THRIVE BEHAVIORAL HEALTH
MEETING PEOPLE WHERE THEY ARE

Phone (410) 780-5203

☐ 1114 Benfield Blvd Suite G	☐ 9627 Philadelphia Rd #160	☐ 12501 Prosperity Dr Suite 235	☐ 5720 Executive Dr #102
Millersville, MD 21108	Rosedale, MD 21237	Silver Spring, MD 20904	Catonsville, MD 21228
Fax (410) 987-4301	Fax (410) 780-5205	Fax (240) 641-8042	Fax (410) 747-7000

Client Name: _____ Date of Birth: _____

Proof of Identification

Acceptable forms of identification include:

- Driver's License or State Issued Identification
- Passport
- Proof of resident as evidenced by 2 household bills or official state/federal correspondence

☐ ID verified by clinician with electronic copy uploaded to chart.

☐ Client/Guardian does not currently have any of the above forms of identification due to:

_____

Client to provide proof of identification (from client or client guardian) within thirty days from intake.

Proof of Guardianship/Custody

☐ Client is 16 years old or older and is electing to sign self into treatment without need for guardian consent.

☐ Client is under the age of 18. The following information has been provided by the guardian of client.

Guardian Name(s) and Relationship(s): _____

I am the legal guardian of the above named child and am legally authorized to provide permission for treatment.

☐ Birth certificate	☐ Probation order indicating guardianship
☐ Power of attorney	☐ Court order
☐ Kinship care affidavit	☐ Custody agreement
☐ Caregiver unable to provide any of the above but agrees to provide within 30 days and understands services may not proceed without proof of custody.	

Due to state regulations, Thrive staff are not permitted to complete the Intake Evaluation without proof of identification and proof of guardianship/custody as appropriate. In the event of a custody dispute where there is no existing order or agreement designating legal custody, or where a court order provides for joint legal custody, Thrive reserves the right to require that all individuals with legal custody rights sign the Consent for Treatment form prior to the start or continuation of treatment by Thrive.

Communication

I authorize Thrive Behavioral Health to communicate regarding appointments through use of:

☐ Neither Text Message or Email ☐ Text message ☐ Email: _____

_____ _____

Adult Client or Parent/Guardian of Minor Client Date

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Client Name: _____ Date of Birth: _____

Emergency Medical Care

☐ I authorize Thrive Behavioral Health to seek emergency health care in the event of a medical emergency or mental health crises. This may include contacting and disclosing protected health information to a local crisis service or first responders in order for urgent assessment and care to be provided.

Emergency Contact Name/ Phone Number

I authorize Thrive Behavioral Health to contact an individual in case of emergency or urgent mental health matter. Verbal and written communication relevant to the urgent matter is authorized.

☐ True ☐ False

Emergency Contact Name: _____ Phone Number: _____

Relationship to Client: _____

Authorization to Bill and Communicate with Insurance Company

☐ I authorize Thrive Behavioral Health to share protected health information with the insurance company listed below for the purposes of authorization, quality or compliance audits, and billing purposes. I understand that Thrive Behavioral Health charges my insurance company for services provided and that if my insurance changes, I must inform Thrive Behavioral Health or I will be responsible for charges incurred.

_____ _____

Adult Client or Parent/Guardian of Minor Client Date

THRIVE BEHAVIORAL HEALTH

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Client Name: _____ Date of Birth: _____

Consent for Treatment

I am requesting and give permission to THRIVE Behavioral Health to provide mental health services to myself/my child. These mental health services may include individual, family, and/or group therapy services.

I agree to a Diagnostic Evaluation to determine if treatment is appropriate for myself/my child. I agree that I may be evaluated by a psychiatrist for a Diagnostic Evaluation to determine if the psychiatrist has any recommendations, including medication or referrals to other services. I understand that I will be informed of any side effects of medication that is prescribed.

I understand that therapy entails, at times, discussing emotional, painful topics & age appropriate topics. (This includes, but is not limited to, past/current abuse, neglect, trauma, self-care, wellness, and birth control options).

Confidentiality and its limitations have been reviewed with me. I understand that:

- Thrive staff communicate with other members of the Thrive treatment team as clinically appropriate to ensure quality of care, such as psychiatrists, supervisors, directors, and other staff.
- Thrive must report suspected abuse, sexual abuse, sexual exploitation, neglect, mental injury, or substantial risk of harm of a child, adolescent, or vulnerable adult, even if the events happened in the past, the perpetrator's name is not known or is believed to be deceased, or the abuse was previously reported.
- Thrive must take action to ensure safety if someone is presenting an imminent danger to self or others, such as seek emergency hospitalization or report a threat to an individual or group of people.
- Maryland regulations require Thrive respond to questions regarding OPEN, active protective service investigations even if Thrive staff believe the agency has no helpful information to offer.
- Thrive must respond to subpoenas, but Thrive staff typically consult with an attorney prior to releasing privileged information.
- That information shared by a child or adolescent is typically kept private and not shared with parents unless there is indication there is imminent danger to the child or others.

CLIENTS 16 YEARS AND OLDER:

Maryland law gives the right to anyone 16 years of age and over to be involved in decisions about their mental health treatment. However, a parent or guardian of a person under the age of 18 years may authorize treatment, even over the objection of the minor. The law also notes that at times, some persons are unable to make treatment decisions. Maryland law states that you have the right to make decisions in advance, including mental health treatment decisions, through a process called advance directive. An advance directive can be used to state your treatment choice or can be used to name a health care agent, which is someone who can make health care decisions for you.

☐ I do not have a mental health advanced directive but I am aware I can request that my therapist help me develop one if I so choose.

☐ I have an advanced directive and I will supply my therapist with a copy of this directive.

☐ Client is under the age of 16, advanced directive is not applicable at this time.

_____ _____

Adult Client or Parent/Guardian of Minor Client Date

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Client Name: _____ Date of Birth: _____

MEDICAL

- ☐ Client does not currently have a PCP
- ☐ Client is currently seeking a PCP
- ☐ Client prefers not to release at this time
- ☐ Client unable to recall information

Authorization and Consent for Release of Information

WHO

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To and From: _____ Phone: _____ Fax: _____

Address (if available): _____ Dates of Service: Any and all, unless indicated here: _____

WHAT

I specifically authorize the exchange of the following information:

__ Medical Records
__ School and educational records
__ Verbal discussion of case (including, but not limited to diagnosis, attendance, treatment progress, interventions, psychosocial history, and recommendations).
__ Mental Health Records including Evaluations, Individualized Treatment Plans, and Medication History
__ Information related to and/or including substance use, substance abuse history, assessment, treatment, progress and referrals
__ Information related to and/or including HIV, AIDS, or other STD related information
__Other: _____

WHY

__ Continuity of Care/Treatment coordination __Client or Parent/Legal Guardian's request __ Legal purposes
__ Other: _____

Important Information

I understand that:

- This authorization is voluntary. My treatment will not be impacted if I do not sign this authorization. I do understand that Thrive psychiatrists or nurse practitioners are not required to prescribe medication if they determine they do not have enough information in order to make an informed medical decision.
- This authorization is valid 1 year from date signed unless otherwise indicated and specified here:_____.
- I may revoke/withdraw this authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by notifying Thrive in writing of withdrawal of authorization to release information.
- Once my health information is exchanged/released, it may no longer be protected by federal law and could be redisclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature

Client/Legal Guardian: _____ Date: _____

Relationship to Client: ___ self ___Other: _____ (must have legal guardianship to authorize release of information)

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Client Name: _____ Date of Birth: _____

Previous Psychiatrist and/or Mental Health Provider

☐ Does not currently have a previous psychiatrist

☐ Does not want to release information from previous psychiatrist

☐ Client unable to recall information

Authorization and Consent for Release of Information

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To and From: _____ Phone: _____ Fax: _____

Address (if available): _____ Dates of Service: Any and all, unless indicated here: _____

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I specifically authorize the exchange of the following information:

__ Medical Records

__ School and educational records

__ Verbal discussion of case (including, but not limited to diagnosis, attendance, treatment progress, interventions, psychosocial history, and recommendations).

__ Mental Health Records including Evaluations, Individualized Treatment Plans, and Medication History

__ Information related to and/or including substance use, substance abuse history, assessment, treatment, progress and referrals

__ Information related to and/or including HIV, AIDS, or other STD related information

__ Other: _____

WHY

__ Continuity of Care/Treatment coordination __Client or Parent/Legal Guardian's request __ Legal purposes

__Other: _____

Important Information

I understand that:

- This authorization is voluntary. My treatment will not be impacted if I do not sign this authorization. I do understand that Thrive psychiatrists or nurse practitioners are not required to prescribe medication if they determine they do not have enough information in order to make an informed medical decision.
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- Once my health information is exchanged/released, it may no longer be protected by federal law and could be redisclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature

Client/Legal Guardian: _____ Date: _____

Relationship to Client: ___ self ___Other: _____ (must have legal guardianship to authorize release of information)

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Client Name: _____ Date of Birth: _____

Previous Psychiatric Hospitalization

☐ Does not have previous provider
☐ Does not want to release information from previous provider
☐ Client unable to recall information

Authorization and Consent for Release of Information

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To and From: _____ Phone: _____ Fax: _____
Address (if available): _____ Dates of Service: Any and all, unless indicated here: _____

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__ Medical Records
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__ Mental Health Records including Evaluations, Individualized Treatment Plans, and Medication History
__ Information related to and/or including substance use, substance abuse history, assessment, treatment, progress and referrals
__ Information related to and/or including HIV, AIDS, or other STD related information
__Other: _____

WHY

__ Continuity of Care/Treatment coordination __Client or Parent/Legal Guardian's request __ Legal purposes
__Other: _____

Important Information

I understand that:

- This authorization is voluntary. My treatment will not be impacted if I do not sign this authorization. I do understand that Thrive psychiatrists or nurse practitioners are not required to prescribe medication if they determine they do not have enough information in order to make an informed medical decision.
- This authorization is valid 1 year from date signed unless otherwise indicated and specified here:_____.
- I may revoke/withdraw this authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by notifying Thrive in writing of withdrawal of authorization to release information.
- Once my health information is exchanged/released, it may no longer be protected by federal law and could be redisclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature

Client/Legal Guardian: _____ Date: _____
Relationship to Client: ___ Self ___Other: _____ (must have legal guardianship to authorize release of information)

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Client Name: _____ Date of Birth: _____

Pharmacy

☐ Does not have pharmacy

☐ Does not want to release information to/from pharmacy

☐ Client is unable to recall information

Authorization and Consent for Release of Information

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To and From: _____ Phone: _____ Fax: _____

Address (if available): _____ Dates of Service: Any and all, unless indicated here: _____

WHAT

I specifically authorize the exchange of the following information:

__ Medical Records
__ School and educational records
__ Verbal discussion of case (including, but not limited to diagnosis, attendance, treatment progress, interventions, psychosocial history, and recommendations).
__ Mental Health Records including Evaluations, Individualized Treatment Plans, and Medication History
__ Information related to and/or including substance use, substance abuse history, assessment, treatment, progress, psychotherapy notes, medication and referrals
__ Information related to and/or including HIV, AIDS, or other STD related information
__ Other: Medication History, Physician/NP orders, Data for preauthorization, Symptoms, Side Effects

WHY

__ Continuity of Care/Treatment coordination __Client or Parent/Legal Guardian's request __ Legal purposes
__ Other: _____

I understand that:

- This authorization is voluntary. My treatment will not be impacted if I do not sign this authorization. I do understand that Thrive psychiatrists or nurse practitioners are not required to prescribe medication if they determine they do not have enough information in order to make an informed medical decision.
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- Once my health information is exchanged/released, it may no longer be protected by federal law and could be redisclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature

Client/Legal Guardian: _____ Date: _____

Relationship to Client: ___ self ___Other: _____ (must have legal guardianship to authorize release of information)

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Client Name: _____ Date of Birth: _____

EDUCATIONAL

☐ Declines to consent to release information to/from school

☐ Client is unable to recall information

☐ Not Applicable

Authorization and Consent for Release of Information

WHO

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To and From: _____ Phone: _____ Fax: _____

Address (if available): _____ Dates of Service: Any and all, unless indicated here: _____

WHAT

I specifically authorize the exchange of the following information:

__ Medical Records

__ School and educational records

__ Verbal discussion of case (including, but not limited to diagnosis, attendance, treatment progress, interventions, psychosocial history, and recommendations).

__Mental Health Records including Evaluations, Individualized Treatment Plans, and Medication History

__Information related to and/or including substance use, substance abuse history, assessment, treatment, progress and referrals

__ Information related to and/or including HIV, AIDS, or other STD related information

__ Information regarding diagnosis and medication; information related to attendance and treatment participation; educational recommendations;

__ Permission for Thrive staff to provide services on school grounds

__ Thrive Behavioral Health may provide protected health information to schools with formal partnerships. The school may use the protected health information for research or other data related reasons.

WHY

__ Continuity of Care/Treatment coordination __Client or Parent/Legal Guardian's request __ Legal purposes

__Other: _____

I understand that:

- This authorization is voluntary. My treatment will not be impacted if I do not sign this authorization. I do understand that Thrive psychiatrists or nurse practitioners are not required to prescribe medication if they determine they do not have enough information in order to make an informed medical decision.
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Signature

Client/Legal Guardian: _____ Date: _____

Relationship to Client: ___ self ___Other: _____ (must have legal guardianship to authorize release of information)

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Client Name: _____ Date of Birth: _____

PRP or Other Current Treatment Provider

☐ Not Applicable

Authorization and Consent for Release of Information

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To and From: _____ Phone: _____ Fax: _____

Address (if available): _____ Dates of Service: Any and all, unless indicated here: _____

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__Other: _____

WHY

__ Continuity of Care/Treatment coordination __Client or Parent/Legal Guardian's request __ Legal purposes
__Other: _____

Important Information

I understand that:

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Signature

Client/Legal Guardian: _____ Date: _____

Relationship to Client: ___ self ___Other: _____ (must have legal guardianship to authorize release of information)

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Client Name: _____ Date of Birth: _____

Referring Agency

☐ Not Applicable

Authorization and Consent for Release of Information

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To and From: _____ Phone: _____ Fax: _____

Address (if available): _____ Dates of Service: Any and all, unless indicated here: _____

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__ Information related to and/or including HIV, AIDS, or other STD related information
__Other: _____

WHY

__ Continuity of Care/Treatment coordination __Client or Parent/Legal Guardian's request __ Legal purposes
__Other: _____

Important Information

I understand that:

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Signature

Client/Legal Guardian: _____ Date: _____

Relationship to Client: ___ self ___Other: _____ (must have legal guardianship to authorize release of information)

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Rosedale, MD 21237
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Silver Spring, MD 20904
Fax (240) 641-8042

☐ **5720 Executive Dr #102**
Catonsville, MD 21228
Fax (410) 747-7000

Client Name: _____ Date of Birth: _____

Crisis Response

☐ **Declines to sign, but understands that Thrive Behavioral Health may contact emergency or crisis services in the event of a psychiatric emergency or to ensure wellness**

WHO

By signing below, I authorize **Thrive Behavioral Health** and staff members to release and receive written and or/verbal information related to the client listed above to the person or agency indicated below:

To and From(Local Crisis Agency): _____ Phone: _____ Fax: _____
Address (if available): _____ Dates of Service: Any and all, unless indicated here: _____

WHAT

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__ Information related to and/or including HIV, AIDS, or other STD related information
__Other: _____

WHY

__ Continuity of Care/Treatment coordination __Client or Parent/Legal Guardian's request __ Legal purposes
__Other: _____

Important Information

I understand that:

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Signature

Client/Legal Guardian: _____ Date: _____
Relationship to Client: ___ self ___Other: _____ (must have legal guardianship to authorize release of information)

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Client Name: _____ Date of Birth: _____

Consent for Release of Information—General

☐ Not Applicable

Authorization and Consent for Release of Information

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__ Information related to and/or including HIV, AIDS, or other STD related information
__Other: _____

WHY

__ Continuity of Care/Treatment coordination __Client or Parent/Legal Guardian's request __ Legal purposes
__Other: _____

Important Information

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- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature

Client/Legal Guardian: _____ Date: _____
Relationship to Client: ___ self ___Other: _____ (must have legal guardianship to authorize release of information)