CHILD INTAKE FORM
(Please complete in Ink)

CHILD

1. Child's Name________________________________Sex______Age_____DOB_________
2. Natural Child Yes / No   If adopted, at what age_______Foster since ______________
3. Parent's Names (include step-parents, foster parents, etc.)

   ____

   ____

4. Comments about custody and visitation (if applicable):

   ____

   ____

5. Primary reason you are concerned about your child?

   ____

   ____

   ____

SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

a. __ Sleep problems
______Lack of interest in activities
______Unassertive
______Fatigue/low energy
______Concentration problems
______Appetite/weight changes
______Withdrawal
______Morbid thoughts
______Suicidal thoughts or threats
______Suicidal plans / attempts
______Mood swings
______Depression
______Changed level of activity
______Cries easily

b. __ Forgetful/memory problems
____Short attention span
____Aggressive behavior
____Can't sit still
____Not interested in peers
____Picked on / bullied by peers
______Talks excessively / interrupts
______Easily distracted
______Irritable
______Impulsive
______Difficulty following rules
______Problem completing schoolwork

c.
______Excessive worry / fearfulness
______Anxiety or panic attacks
______Social fears, shyness
______Separation problems
______Bedwetting / soiling
______Headaches, stomachaches
______Odd beliefs / fantasizing
______Nightmares
______Frequent tantrums
______Resistive to change
______School refusal
______Perfectionism
______Odd hand / motor movements
______Hallucinations

d.
______Lying
______Trouble with the law
______Running away
______Truancy, skipping school
______Hurting others sexually
______Alcohol / drug use
______Argumentative / defiant
______Swears
______Blames others for mistakes
______Stealing
______Being destructive
______Fire setting
______Hurting others / fighting
______Acts as if has no fear
______Short tempered
______Easily annoyed / annoys others
______Discipline problem
______Angry and resentful

Brothers and Sisters

First Name – Last Name	Sex	Age	Relationship to child (full, step, half, foster)
1.			
2.			
3.			
4.			
5.			
6.			

SCHOOL HISTORY

1. Present School:________________________________Grade:_____Teacher:________________
2. Has child ever repeated any grade? ____
3. Is child in special education services? No_____Yes, what kind? _________________________
4. Please describe academic or other problems your child has had in school

____

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1. Pregnancy

Mother used during pregnancy: alcohol______drugs_______cigarettes _______

Delivery: Normal______Breech_______Cesarean_______Transectional_______
Full-term______Premature______if premature, number of weeks ______

Birth Weight: ___________

Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc)

____

2. **Developmental History**

- State approximate age when child did the following:

  Walked alone______Said first word_______Used 2-word phrases _______

- Understood and followed simple directions ______
- Reasonably well toilet trained ______
- Did child cry excessively?______Rarely cried _______

3. **Health History of Child**

In the first two years, did your child experience:_____Separation from mother,

___Out of home care,____Disruption in bonding,____Depression of mother, ___Abuse,

___Neglect,____Chronic pain,____Chronic Illness, _Parental Stress

- Child's Doctor: ____
- Date of last physical exam: ______________________
- Vision problems? Yes_______No_______Hearing problems? Yes_______No _______
- Dental problems? Yes_____No _____
- Any head injuries or loss of consciousness? Yes_______No _______
- Child's history of serious illness, injury, handicaps, or hospitalization?

  No_______ Yes – describe and give dates ____________________

- Is your child currently taking any medications? No_____Yes_____name medications

  ____

- List any medicines previously used for emotional problems: were they helpful? _____

  ____

- Allergies to drugs or medicines? No_____Yes_____(list) ______________________
- Allergies to any foods? No_____Yes_____(list) ______________________________
- Are there any foods that you limit or do not give this child? No_____Yes _____

  (list)____.
- Allergies to environmental conditions? No_____Yes_____(list) __________________
- Does anyone in the household smoke? No_____Yes _____
- About how many hours does this child watch TV, videos, etc per day ________
- Are you afraid someone you know may injure/harm this child? No_____Yes _____

  National Domestic Violence Hotline 1-800-799-7233
- Does this child have a Health Care Directive? No_____Yes _____

  If yes, please list where (clinic) it is on file _______________________________
- Any previous psychological or psychiatric treatment? No______Yes _______

  Whom/where________________________________when_______________
- Any previous testing (school/psychological)? No______Yes _______

  Whom/where_________________________________when_______________
- Do you think your child's use of chemicals is a problem? No______Yes _______

  Type: Alcohol_______ Marijuana_______ Other drugs ______________________

  Comments: ____

Family History:

Chemical use (now & past): No______Yes______Which parent _________________

Type: Alcohol_______ Marijuana_______ Other drugs_______________________

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):
____

____

Has child witnessed domestic violence?___Y,___N, Specify: ________________________

____

How is your child disciplined? Please list each method and frequency of use: ______________

____

____

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused?___Y,___N,___Suspected. Specify: _______________

____

2. Has your child been physically abused?__ Y,___N, Suspected. Specify: ________________

____

3. Has your child been sexually abused?___Y,___N,___Suspected. Specify: _______________

____

4. Other stressors or traumas?____

____

What are your child’s strengths?

Any additional comments or information that would be helpful to us?

Signature of person completing form / relationship to client:

____Date:________________
Name   Relationship

Parent Form

Section 1: Print Clearly

Full Name: ____

Address: ____

Home Phone:__________________________Work Phone:__________________________Cell Phone: ____________________________

Married_____Single____Divorced____Your email:______________________________Spouse email: _____________________________

Preferred Phone Contact Number:________________Sex:_____M_____F Date of Birth:______/_____/______

Race:___________White__________Black___________Hispanic_________Asian__________Other

Ethnicity:________Puerto Rican____________Mexican________Cuban__________Other__________Not of Hispanic Origin

Highest Grade Completed:_______________________Family Income:_________________per year

Employee Status:_________Full-Time_______Part-time_______Homemaker______Unemployed______Retired/ Disable

Source of Income:________Wages/Salary___________Retirement/Pension_________Public Asst._______Self-Employment

Living Arrangements:____________Homeless_______________Dependent Living_______________Independent Living

Number of Children:_____________Currently Pregnant? Yes / No Tobacco Use Past 30 days? Yes / No

Use of illegal drugs past 30 days? Yes/ No Do you use alcohol? Yes / No How many times/week? ___________

How many drinks do you have per occasion?________Have you ever been arrested? Yes / No # ofArrests? _______

Reason for Arrest(s)? ____

In case of emergency, please contact:

1. ________________________/_____________________/_____________________ (Contact Name/ Phone/ Relationship)

2. ________________________/_____________________/_____________________ (Contact Name/ Phone/ Relationship)

Section 2:
Reason for appointment at Bay Area Christian Counseling

1. Self-Referral *___________2. Attorney Referred*______3. Court Referred*_____4. Other _______________
   *Please list referral source: ____
   Presenting Problem: ____

   I or a family member are currently seeing a:
   Counselor______________2. Psychologist_________3. Psychiatrist___________4. Other ________________
   Reason for seeing above professional:
   ____
   Current Mental Health Problems: yes / no Diagnosis:____
   Please check any of the following that you suffer from:
   ________Trouble getting out of bed _____Difficulty working w/ others__________Difficulty staying focus
   ______Over/Under Eating Difficult Relationships _____Frequent Worrying________Depression
   List anything else you'd like your clinician to know:
   ____
   ____

   Patient Signature (or Legal Guardian)____Date:_______________

INFORMATION FORM

Full Name:____Birth Date: _________________

Parent SS #:_________________Driver's License #: ____

Employer Name:________________________________Employer Address: ____________________________________

Occupation: ____

Emergency Contact Person:____Phone: ___________________________

Name of Spouse or Parent/Guardian: ____

Referring Doctor (if applicable):___________________________Phone: _________________________________

Primary Care Doctor:____________________________________Current Medication and Dosage: ____________________

____

____

Insurance Information

Please present ALL insurance cards and Driver's License to the clinician.

PRIMARY:_______________________________MBR ID#:_________________________Group#: ___________________

Policy Holder Name/Relationship:____Co-Payment amt.: ____________

Policy Holder Date of Birth:_________________Policy Holder SS#: _________________________

SECONDARY:_____________________________MBR ID#:_________________________Group#: ___________________

Policy Holder/ Relationship:____Co-Payment amt.: ____________

Policy Holder Date of Birth:_________________Policy Hold SS#: ___________________________

Guarantor Name: (Person responsible afterinsurance): ____

Relationship:______________________Address: ____

Home Phone:______________________Work Phone:______________________Cell: ____________________________

ASSIGNMENT, RELEASE, and HIPPA COMPLIANCE

I hereby assign all medical benefits to which I am entitled to Bay Area Christian Counseling for services rendered by Bay Area Christian Counseling. This will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure payment. I hereby assume all financial responsibility for all charges whether or not paid by said insurance. I further understand that all balances due are to be paid within 30 days of receipt of Statement. I also acknowledge that this office is HIPPA compliant, and that all efforts will be made to ensure my privacy, and that all records and copies of HIPPA privacy practices are available to me upon request.

____ ___________________________

Patient Signature (or Legal Guardian) Date

Confidentiality of Patient Records

Client Name: ____

Social Security #:__________/________________/________________Date of Birth: _________________________

Federal law and regulations protect all confidential patient records maintained by this agency. The staff or counselors will not say to a person outside the agency that a patient attends counseling or disclose any information identifying the patient unless:

1. The patient consents in writing,
2. The disclosure is allowed by court order,
3. The disclosure is made to medical/police personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation, or

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

I have received and understand the above reference to my confidentiality right at Bay Area Christian Counseling. I am aware that Bay Area Christian Counseling does not communicate via e- mail, text, or cell phone unless utilizing our secure online counseling services located at www.bayareachristiancounseling.org . I further understand this form and my signature are to become a permanent part of my record at Bay Area Christian Counseling, Inc.

Client/Guardian Signature:________________________________Date:___________________

Clinician Signature:______________________________________Date: ___________________

Bay Area Christian Counseling, Inc.

Informed Consent for Treatment

I have reviewed the Bay Area Christian Counseling Patient Information Packet, which Includes information regarding access, fees, Patient Rights and Responsibilities and Privacy Practices. I accept those policies and practices. I understand I may request a copy of these notices if I wish to keep them for my personal records.

Behavior health treatment offers no guarantees. Yet, by working with my therapist, doctor and/or counselor, I will get the support necessary to manage the concerns I bring to Bay Area Christian Counseling. I recognize I will need to try new ways of dealing with these issues. Together with my therapist, doctor, and/or counselor, I may be asked to develop practices, tasks and/or exercises I will complete outside of therapy that will complement and enhance the effectiveness of treatment. My openness and willingness to engage in these activities may well have a direct impact on the efficacy of the therapy process.

I agree to fully collaborate with my therapist, doctor, and/or counselor. I agree to ask any questions I have to clarify my therapeutic goals and how therapy is address them.

I understand therapy may not continue to be necessary when the concerns I initially had are resolved. I also understand I can terminate my therapy at any time I wish. I may also ask to transfer to another therapist, doctor, and/or counselor if I feel my current therapy has been ineffective. I agree to notify my therapist, doctor, and/or counselor of my interest in transferring or intent to end therapy and to schedule a transitional session to discuss the reasons for my decision and the possible risks of premature termination of therapy with that treating clinician prior to transferring or terminating therapy.

I also understand my therapist, doctor and/or counselor may end my treatment if we do not make progress, or if our relationship becomes too strained to continue working together. If treatment is to be terminated, upon request, my therapist, doctor, and/or counselor will make suggestions to guide me in finding another provider of my choice. I will make every effort to follow these suggestions.

______________________________________   _____/_____/_____

Client/ Legal Guardian Signature   Date

______________________________________   _____/_____/_____

Witness Signature   Date

102 Old Solomons Island Road, Suite 202
Annapolis, MD 21401-3879

PARENTAL CONSENT FOR TREATMENT

I,______________, hereby authorize Bay Area Christian Counseling, Inc. to provide mental health counseling and/or treatment to________________, date of birth___________, a minor. This authorization is effective immediately and remains in force and effect unless and until I revoke it in writing.

In providing this authorization, I state the following:

_______ I am the natural or adoptive parent of the minor and there are no court orders in effect regarding legal custody or the ability of any person to authorize mental health counseling or treatment; or

________I am the entitled by Court order to authorize mental health counseling or treatment (a copy of that Order is attached) and I am not aware of any subsequent Court orders; or

I understand that Bay Area Christian Counseling, Inc. and its employees and agents have relied upon this Consent form in agreeing to render counseling and/or treatment to the minor and I will indemnify and hold them harmless in the event the statements above are not true or accurate.

_______________________   ___________________________
Date   Authorizing Person

RELEASE AND/OR OBTAIN INFORMATION FORM

I AUTHORIZE BAY AREA CHRISTIAN COUNSELING TO RELEASE/OBTAIN INFORMATION CONCERNING MY TREATMENT TO/FROM

____

For Client: ____

REGARDING THE FOLLOWING INFORMATION:

______Initial Interview ______Psycho-Social History

______Counselor's Notes ______Discharge Summary

______Medical History, Physical Exam, ______Disability Report or Forms Laboratory Reports

Other (Specify): ____

I WOULD LIKE THIS INFORMATION FORWARDED BECAUSE:

______It will contribute to a comprehensive treatment plan for me.

______It will provide information to my insurance company r third party payees as needed for billing.

Other reasons (Specify): ____

I understand that my treatment records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for by Regulations. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it (e.g. probation, parole, court ordered, etc.). I also understand that this consent expires automatically at the completion of the disclosure unless specifically provided for the following date, event or condition, which marks the expiration of consent:

DATE CONSENT INITIATED: ________________

Client/Guardian Signature & Date: ____

Witness Signature & Date: ____

PROBATION OF REDISCLOSURES

This information has been disclosed to you from records whose confidentiality is protected by Federal Law, Federal Regulations (42CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical information is NOT sufficient for this purpose.

Notices of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information also called protected health information, or PHI. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with the notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

How we may use and disclose your PHI,

Your privacy rights in your PHI,

Our obligations, concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created of maintained in the past, and for any of your records that we create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times. And you may request a copy of our most current Notice at any time.

B. If you have any questions about this Notice, please contact Jim Stafford, Executive Director.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood and urine) tests and we may use the results to help us reach a diagnosis or to provide comprehensive treatment. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice including, but not limited to, our clinicians and assistants may use or disclose you PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to other Health care providers for purposes related to your treatment.
2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose you PHI to other health care providers and entities in their billing and collection efforts.
3. Healthcare Operations. Our practice may use and disclose you PHI to operate our business. As examples of the way in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of your care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose you PHI to other health care providers and entities to assist in their health care operations.
4. Appointment Reminders. Our practice may use and disclose you PHI to contact you and remind you of your appointment.
5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options and alternatives.
6. Health-related Benefits & Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. Release of Information to Family/Friends. Our practice may use or disclose your PHI to family members or a friend that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the counselor/psychiatrist for a mental health appointment. In this example, the babysitter may have access to this child's medical information.
8. Disclosure Required by Law. Our practices will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain circumstances.

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purposes of:
   - Maintaining vital records, such as births and deaths,
   - Reporting child abuse or neglect,
   - Preventing or controlling disease, injury, or disability
   - Notifying a person regarding potential exposure to a communicable disease,
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition,

- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency (i.e.) and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or medical surveillance.

2. Health Oversight Activities. Our practices may disclose your PHI to a health oversight agency for activities authorized by the law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the health care system in general.
3. Lawsuits & similar proceedings. Our practice may disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceedings. We also may disclose our PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. Law Enforcement. We may disclose your PHI if asked by a law enforcement official:
   - Regarding a crime victim in certain situation, if we are unable to obtain the person's agreement,
   - Concerning a death, we believe has resulted from a criminal conduct,
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena, or similar legal process,
   - To identify/locate a suspect, material witness, fugitive or missing person,
   - In an emergency, to report a crime (including the location or victim (s) of the crime, or the description, identify or location of the perpetrator).
5. Deceased patients. Our practice may release your PHI to the medical examiner or coroner to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. Organ & tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, include organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of our authorization satisfies all of the following conditions:
   a. The use or disclosure involves no more than a minimal risk to our privacy based on the following: (i) a adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other per or entity (except as required by law) for authorized oversight of the research study. Or for other research for which the use of disclosure would otherwise be permitted;
   b. The research could not practicably be conducted with the waiver,
   c. The research could not practicably be conducted without access to and use pf PHI
8. Serious Threats to health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. Military. Our practice may use and disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president other officials or foreign heads of state, or to conduct investigations.
11. Inmates. Our practice may disclose you PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals.
12. Workers compensation. Our practice may release you PHI for workers" compensation and similar programs.

E. Your rights regarding PHI:
You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication you must make a written request to Jim Stafford, Executive Director specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. Requesting restrictions. You have the right to request a restriction in our use of disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your

care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make a request in writing to Jim Stafford, Executive Director, 102 Old Solomons Island Rd, Ste 202, Annapolis, MD 201401. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspections & Copies. You have the right to inspect and obtain a copy of your PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Jim Stafford, Executive Director, 102 Old Solomons Island Rd, Ste 202, Annapolis, MD 21401 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. Amendment. You make ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be in writing and submitted to Jim Stafford, Executive Director, 102 Old Solomons Island Rd, Ste 202, Annapolis, MD 21401. You must provide us with a reason that supports your request for the amendment. Our practice will deny your request if you fail to submit your (and the reason for supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not kept of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to insect and copy; or (d) not created by our practice, unless the individual or entity that created the information was not available to amend the information.
5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An accounting of disclosures is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment payment or operations. Use of your PHI s part of the routine patient care is our practice is not required to be documented (For Example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim). In order to obtain an accounting of disclosures, you must submit your request in writing to Jim Stafford, Executive Director, 102 Old Solomons Island Rd, Ste 202, Annapolis, MD 21401. All requests for an "accounting of disclosures" must state a time period, which may not be longer that sic years from the date of disclosure and may not include dates before August 2015. The first list you request within a 12-month period is free of charge, but our practice must charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. Right to a paper copy of this notice. You are entitled to receive a copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice contact Jim Stafford, Executive Director.
7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Jim Stafford, Executive Director. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization Please note we are required to retain records of your care.

Again, if you have any questions regarding this notice of our health information privacy policies, please contact us at 410.266.3058.

Client/Guardian Signature HIPPA Disclosure **Date**

Clinician Signature **Date**

CREDIT CARD ON FILE POLICY

Bay Area Christian Counseling has updated our billing practice regarding receiving patient payments. Effective 1/15/20, we will **require a credit card, debit card, or HSA/FSA card to be on file** with our office OR **a deposit be made on your account** to cover client responsibility of payments at each appointment. A $100 minimum is required on all visits. If you keep your FSA/HSA card on file, however, since FSA/HSA funds are limited, we may require an additional card to be kept on file should the funds in your HSA account become insufficient or you owe late cancelation or missed fees.

With the changing environment in healthcare, more responsibility of payment is being placed on the client. We need to be sure client balances are paid in a timely manner. To do this, we need to ensure we have a guarantee of payment on file in our office.

This policy applies to all clients. We have wonderful clients, and we know most of you pay your balances. Unfortunately, this is not always the case.

Client responsible payments such as cash pays, copays and co-insurances are due at the time of service. You will be expected to pay for your services until your deductible is met. If you have a very large deductible, called a high-deductible insurance plan, you may have to pay out of pocket for most of your sessions. This will be determined on your individual insurance plan and shown on your Explanation of Benefits (EOB).

When we receive the EOB from your insurance company, it will be posted to your account. We will **email** you a statement five business days prior to charging your card if your patient responsibility is higher than the originally collected amount or you will have a credit on your account if your patient responsibility is lower than the originally collected amount. Late cancels or missed fees will be charged within the week of the late cancel/missed appointment. Please refer to the Missed and Late Cancelation Policy.

Frequently Asked Questions

What is a Deductible and How Does It Affect Me? An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance coverage begins to pay. For example, if your policy has a $2,000 deductible, you must pay the first $2,000 of medical expenses before the insurance company begins to pay for any services. This works just like the deductible for your car insurance or homeowner's insurance policy does. Deductibles begin at the start of your plan year. Some plans also have co-insurance and copays which are the client's responsibility.

How will I know when my deductible has been met? You can call your insurance company at any time to check on how much of your deductible has been met and some insurance companies have this information available online. Every time you receive services, you should receive notification from your insurance company (either by mail or online) by way of an EOB. This will show if the amount went to your deductible or coinsurance, and what you are responsible to pay.

But wait, I'm nervous about leaving you my credit card. We do not store your sensitive credit card information in our office. We store it on a secure website called a gateway. The gateway we use is a secure clearinghouse that meets the industry standards set forth from the Payment Card Industry Data Security Standard (PCI-DSS) and is certified at the highest level attainable.

Once we enter your information through this gateway, your information is securely encrypted and we do not have access to view or edit the information. This gateway is only used to process your payment. We will email you a receipt once payment is processed.

What is PCI-DSS? Payment Card Industry (PCI) Security Standards Council offers robust and comprehensive standards to enhance payment card data security and reduce exposure to credit card fraud. PCI Data Security Standard (DSS) provides an actionable framework for developing a robust payment card data security process, including prevention, detection, and appropriate reaction to security incidents.

When do I give you my credit card? We prefer for you to fill out the Payment Policy Authorization Form and at your first appointment you will give us your credit card in person. We will input your credit card to a secure system that will upload your credit card number into the gateway and return the card to you. After input we only see the last four digits of your credit card. You can deliver your credit card information over the phone or by mail, but the most secure way is in person.

What if I need to dispute my bill? We will always work with you to understand if there has been a mistake. We will refund your credit card if we or if your insurance company has made a billing error. We will only charge the amount that we are instructed to by your insurance carrier, in the EOB they send to us, in the same way we normally determine how much to send you a bill for in the mail.

TERMS OF CREDIT CARD ON FILE:

Your credit card information is not kept on file in this office. It is kept securely offsite by our Payment Gateway and our office does not have access to the full credit card number once it is entered into our system.

Be assured this payment method in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. If you have any questions about this payment method, do not hesitate to ask.

- **I understand** I must keep this card information current in this office. Cards denying could incur additional fees.
- **I understand** once my insurance has paid their portion for the counseling session, we received at Bay Area Christian Counseling, the remaining balance is my responsibility as shown on my EOB from my insurance company.
- **I understand** Bay Area Christian Counseling will charge my payment card on file for the balance due once the EOB is received or if we incur a late cancel or missed appointment fee.
- If I have more than one type of payment card on file Bay Area Christian Counseling will process my Health Savings card - before charging my credit card for the remaining balance.
- If I am self-pay my payment card will be charged at the time of service.
- If the payment card is declined for any reason an additional fee of $35.00 will be applied to my account (same as a bad check fee).
- If your HSA card is declined, you will receive an email and be given the opportunity to give us another card to use.
- If the amount billed to my credit / debit /FSA/ HSA card will be over $100 you will receive a courtesy notification prior to it being charged.

What if I have more questions? Our staff is happy to speak with you about your account at any time.

Payment Policy

Bay Area Christian Counseling revised its billing policy in order to deliver a more convenient and consistent payment experience to our clients We **require a credit card, debit card, or HSA/FSA card to be on file** with our office OR **a deposit be made on your account** to cover client responsibility of payments at each appointment. A $100 minimum deposit is required on all visits. If you keep your HSA/FSA card on file, however, since HSA/FSA funds are limited, we may require an additional card to be kept on file should the funds in your HSA/FSA account become insufficient or you owe late cancelation or missed fees. If you have questions regarding our new policy, please refer to the documents in this packet or go to our website to review the Credit Card on File Policy.

With the changing environment in healthcare, more responsibility of payment is being placed on the client. We need to be sure client balances are paid in a timely manner. To do this, we need to ensure we have a guarantee of payment on file in our office.

To be fair, the policy applies to all clients. We have wonderful clients, and we know most of you pay your balances. Unfortunately, this is not always the case.

Client responsible payments such as cash pays, copays and co-insurances are due at the time of service**.** We will charge your card the amount your insurance company determines is your responsibility if there is a difference from the payment made at the time of service or for any missed or late cancel fees you incur. Please refer to the Missed and Late Cancelation Policy.

HSA or FSA Card Information:

Type of Card: VISA or MasterCard

Name on Card:___________________________________ Card Holder Signature:______________________________

Billing Address:____

Credit Card Information:

Type of Card: VISA or MasterCard or American Express or Discover

Name on Card:___________________________________ Card Holder Signature:_____________________________

Billing Address: ____

I have read and agree to the Fees and Late Cancelation/Missed Appointment Policy:

Client/Guardian Signature:___________________________________ Date: ___________________

I have read and agree to the Credit Card Policy and authorize its use for payment:

Client/Guardian Signature:___________________________________ Date: ____________________

I authorize Bay Area Christian Counseling or a designated third-party billing agency, holder of my medical information about me, to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services. Please note: Co-pay/co-insurance is subject to change at any time. For further co-pay/ co-insurance information please contact your insurance company. I understand my signature below requests payment be made and authorizes release of medical information necessary to pay the claim.

In addition, I understand it is my responsibility to provide accurate insurance information if I intend to use my insurance coverage. If for any reason my insurance company does not cover or pay for my services, I agree to pay for all services rendered no later than 30 days after my notification of such charges.

Client Guardian Signature:_____________________________________ Date: ____________________

Clinician Signature:____ Date: ____________________