



PSYCHIATRY UTOPIA

10400 Connecticut Ave., Suite 311, Kensington, Maryland 20895

Email: info@psychiatryutopia.com

Phone: 301-828-2348 Fax: 240-244-0796

Intake Packet

Authorization to Bill Insurance

ID #:

DOB:

Client Name:

Date:

I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from the staff at the clinic named above. I therefore authorize the medical staff and personnel to release me or my minor child's medical information to the insurance company listed above for the purpose of determining and receiving benefits for 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, co-payments, 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 service and/or a legal claim against me for non-payment.

Signature

Date



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INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name:

Date of Birth:

ID#:

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment 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 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, except 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 physically 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 an 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 concerns you may have.



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By my signature below, I voluntarily request and consent to behavioral health assessment, care, treatment, or services and authorize 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 acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Signature:

Date:

Witness Signature:

Date:



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Telehealth Services Informed Consent

ID #:

DOB:

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 confidentiality 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 videoconferencing 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 may involve electronic communication of my personal medical information to other medical practitioners who may be 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 purposes 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 consultation 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.



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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 contents including the 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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NOTICE OF PRIVACY PRACTICES

Name:

ID#:

DOB:

Effective April 29, 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 Practices 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 ("HIPAA"), 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 respect to PHI. Your provider is required to abide by the terms of this Notice of Privacy Practices. Your provider reserves the right to change the terms 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 DISCLOSE 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 medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, only the minimum amount of PHI necessary for purposes of collection will be disclosed.

For Health Care Operations: Your provider may use or disclose, as needed, your PHI in order to support his or her 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 about treatment



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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, disclosures 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 of 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 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.

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 regarding 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 copy PHI that may be used to make decisions about your care. Your right to inspect and copy 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 a reasonable fee if you request more than one accounting in any 12-month period

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



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Right to Request Confidential 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. Filing a complaint will not affect your right to further treatment or future 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

ACKNOWLEDGMENT 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:

Client Signature:

Date:

If signed by other than client, indicate relationship here: