WHOLE FAMILY
HEALING GROUP
A HEALING PLACE FOR THE WHOLE FAMILY

Greetings Family!!

Thank you for contacting Whole Family Healing Group for you and your loved one's healing process. We are a healing place for the whole family!

Attached in the patient portal you will see all the intake forms that must be completed prior to scheduling your appointment. Through the portal, you will also schedule, manage appointments, submit your intake paperwork, and connect to your Telehealth appointments, unless told otherwise. Please let us know if you have any issues with any of the forms. It is best that you be sure that your browser is updated, and that you are using a laptop or desktop, and not your cellular device.

To complete your chart, and as required by your insurance company and Maryland State Law, we will need a copy of your photo ID and insurance card. If you are not the policy holder for the insurance, we will need the contact information, and photo ID of the policy holder as well. Please upload copies of those through the portal with the ID and Insurance Card Agreement for Virtual Submission. If you are unable to upload it there, you may send those copies to our HIPAA compliant email: scheduling@wholefamilyhealinggroup.com.

If you are responsible for any cost-sharing with your insurer, such as co-pays. co-insurance, or deductibles, fees are due on the day of your session if paying in person. If your appointment is virtual, you will receive an invoice to pay from our billing agency PBS Inc. Billing. Please complete the Payment Authorization form included in the intake documents. We will use that payment information to charge you for your balances after each session. You will receive a receipt via email. If you have any issues with this, please contact us via email at scheduling@wholefamilyhealinggroup.com. Please note that we no longer allow patients to carry balances over $25. If you have not paid your balance in full, or to at least no more than $25 remaining, we will need to decline your appointment requests and make a referral to another provider. We also no longer accept insurance for couples, marriage, and family counseling. One patient must be in therapy and have a diagnosable mental health disorder of insurance to be used. Insurance companies will only pay for certain issues. We will gladly provide you with a receipt to submit to your insurance.

All new intakes will be done virtually. On the day of your scheduled appointment, you will log onto your Telehealth session via the client portal. We suggest that you try to log on about 5 minutes prior to test your connection. You may use your cell phone, tablet, laptop, or desktop computer to connect if it has a front facing camera. If you have trouble connecting to your session, please text our office manager, Destiny Rice, at 443-675-6801, or at 443-353-9348.

Patient Signature: _____ Date: _____

WHOLE FAMILY™
HEALING GROUP
A HEALING PLACE FOR THE WHOLE FAMILY

OFFICE POLICIES AND PROCEDURES

Whole Family Healing Group, LLC
"A Healing Place for The Whole Family"

104 Church Lane, Suite #120, Pikesville, MD 21208
Phone: 410-413-6043
Fax: 410-559-6510
Scheduling: scheduling@wholefamilyhealinggroup.com
General Inquiries: info@wholefamilyhealinggroup.com
www.wholefamilyhealinggroup.com

OFFICE HOURS

WFHG office hours are Monday-Friday from 9:00am-7:00pm, and Saturdays from 10am-3pm. You may call the office to make inquiries during this time. After hours, and times when we are not able to answer, you may send a text message to 443-353-9348, or send an email to one of the emails listed above. If you call, please leave a voicemail and a staff member will return any non-urgent phone calls within 72 hours. We will do our best to respond to urgent matters within 24 hours. You may also contact your provider directly at the phone number they have provided to you. WFHG also communicates through text messaging. We may text you up until to 9:00pm.

If you are having a crisis or other emergency, please contact your provider directly, call 911, or go to the nearest emergency room. See crisis contacts below. We also have emergency resources via our website at **www.wholefamilyhealinggroup.com**

Resources

https://suicidepreventionlifeline.org/
https://www.nami.org/
https://www.maryland.gov/Pages/default.aspxhttps://www.maryland.gov/Pages/default.aspx
https://www.who.int/
https://www.cdc.gov/
https://www.cdc.gov/healthyschools/success-stories/maryland.htmhttps://www.cdc.gov/healthyschools/success-stories/maryland.htm

If you or a loved one need assistance, are thinking of suicide, or are experiencing another mental health crisis; please seek help immediately.

MARYLAND CRISIS HOTLINE	Call: **988, 911, or 1-800-422-0009**; Available 24 hours a day, 7 days a week. *OR DIAL*; 2-1-1, Press 1

MARYLAND CORONAVIRUS HOTLINE

AFTER HOURS CONTACT

If you contact your provider after hours for a crisis, the provider and WFHG reserve the right to bill you **for the** service according to the amount of time spent. These services will be billed to your insurance, or you will receive an invoice like you normally would for a routine office visit.

CANCELLATION POLICY

WFHG reserves the right to charge a cancellation fee of $100 for any appointment that is missed or cancelled with less than 24 hours advance notice. Three same-day cancellations or missed appointments will result in the termination of your relationship with this group. You will be required to sign a notice acknowledging your understanding of this. If you choose not to sign, you will not be able to schedule any appointments with WFHG.

INSURANCE AND PAYMENTS

WFHG accepts a variety of insurance plans as well as self-pay clients. If your policy requires a copay, it will be collected at the time of your visit. If you have a balance left over from services (after your insurance has been billed), you will be required to make a payment before any further services are rendered. Please contact your insurance company prior to receiving services to inquire about your mental health coverage. Some plans do require deductibles and/or co-insurance. It is your responsibility to familiarize yourself with your insurance plan.

WFHG does accept insurance for couples or family therapy, however one person MUST BE the IDENTIFIED PATIENT with a DIAGNOSABLE MENTAL ILLNESS. We can offer services for couples and families without the use of insurance. Please visit our website's FAQ section under the GET HELP tab for more information and for fees associated with the service. Please see the fee schedule below for pricing of those services. WFHG **accepts FSA and credit cards only for payment**. A list of insurances and payment methods we accept, as well as payment procedures are below.

INSURANCES ACCEPTED AT WFHG

- Medicaid
- Medicare
- Carefirst/Blue Cross/Blue Shield
- Cigna
- Aetna
- Beacon/Value Options
- Hopkins/EHP
- United Healthcare/Optum
- Tricare Military **Families**
- **VACCN for Military Veterans**

CREDIT CARDS ACCEPTED BY WFHG

- Visa
- American Express
- Mastercard
- Discover
- FSA

FEES

Fees for service may vary per clinician and for the type of services rendered. Please visit our website at **www.wholefamilyhealinggroup.com** for a comprehensive price list for each clinician and types of services they provide. This can be found under the "Get Help" tab and clicking FAQ.

PAYMENTS

- Copays are due at the time of service**, and for Telehealth clients, it will be due prior to the next appointment**.
- Payment is required at the time of service for self-pay/non-insured clients**, and via invoice sent to your email**.
- Balances left over after sessions must be paid before your next appointment. You may inquire about a payment arrangement with staff.
- **We no longer allow clients to carry balances in between sessions of more than $25. All fees are due at time of service, no later than prior to the next scheduled appointment. We reserve the right to decline your request for an appointment, and restrict your client portal access if this policy is not adhered to.**

AUTOMATIC PAYMENTS

WFHG does require that you put a credit or debit card on file for collection of copays, balances, and fees. A receipt will be sent to you via email and or USPS mail from our billing agency PBS INC Billing Solutions.

BEHAVIOR

WFHG will not tolerate any harassment, abuse-verbal or otherwise, or any other unacceptable behavior from any client for any reasons. We want to make sure that we provide an environment that makes our patrons and staff feel safe and comfortable. WFHG reserves the right to terminate relationships with anyone who we feel violates this policy and exhibit inappropriate conduct with or without notice.

FORMS/LETTERS/DISABILITY/FMLA/EMOTIONAL SUPPORT ANIMALS

Please allow up to 30 days for the completion of any forms or requested letters from your provider. Fees will be assessed for the completion of forms. The fee is $25 per 1-page letter. Any additional pages will incur an additional fee of $10 per page. Insurance is NOT billed for this. This will be the responsibility of the Patient making the request. Payment is required before documents are released. Please keep in mind the time-frame for when you need the documents. We will not accept any requests less than 30 days in advance. Disability forms and any documents related to court proceedings have separate fees and procedures. Please refer to the intake packet or you can send an inquiry by email to us at info@wholefamilyhealinggroup.com. **If you need to be evaluated for disability or leave based on mental health conditions, please make this known during your intake session if this your primary reason for seeking services. Same for emotional support animal letters.**

MEDICAL RECORDS

In accordance with HIPAA, WFHG will not release any records on a client without their written consent. If WFHG needs to obtain records from a previous provider or a physician, we will request that you sign a release of information (ROI) form. If you are requesting records for personal use or documentation, there will be a charge per page.

ACKNOWLEDGEMENT OF RECEIPT

I, _____, acknowledge that I have received, reviewed, understand, and will comply with the office policies and procedures outlined in the **Whole Family Healing Group Office** *Policies and Procedures form*. I also understand that the policies are subject to change without prior notice.

Name: _____ **DOB:** _____

Signature: _____ Date: _____

CANCELLATION POLICY

Dear valued WFHG client:

Each time an appointment is missed without providing proper notice, another person is prevented from receiving services. Therefore, effective February 1, 2022, WFHG reserves the right to charge a fee of $100.00 for all missed appointments (NO SHOW/NO CALL, etc.) and appointments that are not cancelled/rescheduled within a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Medicaid/Medicare/Tricare members cannot be legally charged administrative fees IF you are using that specific insurance and IF the service can be billed as the primary insurance for either of those insurance providers. However, WFHG has the right to make the decision that any patient can be discharged for frequent no shows and cancellations. Two or more no shows/no calls/no cancellation or rescheduling within a 24-hour advanced period, in any 12-month period, may result in dismissal from our practice. Beginning February 1, 2022 this policy will be strictly enforced.

Thank you for your understanding and cooperation. By signing below, you acknowledge that you have received this notice and understand this policy.

Sincerely,

WFHG Team

Name:

If patient is a Minor, please place name of Minor and sign as legal guardian:

Signature:

Date:

INFORMED CONSENT FOR MINORS

Below you will find information pertaining to providing confidential mental health services to your child. You will also sign to agree to this office's confidentiality practices and acknowledge that you will adhere to them. In addition, you confirm that you are the legal guardian for _____, which means that you have legal rights to make decisions that can be upheld in the Maryland State Court of Law. (On the last page, you may read the MD Health-General Article associated with this consent. You may also find it via this link should you prefer to read it online. **https: /health.maryland.gov/psych/pdfs/Treatment.pdf**

CONFIDENTIALITY

Please see the chart below on Maryland confidentialit laws for minors

Minors of Any Age May Consent:	Law	Confidentiality and/or Informing Obligation of the Healthcare Provider
Outpatient mental health services	A minor who is 16 years old or older has the same capacity as an adult 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)] 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 express 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., Health-Gen. II § 20-102(f)]

CONSENT

I, _____, the legal parent/guardian of _____ authorize Whole Family Healing Group, LLC to provide mental health services to my child. I understand that mental health services are confidential, even for minors. I acknowledge that my child's therapist/counselor will always maintain their privacy, with exception to the circumstances below:

- Reasonable concern that the child/adolescent may harm themselves or others.
- The child's admission or acknowledgement of harm, neglect, or abuse toward them or others (whether that abuse is mental/emotional, physical, or sexual); in which case, the therapist is required by law to report it to the proper authorities and/or child protective agencies.
- Court order for disclosure.

REVOKING CONSENT

Both you and your child have the right to end the counseling relationship at any time without penalty or prejudice, apart from the cancellation and no-show policies outlined in our "Office Policies" and "Cancellation Policies" forms.

While free to discontinue services at any time, it is preferable to have a closing session or phone call to ensure the adolescent/child understands that counseling is ending and to provide closure to the experience and relationship. You also have the right to refuse this final session.

Before terminating services due to dissatisfaction, it is encouraged to complete a session or phone call to discuss the option of modifying any of the therapist's techniques, practices, or methods you believe may be harmful or unproductive in regard to achieving the goals of therapy agreed upon by the patient, parent, and therapist. I also understand that this is a suggestion, not a requirement.

Parent/Guardian Name: _____

Signature: _____ Date: _____

HEALTH-GENERAL ARTICLE, §§20-102 , 20-104

§ 20-102. Treatment for health-related problems

(a) Minor who is married or parent

A minor has the same capacity as an adult to consent to medical treatment if the minor:

(1) Is married; or
(2) Is the parent of a child.

(b) Emergency treatment

A minor has the same capacity as an adult to consent to medical treatment if, in the judgment of the attending physician, the life or health of the minor would be affected adversely by delaying treatment to obtain the consent of another individual.

(c) Consent for specific treatment

A minor has the same capacity as an adult to consent to:
(1) Treatment for or advice about drug abuse;
(2) Treatment for or advice about alcoholism;
(3) Treatment for or advice about venereal disease;
(4) Treatment for or advice about pregnancy;
(5) Treatment for or advice about contraception other than sterilization;
(6) Physical examination and treatment of injuries from an alleged rape or sexual offense;
(7) Physical examination to obtain evidence of an alleged rape or sexual offense; and
(8) Initial medical screening and physical examination on and after admission of the minor into a detention center.

(c-1) **Capacity to refuse treatment** -- The capacity of a minor to consent to treatment for drug abuse or alcoholism under subsection (c)(1) or (2) of this section does not include the capacity to refuse treatment for drug abuse or alcoholism in an inpatient alcohol or drug abuse treatment program certified under Title 8 of this article for which a parent or guardian has given consent.

(d) Consent to psychological treatment

A minor has the same capacity as an adult to consent to psychological treatment as specified under subsection **(c)** (1) and (2) of this section if, in the judgment of the attending physician or a psychologist, the life or health of the minor would be affected adversely by delaying treatment to obtain the consent of another individual.

(di) Liabilities

A physician, psychologist, or an individual under the direction of a physician or psychologist who treats a minor is not liable for civil damages or subject to any criminal or disciplinary penalty solely because the minor did not have capacity to consent under this section.

(dii) Disclosure

Without the consent of or over the express objection of a minor, the attending physician, psychologist, or, on advice or direction of the attending physician or psychologist, a member of the medical staff of a hospital or public clinic 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 under this section, except information about an abortion.

§ 20-104. MENTAL OR EMOTIONAL DISORDER.

(diii) Capacity to consent

(1) A minor who is 16 years old or older has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or a clinic.

(2) 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 under paragraph (1) of this subsection 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.

(div) Disclosure

(1) Except as provided in paragraph (2) of this subsection, without the consent of or over the express objection of a minor, the attending physician, the psychologist, or, on advice or direction of the attending physician or the psychologist, a member of the medical staff of a hospital or public clinic 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 under this section.

(2) If a psychologist is on a treatment team for a minor that is headed by a physician, the physician heading the treatment team shall decide whether a parent, guardian, or custodian of the minor or the spouse of the parent should receive information about treatment needed by the minor or provided to the minor under this section.

(dv) Liabilities

Unless the parent, guardian, or custodian of a minor consents to consultation, diagnosis, or treatment of the minor, the parent, guardian, or custodian is not liable for any costs of the consultation, diagnosis, or treatment of the minor under this section.

TELEHEALTH INFORMED CONSENT

I, _____ , hereby consent to participate in tele-mental health services with WFHG and my practitioner, _____ as part of my psychotherapy. I understand that tele-mental health is the practice of delivering clinical and mental health services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following regarding tele-mental health services:

1. I understand that I have the right to withdraw my consent at any time without affecting my future care, services, or program benefits.

2. I understand that there are risks, benefits, and consequences associated with telehealth including, but not limited to:

   a) Disruption of transmission by technology failures
   b) Interruptions
   c) Breaches of confidentiality by unauthorized persons
   d) Limited ability to respond to emergencies

3. I understand there will be no recording of any online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential. They may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4. I understand that the privacy laws that protect the confidentiality of my PHI also apply to telehealth unless an exception to confidentiality applies. Exceptions to confidentiality include the following:

   a) Mandatory reporting of child, elder, or vulnerable adult abuse
   b) Danger to self or others
   c) Mental/emotional health issues raised in a legal proceeding

5. I understand if I am having suicidal or homicidal thoughts, or actively experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate, and a higher level of care is needed.

6. I understand that during a tele-mental health session we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within 10 minutes, please call me at _____ to discuss an alternative or reschedule.

7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

☐ I have read the information above and discussed any concerns with my provider. All questions have been answered to my satisfaction. I understand and consent to tele-mental health services.

Patient Name: _____ **Date of Birth:** _____

I authorize Whole Family Healing Group, LLC to obtain records from:

Name of Facility/Provider: _____

Address: _____

Phone: _____ **Fax:** _____

INFORMATION TO BE DISCLOSED

☐ Discharge summary	☐ Drug/alcohol information and testing
☐ Program notes	☐ Court/legal proceedings
☐ Attendance/behavior records	☐ Case Planning
☐ Psychological evaluation and treatment	☐ Psychiatric history and treatment

PURPOSE FOR DISCLOSURE

☐ Treatment/follow up	☐ Case planning
☐ Insurance	☐ Court/legal proceedings

I understand that:

- I have the right to revoke this authorization at any time, provided that the revocation is submitted in writing to this practice; except if action has already been taken relying on this consent or if the authorization was obtained as a condition of insurance coverage.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and no longer be protected by HIPAA privacy rules.
- Treatment may be conditional to providing this authorization.
- I have the right to access or request copies of my PHI and this authorization.
- This authorization will remain in effect until I have revoked my authorization or one year from the date of signature.

☐ I understand that this authorization may also be used for exchange of information, whether verbal or written with the party specified above.

Signature of patient/legal guardian: _____

Printed name: _____ **Date:** _____

Therapist: _____

Signature: _____ **Date:** _____

COVID-19 CONSENT

Name: _____ **DOB:** _____ **Date:** _____

Please check the box if you have had any of the following symptoms in the last 14 days.

Cough	☐	Fever	☐
Shortness of Breath	☐	Loss of taste or smell	☐
Headaches	☐	GI upset (nausea, vomiting, or diarrhea)	☐
Sore Throat	☐	Congestion or Runny Nose	☐
Chest Pain	☐	Body Aches	☐

Temperature: _____ **Date & Time Taken:** _____

Staff initials _____

I, _____ , attest to the fact the following statements.

- I have not traveled outside of Maryland in the last 14 days.
- I have not had any of the COVID-19 symptoms listed above in the last 14 days.
- I have not tested positive for the COVID-19 virus in the last 14 days.
- I have not knowingly been exposed to someone that tested positive for the COVID19 virus.
- I acknowledge that **Whole Family Healing Group, LLC** is not responsible in any way for any illness obtained on the premises.

Signature: _____ Date: _____

CREDIT CARD ON FILE: AUTHORIZATION FORM

INFORMATION TO BE COMPLETED BY CARDHOLDER

The undersigned agrees and authorizes medical practi eto save the credit card indicated below on file. The use of this form is optional and or your convenience.

Medical Practi e: _____

Patie t's Name: _____

Name as it Appears on the Credit Card: _____

Type of Credit Card:

☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Digits of Card: _____ 3 digits on back of card: _____ Expiration Date: _____

I, _____ authorize the above medical practice to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

Cardholder's Signature: _____ Date: _____

PROFESSIONAL DISCLOSURE STATEMENT

PROFESSIONAL THERAPY SERVICES FOR **INDIVIDUALS, ADULTS, COUPLES, FAMILIES, CHILDREN, TEENS, VETERANS AND GROUPS**

SPECIALIZATION:

Miesha Rice, *MSW, LCSW-C* (License #19531) is a Licensed Certified Social Worker-Clinical
Catherine Pitchford, *LMSW* (License #24415) is a Licensed Master of Social Work
Ashley Gash, *LMSW* (License #20625) is a Licensed Master of Social Work
Ameka Smith, *LMFT* Candidate under the direct supervision of Miesha Rice (No insurance accepted)
Clifton Sherrod, *LMSW* Candidate under the direct supervision of Miesha Rice (No insurance accepted)

FEE SCHEDULE:

Payment is made at the start of each session by cash, credit/debit/FSA card. I can provide additional receipts for you at your request if needed for your insurance or tax purposes. Cost of each session is listed in the chart below. Please visit our **FAQ** Section of the website for out-of-pocket fees for Family Therapy Sessions for 2 or more family members. **www.wholefamilyhealinggroup.com/faq**

TYPE OF SESSION	LENGTH OF SESSION	PRICE
Psychotherapy Intake (1st session)	60-90 minutes	$100-$300
Psychotherapy Session-90837	60 minutes	$60-$150
Psychotherapy Session-90834	45 minutes	$45-$100
Psychotherapy Session-90832	30 minutes	$30-$75
Consultation	15 minutes	***$25***
Bariatric Surgery Evaluation, Disability Evaluation, and Other Specialty Services (includes the completion of forms)	60-120 minutes	$450

Please note that our BILLING AGENCY is PBS INC BILLING SOLUTIONS. You must complete a payment authorization form and you will be contacted by them either via mail, phone, or email regarding your payments.
You can contact them at

Physician Billing Solutions, nc.
PO Box 973, Westminster, MD 21158
Phone: **(410) 848-5785** Fax: **(410) 848-5629**

You may also reach them at one of the phone numbers listed on their website **https://www.pbsincbilling.com/**

If you are using your health insurance, please contact your insurance company prior to your intake session to find out (A) what your co-pay is, if any, and (B) whether outpatient mental health is covered under your plan. Additionally, how many sessions you are allowed each month/year, and if you have a deductible to meet, etc. Your co-pay will be due at the time of your scheduled appointment. NO EXCEPTIONS.

If you need evaluation for bariatric surgery, disability, legal/court proceeding, or other specific services, please make us aware prior to scheduling. If you do not inform the scheduler prior to attending your intake session, there is no guarantee that those specialty services will be rendered.

If you carry a balance after the claim has been processed by your insurance, a payment is required before any further services are rendered. Any amounts owed for 6 months or more will be sent to collections. **We reserve the right to decline new appointment requests for persons owing more than $25.**

If you are using MEDICAID, you must provide your MA# prior to your appointment so that we may get a pre-authorization to provide outpatient mental health services.

If you have MEDICAID, and have an open authorization with another provider, YOU MUST BE DISCHARGED FROM YOUR FORMER PROVIDER BEFORE STARTING YOUR SESSIONS with Whole Family Healing Group. NO EXCEPTIONS.

A cancellation fee of $100.00 is assessed for missed appointments or appointments that are not canceled within 24 hours prior to your scheduled appointment time. ***This fee is your responsibility and cannot be billed to your insurance company. This fee is not allowed to be billed by Medicaid/Medicare or Tricare members. However, if you are a member of Medicaid/Medicare/Tricare, and you no call/no show for more than 2 scheduled appointments, we will provide you with a referral to see another provider who may be able to better accommodate your schedule.***

CLIENTS RIGHTS AND IMPORTANT INFORMATION:

1. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can make this determination), and my fee structure. Please ask if you would like to receive this information.

2. You are entitled to seek a second opinion from another mental health professional and/or to terminate therapy at any time. Please inform me of your decision to terminate therapy.

3. Sexual intimacy/contact and/or personal relationships between the therapist and a client are unethical and prohibited. If sexual intimacy or contact occurs, it should be reported to the Maryland State Department of Health and Mental Hygiene-Board of Social Work Examiners.

4. Generally, the information provided by and to the client during the therapy session is legally confidential. The therapist is bound to keep this information confidential within the scope of the practicing agency and cannot release information without the client's written consent. Limits of confidentiality include suspected child, dependent adult, or elder abuse, client's threats to harm or kill self or threats to harm or kill others. You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as required by law. Therapist will make every effort to inform you of exceptions as they arise in the course of therapy.

5. All health professionals are mandated reporters and must act accordingly should any issues mentioned in #4 be reported to therapist.

6. If you have any questions, please feel free to ask.

☐ **I have read the preceding information and understand my consumer rights**

Name: _____ Date: _____

Signature: _____ Date: _____

CLIENT INFORMATION

Name (Client#1): _____ **Date of Birth:** _____

Name (Client#2): _____ **Date of Birth:** _____

Preferred Pronouns: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone (Client#1): _____ **E-mail** (Client #1): _____

Cell Phone (Client#2): _____ **E-mail** (Client #2): _____

Treatment Unit/Services Requested:

☐ Family ☐ Couple ☐ Individual ☐ Other _____

Insurance Company and Policy/Group Number: _____

NOTE: *Social Security Number is required for persons using their medical insurance. No Exceptions. We cannot bill without it.*

LIST ALL MEMBERS IN THE HOUSEHOLD (LIST ADULTS FIRST)

NAME	SEX	DOB	AGE	MARITAL STATUS	LENGTH	ROLE IN FAMILY	ED LEVEL	INSURANCE ID#	SSN

MEDICAL/PHYSICAL CONDITIONS

Primary Care Physician Name: _____

Address: _____ Phone: _____

Medical or health problems: ☐ Yes ☐ No Describe: _____

Medications: ☐ Yes ☐ No Describe: _____

Drugs/Alcohol: ☐ Yes ☐ No Describe: _____

Pending legal action: ☐ Yes ☐ No Describe: _____

Danger of abuse, suicide, or homicide? ☐ Yes ☐ No Describe: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Your health record contains personal information about you and your health. This information about you may identify you as it relates to your past, present or future physical or mental health, or condition and related health care services; It is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable laws and the NASW code of ethics. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notices of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail or via email upon request. A copy can also be provided to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

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

For Payment: I may use and disclose PHI so that I can provide the necessary information for your insurance carrier, explaining the treatment services you received. This will only be done with your authorization. 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 medical necessity, or undertaking utilization review activities.

For Communication with You: When I need to contact you by phone, I will use the phone numbers you have given me on the signature form to do so. I may also need to contact you by text and/or email. Please sign below authorizing communication of these types from our office. You can also decide to opt out of either, and list your preferred method of communication.

Required by Law: Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purposes of investigating and determining my compliance with the requirements of the Privacy Rule.

Signature: _____ Date: _____

Without Authorization: Applicable law and ethical standards permit me 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 of child abuse or neglect or mandatory government agency audits or investigations (such as the Board of Social Work Examiners or the Department of Health and Mental Hygiene).
- Required by Court Order.
- Necessary to prevent or lessen a serious and 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 threat.

Client: _____ Signature: _____ Date: _____
(Please Print)

Client: _____ Signature: _____ Date: _____
(Please Print)

PART II: RISKS AND BENEFITS OF THE THERAPEUTIC PROCESS-PLEASE READ CAREFULLY

Therapy will seek to meet goals established by all persons involved, usually revolving around specific presenting problems. A benefit that may be gained from participating in therapy includes a better ability to handle or cope with marital, family, and other interpersonal relationships. Another possible benefit may be a greater understanding of self, family, personal goals and values; which may lead to a greater maturity, increased happiness, and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy. **IT IS IMPORTANT TO DO YOUR WORK OUTSIDE OF THERAPY FOR BEST RESULTS.**

In working to achieve these potential benefits, however, therapy will require that firm efforts be made to change and may involve the experiencing of significant discomfort. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems may similarly lead to discomfort as well as relationship changes that were not originally intended. We will ensure that during therapy, you will be in a safe and confidential space to process all intense feelings and emotions.

PART III: FEES AND LENGTH OF THERAPY SESSIONS: #1-CASH PAYMENTS ONLY

1. I agree to enter therapy with ***Whole Family Healing Group, LLC.*** I agree to pay $ _____ for the first intake session for 60/90-minutes and $ _____ for each 60-minute session thereafter. $ _____ for each 45-minute session and $ _____ for each 30 minute session. An additional $30.00 will be assessed for each 30-minute extended period beyond the initial scheduled session. Payment is due at the beginning of each session, and no balance will be carried. Extended session fee must be paid at end of session if assessed.

IF NOT PAYING CASH, AND USING INSURANCE-SKIP TO #2 (excluding Medicaid/Medicare/VACCN/ Tricare Members)

2. A twenty-four (24) hour notice is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay a **$100.00** fee. I understand that this will be solely my responsibility and is not a charge covered by my health insurance company. This fee must be paid in advance of continued services.

3. If you are more than 15 minutes late for your scheduled appointment, you will need to re-schedule, and you will be subject to the **no call/no show fee of $100.00 as well**, which will be due prior to your next scheduled appointment.

4. I understand that I can terminate therapy at any time and that I have no moral, legal, or financial obligation to complete any number of sessions unless required by the appropriate legal authority. I am contracting only to pay for completed therapy sessions and those scheduled and not attended or for those which I did not provide enough notice (addressed in Part III, number 2).

5. Whole Family Healing Group, LLC will apply a $500 fee for any requests to appear in court on your behalf, this includes the receipt of court summons. That fee must be paid in full at least 21 days prior to the scheduled court date. **This fee must be paid by cash or money order ONLY**. This fee is not billable through your insurance company, and it is not refundable. In addition, for administrative needs associated with your case, ***Whole Family Healing Group, LLC*** will apply a $25/hour fee for all forms and/or written correspondence to any attorneys, judges, etc. This fee must be paid in full and it will be per correspondence, including fax, email, USPS, etc. mail.
NO EXCEPTIONS.

6. If you are seeking an assessment for court appearances, disability claims, workman's comp, etc., Whole Family Healing Group will assess a **$350 fee** for assessments, and the same $500 specifically for court or other special appearances. Whole Family Healing Group, LLC releases itself from any recourse, legal or otherwise, regarding any outcome from the assessment, financial, criminal, or other findings of your work, workman's comp, or disability claims, etc.

7. I understand that my therapist and/or the company that employs him/her, **has the right to seek legal recourse to recover any unpaid balances.** In pursuing these measures, she/he will only disclose biographical information and the amount owed to ensure confidentiality.

8. I understand that **Whole Family Healing Group, LLC** will gladly provide any receipts, letters, or invoices required by my insurance company for reimbursement. Whole Family Healing Group, LLC is required to directly file electronically or paper forms with insurance companies that they are in-network providers with.

Client: _____ Signature: _____ Date: _____
(Please Print)

Client: _____ Signature: _____ Date: _____
(Please Print)

Briefly Describe Why You Are Requesting Therapy? What are your General Concerns?

Who shall we call in case of an emergency:

Name: _____
Relationship: _____
Phone: _____
Address: _____
E-Mail: _____

Name: _____
Relationship: _____
Phone: _____
Address: _____
E-Mail: _____

The Maryland State Board of Social Work Examiners is responsible for regulating the practice of Social Work and they can be contacted at: 4201 Patterson Avenue, Baltimore, MD 21215; (410)764-4788.