CHESTER RIVER BEHAVIORAL HEALTH, LLC
410-778-5550

CLIENT INFORMATION

Name, First:_____MI____Last_____

Address:_____

City:_____State_____Zip:_____

SS#:_____Phone(h)_____(w)_____

Cell_____

Birth Date:____/____/_____Sex: M_____F_____

In case of emergency, please contact:_____

Marital Status: single married other

Employment/School Status: employed full time employed part time full time student part-time student

Condition Related to Employment? Yes No

Auto Accident? Yes No State accident occurred:_____Date of Accident_____

Client's Primary Physician_____

Address:_____Phone_____

INSURANCE COMPANY INFORMATION:

Please submit your insurance card at your first appointment so that we may make a copy of it

Policy Holder Name:_____DOB_____

Address (if different from above):_____

City:_____State_____ Zip_____

SS#_____Phone(h)_____(w)_____

Employer of Policy Holder:_____

Primary Insurance Co Name:_____

Secondary Insurance Co Name:_____

Chester River Behavioral Health, LLC
FEE AGREEMENT & INSURANCE AUTHORIZATION

Fees for Services

Initial Evaluation	Individual	$200.00/hr.
	Couples/Families	$225.00/hr.
Individual Psychotherapy (30 min.)		$100.00
Individual Psychotherapy (45 min.)		$125.00
Individual Psychotherapy (60 min.)		$185.00
Couples/Families (45 min.)		$150.00
Group Psychotherapy		$ 50.00
Psychological Testing/Evaluation		$125.00/hr.
Phone Conversation > (5 min.)		$ 60.00 ½ hr.
School Conferences or Meetings (mtg/travel time+mileage @.50 per mi.)		$125.00/hr.
Court Testimony or Depositions (mtg/travel time+mileage @.50 per mi., retainer required)		$300.00/hr.
Emergency/Crisis Evaluation (individual)		$275.00/hr.
Letter Writing		$ 60.00 per ½ hr.
Records Fees		$ .76 per page
Preparation Fee		$ 22.88 + postage
Fail To Keep Appointment		$ 60.00
Return Check Fee		$ 25.00
Record Review		$ 60.00 per ½ hr.
Urinalysis		$ 30.00

I am aware that if I am utilizing my health insurance to pay for any of the above services, I am responsible for any deductible and/or co-payments as outline in my current policy. I agree to make the required payment at the time of service. I also agree to pay in full all balances owed to Chester River Behavioral Health, LLC should my insurance company not make payment. I agree to supply information regarding changes in my insurance coverage, mailing address and phone numbers. I will be responsible for any balances due as a result of my failure to advise.

Payment for services for minors: The amount due for each session must be paid in full upon arrival. Chester River Behavioral Health will not divide co-payments due to court orders, divorce decrees or separation agreements. Whoever brings the minor to the appointment is expected to make the payment, or if minor comes alone, arrangement for payment must be made in advance.

I am aware that cancellations of appointments (except for situations which would be considered emergencies) require 24 hours advance notice. If I am unable to cancel with adequate notice or if I fail to keep a scheduled appointment, I agree to pay a $60.00 fee for the missed session. I am aware that my insurance does not cover missed appointments.

I am aware that I may terminate my treatment at any time without consequence and that I will be responsible for payment for the services I have received.

I am aware that failure to meet my financial obligation may result in referral to a collection agency. The patient, and/or guarantor, shall be responsible for and agree to pay all reasonable costs of collection including, but not limited to, reasonable collection agency fees, attorney's fees, and court costs. If any suit must be filed to collect an unpaid balance on an account, patient, and/or guarantor, agrees that such suit may be brought in courts of Kent or Queen Anne's Co., MD, and waives any objection to jurisdiction or venue.

I am aware that my insurance provider or its agent may request and be provided with information about the type, cost, and date of any treatment I receive from Chester River Behavioral Health, LLC so that payment may be provided to the therapist. I agree that this information may be released.

I am aware that the development of treatment plans and reviews of progress may be requested by my insurance provider or its agent. I agree to this information being released if my insurance provider or its agent requests it for authorization of treatment sessions and/or for payment.

I have been provided a copy, I have read, and am aware of and agree to the terms described in the Maryland Notice Form regarding the Health Insurance Privacy and Portability Act. (HIPPA).

This agreement shall remain in effect for the length of time I am in treatment or until all financial obligations are met, whichever is longer.

_____ _____ _____

Signature of Client **Date** **Printed Name**

Witness

CHESTER RIVER BEHAVIORAL HEALTH, LLC
CLIENT RIGHTS AND RESPONSIBILITIES

Statement of Clients' Rights

- Clients have the right to be treated with dignity and respect.
- Clients have the right to fair treatment, regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
- Clients have the right to have their treatment and other client information kept private.
- Only in an emergency, or if required by law, can records be released without Client permission.
- Clients have the right to have an easy to understand explanation of their condition and treatment.
- Clients have the right to know about their treatment choices regardless of cost or insurance coverage.
- Clients have the right to information about providers' professional credentials.
- Clients have the right to know the clinical guidelines used in providing and/or managing their care.
- Clients have the right to provide input on Chester River Behavioral Health's policies and services.
- Clients have the right to know about the complaint, grievance and appeal process.
- Clients have the right to know about State and Federal laws that relate to their rights and responsibilities in the treatment process.
- Clients have the right to share in the formation of their treatment plan.

Statement of Clients' Responsibilities

- Clients have the responsibility to give providers the information they need to deliver the best possible care.
- Clients have the responsibility to ask their provider questions about their care, to follow plans and instructions for their treatment, and to let their provider know when their treatment plan no longer works for them.
- Clients have the responsibility to inform their provider about medication and medication changes.
- Clients have the responsibility to keep their appointments. Clients should provide 24 hours notice for any appointment they need to reschedule or cancel.
- Clients should respect the confidentiality of other clients
- Clients have the responsibility to pay co-payments at the time of service.
- Clients are responsible for the supervision of their children. Children, who are unable to sit quietly in the waiting area, may NOT be left unsupervised.

- I have read and received a copy of my rights and responsibilities.

Signature_____

Date_____

Please sign and return

CHESTER RIVER BEHAVIORAL HEALTH LLC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and progress.

I,_____
Name Birth date

authorize_____, to release protected health information related to my
Provider Name
evaluation and treatment to:_____.
PCP Name PCP Phone

I saw_____on_____for_____.
Patient Name Date Reason/Diagnosis

If you have any questions or would like to discuss this case in greater detail, please call me at:_____.
Phone Number

_____
Provider Signature Licensure

PATIENT RIGHTS

- You can end this authorization (permission to use or disclose information) any time by contacting our administrative staff.
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- Information that is disclosed as a result of this authorization may be re-disclosed by the recipient and no longer protected by law.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to disclose your information.

Patient Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire twelve (12) months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization:

PLEASE CHECK ONE

_____ To release any applicable mental health/substance abuse information to my primary care physician.
_____ To release only medication information to my primary care physician.
_____ I DO NOT give my authorization to release any information to my primary care physician.

_____
Patient Signature Date Signature of Authorized Representative Date

If signed by Authorized Representative, describe relationship to patient:: _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records, the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (43 CFR Part2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information in NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.