Carroll Counseling – Bay Area
650 Ritchie Hwy. Suite 207
Severna Park MD 21146

DATE OF FIRST VISIT: _____

CHILD INFORMATION (17 YRS AND UNDER)

FIRST NAME: _____ MIDDLE INITIAL: _____

LAST NAME: _____ SSN: _____

ADDRESS: _____ SEX: _____

CITY, STATE, ZIP: _____ DATE OF BIRTH: _____

FATHERS' NAME: _____

CONTACT NUMBER: _____

MOTHERS' NAME: _____

CONTACT NUMBER: _____

GUARDIAN NAME: _____

CONTACT HUMBER: _____

INSURANCE INFORMATION

INSURANCE COMPANY: _____ PHONE #: _____

POLICY HOLDERS NAME: _____ (FIRST/ INITIAL/ LAST)

SEX: MALE ____ FEMALE ____

ADDRESS (IF DIFFERENT THEN PATIENTS'): _____

CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMPLOYER: _____

POLICY ID #: _____ GROUP #: _____

PATIENT RELATIONSHIP TO INSURED: CHILD: __ STEPCHILD: __ OTHER: _____

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

MINORS IN TREATMENT

1. The parent/Legal Guardian whose signature is on the Child Intake form is ultimately responsible for prompt payment on the account. This policy applies no matter which parent schedules the appointment, brings the child or incurs late cancelation charges. It is important that the parent who signed the Child Intake form fully informs the other parent as to our financial polices to avoid confusion. This is especially important when the parents are divorce or not living together. Whoever signs the Child Intake form is responsible for any and all billable charges on the child's account. Disputes on who scheduled the child's appointment or requested the services are to be resolved between the parents and not with our office.

2. In order for children to participate and speak freely in therapy they need to be assured of their rights to confidentially. The child needs to know what information will be kept between the child and therapist and what information will be shared with parents and other parties.

3. When a child makes a comment or shows other signs that indicate a suicide risk may be present a parent is informed immediately.

4. When a child indicates that they are intending to physically harm another person the parents and the other person are promptly notified.

5. When a child makes a comment, or shows signs, that physical or sesual abuse may have taken place both the parents and Children Services are notified. Physical/sexual abuse suspicions must be reported to Children Services as stipulated by Maryland state law.

6. Parents are always informed of progress in therapy. The child's primary relationship is with their parent(s). The main purpose of mental health therapy with a child is to enhance and improve the child's life outside of the therapy session.

By signing this form you as the parent are indicating that you understand the therapy information that will be kept confidential and the information that would be promptly shared with you. By signing you are also giving the assigned provider your permission to provide mental health counseling to your child at Carroll Counseling – Bay Area.

Print Name of child: _____

Parent/Legal Guardian Signature: _____

Print Name: _____

Date: _____

CARROLL COUNSELING – BAY AREA

AGREEMENT FOR 17 AND UNDER

PLEASE PRINT NAMES:

I _____(please print) parent or legal guardian for patient

_____ who is 17 years or younger, agree to allow him/her to be seen at Carroll Counseling – Bay Area for treatment without me being on site (not in the waiting room) for the sessions. I understand by allowing the above named patient to be seen without my presence ***I must have a credit card on file*** to be used for all payments that are due at the time of service. See "Auto Credit Card Information" attached.

_____ _____

Signature of parent or legal guardian Date

CARROLL COUNSELING AT BAY AREA
650 Ritchie Hwy
Suite 207
Severna Park, MD 21146

Patient name: _____
PLEASE PRINT

Responsible Party name if different than the above name:

_____
PLEASE PRINT

Welcome to our office. We would like for your time with us to be as stress free as possible, thus we want to make certain that you have Outpatient Mental Health Benefits through your insurance carrier. It is very important that you know your benefits. You should know if you:

Have a deductible to meet; if so, how much is it.
Have a maximum number of visits annually.
Do I need authorization - if so how do I go about getting it?
What will I have to pay at the time of my visit?
A "copay" is a flat fee, and a "Coinsurance Payment "is a % of whatever the allowed amount is.
If I have another insurance card – which one is Primary?

I have contacted my insurance carrier regarding my benefits for Outpatient Mental Health. I understand that I will be responsible for any benefit that is not covered by my insurance.

_____ _____
Responsible Party Date

Welcome to our practice. This document contains important information about our professional services and business policies. Please read it carefully. When you sign this document it will represent an agreement between us.

COMMUNICATION: We may contact you to remind you of appointments and to provide you with other information. May we have your permission to leave appointment reminders on your answering machine? Yes____ No ____ Best number to call is _____

CANCELLATIONS: The patient must notify us at least 24 hours prior to the scheduled appointment time. Failure to provide us with 24 hour notice may result in a $95.00 charge for the missed appointment.

IF YOUR INSURANCE COMPANY REQGUIRES A REFERRAL OR AUTHORIZATION: If the patient's insurance requires a referral, a valid referral must be brought with the patient at the time of the appointment in order to be seen by the provider. Failure to obtain a proper referral may result in payment in full for your sessions.

PRESCRIPTION REFILLS: Medications will not be filled over the phone. You must be seen by the Doctor for all refills every 3 months. Please allow 72 hours for refill request.

PAYMENT FOR SERVICES: Co-payments, coinsurance and any previous balances are due at check in. If you would like us to automatically charge your credit card, please ask for a signature page.

INSURANCE BILLING: We will submit claims to all primary insurance carriers. The patient must present their valid insurance card upon registration for the appointment. If coverage changes, we MUST BE NOTIFED WITHIN 30 DAYS of the effective date. We will not refile claims past 30 days. You will be responsible for payment in full for those dates.

CONFIDENTIALITY: In general, the privacy of all communications between a patient and a provider is protected by law, and the provider can only release information about our work to others with your written permission. The practice follows all HIPAA regulations.

TREATMENT RECORDS: Any information from your record will be released to a third party only after you have given your signed consent. It takes about 2 weeks to process any request for copying of records. In most circumstances, you will be charged a copying fee of $.76 per page and a processing fee of $22.88.

Your signature below indicates that you have read and understand the information in this document and agree to abide by its terms during your association without office. A copy of this form will be provided to you at your request.

_____	_____	_____
Signature Patient or Parent	Minor's Name (Please Print)	Date

Patient Name: _____

BENEFIT ASSIGNMENT AUTHORIZATION

I, _____, hereby authorize Payment of any medical insurance for which I am entitled to be made directly TO CARROLL COUNSELING AT BAY AREA. I agree to pay the balance of any charges not paid under my insurance plan for which I am liable.

I also authorize the release of medical information necessary to process any and all claims.

SIGNATURE_____ DATE_____

MENTAL HEALTH BENEFITS

I understand that it is my responsibility to know my Mental Health Insurance Benefits prior to my visit. I also understand that it is my responsibility to review my Explanation of Benefits statement from my insurance company and that if there is a question or concern; I will call my insurance company directly.

I realize that failure on my part to know and understand my benefits may result in my benefits being denied or reduced by my insurance.

I understand that failure on my part to notify Carroll Counseling at Bay Area of any insurance changes regardless of the reasons will result in my having to pay for all dates of service that are effective by the change.

I agree to these terms by my signature below.

_____ _____

Patient or Parent Signature Date

CARROLL COUNSELING AT BAY AREA
650 Ritchie Highway
Suite 207
Severna Park, MD 21146
Tele: 410-315-9350 Fax: 410-421-9135

Patient Name: _____

Informed Consent for Treatment

I _____agree and consent to participate in behavioral health care services offered at Carroll Counseling and provided by, _____ a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within the scope of the provider's license, certification, and training. If the patient is under the age of eighteen or unable to consent to treatment, I attest that, I have legal custody of the individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature_____ Date _____

Relationship to Patient (if applicable) _____

CARROLL COUNSELING AT BAY AREA

650 Ritchie Highway
Suite 207
Severna Park, MD 21146

PLEASE CHECK ALL BOXES:

Is the reason for this appointment associated with a vehicle accident? ___YES ___ NO

Is the reason for this appointment associated with your employment? ___YES ___ NO

Have you ever been treated for alcohol or substance abuse? ___YES ___ NO

If YES, is the reason for this appointment associated with alcohol or substance abuse? __YES __ NO

Is the appointment related to any on-going court case, custody battle, workers compensation claims, disability application issues, or any other situation where a provider might be asked for written documentation or discovery of findings? ___YES ___NO. If YES, you must fully explain your intentions to the provider within your first visit.

I agree that by signing this statement, these facts are true and should not change in the near future.

_____ _____

Patient or Parent Signature Date

Original in Business **Copy in Clinical**

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.

Section 1. The Patient

Last Name	First Name	Middle Initial

Subscriber Number From ID Card	Insurance Company Name	Date of Birth (MM/DD/YYYY)	Phone Number

I hereby authorize the disclosure of protected health information about the individual named above.

I am: ☐ the individual named above (complete Section 8 below to sign this form)

☐ a personal representative because the patient is a minor, incapacitated, or deceased (complete Section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following behavioral health provider may disclose the information:

Name (a person, or an organization if you are naming a facility)	Phone Number (if known)
BAY AREA BEHAVIORAL HEALTH	

Section 3. Who Will Be Receiving Information About the Individual?

The information may be disclosed to the following primary care physician:

Name (a person, or an organization if you are naming a practice)	Phone Number (if known)

Street Address (if known)	City, State and Zip Code (if known)

Section 4. What Information About the Individual Will Be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

Section 5. The Purpose of the Disclosure

To release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

Section 6. The Expiration Date or Event

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Section 8. Signature of the Individual

Signature_____ Date (required) _____

Section 9. Signature of Personal Representative (if applicable)

Signature_____ Date (required) _____

Relationship to the individual (required): _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited 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.

Last Updated: 09/20/06

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AUTOPAY CREDIT CARD INFORMATION:

CIRCLE ONE: AMEX DISCOVER MASTERCARD VISA

CARD NUMBER: _____

EXPIRATION DATE: _____/_____ CVV _____

I _____give permission to charge
CARDHOLDER'S NAME

to this account all payments and deductibles or any other fees for patient

_____ to the
PRINT PATIENT'S NAME

above listed credit care. I understand that this information will be kept in a secure location at CARROLL COUNSELING AT BAY AREA office and will not be disclosed for any reason whatsoever.

This card will remain in effect until the expiration date on the card or until I advise the staff to do otherwise.

CARDHOLDERS SIGNATURE: _____

DATE: _____