The Anxiety and Stress Disorders Institute of Maryland, LLP
Gibson Building, West Wing, Suite 224 • 6525 N. Charles Street • Towson, Maryland 21204
Telephone: 410-938-8449 • ***Fax:*** 410-825-7105 • **WWW.ANXIETYANDSTRESS.COM**

PAGE 1: REGISTRATION FORM FOR A MINOR

It would be helpful to bring this completed form to your first visit.

Child's Last Name: _____First Name:_____ MI: ___
Age:_____ Date of Birth:_____ School:_____ Grade:___ Pediatrician:_____

Parent #1's Last Name: _____First Name:_____MI: ___
Address: _____City:_____State:_____Zip:_____
Phone numbers (circle preferred):_____Email:_____
Employer:_____

Parent #2's Last Name: _____First Name:_____MI: ___
Address: _____City:_____State:_____Zip:_____
Phone numbers (circle preferred):_____Email:_____
Employer:_____

If separated/divorced, parent with primary physical custody: _____ Do you have joint legal custody? Yes/No

Emergency contact (name/phone number):_____

Who referred you to ASDI? _____

Do we have your permission to send a letter acknowledging your visit to your referral source? Yes / No

Do we have your permission to send a letter acknowledging your visit to your primary care provider (PCP)? Yes / No
If yes, PCP name _____ PCP Address_____

If you choose to communicate with your therapist by text or e-mail please know that confidentiality cannot be guaranteed. Please initial that you have read this statement ____.

I understand that I am responsible for all fees incurred during treatment, for payment at the time of each service, and for submitting my own insurance claims for reimbursement. I give permission for ASDI to release otherwise confidential information to my insurer or managed care company so that I can seek reimbursement.

Signature of responsible parent: _____ Date:_____

For office use only:

Intake Date: _____ Dx: _____ Therapist:_____

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PAGE 2: GENERAL INFORMATION AND INFORMED CONSENT FOR A MINOR

Although we prefer to proceed with the therapeutic relationship informally, the following information has been proven helpful in avoiding future misunderstandings:

1. Therapy sessions are usually 45-50 minutes long and must stop on time in consideration of the next person, even if you arrive late. If unable to keep your appointment, please notify your therapist 48 hours in advance or you *may* be billed for the missed visit. Insurance companies do not reimburse missed visits.

2. Payment in full is expected at each session (except for Medicare patients). You are responsible for clarifying your insurance benefits and whether authorization is necessary. Statements will be provided for you to submit to your insurer; your therapist will complete other forms that may be required by your insurer. However, authorization and reimbursement by your insurer may end before your need for treatment ends. Bills outstanding 60 days may incur late fees or be referred for collection.

3. If you choose to use insurance benefits to pay for a portion of treatment, your therapist may be required to submit clinical information, such as diagnostic codes, to insurance industry data banks which *could* have implications for your future insurance purchases. If we are required to submit otherwise confidential information about you, we can no longer promise that such information will remain confidential once it leaves ASDI.

4. All information pertaining to your treatment will remain confidential unless you sign a release to a specific person or organization. The only exceptions to this are: (a) releases contractually required by insurers and managed care companies to establish what they define as "medical necessity" and to secure reimbursement; (b) your therapist assesses you to be of imminent danger to yourself or others, requiring action in the interest of safety; (c) by court order; (d) if you are a plaintiff in a lawsuit in which your emotional health is an issue; (e) information discussed in professional supervision; or, (f) as otherwise provided under Maryland law. (This last exception may include possible danger to a child or other vulnerable person, or your disclosure of a history of sexual abuse by an identifiable person). The federal HIPAA requirements are contained in pages 3-5 of this document.

5. Messages should be left on your therapist's own telephone line rather than the general ASDI line. In an emergency, when you are unable to contact your therapist, you may reach an ASDI psychologist on-call by calling the main ASDI telephone number (410) 938-8449. Telephone calls over 10 minutes may be charged a prorated session fee. When your therapist is out of town, professional coverage will be provided for emergencies. However, your local hospital emergency room is the best place to go in a real emergency.

6. ASDI is a private group independent from Sheppard-Pratt Hospital since 1992. Your being treated at ASDI is not under the auspices of Sheppard-Pratt Hospital and will not result in a medical record there, (i.e., by coming to ASDI, you are not a Sheppard-Pratt patient). Contact ASDI directly rather than trying to contact us through Sheppard-Pratt.

.....

I understand and agree to abide by these ASDI policies. I will ask my child's therapist about any remaining questions I may have, (e.g., fees, what to expect from therapy, scheduling, special arrangements, family involvement, etc.).

Parent's Signature:_____Date_____

Older Minor's Signature (optional):_____ Date_____

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PAGE 3: Federal HIPAA Law

The Anxiety and Stress Disorders Institute of Maryland, LLP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for The Anxiety and Stress Disorders Institute of Maryland, LLP

_____ _____
Signature of client (or personal representative) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

This Form will be retained in your Medical Record

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PAGE 4: FEDERAL HIPAA LAW II

ANXIETY AND STRESS DISORDERS INSTITUTE OF MARYLAND, LLP

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. PLEASE REVIEW IT CAREFULLY.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the privacy practices that are described in this Notice (which may be amended from time to time). At ASDI, we may follow State law which may be MORE stringent for your protection.

For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed in Section II G of this notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures without Your Written Authorization

We may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: We may use and disclose PHI in order to provide treatment to you. For example, we may use PHI to diagnose and provide counseling service to you. In addition,we may disclose PHI to other health care providers involved in your treatment.

2. Payment: We may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

3. Health Care Operations: Wel may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. Required or Permitted by Law: We may use or disclose PHI when we are required or permitted to do so by law. For example,wel may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, we may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law. We may contact you about reminders regarding an appointment, and we may send you information about treatment alternatives or other health related services, as well as about research participation options. You have the right to object to such disclosures.

B. Uses and Disclosures Requiring Your Written Authorization

1. Psychotherapy Notes: Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

2. Marketing Communications: We will not use your health information for marketing communications without your written authorization.

3. Other Uses and Disclosures: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before we can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

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PAGE 5: FEDERAL HIPAA LAW III

II. YOUR INDIVIDUAL RIGHTS

A. **Right to Inspect and Copy.** You may request access to your medical record and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you, consistent with State law.

B. **Right to Alternative Communications.** You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. **Right to Request Restrictions.** You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. We are not required to agree to any such restriction you may request.

D. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by us after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. **Right to Request Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

F. **Right to Obtain Notice.** You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

G. **Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact the **Privacy Officer, Sandy Schultheis, at 410 938-8449** . You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Wel will not retaliate against you if you file a complaint with the Director or us.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on April 14, 2003.

B. Changes to this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our offices. You may also obtain any revised notice by contacting the Privacy Officer.

Thank you for your patience and perseverance in completing this form.