BEHAVIOR THERAPY CENTER
OF GREATER WASHINGTON

Dear Prospective Client:

Welcome to the Behavior Therapy Center of Greater Washington! We strive to provide exceptional services and are committed to meeting your expectations. We are confident that our skilled staff of psychologists, clinical social workers, and professional counselors will tailor treatment to meet your therapeutic needs. Established over 30 years ago, BTC is nationally recognized as a leading center for cognitive behavioral treatment. We specialize in the treatment of a wide range of problems including Obsessive Compulsive Disorder and related disorders, anxiety and mood disorders, and behavioral problems occurring in persons of all ages.

We request that you complete the New Client Packet and bring all the forms to your first appointment. The completion of these forms will allow us to spend more time together helping you rather than focusing on paperwork. Included in this packet are:

- Patient Information Form
- Pre-Screening Questionnaire
- Patient Services Agreement
- HIPAA Policies and Practices
- Insurance and Financial Summary Form
- Handling of Information Form
- Consent for Releasing Confidential Information
- Credit Card Authorization Form
- Directions to BTC

If the new client is under 18, the forms should be completed by the custodial parent or guardian.

Should you have any questions prior to your first appointment, please contact our administrative staff for assistance. We are looking forward to working with you and appreciate the opportunity to help you reach your treatment goals!

Sincerely,

Charles S. Mansueto, Ph.D.
Licensed Psychologist; Director

BEHAVIOR THERAPY CENTER
OF GREATER WASHINGTON

For office use only
Special Requests:_____
☐ CC/Dep
☐ TC/CVA/US FAM HP ☐ NTC ☐ NTC Eligible
☐ MC ☐ NMC ☐ MC Eligible
☐ MAR ☐ DIV/SEP-SOLE ☐ DIV/SEP-JOINT*
☐ Returning Client?
Therapist: _____
DX: _____
_____

PATIENT INFORMATION FORM

☐ Check this box if the patient is the financially responsible party. Date: _____

Patient Name: _____
(First) (Middle) (Last)

Address: _____
(Number) (Street)

_____
(City) (State) (Zip)

Home Phone: ( )_____ Social Security # _____

Work Phone: ( )_____ Date Of Birth: _____

Cell Phone: ( )_____ Age: _____

Gender: ☐ Male ☐ Female

Referred By: _____

Medication(s): _____

Physician(s): _____

Address: _____

Phone: ( )_____ Last Visit: _____

ADDITIONAL INFORMATION FOR PARENT(S) / GUARDIAN(S)

Name(s): _____ Name(s): _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

_____ _____

Social Security # _____ Social Security # _____

Home Phone: ( )_____ Home Phone: ( )_____

Work Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ Cell Phone: ( )_____

☐ Check if this individual is the financially responsible party.

☐ Check if this individual is the financially responsible party.

_____ _____
Signature* Date

_____
Relationship to Client

_____ _____
Print Client's Name Client's DOB

*If parents are ***separated*** or ***divorced*** and have ***joint custody*** of the client, then both parents' signatures are *required.*
Only one parent's signature is required if parents are married to each other.

_____ _____
Additional Parent Signature Date

_____ _____
Print Name Relationship to Client

Revised: 4/14/14

BEHAVIOR THERAPY CENTER
OF GREATER WASHINGTON

PATIENT SERVICES AGREEMENT

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice contains a description of HIPAA and its application to your personal health information. We are required to obtain your signature acknowledging that we have provided you with this information **prior to your first session**. It is very important that you read these documents carefully before our first session. We can discuss any questions you have about the procedures at that time. **When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time.** That revocation cannot be retroactive and cannot prevent us from meeting obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy, or from taking steps to collect if you have not satisfied any financial obligations you have incurred with us.

PSYCHOLOGICAL SERVICES
Psychotherapy is a set of psychological interventions designed to help people resolve emotional, behavioral, and interpersonal problems and improve the quality of their lives. There are many different interventions we may use to deal with the problems that you hope to address. Cognitive-behavioral psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, it will be important for you to work on the things we talk about, both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience transient uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy may lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

During our first few sessions, we typically conduct an evaluation of your treatment needs. By the end of this evaluation process, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow if you decide to continue with therapy. You are encouraged to evaluate this information along with your own opinions of whether you feel comfortable working with us. As therapy involves a large commitment of time, money, and energy, we strive to provide you with a good fit in matching you with a therapist. If you have questions about our procedures, we can discuss them as they arise. Should you request a second opinion, we will be happy to refer you to another mental health professional.

PROFESSIONAL FEES
In addition to the fees for weekly appointments, we may charge a pre-determined amount for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services for which you may be billed include report writing, conversing with you by telephone if the conversation lasts longer than a few minutes, consulting with other professionals with your permission, preparation of treatment summaries or similar records, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party.

APPOINTMENTS AND CANCELLATION POLICY
We normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if we are the best persons to provide the services you need to meet your treatment goals. If psychotherapy has begun, we will usually schedule one 45-50 minute session per week at a time we agree on, although some sessions may be longer or more frequent.

Unless a session is cancelled 24 hours in advance, you will be charged for the missed appointment. Additionally, you will be charged the full session fee for any late arrivals. It is important to note that most insurance carriers do not reimburse for missed sessions.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time of service. Payment schedules for other professional services will be agreed to when they are requested. Credit card information is required prior to the first session. If credit card information is not provided, then a deposit will be required prior to the first session. Your credit card will be used to collect outstanding balances unless other arrangements are made. There will be a $25.00 additional charge for returned checks. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we may hire a collection agency or go through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim. Additional measures may be necessary if your unpaid balance becomes excessive.

INSURANCE REIMBURSEMENT

We do not participate in any managed care or insurance agreements, including Tri-Care, ChampVA, and Medicare. We are a fee-for-service practice, so you (not your insurance company) are responsible for full payment of our fees. We will provide you with a Services Rendered Form (SRF) that you may submit to your insurance company when seeking reimbursement.

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services and it may be necessary to seek approval for more therapy after a certain number of sessions. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's normal level of functioning. Although much can be accomplished in short-term therapy, some patients decide they need more services after insurance benefits end. Before beginning treatment, it is very important that you ascertain which mental health services your insurance policy covers. If you have questions about the coverage, call your insurance plan administrator.

Sometimes your insurer may require us to provide clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. If so, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. Maryland law prevents insurers from making unreasonable demands for information, but there are no specific guidelines defining what is unreasonable. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

TRICARE, CHAMPVA, and US FAMILY HEALTH PLAN PATIENTS ONLY: If you are insured through TRICARE, CHAMPVA, or US FAMILY HEALTH PLAN (or are eligible for either of these plans), you need to know that we are billing "above the 115 percent limit" allowable through your health insurance plan. If you have TRICARE, CHAMPVA, or US FAMILY HEALTH PLAN as a primary or secondary insurance, then you cannot receive services from BTC unless you understand, agree to, and follow the instructions for submitting a request for the *Granting of Waiver for Balanced Billing Limitations* to your insurance in writing. You are also required to provide BTC with a copy of your request for the *Granting of Waiver for Balanced Billing Limitations*. This must be completed, and your insurance must authorize the waiver prior to your first visit to BTC. Your signature on the attached signature page indicates that you are willing to pay the additional amount, and that the *Granting of Waiver for Balanced Billing Limitations* has been submitted and approved by your insurance. We will not be able to provide services to TRICARE, CHAMPVA, or US FAMILY HEALTH PLAN PATIENTS without this agreement.

MEDICARE PATIENTS ONLY: BTC is not a Medicare provider. If you are insured through Medicare and want to be treated at BTC, there is a form you must sign indicating that you are opting out of Medicare reimbursement for BTC services.

CONTACTING US

The office staff is usually in the office between 9 AM and 5PM to answer the main phone line. Therapists' work schedules may preclude them from answering their extensions immediately but you may leave a confidential

voicemail message. We will make every effort to promptly return your call. Response times are likely to be longer on weekends and holidays. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach your therapist and feel that you can't wait for your therapist to return your call, contact your family physician or the nearest emergency room and ask for the therapist on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, should you find it necessary.

Therapists and staff members do have e-mail accounts. Should you choose, you may communicate with your therapist via e-mail; however, please be aware that e-mail is not a secure form of communication and your confidentiality can not be assured. We recommend limiting e-mail use to scheduling and basic logistics. Please speak with your individual therapist for further details regarding their specific usage of e-mail.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a therapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA and/or Maryland law. However, in the following situations, no authorization is required:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. These other professionals are also legally bound to keep the information confidential. Unless you object, we will only tell you about these consultations if we feel that it is important to our work together. All consultations will be noted in your Clinical Record (which is called "PHI" in our Notice of Policies and Practices to Protect the Privacy of Your Health Information).

- We practice with other mental health professionals and we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All administrative staff have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-patient privilege law. We cannot provide any information without your written authorization or a court order. If you are involved in or contemplating litigation, consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

- If a patient files a complaint or lawsuit against us, state law permits us to disclose relevant information regarding that patient in order to defend ourselves.

There are some situations in which we are legally obligated to take actions that we believe are necessary to protect others from harm and in which we may have to reveal some information about a patient's treatment. These situations are unusual in our practice, but they include:

- If we have reason to suspect that a child or vulnerable adult has been subjected to abuse or neglect, or that a vulnerable adult has been subjected to self-neglect or exploitation, the law requires that we file a report with the appropriate government agency, usually the local office of the Department of Social Services. Once such a report is filed, we may be required to provide additional information.

- If we know that a patient has a propensity for violence and the patient indicates that he/she has the intention to inflict imminent physical injury upon a specified victim(s), we may be required to take protective

actions. These actions may include establishing and undertaking a treatment plan targeted to eliminate the possibility that the patient will carry out the threat, seeking hospitalization of the patient, and/or informing the potential victim or the police about the threat.

- If we believe that there is an imminent risk that a patient will engage in potentially life-threatening behaviors or that immediate disclosure is required to provide for the patient's emergency health care needs, we may be required to take appropriate protective actions, including initiating hospitalization and/or notifying family members or others who can protect the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action, and we will limit the disclosure to what is necessary.

While this written summary of exceptions to confidentiality aims to inform you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we in situations where specific guidance is required, formal legal advice may be needed.

USE OF REPORTED INFORMATION
Some of your reported information may be used for administrative or research purposes or both; any use of such information will be in aggregate (group) form, and you will not be personally identifiable either directly or indirectly. Your therapist will be happy to answer any questions that you might have regarding these issues.

PROFESSIONAL RECORDS
The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record if you request it in writing. In unusual circumstances in which disclosure is reasonably likely to endanger the life or physical safety of you or another person, we may refuse your request. In those situations, you have a right to a summary and to have your record sent to another mental health provider. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, the State of Maryland permits a copying fee and certain other expenses. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

PATIENT RIGHTS
HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include: requesting that we amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS & PARENTS
It is important for patients under 18 years of age who are not emancipated and their parents to be aware that the law may allow parents to examine their child's treatment records. However, because privacy in psychotherapy is very important, particularly with teenagers, we usually ask parents to respect the child's privacy and allow for the therapist and minor to keep elements their interactions in confidence, though not any related to danger to the child (see Limits on Confidentiality). On the other hand, because parental involvement in therapy is essential to successful treatment, we are always willing to share with parents general information about the progress of treatment and their child's attendance at scheduled sessions. Parents may also request an oral summary of their child's treatment when it is complete. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

PLEASE RETAIN THIS DOCUMENT FOR YOUR PERSONAL RECORDS

OFFICE FILE COPY

Your signature below indicates that you have read the patient services agreement and that you agree to its terms. It also serves as an acknowledgement that you have received the Maryland HIPAA notice.

TRICARE, CHAMPVA, and US FAMILY HEALTH PLAN PATIENTS ONLY: If you are insured through TRICARE, CHAMPVA, or US FAMILY HEALTH PLAN (or are eligible for either of these insurances), you need to know that we are billing "above the 115 percent limit" allowable through your health insurance plan. Your signature below also indicates that you are willing to pay the additional amount, and that the *Granting of Waiver for Balanced Billing Limitations* has been submitted in writing and approved by your insurance. We will not be able to provide services to TRICARE, CHAMPVA, or US FAMILY HEALTH PLAN PATIENTS without this agreement.

MEDICARE PATIENTS ONLY: We are not a Medicare provider. If you want to receive services at BTC, please request and sign the form indicating that you are opting not to submit to Medicare for reimbursement for BTC services and fees.

_____ _____

Signature* Date

_____

Relationship to Client

_____ _____

Print Client's Name Client's DOB

*If parents are ***separated*** or ***divorced*** and have ***joint custody*** of the client, then both parents' signatures are *required*.

Only one parent's signature is required if parents are married to each other

_____ _____

Additional Parent Signature Date

_____ _____

Print Client's Name Relationship to Client

BEHAVIOR THERAPY CENTER
OF GREATER WASHINGTON

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW YOUR PSYCHOLOGICAL AND MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information (PHI),* for *treatment, payment, and health care operations* purposes with your *written authorization.* To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
  - *Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist.
  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within our practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.
- *"Authorization"* is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations (of PHI) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If we have reason to believe that a child has been subjected to abuse or neglect, we must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse* – We may disclose protected health information regarding you if we reasonably believe that you are a victim of abuse, neglect, self-neglect or exploitation.
- *Health Oversight Activities* – If we receive a subpoena from the Maryland Board of Examiners of Psychologists (or the Maryland Board of Examiners of Social Workers or the Maryland Board of Examiners of Professional Counselors and Therapists) because they are investigating our practice, we must disclose any PHI requested by the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written

authorization or a court order. The privilege does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If you communicate to use a specific threat of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a therapist. On your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You have the right to inspect or obtain a copy (or both) of Psychotherapy Notes unless we believe the disclosure of the record will be injurious to your health. On your request, we will discuss with you the details of the request and denial process for both PHI and Psychotherapy Notes.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide you with a revised notice by mail or subsequent visit.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact our Director, Dr. Charles S. Mansueto, Ph.D., at (301) 593-4040. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on March 1, 2005.

- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide you with a revised notice by mail or subsequent visit.

BEHAVIOR THERAPY CENTER
OF GREATER WASHINGTON

Handling of Confidential Health Information

Telephone

Home	**Cell**	**Work**
May we telephone you at home? Yes No	May we telephone you on your cell? Yes No	May we telephone you at work? Yes No
May we leave messages at home? Yes No	May we leave messages on your cell? Yes No	May we leave messages at work? Yes No

Written Communication

May we send mail to your home address? Yes No*
*If no, please provide an alternate address for mailing:

_____
(Number) (Street)

_____
(City) (State) (Zip)

Electronic Communication

The Behavior Therapy Center of Greater Washington cannot guarantee confidentiality with electronic communications. It is important that you understand that the nature of the Internet is that any e-mails you send or receive may also be intercepted by other people. Therefore, if you send your therapist an e-mail or if you ask your therapist to respond to you about something via an e-mail, you must understand that it is not entirely confidential and may be intercepted by others.
May we communicate with you via e-mail? Yes No
If yes, please provide an e-mail address: _____@_____
Are there any restrictions for e-mail? Yes* No
*If yes, please describe:
_____
_____

Other Requests

All reasonable requests to receive communication of your health information by alternative means will be granted. Please describe any additional means of communication by which you prefer to receive your health information.
_____
_____

_____ _____
Signature* Date

_____
Relationship to Client

_____ _____
Print Client's Name Client's DOB

*If parents are ***separated*** or ***divorced*** and have ***joint custody*** of the client, then both parents' signatures are *required.*
Only one parent's signature is required if parents are married to each other.

_____ _____
Additional Parent Signature Date

_____ _____
Print Name Relationship to Client

Revised: 4/14/14

BEHAVIOR THERAPY CENTER
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New Client Pre-Screening Questions

(If client is a minor, please have guardian respond as appropriate for the child)

Have you received the notice of our HIPPA policies and procedures?	YES	NO
Have you read and signed the Patient Services Agreement (PSA)?	YES	NO
Do you understand that, under particular circumstances, we may be required to release information about you without your permission?	YES	NO
Have you (or your child) ever had a psychiatric hospitalization?	NO	YES

If so, on what dates? _____

Have you (or your child) ever attempted to commit suicide?	NO	YES
Do you (or your child) ever think about committing suicide or talk about wanting to die?	NO	YES
Do you (or your child) ever intentionally harm or injure yourself?	NO	YES
Do you (or your child) ever think about harming or killing someone else?	NO	YES
Have you (or your child) ever had unusual perceptions or bodily sensations?	NO	YES
Are you (or your child) currently under the care of another mental health provider?	NO	YES

If so, who? _____

Have you (or your child) ever exercised for longer than an hour at a time, used laxatives, or induced vomiting in order to control your weight?	NO	YES
Are you (or your child) excessively concerned about weight?	NO	YES
Are you (or your child) now, or have you ever been, a victim of violence or abuse?	NO	YES

If yes, by whom? _____

Have you (or your child) ever been violent or abusive toward someone else?	NO	YES
Has anyone in the family ever been violent or abusive?	NO	YES

If yes, who? _____ and to whom?_____

Have you (or your child) ever had, or been told you have, a problem with alcohol or drugs?	NO	YES
Have you (or your child) ever been arrested or incarcerated?	NO	YES

Specific for clients under the age of 18

Are the parents of the minor married to each other?	YES	NO
If the parents are not married, do you have sole or joint custody of the minor being brought for treatment?	SOLE	JOINT*

*If parents are separated or divorced and have joint custody, both parents' signatures are *required* on all paperwork

_____ _____
Signature* Date

_____
Relationship to Client

_____ _____
Print Client's Name Client's DOB

*If parents are ***separated*** or ***divorced*** and have ***joint custody*** of the client, then both parents' signatures are *required.*
Only one parent's signature is required if parents are married to each other.

_____ _____
Additional Parent Signature Date

_____ _____
Print Name Relationship to Client

BEHAVIOR THERAPY CENTER
OF GREATER WASHINGTON

Insurance and Financial Summary

Please Initial (If client is a minor, please have guardian respond as appropriate for the child)

INSURANCE COVERAGE

_____ I understand that BTC does not participate in any insurance programs. However, I may be eligible for reimbursement for services by my insurance company. I understand that I am responsible for contacting my insurance plan administrator with any questions I may have regarding submission requirements and coverage for BTC services prior to my first visit.

TRICARE, CHAMPVA and US FAMILY HEALTH PLAN INSURANCE (Check One)

_____ I am not eligible for TRICARE, CHAMPVA or US FAMILY HEALTH PLAN

_____ I am a TRICARE, CHAMPVA, or US FAMILY HEALTH PLAN patient (or am eligible for TRICARE, CHAMPVA, or US FAMILY HEALTH PLAN) and have read the TRICARE/CHAMPVA/US FAMILY HEALTH PLAN-specific instructions found in the Patient Services Agreement (PSA).

_____ I am a TRICARE, CHAMPVA, or US FAMILY HEALTH PLAN patient (or am eligible for TRICARE, CHAMPVA, or US FAMILY HEALTH PLAN) and I have submitted in writing a request for the Granting of Waiver for Balanced Billing Limitations. This written request has been approved by my provider and I have provided BTC with a copy of this request.

MEDICARE (Check One)

_____ I am not eligible for Medicare.

_____ I am a Medicare patient and agree to opt-out of Medicare reimbursement for BTC services.

_____ I will be eligible for Medicare within the next two years.

FEE SCHEDULE

_____ I have read and understand the fee schedule for clinical services provided by BTC as listed below.

Length of Individual Session*	Dr. Mansueto	Staff Therapists
30 minutes	$160	$145
45 minutes	$245	$210
60 minutes	$290	$250

**Other services (phone calls, school consultations, report/letter writing, travel time) will be charged the same rate as sessions*
**Sessions and other services longer than 60 minutes will be charged proportionately based on the 60-minute session cost.*

BILLING AND PAYMENTS

_____ I understand that payment is to be made at the time of service and that I am responsible for services rendered.

_____ I understand that credit card information is required prior to the first session. I understand that if credit card information is not provided, then a deposit of $190.00 will be required.

_____ I understand that my credit card will be used to collect outstanding balances unless other arrangements are made.

_____ I understand that there will be a $25.00 additional charge for returned checks.

UNPAID BALANCE

I understand that excessive outstanding balances or longstanding owed payments may be collected through a collection agency or through other legal means.

MISSED APPOINTMENTS AND LATE ARRIVALS

I understand that, because the therapist sets aside time exclusively for my appointment, at least 24-hour cancellation notice is required. I will be charged the full session fee for any late arrival or missed appointment with less than 24-hours notice.

_____ Signature*
_____ Print Client's Name _____ Date
_____ Relationship to Client _____ Client's DOB

*If parents are ***separated*** or ***divorced*** and have ***joint custody*** of the client, then both parents' signatures are *required.* Only one parent's signature is required if parents are married to each other.

_____ Additional Parent Signature
_____ Print Name _____ Date
_____ Relationship to Client

BEHAVIOR THERAPY CENTER
OF GREATER WASHINGTON

CREDIT CARD AUTHORIZATION FORM

Because there are times that our clients may not pay at the time of sessions (e.g. forgotten checkbooks, minors coming to therapy without parents, etc.), we ask that you provide us with a credit card number to keep on file, to which any unpaid balance may be charged on a monthly basis. If credit card information is not provided, then a deposit equivalent to the charge for a single session will be required prior to the first appointment.

I, _____, authorize the Behavior Therapy Center of Greater Washington, P.A., to keep my signature on file and to charge my credit card as outlined above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

_____
PATIENT NAME

_____
CARDHOLDER NAME

_____
BILLING ADDRESS

_____
CITY STATE ZIP

CIRCLE CREDIT CARD TYPE: MASTERCARD VISA

_____
CREDIT CARD NUMBER

_____
EXPIRATION DATE V-CODE

_____
CARDHOLDER SIGNATURE

_____
TODAY'S DATE

BEHAVIOR THERAPY CENTER
OF GREATER WASHINGTON

Authorization to Release Information

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate. A different form must be completed for each person you are designating.

I, _____*(print name)*, DOB_____, authorize administrative and/or clinical staff at BTC to release:

- ☐ Billing Information
- ☐ Intake Evaluation
- ☐ Progress Notes
- ☐ Treatment Plans
- ☐ Discharge Summary
- ☐ Other (Please Specify:_____)

Please specify any limitations for this release or any information you do ***NOT*** authorize me to release:

_____

_____

This information should only be released to: Name_____

Address_____

Telephone_____ City, State, ZIP_____

I am requesting my therapist to release this information for the following reasons:

_____

☐ At the request of the individual *(All that is required if you are my patient and you do not desire to state a specific purpose.)*

I understand that my therapist cannot re-disclose information received from another health care provider unless that other provider permits it.

This authorization shall remain in effect until _____
(expiration date may not exceed one year from signing)

or until _____
(fill in an event that relates to the individual or the purpose of disclosure-again not to exceed one-year)

You have the right to revoke this authorization in writing at any time by sending such written notification to BTC. However, your revocation cannot be retroactive, and the revocation will not be effective if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature* Date

_____
Relationship to Client

_____ _____
Print Client's Name Client's DOB

*If parents are ***separated*** or ***divorced*** and have ***joint custody*** of the client, then both parents' signatures are *required*.
Only one parent's signature is required if parents are married to each other.

_____ _____
Additional Parent Signature Date

_____ _____
Print Name

Relationship to Client

Revised: 2/22/17

BEHAVIOR THERAPY CENTER
OF GREATER WASHINGTON

Psychotherapy Discontinuation or "Termination"

Psychotherapy with your therapist may come to an end in a variety of ways. Some clients will inform their therapist directly of their intention to terminate the treatment process. Others may drift out of therapy with the intention of taking a break or coming back at an unspecified time. Others may decide to end treatment in concert with their therapist because the therapy succeeded in its goals or because the treatment failed to have its intended or desired impact. Clients may terminate treatment at any time for any reason.

BTC strongly encourages all clients to remain in communication with their therapists during time away from the therapy process. Clients should specify their intentions to return at a particular time or terminate the treatment if that is their intention. If a therapist does not hear from a client within a (1) month period of time from last communication, the therapist will consider the psychotherapy process to have come to an end, an outcome that is referred to as "psychotherapy termination." Once psychotherapy termination occurs, clients agree to absolve BTC of all ethical and legal obligations associated with their care. Clients may reinstate their active status at any time by request to their therapist.

Any client who wishes to terminate treatment for any reason may receive one or more referrals to another therapist or psychotherapy agency. BTC will coordinate any transition of care at the request of the client to the requested therapist or agency with an appropriately signed release of information.

I agree to the terms stated above:

_____
Client Name (Please print your full name and sign below)

_____ _____
Signature Date

11227 LOCKWOOD DRIVE, SILVER SPRING, MD 20901 TEL: (301) 593-4040 FAX: (301) 593-9148

BEHAVIOR THERAPY CENTER
OF GREATER WASHINGTON

BEHAVIOR THERAPY CENTER OF GREATER WASHINGTON
11227 Lockwood Drive, Silver Spring, MD 20901

DIRECTIONS

FROM NORTHERN VIRGINIA & BETHESDA - Take the Beltway (Rt. 495) north/east to Exit 30A (Rt. 29 North to Columbia, Colesville Road). Your exit will take you up over the beltway. You will continue north through two traffic lights (very close together) in the commercial area known as "Four Corners". You will then enter a residential section and a third traffic light. Make sure you are in the right hand lane at this point and continue past a gas station, an auto body shop and a "6 – 12 " convenience store. Just past the 6-12 you will see a road that bears off to the right (it is **NOT** a sharp right turn, like a **Y** in the road) – this is Lockwood Drive. Continue for several blocks and where the road widens on the right you will see the White Oak Professional Park complex.

FROM PRINCE GEORGES COUNTY – Take the Beltway (Rt. 495) north/west to Exit 28A (Rt. 650 – New Hampshire Avenue, North towards White Oak). Exit 28A is the first exit after the Rt. 95 interchange on the Beltway, traveling from your direction. Go to the 5th light, Lockwood Drive (Office Depot, McDonalds, and a Shell station are on your left.) and turn left onto Lockwood Drive and then a left at the first driveway past the Shell station into the White Oak Professional Park.

FROM ROCKVILLE AREA - Take Randolph Road east. Turn right on New Hampshire Avenue and go through several lights. At the White Oak Shopping Center there is a Sears and a Boston Market on the left. At this intersection light turn right onto Lockwood Drive and make an immediate left at the first driveway past the shell station, into the White Oak Professional Park.

FROM COLUMBIA - Take Rt. 29 south to the Rt. 650 New Hampshire Avenue interchange. Take New Hampshire south to the first light (Lockwood Drive). Turn right onto Lockwood and make an immediate left at the first driveway past the Shell station, into the White Oak Professional Park.

FROM WASHINGTON VIA16TH STREET - Follow 16th St. to Colesville Road (Rt. 29). Turn right onto Colesville Rd. and follow Colesville past the Beltway entrance. Go through the major intersection of University and Colesville Road and continue north for another 1/2 mile. Make a soft right onto Lockwood Drive (just after the 6-12 Market on your right) and follow Lockwood for about .8 of a mile. Turn right into White Oak Professional Park (just before the Shell station at the corner of Lockwood and New Hampshire Avenue).

Upon entering White Oak Professional Park, the Behavior Therapy Center is located in the center section of the U, off to the right in Unit 11227. Look for the sign, enter, and go upstairs to the main waiting room on the second floor.

Please be aware that many GPS devices and computer-based mapping programs misidentify the location of our office. BTC is ***NOT*** located on the east side of New Hampshire Avenue, but on the west. White Oak Professional Park is a cluster of red brick townhouses directly behind the Shell station on the corner of Lockwood Drive and New Hampshire Avenue.