Authorization to Bill Insurance

Client Name: _____ Date:_____

I _____, hereby certify and attest that I have sought evaluation, treatment, or medical advice from the at Alpha New Hope Health Services. I therefor authorize the medical staff and personnel to release my or my child's medical information to the insurance company _____for the purpose of determining and receiving benefits for the medical bills.

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, copayments, and co-insurance payments required.

I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of services and/or a legal claim against me for non-payment.

Signature _____ Date_____

Alpha New Hope Health Services
Phone: 443-453-6719
2319 Maryland Avenue Baltimore MD 21218
Fax: 410-529-1936

Informed Consent for Assessment and Treatment

Name: _____ Date of Birth_____

I understand that I am eligible to receive a rang of services from my provider. The type and extent of services that I receive will be determined following an initial assessment and through discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, is provided over the course of several weeks.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as- needed basis during the course of treatment and that I have the right to consent to or refuse such treatment. I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may not stop treatment at any time but agree to discuss this decision first with my provider.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, expect in the following circumstances

- When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.]
- When there is suspicion that a child or elder is being sexually or physical abused, or is at risk of such abuse, my provider is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

While this summary is designed to provide and overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations and discuss with your provider any questions or concern you may have.

By my signature below, I voluntary request and consent to behavioral health assessment, care, treatment, or services and authorization my provider to provide such care, treatment, or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. By signing this Informed Consent to Treatment Form, I acknowledged that I have both read and understand the terms and information contained herein. Ample opportunity has been offered to me ask questions and seek clarification of anything unclear to me

Client Signature: _____ Date:_____

Witness Signature: _____ Date:_____

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Notice of Privacy Practice

Effective April 29th, 2015

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information (PHI). This Notice of Privacy Practice describes how your provider may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), your provider is required to maintain the privacy of PHI and to provide you with notice of his or her legal duties and privacy practices with provider reserve the right to change the terms of this Notice of Privacy Practices. Your provider is required to abide by the terms of this Notice of Privacy Practices. Your provider reserves the right to change the term of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that your provider maintains at that time. Your provider will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or by providing one to you at your next appointment.

HOW YOUR PROVIDER MAY USE AND DICLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your healthcare treatment and related services. This includes consultation with clinical supervisors or other treatment team members. Your provider may disclose PHI to any other consultant only with your authorization

For Payment: Your provider may use and disclose PHI so that he or she can receive payment for the treatment services provided to you. Examples of payment- related activities are making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medically necessity, or undertaking utilization review activities. If it becomes necessary to use collection process due to lack of payment for services, only disclose the minimum amount of PHI necessary for purpose collection will be disclosed.

For Health Care Operations: Your provider may use or disclose, as needed, your PHI order to support his or business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging other business activities. For example, your PHI may be shared with third parties that perform various business activities provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. Your PHI may be

used to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services.

Required by Law: Under the Law, your provider must make disclosures of your PHI to you upon your request. In addition, disclosure must be made to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit your provider to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting child abuse or neglect or elder abuse, or mandatory government agency audits or investigations.
- Required by Court Order
- Necessary to prevent or lessen a serious an imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the treat.

Verbal Permission: Your provider may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights PHI maintained about you. To exercise any of these rights, please submit your request in writing to your provider.

Right of Access to Inspect and Copy. In most cases, you have the right to inspect and copay PHI that may be used decisions about your care. Your right to inspect and copay PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. Your provider may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI your provider has about you is incorrect or incomplete, you may ask for it to be amended, although your provider is not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures that your provider makes of your PHI. Your provider may charge you and reasonable fee if you request more than one according in any 12-month period.

Right to Request Restriction. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or healthcare operation. Your provider is not required to agree to your request.

Right to Request Confidentiality Communication. You have the right to request that your provider communicate with you about medical matters in a certain way or at a certain location.

Right to a Copy of This Notice. You may ask your provider for a paper copy of this notice at any time.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a complaint with the Federal Government. Filling complaint will not affect your right to further treatment or further treatment. To file a complaint with the Federal Government, contact

Secretary of the U.S. Department of Health and Human Services

200 Independence Avenue, SW

Washington, DC 20201

(202) 619-0257

ACKNOLOWLWGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and the limits on ways my provider may use or disclose personal health information to provide service

Client Name:_____ Signature _____

Relationship to Client: _____ Date:_____

Records Release Authorization

For The Release of Protected Mental Health Information

By siging this form, confidential psychological and psychiatric information can be released to and/ or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

Patient Name: _____ Date of Birth_____

1. ☐I authorize my provider to ☐Release ☐Receive psychological/psychiatric mental health information to/form the Second Party as directed below:

2. Second Party

Name: _____

Address: _____

Fax Number: _____ Phone Number:_____

3. Type of Information

☐ I authorization disclosure of all health information, including information relating to medical, pharmacy, mental health, substance abuse, and psychotherapy

☐ I authorize only the disclosure of the following information

_____

4. Purpose

☐ My health information is being disclosed at my request or at the request of my personal representative; or

☐ My health information is being disclosed for the following purpose.

_____

5. Note any exclusions or limitations here: _____

I understand that treatment, payment, enrollment in a health plan, or eligibility for the benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my provider authorization to disclose my records. I understand that I may revoke this authorization at any time by providing a written notice to my provider, however the revocation will not have an effect on any actions taken prior to the date my revocation is received. I understand that my information may be redisclosed by authorization person/ organization receiving the information, and at that point, the

information may no longer be protected under the terms of this agreement. This authorization will expire one year following the date signed unless revoked in writing.

Signature: _____ Date:_____

☐ Authorization is given on this patient's behalf due to being a minor or unable to sign.

_____

Legal Guardian/Personal Representative Signature Date: _____

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Telehealth Services Informed Consent

Name: _____ Date:_____

Definition of Telehealth

Telehealth involves the use of electronic communications to enable professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data

I understand that I have the rights with respect to telehealth

1. I understand privacy and the confidently laws apply to telehealth, and that no information obtained through the use of telehealth services will be disclosed to researchers or other entities without my written consent.
2. My health care provider has explained how the videoconferencing technology will be used to conduct a telehealth session, that unlike a direct patient/provider in person, I will not be in the same room as my health care provider.
3. I understand the potential risks to technology including interruptions, unauthorized access, and technical difficulties. I understand my health care provider, or I can discontinue the videoconference consult/visit if it is believed videoconference technologies are not adequate for the situation
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
5. I understand that telehealth my involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that no results for anticipated benefits can be guaranteed or assured by my provider.
7. I understand my healthcare information may be shared with other individuals for purpose of scheduling and billing. Individuals other than my healthcare provider may be present during the session in order to operate videoconferencing equipment. I further understand that I will be informed of their presence, and that such individuals will maintain confidentiality on information obtained during the session. Furthermore, I have the right to request the following:
    - Ask non-medical personnel to leave the telehealth examination room; and/or
    - Terminate the consultations at any time.
8. I agree certain situations- such as emergencies and crisis are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis- oriented healthcare facility in my immediate area.

Consent to the use of Telehealth

By signing this form, I certify:

- That I have read or had this form read and/ or had this form explained to me.
- That I fully understand its content including that risks and benefits of the procedure (s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature _____ Date:_____

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