Patient Forms

Basic Information

Full Name _____
First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Unknown

Date of Birth ___ / ___ / ___

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number _____

Email _____

Social Security Number _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____ **Zip** _____

Marital Status _____

Maiden Last _____

Driver's License State _____

Driver's License # _____

Demographics

Sexual Orientation _____

Gender Identity _____

Hispanic or Latino? ◯ Yes ◯ No ◯ Decline to Specify

Ethnicity _____

Race _____

Language _____

Emergency Contact

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number _____

Email _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____ **Zip** _____

Financial Information

Responsible Party

Who will be financially responsible for you? ◯ Myself ◯ Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ◯ **Home** ◯ **Mobile** ◯ **Work** **Phone Number** _____

Method of Payment

What will be your method of payment? ◯ Insurance ◯ Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company _____ **Policy Number** _____

Insurance Plan _____ **Insurance Phone Number** _____

Group Number _____

Insurance Company Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Relationship to Primary Policy Holder _____

If you are not the primary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** ____ / ____ / ____

Policy ID Number _____ **Social Security Number** _____

Policy Holder Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company **Policy Number**

Insurance Plan **Insurance Phone Number**

Group Number

Insurance Company Address **Address Line 2**

City **State** **Zip**

Relationship to Secondary Policy Holder

If you are not the secondary policy holder, please fill out the following:

Full Name
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** / /

Insurance ID Number **Social Security Number**

Policy Holder Address **Address Line 2**

City **State** **Zip**

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us?

Associated Behavioral Health Services, LLC
939 Elkridge Landing Rd, STE 350
Linthicum, MD 21090-2766
443-354-8903

Consent for Outpatient Evaluation and Treatment, Including Psychotherapy and Medication Management

General Information-Consent for Treatment (Psychotherapy and Medication Management if required)

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the check box at the end of this document.

You have taken a very positive step by deciding to seek therapy or medication management. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. Please let your therapist or prescriber know of significant concerns or side effects.

1. As the Legal Guardian of the aforementioned Patient, have reviewed all of the Policies and Procedures regarding Treatment, I am requesting the Patient to receive from Associated Behavioral Health Services of Maryland, LLC. I, as the Patient's Legal Guardian, deem that Medical Treatment to be medically necessary, appropriate, usual and customary, and therefore agree on behalf of the Patient to the provision and delivery of such Medical Treatment. It is further understood, I may at any time, acting on behalf of the Patient, revoke my CONSENT FOR MEDICAL TREATMENT. …OR, IS AN ADULT AND COMPETENT TO AUTHORIZE TREATMENT ON HIS OR HER OWN BEHALF.

2. I, as the aforementioned Patient, have reviewed all of the Policies and Procedures regarding the Medical Treatment I am requesting to receive from Associated Behavioral Health Services of Maryland, LLC and its qualified Mental Health Providers and Agents to provide such Outpatient Mental Health Services and related Medical Services as deemed medically necessary, appropriate, usual and customary. It is further understood, I may at any time, acting on my own behalf, revoke my CONSENT FOR TREATMENT.

3. I understand that all information concerning participation in Mental Health Treatment is privileged and confidential, and except where specifically required by Law, will not be provided to any source without my specific written consent.

4. I agree that I have been fully oriented to the Services offered by Associated Behavioral Health Services of Maryland, LLC and the treatment which is being proposed for me. I have reviewed my Patient Bill of Rights and also my responsibilities as a Consumer, and I am fully aware of the grievance process. a. In accepting services, I understand I will assist in the development of my Individualized Treatment Plan (ITP) which has or will be developed by the treating clinician, and which will greatly improve my opportunities for success in Treatment; b. I agree to pay for any and all services not covered by third-party insurance myself, at the time service is rendered, unless other arrangements are made, in writing. c.I understand that my clinician may be under the supervision of a clinically licensed provider and that I may request a consultation with the supervising provider at anytime. d. I promise to keep all scheduled appointments with my Treatment Team, or if unable to attend, to telephone to cancel my appointment at least Twenty Four (24) Hours in advance. I understand if I choose to miss any appointment without appropriate pre-cancellation, I will be held personally responsible for payment of the missed appointment myself.

Patient Rights and Responsibilities

1. Each Patient has the right to be treated as an individual, evaluated according to his/her individual clinical needs, and receives assistance as necessary, in providing for his/her basic personal needs.

2. Each Patient has the right to expect that he/she will be treated by competent staff according to a professional code of ethics; that preserves the Patient's personal privacy and dignity.

3. Each Patient has the right to expect that all records concerning his/her treatment shall be kept confidential and only released with the written permission of the Patient, or as specifically dictated by law, including HIPAA.

4. Each Patient will receive an orientation to the clinical services which will include the responsibilities of the staff and Patient. Each Patient has the right to appropriate screening and referral for management of pain.

5. Each Patient has the right to receive aftercare/discharge planning that is initiated early in his/her treatment, and to receive assistance in making plans for follow-up mental health/chemical dependency services, rehabilitation, and living arrangements, as necessary, for the period following treatment with Associated Behavioral Health Services of Maryland, LLC

6. No Patient shall be discriminated against on the basis of age, race, religion, color, creed, ethnicity, ancestry, gender, marital status, sexual orientation, national origin, handicap, or drug of choice.

7. Each Patient has a right to know what agency rules and regulations apply to his/her conduct and/or treatment as a Patient of Associated Behavioral Health Services of Maryland, LLC

8. Each Patient has a right to expect emergency interventions to be implemented without unnecessary delay.

9. Each Patient has a right to high quality care and high professional standards that are continually maintained and reviewed, with direct input of the Patient.

10. Each Patient has the right to full information and counseling on the availability of known financial resources for recommended treatment. The integrity of clinical decision making is based upon the bio-psychosocial needs, assessments and reassessments of the Patient and not on financial incentives.

11. Each Patient has the right to be provided with information concerning his/her own diagnosis, treatment, and prognosis and to participate in decisions involving his/her treatment.

12. Each Patient has the right to refuse treatment and/or medication. In this event, the Patient has the right to be informed of the medical consequences of this action.

13. Each Patient has the right to inspect his/her clinical chart, and to obtain copies thereof, in accordance with applicable state and federal regulations, including HIPAA, and agency policy and to submit rebuttal statements and amendments.

14. Each Patient has the right to be advised of the hours of operation, the fee schedule, services provided, including Privacy practices under HIPAA.

15. Each Patient has the right to be advised of the criteria for admission, treatment and discharge.

16. Each Patient is responsible to respect the dignity and rights of other Patients and to exercise care for the physical surrounding.

17. Each Patient is responsible to interact with his/her provider/treatment team and/or Associated Behavioral Health Services of Maryland, LLC

18. Each Patient is responsible for complying with all reasonable requests for information and to actively participate in the Intake/Evaluation process, as well as on-going treatment and aftercare planning.

19. Each Patient is responsible, in the context of group therapy, to maintain the confidentiality of others Patients.

20. Each Patient is responsible to give written permission for the release of necessary information to qualified professionals involved in his/her treatment program.

21. Each Patient is responsible to make known, directly to his/her counselor and/or other professional staff, questions, differences, complaints, and grievances, and to expect a prompt reply.

22. Each Patient has the responsibility to keep all scheduled diagnostic or treatment appointments on time or give adequate notice of delay or cancellation.

23. Each Patient has the responsibility to communicate with his/her provider so that he/she can develop a Patient-provider relationship based on trust and cooperation.

24. Each Patient has the responsibility to help his/her provider maintain accurate and current medical records by being open and honest.

25. Some of the professionals at ABHSM may chose to communicate with me via email. If I choose to communicate in this manner, I understand that email is not a confidential means of communication. Although it is unlikely, there is a possibility that information included in an email can be intercepted and read by other parties besides the person to whom it is addressed. Please do not include personal identifying information such as your birth date, or personal medical information, in any emails you send to us. Although email will be checked on a regular basis, I understand that ABHSM cannot ensure email messages will be received and responded to in a timely fashion. I understand email is not the appropriate way to handle confidential information, emergencies, diagnosis and/or medication changes.

26. With certain exceptions, under HIPAA Patients have the right to an accounting of disclosures made of protected health information.

If your therapist or prescriber leaves or has an extended absence from the practice, you may transfer to another therapist or prescriber at Associated Behavioral Health Services of Maryland, or be given a list of providers in the area. Please note that engaging in psychotherapeutic services, there may be both significant gain or risks to self as a result of exposure to uncovering undiscovered information about self and family. You could feel worse before you feel better. You may have opportunities for significant improvement. I have been notified of these risks and gains. I consent to treatment.

Associated Behavioral Health Services, LLC
939 Elkridge Landing Rd, STE 350
Linthicum, MD 21090-2766
443-354-8903

On File Credit Card and HRA Card

Primary Credit Card (Required)

Name on Card:

Card Number:

Exp. Date

CVV(3 Digit)

Zip Code

Primary HSA Card (Only to be used for Patient Copays and Deductibles - Optional)

Name on Card:

Card Number:

Exp. Date

CVV(3 Digit)

Zip Code

I hereby authorize Associated Behavioral Health Services, LLC (ABHS) to charge my credit card for no show or late cancelation fees accrued as a result of failing to show for scheduled appointments or not canceling appointments 24 hours prior to my appointment, as agreed upon in the consent for treatment found in the signatory of the ABHS Financial Agreement at time of admission. Please note that you may be denied future services if you have not paid your copays, deductibles, no show fees and late cancellation charges.

Patient Name: _____ Date:_____

Signature:_____

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ABHS Financial Responsibility Agreement / Statement of Standard Fees

FINANCIAL AGREEMENT - Please review and ask any questions that you may have regarding your patient account

INSURANCE

I will provide updated information regarding any changes to your insurance or payment status. I understand that failure to update insurance information does not release me from my financial responsibility for charges incurred. If fee schedules change, you will be notified in writing of scheduled changes. By signing this agreement, I understand and agree to allow this Practice to submit my insurance for reimbursement. I understand that the Practice may bill my insurance under a Supervising Provider for services rendered by a supervised Provider at the time of service.

STANDARD FEES / CANCELLATIONS / LATE CANCELLATIONS/ NO SHOWS

I understand that it is important that I keep any scheduled appointments in order to have the best care possible. I agree to schedule appointments at the frequency suggested by the treating physician or therapist. I understand that I must give at least 24 hours advance notice to cancel a scheduled appointment.

Should I fail to contact the office I will be charged: These fees are my responsibility and will not be paid by my insurance company.

STANDARD FEES IF NOT UTILIZING INSURANCE BENEFITS

90791 Initial Diagnostic Evaluation $225.00

90833 Medication Management Consultation $150.00

90834 Individual Therapy 45 minutes $150.00

90832 Individual Therapy 30 minutes $120.00

90846 Family Therapy w/o patient 45 min $150.00

90847 Family Therapy with patient 45 min $200.00

90837 Individual Therapy 60 minutes $200.00

90792 Diagnostic Evaluation w/Rx 275.00 Medication Visit

99212 Expanded 110.00 Medication Visit

99213 Expanded 120.00 Medication Visit

99214 Moderate 200.00 Medication Visit

99215 Complex 275.00

99214/90833 Moderate Medication Visit with Therapy Add-on 350.00

Non-Appointment Prescription Refills 25.00

LATE AND NO SHOW FEES

$100.00 for missed intake evaluation.

$75.00 no show fee for the first missed appointment

$100.00 no show fee thereafter the first missed appointment fee

$50.00 for first late cancellation

$75.00 for second late cancellation

I am aware that multiple cancellations or no shows may lead to discharge from psychiatric and or psychotherapeutic services. If you wish to schedule another initial intake after missing your first intake you must pay the "missed intake appointment" fee before another appointment will be scheduled for you. In addition, any missed intake appointments will require a valid credit card be kept on file before any additional appointments will be scheduled.

PAYMENTS, CO-PAYMENTS, DEDUCTIBLES

I understand that payment of co-pays, deductibles and balances are due when services are rendered. I understand that it is imperative that my account stays current. In case of financial difficulties, I will contact the billing office to make appropriate payment arrangements. I may discuss and questions or discrepancies with the billing department at any time, this communication may be by phone or through written communication. THERE ARE NO COPAY, CANCELLATION, LATE CHARGES OF FEES FOR RX WITHOUT APPOINTMENT FOR MARYLAND PHMS MEDICAL ASSISTANCE PATIENTS.

COURT AND LEGAL COST

The cost of a court appearance or subpoena is not covered by insurance. The cost of court appearance and paperwork preparation will be $500.00 per hour, plus the cost of documentation and travel.

METHOD OF PAYMENTS

I understand that I may pay for services, co-pays and deductibles via Visa, MasterCard, Discover, or American Express, HRA accounts or Check, payable to ASSOCIATED BEHAVIORAL HEALTH SERVICES, LLC.

FINANCIAL AGREEMENT

I have reviewed the conditions stated above and understand my financial responsibilities. I agree to my financial responsibility for psychotherapeutic services rendered, as stated above.

Patient Name: _____

☐ I am the parent or guardian of this patient

Signature:_____

Date:_____

Associated Behavioral Health Services, LLC
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ABHS Notice of Privacy Practices

HIPAA PRIVACY NOTIFICATION: THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. 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. If you have any questions about this Notice or want additional information, please contact K. Reed Gehring, Angela Hart-Hess or Samuel T. Bolin (Privacy Contacts) at 443-231-4945.

Notice of Privacy Practices:

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Notice of Privacy Practices Acknowledgement Page:

We participate in the CRISP health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP medical record sharing policies at www.crisphealth.org.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For my use in treating you.

b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For my use in defending myself in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

e. Required by law and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it. Complaints: If you believe we have violated your privacy rights, you may complain to us or to the Secretary of Health and Human Services. You may file a complaint with us by notifying our Privacy Contact. We will not retaliate against you for filing a complaint. Contacting Privacy Officers: K. Reed Gehring, Angela Hart-Hess, or Samuel T. Bolin (Privacy Contacts) at 443-231-4945, 939 Elkridge Landing Rd, Suite 350, Linthicum, Maryland 21090

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

Associated Behavioral Health Services, LLC
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Telehealth Consent Form

Telehealth is the use of video and audio to provide health care services when the provider and the client are not in the same location. Telehealth consists of a phone call, text or audio / video session.

- I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to ABHSM to provide health care services to me via telehealth.

- I understand that while there are many benefits of telehealth in reducing barriers to treatment, there are potential risks, which include, but are not limited to:

o It may not be appropriate for the treatment of serious psychiatric illnesses or symptoms.

o It may not be appropriate for more complex situations.

o Telehealth can sometime prevent the exchange of important information such as, facial expressions, vocal

signals, or body language that may be less evident through telehealth.

o Sessions may have to be interrupted or discontinued if technology issues interfere with the ability for the service

provided in a clinically appropriate and ethical manner.

o Telehealth interferes in the ability of clinicians to utilize some interventions, such as those using specific materials

or tools.

o Telehealth may limit the ability of a practitioner to identify a symptom that is not apparent through telehealth.

- I understand that ABHSM is permitted can only provide telehealth services as permitted by national, state, and individual insurance company regulations. Telehealth services may not be available as insurance coverage or regulations change. Some insurances do not permit telehealth services.

- I understand that telehealth communications are not recorded or stored.

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth.

As always, your insurance carrier will have access to your medical records for quality review/audit. Other limitations of confidentiality as reviewed in ABHSM consent to treatment continue to apply.

- I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit.

- 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. I understand that during a state of emergency, ABHSM may only be providing telehealth services and refusal to consent, may lead to inability for ABHSM to provide treatment.

- I may revoke my consent orally or in writing at any time by contacting Associated Behavioral Health Services as long as this consent is in force (has not been revoked), Associated Behavioral Health Services of Maryland and it's contractors may provide health care services to me via telehealth without the need for me to sign another consent form.

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Patient Signature and Acknowledgment

I hereby sign this form as an acknowledgment that I have read and understand all of the information provided in this intake. I understand that if I would like to revoke or remove consent for treatment at any time, I must do so by providing a letter of such intention and submitting it to:

Administration C/O ABHS
939 Elkridge Landing Rd, STE 350
Linthicum, MD 21090

Patient Name:_____

Guardian Name:_____

Date:_____

Patient Signature:_____

Guardian Signature:_____

Witness Signature:_____