for all private pay patients, Medicare patients for non-assigned services (urinalysis, office visit, injections, etc.) and/or fees not covered by your insurance.
If coverage is contingent on a referral of pre-certification, it is your responsibility to inform us.
If you are unable to keep your appointment, we require a 24-hour cancellation notice or your account will be charged $50.
We accept cash and the following credit cards: Visa, MasterCard, and Discover.

Any outstanding account turned over to a collection agency will be charged an additional $35.00 fee.

I hereby authorize Hightower Behavioral Health to provide me with medical treatment. I understand and agree that I am responsible for all fees not covered by my insurance company. I hereby authorize the release of any medical information necessary to file a claim with my insurance company. If my account is turned over to a collection agency, I understand and agree that I will be responsible for any collection fees, attorney fees, court costs, or other fees incurred by me.

Patient/Responsible Party Signature _____ Date _____

HIPAA NOTICE

I understand Hightower Behavioral Health follows the laws and guidelines of the HIPAA regulations. All services and records are confidential and private to protect the patient.

Patient Signature _____ Date _____

If the patient is a minor, it is mandatory by HIPAA for the patient to sign a consent form to release information to a parent or any other guardian if related to the following:

- **Contraceptive Care and Counseling**
- Prenatal Care
- **Abortion**
- **Sexually Transmitted Diseases**
- **HIV/AIDS**
- Substance Abuse
- Emergency Care

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HIGHTOWER BEHAVIORAL HEALTH

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, the Undersigned, authorize: HIGHTOWER BEHAVIORAL HEALTH to

allow the use and sharing of protected health information about:

Client name: Date of Birth: _____

Once completed and signed, this authorization will remain in effect until: (specify date)

The Mental Health Information Authorized for Release includes: (check all that apply)

Copies of Records Discharge Summaries COlâStl J1at1Ori

School Visitation: _____

Person/Organization authorized to receive your information:

School: _____

Address: _____

Phone #: _____ Fax #: _____

Purpose of Release: _____

1 understand that I can revoke or cancel theis authorization at any time by sending a letter to the Privacy Officer of the organization 1isted above and which is to supply this information. If I do this it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number 4 above, nor will it affect my eligibility! it for benefits. I understand that I may inspect and I\have a copy of the health information described in this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above way be re-disclosed and no longer protected by those regulations. I understand that II is professional or facility will receive compensation for the use or disclosure of my health information, The arrangement has been explained to me and I understand and accept it. I affirm that everything in this form that was not clear to me has been explained and I believe I wow uilderst8iJd all of ii.

I acknowledge that the information to be used or disclosed as a result of this Authorization may include records that are protected by other federal and/or state laws applicable to substance abuse. 1 specifically authorize the release of confidential information relating to drug and/or alcohol abuse, psychiatric, HIV results and or AIDS information. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information. 42 C FR 2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Client/Parent/Guardian Signature Date

_____ _____

Therapist Signature Date

HIGHTOWER BEHAVIORAL HEALTH

CLIENT ACKNOWLEDGEMENT OF INFORMATION

My signature below is acknowledgement that the following information was reviewed all explained to me during the intake process:

./ Privacy (HIPAA.) Laws

./ Client Rights as Participants

./ Grievance Procedure

./ Confidentiality of Records and Release of Information

./ Description of Services offered

As a client or designee of the client, my signature below indicates that I understand the information above and that I agree to adhere to the policy, protocol and/or procedures to each of the items as listed as they relate to me at any given time as a participant in Family Intervention Partners programs.

_____ _____

Client/Parent/Guardian Signature Date

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HIGHTOWER BEHAVIORAL HEALTH

Consent for Treatment

I have chosen to receive mental health services in the form of_____for myself and/or my child from HIGHTOWER BEHAVIORAL HEALTH. My decision is voluntary, and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

Nature of Mental Health **Services**

I understand that during treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

Compliance with treatment plan

I agree to participate in the development of an individualized treatment plan. I understand (hat consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

Supervision

I understand there are certain circumstances which may require HIGHTOWER BEHAVIORAL HEALTH to receive supervision. These circumstances include, but are not limited to the following:

1. State licensure regulations may require my therapist or service provider to receive ongoing supervision
2. Accreditation organizations, as well as insurance companies, may require that my treatment plan be reviewed
3. The standards of care which guide most mental health professional recommend that supervision and/or consultation be obtained in high risk situations such as threats and/or acts of harm to se(f or others
4. Other special circumstances, such as preparation to testify in court

Client Rights

- The right to be treated with dignity and respect by all staff
- The right to be involved in the planning and/or revision of my treatment plan
- The right to know about my treatment progress or lack thereof
- The right to reject the use of any therapeutic technique, and to ask questions at any lime about the methods used
- The right to be spoken to in a language that is fully understood
- The right to a clean and safe environment
- The right to refuse to be videotaped, audio recorded, or photographed
- The right to end treatment at any time unless court ordered
- The right to file a complaint or grievance about the agency or staff

The right to confidentiality of cl)nicaI records and personal information according to federal and state laws

Emergencies

I understand I may reach HIGHTOWER BEHAVIORAL HEALTH at 410 595 6199. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life threatening emergency situation, I *may* call 911 or 410 768 SS22.

I have read, discussed and understood all of the above.

_____
Signature / Date

_____
Witness / Date

HIGHTOWER BEHAVIORAL HEALTH

INFORMED CONSENT FORM

Client name:---------- **Date of Birth:**----------

1, hereby voluntarily consent to receive consultative, diagnostic, and therapeutic services and/or procedures from HIGHTOWER BEHAVIORAL SERVICES as listed below:

Psychosocial Assessment Individual Therapy Group Therapy

Family Therapy Medication Management

I understand the benefits of each service as well as the alternative to recommended treatment. Unless specifically stated otherwise, this consent form expires upon completion of services from HIGHTOWER BEHAVIORAL HEALTH. I further understand that I am free to withdraw this consent for services at any time without prejudice to receiving alternative services from HIGHTOWER BEHAVIORAL HEALTH. I may also be discharged from HIGHTO WER BEHAVIORAL HEALTH if there is non-compliance with the agreed upon services.

Client/Parent/Guardian Signature Date

HIGHTOWER BEHAVIORAL HEALTH

LIMITS OFCONFIDENTIALITY

Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Child ren and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and sum rn aries.

1 agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client Signature (Parent/Guardian if under 18) Today's Date

HIGHTOWER BEHAVIORAL HEALTH

CANCELLATION P O L I C Y

When an appointment is scheduled, that time is reserved specifically for you. If the appointment is missed or cancelled without enough notice, the therapist is unable to make use of that time. Therefore, sessions must be cancelled 24 hours in advance. If a client does not give 24 hours' notice it is considered a "no show".

A $35 fee will be charged for missed appointments or no-show cancellations with less than a 24-hour notice unless due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment.

Thank you for your consideration regarding this important matter.

_____ _____

Client Signature (Parent/Guardian if under 18) Today's Date

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Consumer Rights

1. Be treated, at all times, with consideration and respect for your dignity, autonomy, and privacy.
2. Be informed of your rights
3. Access mental health services and supports
4. Be free from discrimination on the basis of race, color, religion, national origin, language, culture, sex, age, marital status, personal appearance, sexual orientation, familial status, family responsibilities, matriculation, political affiliation, disability, source of income, or place of residence.
5. Be free from physical, emotional, sexual, or financial abuse, neglect, harassment, coercion, and exploitation when seeking or receiving mental health services and supports.
6. Safe, sanitary, and humane treatment conditions.
7. Receive individualized mental health services and mental health supports in the least restrictive, most integrated setting appropriate to your needs.
8. Meaningful participation in the development of **your individual** recovery plan **or individual plan** of care, as well as the opportunity to participate in planning for your transition from one provider to another.
9. Be informed about your condition and legal status, and of proposed or current services, the risks and benefits of treatments, therapies, and other available alternatives. Unless otherwise provided by law, no services or supports will be provided to you without your informed consent or the consent from legal guardians for minors.
10. Make health care decisions including the right to executed advance directives about medical treatment decisions and the right to execute a declaration of advance instructions about your mental health treatment preferences
11. Be free from the administration of medication for the purpose of mental health treatment without your informed consent (or the legal guardian's consent for minors) unless otherwise provided by law
12. Have your mental health information record and all information about you kept confidential unless otherwise provided by law.
13. Have access to your records in accordance with the Mental Health Information Act.
14. Participate in periodic evaluation of mental health services and mental health support, including an evaluation of our providers.
15. File a grievance if you feel that any of your rights have been limited or violated, or you are dissatisfied with the mental health services or mental health supports being provided
16. Request and receive an itemized copy of our bill for mental health services and mental health supports.

Patient Name & Signature _____

Acknowledgment of receipt. A copy of this document has been provided to the consumer and/or parent/guardian.