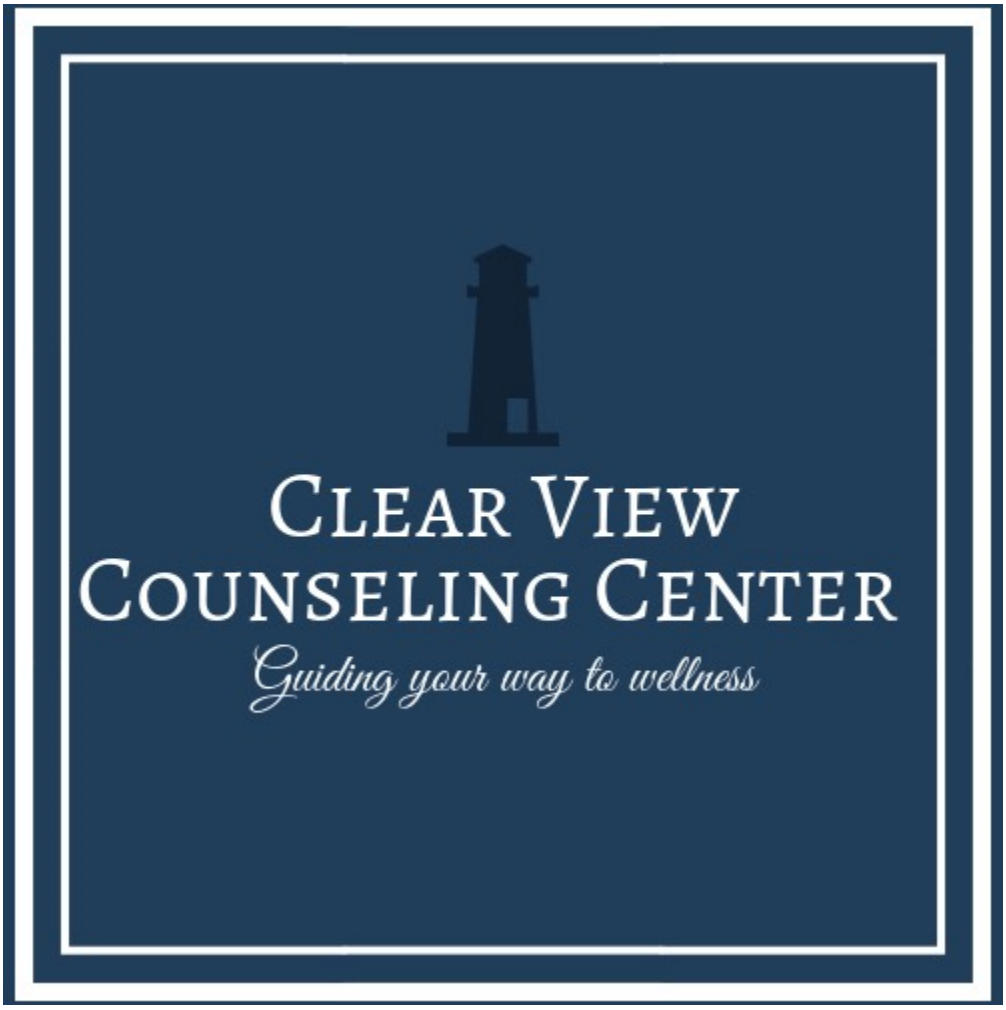
WELCOME PACKET



Clear View Counseling Center
1819 Bay Ridge Ave., STE 190
Annapolis, MD 21403
https://clearviewcounselingcenter.com/

INSTRUCTIONS

The next pages will provide you with information on your patient rights and Clear View Counseling Center policies. Please read through each page carefully and complete all requested information prior to your first appointment. **This packet must be completed prior to your initial appointment**. *Incomplete Welcome Packets at the time of your first appointment will result in the rescheduling of your first evaluation*.

Please note, you must give at least 24 hours' notice for all requests to reschedule or cancel appointments. Intake appointments that result in a late cancellation or missed visit may or may not be able to be rescheduled.

Please bring this completed packet with you along with your insurance card(s) and photo I.D. to your first session. *If your first session is scheduled for tele-therapy, you must complete and return this packet directly to your clinician at least 1 full business day in advance of your initial scheduled appointment.*

COMMUNICATION

You are strongly encouraged to save your clinician's contact information including his or her direct phone number and his or her CVCC email address in your contacts. Email and text messaging are not private, secure methods of contact. Note that you may use non-secure methods of communication with your clinician at your own risk. For your protection and privacy, your clinician is unable to use non-secure methods of communication to send you any messages that may contain private and/or therapeutic content.

My Clinician:
Phone:
Email:

Please be aware that each clinician at the Clear View Counseling Center is an independent contractor and he or she has 100% autonomy over his or her schedule. As such, you must use the Patient Portal to send all requests to schedule, reschedule, or cancel appointments directly to your clinician. For schedule requests with less than 24-hours' notice, you must contact your clinician directly. Our best efforts will be made to forward voicemails and emails left on the general CVCC voicemail to your clinician. However, since this is not an automated task, we cannot guarantee that your messages will be delivered in a timely manner and you may risk incurring a late cancellation/ missed visit fee. **Please ask your clinician for his or her business card and/ or save their number in your phone.**

For further information on communication guidelines, please review our Scheduling Policy and HIPAA Information Form.

CHECKLIST

REQUIRED SIGNATURES

Please read through each section carefully and sign at the end bottom of each page as requested. If you require further explanation of any of the policies outlined in this Welcome Packet, please ask your clinician for clarification.

Form	Page	Completed
Confidentiality	4	
Mental Health Treatment with Minors*	5	
HIPAA Information Form	6	
HIPAA Consent Form	9	
Tele-therapy Informed Consent Form	11	
Insurance Authorization	12	
Insurance Form	13	
Financial Policy	14	
Payment Authorization Form	15	
Scheduling Policy	16	
Missed Visit Policy	17	
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Patient Information Form	19	
Authorization for Release of Information**	20	

*Required for all patients under the age of 18

**Completion of the Authorization for Release of Information Form is not required. However, you may find it beneficial for your clinician to coordinate with any other member of your treatment team, a teacher, family member, etc., you may authorize consent with the completion of this form.

CONFIDENTIALITY

The Clear View Counseling Center takes every precaution in protecting the confidentiality of your visits as well as all clinical records. To ensure quality care, professional consultation may be obtained. We do not reveal confidential information without your written consent, except where required by law, such as if we learn about child abuse or neglect, or abuse of elderly adults or neglect, 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.

I have read, understand, and accept the Confidentiality Policy and I consent to psychological services for myself or my dependent.

Patient Name: _____ DOB:_____

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

MENTAL HEALTH TREATMENT WITH MINORS

Attn: This form is required for all patients under the age of 18 at the time of his or her initial evaluation.

The state of Maryland recognizes there are unique considerations regarding minor assent and consent for their treatment age**.**

***If a patient is under the age of 18 at the time of his or her initial evaluation, the minor patient AND the legal guardian must BOTH sign all forms in this packet.**

Maryland Regulations for Mental Health Treatment with Age-of-Consent Minors:

- The state of Maryland recognizes the legal right for individuals, aged 16 and over, to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or a clinic [Md. Code Ann., Health-Gen. II § 20-104(a)]. Essentially, a minor who is 16 years-old or older has the same capacity as an adult to consent for mental health treatment.
- However, the state of Maryland also reserves that the capacity of a minor to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or a clinic does not include the capacity to refuse consultation, diagnosis, or treatment for a mental or emotional disorder for which a parent, guardian, or custodian of the minor has given consent.
- Without the consent of or over the expressed objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor [Md. Code Ann., HealthGen. II § 20-102(f)]

Patient Name: _____ DOB:_____

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. The Clear View Counseling Center has 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 the 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.

- The Clear View Counseling Center agrees 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: _____ DOB:_____

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

HIPAA INFORMATION FORM

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

The Clear View Counseling Center 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 the Clear View Counseling Center provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when your clinician consults with another health care provider, such as your family physician or another psychotherapist.
  - – Payment is when the Clear View Counseling Center obtains reimbursement for your healthcare. Examples of payment would be when the Clear View Counseling Center discloses 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 the office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside the 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

The Clear View Counseling Center 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 your clinician is asked for information for purposes outside of treatment, payment, or health care operations, he or she will obtain an authorization from you before releasing this information. He or she will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes your clinician has made about your conversations during a private, group, joint, or family counseling session, which they may 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) The Clear View Counseling Center has 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.

III. Uses and Disclosures without Authorization

The Clear View Counseling Center may use or disclose PHI without your consent or authorization in the following circumstances:

• Child Abuse – If your clinician has reason to believe that a child has been subjected to abuse or neglect, he or she must report this belief to the appropriate authorities.
• Adult and Domestic Abuse – Your clinician may disclose protected health information regarding you if he or she reasonably believes that you are a victim of abuse, neglect, self-neglect or exploitation.
• Health Oversight Activities – If your clinician receives a subpoena from his or her licensing board because they are investigating his or her practice, he or she 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 your clinician 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 your clinician a specific threat of imminent harm against another individual or if your clinician believes that there is clear, imminent risk of physical or mental injury being inflicted against another individual, he or she may make disclosures that he or she believes are necessary to protect that individual from harm. If your clinician believes that you present an imminent, serious risk of physical or mental injury or death to yourself, he or she may make disclosures he or she considers 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, your clinician is 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 in treatment. On your request, the Clear View Counseling Center 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. Your clinician 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 your clinician believes the disclosure of the record will be injurious to your health. On your request, your clinician 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. The Clear View Counseling Center may deny your request. On your request, the Clear View Counseling Center 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, the Clear View Counseling Center will discuss with you the details of the accounting process.
• Right to a Paper Copy – You have the right to obtain a paper copy of the notice upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

• The Clear View Counseling Center is 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.
• The Clear View Counseling Center reserves the right to change the privacy policies and practices described in this notice. Unless the Clear View Counseling Center notifies you of such changes, however, we are required to abide by the terms currently in effect.

• If the Clear View Counseling Center revises our policies and procedures, the Clear View Counseling Center will provide you with a revised notice by mail or at the next therapy session.

V. Complaints

If you are concerned that the Clear View Counseling Center or your clinician has violated your privacy rights, or you disagree with a decision we 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.

Patient Name: _____ DOB:_____

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

TELETHERAPY INFORMED CONSENT

I, _____, hereby consent to engage in teletherapy with the Clear View Counseling Center. Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities:

1. I, the client, must be physically located in the state of Maryland during teletherapy appointments (This is a legal requirement for psychologists, social workers, and counselors practicing in this state under a Maryland license.)
2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with the Clear View Counseling Center.
4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my psychologist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.
6. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area.
7. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may not improve, and in some cases may even get worse.
8. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention

Lifeline at 1.800.273.TALK (8255) for free 24-hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in future, my recommend will recommend more appropriate services.

9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment, and internet access for my teletherapy sessions, and
10. (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.

I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

I have read, understand, and agree to the information provided above regarding telehealth:

Patient Name: _____ DOB:_____

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

INSURANCE AUTHORIZATION

As the patient and/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 regards 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 have read, understand, and authorize the Clear View Counseling Center to submit claims to my insurance provider. I agree to be responsible for all charges incurred.

Patient Name: _____ DOB:_____

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

INSURANCE FORM

PATIENT INFORMATION:

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

Home Address: _____ Apt # _____

_____
City State Zip Code Home

Phone #: _____-_____-_____ Other Phone #: _____-_____-_____ Gender: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____
Month Day Year

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

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

Name of Employer / School: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____

Member ID Policy #: _____ Group #:_____

Claims Address: _____ Phone #: _____-_____-_____

Policy holder's Name: _____ Date of Birth: _____/_____/_____
Month Day Year

Social Security #: _____ Effective Date of Insurance: _____/_____/_____
Month Day Year

Policy Holder's Employer: _____ Phone #: _____- _____-_____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Person Responsible for Account: ☐ Patient ☐ Parent ☐ Other_____

_____ Date of Birth: ____/_____/_____ Phone # _____-_____-_____
Name (if different from patient) Month Day Year

Secondary Insurance (If Applicable): _____

MemberID Policy #: _____ Group #:_____

Policy Holder Name: _____Date of Birth: _____/_____/_____
Month Day Year

AUTHORIZATION TO BILL INSURANCE:

Patient or Authorized person's signature: I authorize the Clear View Counseling Center, LLC to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed _____ Date_____

FINANCIAL POLICY

The Clear View Counseling Center believes that mental health care should be affordable and accessible to all. In alignment with this belief, we accept all major insurance carriers. 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.

Payment is due prior to the beginning of your therapy session*. A valid credit or debit card is required to be on file for all tele-therapy patients*. For your convenience, we do accept MasterCard, Visa, American Express, HSA cards, cash and personal checks. You are encouraged to complete the Credit/ Debit Card Authorization Form on the next page to streamline the payment process and keep your credit card on file. For your security, all patient credit card information is kept on our HIPAA compliant EMR.

There is a $35 charge for returned checks. 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.

In 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.**

I have read, understand, and accept the Clear View Counseling Center Financial Policy. I agree to be responsible for all charges incurred.

Patient Name: _____ DOB:_____

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

CREDIT CARD/ DEBIT CARD AUTHORIZATION FORM

Please provide the following information:

I, _____ authorize the Clear View Counseling Center to charge my credit/debit/health
(print cardholder name)
account card for professional fees and services up to 24- hours before each scheduled appointment. If I do not cancel before 24 hours, I recognize that my clinician will charge my card as a late cancel or no show if I do not show up for the appointment.

Billing Address: _____
Street Address Apt #

_____
City State Zip Code

Phone Number: _____-_____-_____ Email:_____

Patient Name (Print): _____ Patient DOB: _____

Credit/ Debit Card:

☐ Visa ☐ Master Card ☐ American Express ☐ Discover

Cardholder Name (Print):_____ Relation to Patient: _____

Account Number: _____ Expiration Date: _____

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

Cardholder Signature: _____

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.

PATIENT PORTAL

To access the Patient Portal, go to the "Patients" tab at our website, www.clearviewcounselingcenter.com,

or scan the QR code using your smart phone's camera. Please let your clinician know if you would like a free one-on-one tutorial to help you get started on the Portal. If you forget your password, ask your clinician to reset it for you.

SCHEDULING POLICY

Patients are provided with a Patient Portal account upon scheduling an initial appointment. Invitations expire after 24-hours but may be re-sent by your clinician by request. Passwords may also be reset by contacting your clinician directly.

ALL scheduling, rescheduling, and cancelling of appointments MUST be sent through the portal ONLY. For requests with less than 24-hours' notice, you MUST contact your clinician directly.

We cannot guarantee that voicemails left on the Clear View Counseling Center main phone line will be passed along to your clinician in a timely manner. We discourage replying to automated appointment reminders via email. Such replies must be forwarded to each clinician individually. As such, we cannot guarantee timely forwarding of such schedule requests. Should you choose to submit schedule requests on the Clear View Counseling Center main voicemail, main email, or reply to automated appointment reminder emails, you do so at risk of incurring a $75 Missed Visit Fee should your clinician not receive your request within 24-hours of your scheduled appointment.

I have read, understand, and accept the scheduling policy. I agree to be responsible for all charges incurred.

Patient Name: _____ DOB:_____

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

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. We 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. Patients who accrue three (3) or more late cancellations or missed visits may be subject to termination.**

We 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.

Patient Name: _____ DOB:_____

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

INCLEMENT WEATHER POLICY

In some cases of inclement weather, we may have to cancel or reschedule your appointment. If there is inclement weather (i.e., hurricane, snowstorm, ice storm under 32 degrees Fahrenheit.) on the day of your appointment, please do the following:

- Check your email to see if you have been notified by your clinician**.** You **will not** receive a call to cancel your appointment. **It is up to you to check your email to confirm your appointment**.
- In some cases, we may call/email you to request that you come in earlier or later than your scheduled time due to the weather.
- If your appointment is cancelled, every effort will be made to reschedule your appointment. Please use the Patient Portal or call your provider to do so.
- If you need to cancel your appointment due to inclement weather, you may cancel without a fee. Please call or email your clinician directly to do so. However, you must call **at least three hours before your appointment to cancel**. If you do not show up or call after your appointment time, you will be charged a missed appointment/late cancellation fee regardless of the weather.
- If you have any doubts or questions, contact your clinician!

I have received and understand the Clear View Counseling Center Inclement Weather Policy:

Patient Name: _____ DOB:_____

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

PATIENT INFORMATION FORM

Patient Name: _____ _____ _____
Last First Middle

Gender: ☐ Male ☐Female ☐ Transgender ☐ Non-binary

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

Driver's License #: _____

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

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

Employer/ Work Ph. #: _____

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

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

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

Emergency Contact: Name:_____
Address: _____
Phone: _____
Relationship to Patient: _____

Referral Information:
☐ Physician ☐ Insurance Co. ☐ Relative ☐ Friend ☐ Website ☐ Psychology Today
☐ Other: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

While sessions are confidential, signing this form allows your clinician to collaborate with anyone who may prove helpful to your treatment including but not limited to a loved one, medical doctors, referring agencies, etc.

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) 281-9430

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: _____ DOB:_____

Patient Signature: _____ Date: _____

Parent/ Guardian Signature: _____ 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.