Welcome to COMMUNITY WELLNESS FOUNDATION! Please fill out this information to the best of your knowledge. Only patient information is to go in patient sections of the form. Make sure you present your insurance card and driver's license to a staff member to receive a copy at this time. *** Note: The demographic information listed on your insurance card/ID will be listed on your medical record and used for billing purposes.*

DATE	

Patient Information:

LAST NAME		**FIRST NAME**		**M.I.**	
DOB		**AGE**		**SSN**		**GENDER:**
STREET ADDRESS		**APT./ UNIT #**	
CITY		**STATE**		**ZIPCODE**	
HOME		**MOBILE**		**EMAIL**	

Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Other

Emergency Contacts *(please provide information for those who may be contacted in case of an emergency):*

NAME		PHONE		RELATIONSHIP	
NAME		PHONE		RELATIONSHIP	

Primary Insurance Coverage: *(If insured by TRICARE, please add the policyholder's SOCIAL SECURITY NUMBER to ensure benefits)*

INSURANCE COMPANY		POLICY HOLDER	
SUBSCRIBER ID		GROUP NUMBER	

Secondary Insurance Coverage: *(if applicable)*

INSURANCE COMPANY		POLICY HOLDER	
SUBSCRIBER ID		GROUP NUMBER	

General Patient Information:

Primary Care Provider Name					
Phone Number		Fax			
Address					
City		State		Zip	

Pharmacy							
Phone		FAX					
Address		City		State		Zip	

What issues/concerns do you have which made you seek help today?

Description of Treatment Process

All clients will receive an initial evaluation from a licensed clinician in order to gather information about client's personal history and assess the client's treatment needs. At the time of intake, the treatment provider will discuss the therapeutic process with clients, including potential reactions to treatment; informed consent and confidentiality; and the client's rights and responsibilities. Clients have the right to discuss, with their provider, the options to the proposed treatment.

Community Wellness Foundation (CWF) strives to provide clients with the best care possible. However, with any type of therapeutic services, there is a potential risk for discomfort. During the client's treatment, the provider will explain any potential risk or harm. MMC encourages clients to talk to their treatment provider if they are uncomfortable with the services being provided and to process their feelings with their provider.

Clients have a right to withdraw or decline treatment at any time. However, withdrawing from treatment may cause clients to regress and/or need additional support services. Clients have the right to speak to their treatment provider and/or the Executive Director regarding any grievances about their treatment or treatment provider.

Each client will collaborate with their therapist to create an initial and reoccurring treatment plan which includes short term goals; interventions; the client's needs, problems, and symptoms; and the service plan. Clients are offered the option to receive a copy of the treatment plan and are expected to participate in the development and achievement of goals.

Description of Services Available

Community Wellness Foundation provides individual, group, family counseling, and psychiatric services.

CWF counselors will use intervention techniques and behavior modification tools specific to each client, each goal, and each type of therapy.

Individual Therapy: One-on-one counseling, which will provide the client with an open space to share his or her feelings with an objective clinician.

Family Therapy: Community Wellness Foundation works with the family to help them cope with the challenges of maintaining a child diagnosed with a mental disorder by providing family therapy. Family therapy sessions consist of the clinician interacting with the parent and child to help them interact in a positive manner and gain insight.

Group Therapy: This type of therapy is for adults as well as children/adolescent clients who are facing similar challenges. The group is facilitated by a licensed clinician.

Psychiatric Services: CWF's prescriber will conduct a psychiatric evaluation to determine if mental health medication is needed. The prescriber will prescribe medication and monitor the client's symptoms.

Community Wellness Foundation strives to provide you with the best care possible. However, with any type of mental health service, there is a potential risk for side effects to the prescribed medication. During your visit, the prescriber will explain and provide you with information regarding your medication. Please keep this information handy, as it will be helpful to refer to if necessary.

TREATMENT CONSENT FORM

I, _____ hereby voluntarily consent to receive consultative, diagnostic, and therapeutic services and/or procedures from Community Wellness Foundation (CWF) as listed below:

☐ Psychosocial Assessment ☐ Individual Therapy

☐ Family Therapy ☐ Group Therapy

☐ Medication Management ☐ Other Information:

_____

I understand the benefits of each service as well as the alternative to recommended treatment. Unless specifically stated otherwise, this consent form expires upon completion of services from CWF.

The first 2 to 4 sessions are a time to evaluate whether the clinician is best person to provide the therapy services needed to meet your goals.

I further understand that I am free to withdraw this consent for services at any time without prejudice to receiving alternative services. I may also be discharged from Community Wellness Foundation (CWF) if there is non-compliance with the agreed upon services.

I certify that the information I have reported regarding my insurance coverage is correct and further authorize the release of any necessary information to my insurance carrier for the purposes of processing my claim. I also permit a copy of this authorization to be used in place of the original and it may be retained on file.

If my insurance company or coverage changes in any way, it is up to me to inform Community Wellness Foundation (CWF) of these changes, and to obtain pre-authorization necessary for my continued care. I agree to take full responsibility for the fee for services rendered. Co-payments are due at the time of each visit.

I understand that I am responsible for any portion of the fee not covered by insurance such as:

- Yearly deductible if not met
- Missed or canceled appointments (unless I provide at least 24 hours' notice)
- Benefits used to their maximum in a calendar year or lifetime

I understand that the therapy session will last 45-50 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time.

If I become involved in court proceedings that require provider's time, I will be expected to pay for professional services in advance at a rate of $250.00 per hour. Services related to court proceedings include, but are not limited to: report writing, telephone calls, court/deposition appearances and travel time.

MDMA Patients are excluded from all out-of-pocket charges.

Client Signature	

Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client **cannot** be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults: If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, *the mental health professional is required to report this information to the appropriate social service and/or legal authorities*.

Prenatal Exposure to Controlled Substances: Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers *(when applicable)*: Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

These situations rarely arise. Should such a situation occur, I would make every effort to openly discuss what will need to occur before taking any action.

I AGREE TO THE ABOVE LIMITS OF CONFIDENTIALITY AND UNDERSTAND THEIR MEANINGS AND RAMIFICATIONS.

Client Signature	

Consent to Use and Disclose Your Health Information

This form is an agreement between you Family Intervention. When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information *(PHI)* about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you agree to let us use your information here and send to it others. *(Insurance Provider, General Practitioner, other Behavioral Health Provider).* The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. By signing this form, you are agreeing to let us use your information here and send it to others. By signing this form, you are acknowledging that you have received a copy of the Community Wellness Foundation Notice of Privacy Practices. Please read the Notice of Privacy Practices before you sign this Consent Form.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practice. If we do change it, you can get a copy by contacting our office at 14504 Greenview Drive, Suite 200 Laurel MD 20708.Phone: 240-297-9646, Mon. – Fri. 09:00 am – 06:00 pm or via email at info@communitywellnessllc.com

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wishes.

After you have signed this consent, you have the right to revoke it *(by writing a letter telling us you no longer consent)* and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

Client Signature	

CONSENT TO RANDOM URINALYSIS SCREENING
(For medication management patients ONLY)

I, _____, do hereby consent to undergo random urinalysis as part of psychiatric assessment and treatment, as required, when recommended by the clinical staff at Community Wellness Foundation.

☐ I understand the results of urine toxicology screening will be shared with me and will be entered into my chart record.

☐ I understand that my mental health record is confidential and will not be shared except under the circumstances described in the Notice of Privacy Practices.

☐ I hereby agree to provide a urine sample for screening when requested.

☐ I reserve the right to refuse to provide a urine sample for toxicology screening at any time, acknowledging that I will be discharged from treatment when doing so.

I acknowledge the only prescribed medications allowed have been discussed and are listed below, and that I will discuss alternative treatment options with my Prescriber or immediately discharged if any unauthorized substances test positive.

CURRENT PRESCRIBED MEDICATION(S):

_____

_____

_____

This agreement is valid for a one-year period from the date it is signed, unless consent is withdrawn in writing.

_____ _____

Patient Name-Print *Date*

_____

Patient Signature

_____ _____

Provider/Clinical Staff Signature *Date*

PATIENT FINANCIAL TERMS AND CONDITIONS

(Maryland Medicaid (MDMA) patients do not need to sign this form)

We are committed to providing you with the best possible care and services. If you have medical insurance, we are happy to assist you to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. **Unless this practice is a participating provider with your insurance plan, it is ultimately your responsibility to pay the provider for services rendered and to assure your insurance properly processes your claim and pays the provider.** If this provider does participate with your plan, your obligation is to remit all relevant insurance policy information to the provider at the time of service. **It is your responsibility to fully understand the terms and conditions of your insurance regarding the procedures for filing claims, what medical procedures and treatments you insurance does and does not cover, what amount, if any, your insurance will pay for medical services, and what your co-payment and deductible amount may be.**

Unless otherwise agreed upon by the provider, payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Amex, Discover. Returned checks will be subject to a $35.00 fee, and any outstanding balances older than 30 days will be subject to interest charges of 1.5% per month. In the unfortunate events collection procedures are required to collect an outstanding account balance, the patient shall be responsible for the reasonable cost (35% of the past due balance) of a collection agency, attorney, and/or court costs.

The undersigned hereby waives any defense he/she may have as to the Statue of Limitations barring future attempts to recover debts owed hereunder in the event of default.

We will gladly discuss your proposed treatments and charges and will answer any questions relating to your insurance.

You must realize, however, that **unless we are a participating provider with your insurance**:

1. Your insurance is a contract between you and the insurance company. We are not a party to that contract and therefore are not bound by its terms and conditions.
2. We are not bound by the fee payment structure of your insurance policy. You are responsible for whatever portion of our charges your insurance does not pay.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These charges are your responsibility.

We must emphasize that as a medical provider, unless we are a participating provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

By my signature, I indicate that I have read, understand and do hereby accept the terms of this agreement.

Client Signature	

Keep this page for your records

CLIENTS RIGHTS, RESPONSIBILITIES AND EXPECTATIONS OF STAFF

Clients have the right to:

- Receive quality services in a respectful manner without discrimination;
- Make an informed choice of services;
- Know the qualifications of staff who provide them with services;
- Receive and understand information and instructions about their service needs;
- Consent to or refuse services before they are provided;
- Know the nature and purpose of services;
- Be informed prior to any transfer or discharge from services;
- Expect confidentiality of information and protection of their child's or their records;
- Receive timely response to their needs along with reasonable continuity and coordination of services;
- Know about charges for services;
- Expect the right to privacy;
- Freedom from abuse, financial or other exploitation, retaliation, humiliation and neglect
- Clients have access to information pertinent to the person served in sufficient time to facilitate his or her decision making
- Access to referral to legal entities for appropriate representation, self-help support services and advocacy support services
- Be part of the process of updating the service plan when his or her needs change; and
- Receive all services at Community Wellness Foundation or be referred to another agency.
- Know how to voice any grievance about their services;
- Receive services based on an individual service plan;

Clients have the responsibility to:

- Give accurate information about their mental health, substance use, and domestic violence issues as well as other circumstances which might impact upon the care of their children;
- Assist by making and keeping a safe environment (including respecting clinician's wishes regarding the use of substances and tobacco products during sessions and exposure to weapons during sessions in the home);
- Notify the agency if scheduled appointments need to be changed;
- Notify the agency if there is a change in your living arrangements;
- Notify the agency if treatment is legally required and provide sufficient time for the agency to provide legally required documentation, such as progress on treatment and verification that client is compliant with services;
- Be involved in family sessions as necessary;
- Work with staff in planning, reviewing and changing their individual service plans

Clients can expect that MMC clinicians will:

- Provide a safe and supportive environment for clients to express themselves and express their needs;
- Be culturally competent, professional and will follow the codes of conduct outlined by the agency;
- Maintain appointments and notify clients in a timely manner if appointments need to be canceled
- Collaborate with clients regarding individual service plans (Counselors with collaborate with clients and/or family to develop treatment goals, interventions, and timelines for goal achievement and progress)

COMPLAINT POLICY AND PROCEDURE

We anticipate a smooth working relationship with you. However, occasional misunderstandings may arise. If they do, we strongly encourage you to contact the Director of Programs so that we can address your concerns. If you are not satisfied with our response, you have the right to launch the complaint process. Community Wellness Foundation complaint policy and procedure does not establish any barriers for you to file a complaint. CWF does not retaliate in any way for reported grievances or complaints. It is our desire to work through any differences that may arise and move forward in our relationship with our clients. Information regarding the complaint policy and procedure is located in this handbook given to all clients during their orientation/intake. The handbook is reviewed and updated annually to include any new information regarding the complaint process.

A complaint is defined as any written or verbal grievance or concern that a client may have with a provider, staff member, or service received at Community Wellness Foundation. If a client needs additional clarification regarding a complaint, they may contact the Director of Programs. If a client needs translation services, in order to make a complaint this will be provided for them.

Community Wellness Foundation believes that complaints can be a way to learn where and how the service can be improved. Therefore, CWF develops and implements CWF own services quality improvement program based on qualitative and quantitative analysis of CWF actions and performances.

Quality assurance checks are completed at least quarterly, to include regular chart audit; annual client satisfaction surveys; and calls to clients to gain information about the quality of the services they are receiving. Supervisors discuss with service providers and staff the results from quality assurance checks. Changes to improve performance are decided by supervisors and may include additional staff training, workshops, or disciplinary actions.

Complaint Policy Overview

1. It is the policy of CWF to comply with, and to require CWF employees to comply with the complaint policy.
2. CWF supports the principle that all customer complaints should be viewed and taken positively.
3. CWF ensures that all complaints will be treated seriously and dealt properly with an emphasis on the honest and thorough process of consideration, with the prime aim of satisfying the concerns of the complainant.
4. All written complaints that are received will be registered within 2 days and a response provided within 10 days. If an additional time for investigation and response will be required, the interim report expressing what findings were made and request of an additional time for investigation should be provided to the complainant. Please note: You will be notified that your complaint was received. If you do not receive notification that your complaint was received please call the office at (240) 297-9646
5. CWF has an established mechanism for responding to and keeping a record of those complaints and findings of investigation.
6. In cases that involve allegations of fraud or time-sensitive issues CWF is obliged to provide expedited review of such complaints.
7. An allegation of any employee, supervised provider, or board member suspected of child abuse or neglect will be given immediate consideration.
8. CWF guarantees that all records, information, organizational reports and summaries regarding received complaints will be available for the accrediting entity or other governmental authorities upon their request.
9. CWF pursues a no discouragement/no retaliation policy meaning that CWF employees are prohibited from discouraging clients from filing a complaint and may not retaliate against a client or prospective client who filed such a complaint.
10. Anonymous complaints cannot be given consideration.
11. Present complaint policy provisions are open to the public and available in electronic and hard copy versions. It is necessary for all CWF clients to be familiarized with these provisions before signing the contract with the agency