CLEAR VIEW COUNSELING CENTER
Guiding your way to wellness

1819 Bay Ridge Ave., STE 190
Annapolis, MD 21403
(Ph) (443) 281-9430
(Fax) (443) 782-2446
Info@ClearViewCounselingCenter.com

Welcome Packet

Please fill out the attached Patient Information Sheet. Please be advised that you are responsible for meeting deductibles, copayments, and/or any charges not covered by your insurance carrier(s) for whatever reason, at the time of each visit. Please note that your insurance carrier may not certify, authorize or reimburse for certain services required, or deemed necessary by your provider. By signing below, you agree to be 100% responsible for these fees which may include, but are not limited to, unauthorized visits, patient treatment plans, medical forms/ records, legal and forensic reports or court testimony. For your convenience, we do accept MasterCard, Visa, American Express, HSA cards, cash and personal checks. However, there is a $35 charge for returned checks and a credit card processing fee. Additionally, patient accounts overdue for more than 30 days, without any payment arrangements, will accrue a 3% interest fee and may be released for collections with a collection fee added to the account balance due.

Due to the overwhelming demand for services, I ask that you be considerate of others needing to schedule appointments, and provide me with at least 24 hours' notice, should you be unable to attend an appointment. **A $75 charge will be made to your account for appointments missed with less than 24 hours' notice. This fee is not covered by insurance**. Repeated late-cancellations and missed visits may result in the termination of treatment. I have 24 hour phone coverage which will allow you to leave a message if you cannot attend a scheduled appointment. An addition, **phone contact lasting over 15 minutes, will be prorated and charged at the regular hourly rate and is not covered by insurance. Written reports requested for purposes other than therapy note documentation are charged $25 per half page.**

As the patient or guardian, I hereby authorize Clear View Counseling Center, LLC, to file directly with my insurance carrier(s) for payment of services covered by my benefit plan. I certify that the information reported with regard to my insurance coverage is accurate and complete. Any changes in insurance information or coverage must be presented or corrected immediately. Insurance claims will not be submitted retroactively. Additionally, authorization is hereby given to release any medical information required by my insurance company to facilitate processing of claims. I permit a copy of this authorization to be used in place of the original. I understand that Clear View Counseling Center, LLC is not liable for information disclosed by my Insurance Carrier such as Explanation of Benefits that may be sent by the Insurance Carrier to the policyholder.

I take every precaution in protecting the confidentiality of your visits as well as all clinical records. To ensure quality care, professional consultation may be obtained. I do not reveal confidential information without your written consent, except where required by law, such as if I learn about child abuse or abuse of elderly adults or adult vulnerable populations; if a patient is a danger to him/herself or others (suicidal, homicidal or engaging in high risk behavior), or if required by a court order to present records.

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Thank you for your cooperation.

I have read, understand and accept the office policies and agree to be responsible for all charges incurred. I consent to psychological services for myself or my dependent.

_____ _____

Name of Patient Date

_____

Signature of Patient

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give my informed consent to Clear View Counseling Center, LLC to:

- ☐ Disclose information to:

  _____

  _____

- ☐ Obtain information from:

  _____

  _____

- ☐ Exchange information with:

  Clear View Counseling Center, LLC
  1819 Bay Ridge Ave., STE 190
  Annapolis, MD 21403
  (443) 826-7457

Regarding copies of and/or discussions related to reports designated below for continuing treatment.

- ☐ Treatment Summary
- ☐ Admission Assessment
- ☐ Psychological Evaluation
- ☐ Psychologist Progress Notes
- ☐ Updated Primary Care Referral
- ☐ Outpatient Treatment Report
- ☐ Pertinent Court/ Legal Documents
- ☐ Termination/ Discharge Summary
- ☐ Social Services Progress Notes
- ☐ Medical Information
- ☐ Dependent's Treatment/ Care
- ☐ Updated Care Referral
- ☐ Other (Specify): _____

Purpose of disclosure:

- ☐ Assessment & Treatment
- ☐ Discharge Planning
- ☐ Forensic/ Attorney Consultation
- ☐ Other:_____

Patient Name: _____ Date of Birth:_____

Signature: _____ Date: _____

Witness: _____ Date: _____

This consent will automatically expire one year from the date signed by the patient, guardian, or legal representative and may be revoked in writing at any time.

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Health Insurance Portability and Accountability Act

Information Sheet and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

I have adopted the following policies:

- Client information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files are stored in a locked file cabinet. The normal course of providing care means that such records may be left out, at least temporarily, those records will not be available to persons other than designated therapist. You agree to the normal procedures utilized within the office for the handling of charts, patient records, protected health information (PHI) and other documents or information.

- Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

- I agree to provide patients with access to their records in accordance with state and federal laws.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy.

Patient Name: _____ Date of Birth:_____

Signature: _____ Date: _____

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Missed Visit Policy

Due to the high demand for psychotherapy services and the limited availability of appointments, **late cancellations** (canceling an appointment with less than 24 hours' notice**) and missed visits result in a charge of $75**. This fee cannot be billed to insurance and will be charged immediately following your missed visit.

It is important that you arrive promptly for your appointment. Due to the intense nature of therapy sessions, abbreviated sessions can often be more harmful than beneficial. I understand that life happens, including emergencies, weather and traffic. Please call ahead if you expect to be late to an appointment. **Tardiness in excess of 20 minutes will result in cancellation of the appointment and a fee of $75 will be charged.**

I understand that a missed visit fee may be financially burdensome. However, this policy is in place in an effort to promote responsible scheduling and therapy attendance. The best therapeutic outcomes are due, in part, to consistent treatment. In addition, failing to provide adequate notice for a cancelled appointment robs other patients from the opportunity to get the help they need during that unused session.

I have read, understand and accept the late cancellation/ missed visit policy. I agree to be responsible for all charges incurred.

_____ _____

Name of Patient Date

_____

Signature of Patient

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Patient Information Form

Patient Information **Today's Date:**_____

Patient Name: _____ _____ _____
Last First Middle

Gender: ☐ Male ☐Female ☐ Transgender

Date of Birth: _____ _____ _____ **Age**:_____ Social Security #: ____ ____ ____
Month Day Year

Marital Status: ☐Single ☐ Married ☐Separated ☐ Divorced ☐Widow

Home Address: _____ **Home Phone**: _____
_____ **Cell Phone:** _____
_____ **Work Phone**: _____

Email Address: _____

Occupation: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Student

Name of Employer/ School: _____
Address: _____
_____
City State Zip Code

Previous Mental Health Treatment: ☐ Psychiatrist ☐ Psychologist ☐ LCSW ☐ Other

Mental Health Provider:
Name:_____
Address: _____
Phone: _____

Primary Care Physician:
Name:_____
Address: _____
Phone: _____

Referral Information:
☐ Physician ☐ Insurance Co. ☐ Relative ☐ Friend ☐ Website ☐ Psychology Today
☐ Maryland Psychological Association ☐ ISTSS ☐ Other: _____

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Credit Card/ Debit Card Authorization Form

For your convenience, you may schedule payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card.

Please provide the following information:

I, _____ authorize Clear View Counseling Center, LLC, to charge my
(print name)
credit/ debit card for the amount of my co-payment, following each appointment for the payment of my therapy session.

Billing Address: _____
Street Address Apt #

_____
City State Zip Code

Phone Number: _____-_____-_____ Email:_____

Credit/ Debit Card:

☐ Visa ☐ Master Card ☐ American Express ☐ Discover

Cardholder Name: _____

Account Number: _____ Expiration Date: _____

CVV (3 Digit Number on Back of Card): _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Clear View Counseling Center, LLC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. In the case of a transaction being rejected for Non Sufficient Funds (NSF) I understand that Clear View Counseling Center, LLC may at its discretion attempt to process the charge again within 30 days, and agree to an additional $35 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

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NOTICE OF PRIVACY PRACTICES

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
  - – Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychotherapist.
  - – Payment is when I obtain reimbursement for your healthcare. Examples of payment would be when I 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 my practice. 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 my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside my office, such as releasing, transferring, or providing access to information about you to other parties.
- "Authorization" is your written permission to disclose confidential mental health information.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversations during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical records. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) the authorization was obtained as a condition of obtaining insurance coverage; the law provides the insurer the right to contest the claim under the policy.

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III. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities.
- Adult and Domestic Abuse – I may disclose protected health information regarding you if I reasonably believe that you are a victim of abuse, neglect, self-neglect or exploitation.
- Health Oversight Activities – If I receive a subpoena from the Maryland Board of Examiners of Psychologists because they are investigating my practice, I must disclose any PHI requested by the Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated by a third party or when the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

IV. Patient's Rights and Psychotherapist's Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not 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 me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect and/or to obtain a copy of PHI in my mental health and billing records used to make decisions about you, for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You have the right to inspect and/or to obtain a copy of Psychotherapy Notes unless I believe the disclosure of the record will be injurious to your health. On your request, I will discuss with you the details of the request and denial process for both PHI and Psychotherapy Notes.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I 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. On your request, I will discuss with you the details of the accounting process.

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• Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, we are required to abide by the terms currently in effect.

• If I revise my policies and procedures, I will provide you with a revised notice by mail or at the next therapy session.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I have made about access to your records, you may contact the Maryland Psychological Association at 10025 Gov. Warfield Parkway, Suite 102, Columbia, MD 21044-3308.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The association listed above can provide you with the appropriate address upon request.

VI. Effective Date of Privacy Policy

This notice will go into effect on April 14, 2015.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices for Clear View Counseling Center., LLC and I consent to the above policies regarding use and disclosure of my PHI.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Printed Name of Patient or Legal Guardian

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  - – Payment is when I obtain reimbursement for your healthcare. Examples of payment would be when I 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 my practice. 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 my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside my office, such as releasing, transferring, or providing access to information about you to other parties.
- "Authorization" is your written permission to disclose confidential mental health information.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversations during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical records. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) the authorization was obtained as a condition of obtaining insurance coverage; the law provides the insurer the right to contest the claim under the policy.

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- Child Abuse – If I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities.
- Adult and Domestic Abuse – I may disclose protected health information regarding you if I reasonably believe that you are a victim of abuse, neglect, self-neglect or exploitation.
- Health Oversight Activities – If I receive a subpoena from the Maryland Board of Examiners of Psychologists because they are investigating my practice, I must disclose any PHI requested by the Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated by a third party or when the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

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Printed Name of Patient or Legal Guardian