THRIVE BEHAVIORAL HEALTH
MEETING PEOPLE WHERE THEY ARE

Phone (410) 780-5203

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

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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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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: _____

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).
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__ 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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__ 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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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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__ 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:

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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: _____

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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- 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

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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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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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__ 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: _____

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

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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: _____

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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__Other: _____

WHY

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

Important Information

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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: _____

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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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Fax (410) 987-4301	**Fax (410) 780-5205**	**Fax (240) 641-8042**	**Fax (410) 747-7000**

Client Name: _____ Date of Birth: _____

Helpful Information – Thrive Copy Page 1

Crisis Plan: In case of an emergency (ex: someone who is in danger of hurting themselves or others) or other crisis situations that cannot wait for a return call from your therapist, you may contact our clinic and access the after-hours emergency line. Phone operators may advise you to call 911, go to your nearest emergency room, or to contact one of the following:

Baltimore City Crisis Response: 410-433-5175
Baltimore County Crisis Response: 410-931-2214
Anne Arundel Crisis Hotline: 410-768-5522
Prince George's Crisis Hotline: 301-429-2185
Montgomery County Crisis Hotline: 240-777-4000
Howard County Crisis Response: 410-531-6677
Harford County Crisis Response: 410-638-5248

Client Rights: Clients have the right to be treated respectfully, to know your condition and progress, to participate in your treatment planning and be offered a copy, request your mental health records unless the treatment team determines it would cause harm to release them, to end your services at any time, and to know the nature and side effects of treatments. You are able to request a one-time therapist transfer if you feel that you are not therapeutically connecting with them. You may also request a one-time prescriber transfer if one is available in your location. Once the discharge process has started, transfer requests will no longer be granted.

Grievance/Feedback Policy: If you are unhappy with how you have been treated or have a concern, we welcome you to let us know how we can improve our program and services. As such, please follow these steps:
Step 1- Discuss the concern with your therapist.
Step 2- If you feel your concern was not addressed, you may contact a supervisor or leave a message at 410- 780-5203.
Step 3- If you have taken steps 1 and 2, you may submit your grievance in writing and mail it to our program. Please address it to the attention of Program Director at the address checked above.
Step 4- You have the option to submit a patient safety event or concern to the Joint Commission through the website: https://www.jointcommission.org/report_a_complaint.aspx
Thrive Behavioral Health also welcomes feedback through our client satisfaction surveys. Please access the survey at the link provided here: https://www.surveymonkey.com/r/ThriveCSS18.

Client Responsibilities
General Responsibilities:

- Follow the **attendance policy** and meet with your therapist regularly.
- Provide **updated phone, address, and insurance** information to Thrive.
- Attend appointments **awake and alert**. Staff are not permitted to meet with clients if it appears the client, guardian, or other people are sleeping, slurring their words, nodding off, or other indicators of possible medication complications or substance use.
- **Do not video tape or otherwise record** a staff member, visitor, or Thrive premises without written consent from Thrive Behavioral Health.
- **Do not forge or alter any documents** related to Thrive Behavioral Health.
- **Do not commit any illegal acts** while a Thrive staff member is on premises or while at a Thrive Behavioral Health location..

Safety Responsibilities:

- Under no circumstances will **threatening or disruptive behavior be tolerated**. Thrive reserves the right to close your case immediately if you (or someone else in the home) yells, curses, or threatens or implies any threat of harm towards a staff member or toward others when a staff member is present.
- Under no circumstances can visitors be in **possession of any weapons, alcohol, drug paraphernalia, or illegal drugs** while in the clinic or on the premises; and if receiving in-home services, ensure that your home or treatment environment remains free from the above at any time during which the therapist is present providing services.
- Inform Thrive if there is a **registered sex offender** living at or visiting the home for in-home services. Staff are not permitted to provide services in the home where a registered sex offender is living or visiting.

THRIVE BEHAVIORAL HEALTH
MEETING PEOPLE WHERE THEY ARE

Phone (410) 780-5203

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

Client Name: _____ Date of Birth: _____

Helpful Information – Thrive Copy Page 2

Medication Related Responsibilities:

- Take medications as prescribed. Misuse, overuse, and stopping/starting of medications without consultation with the prescriber can be dangerous.
- Inform prescriber of all medications or substances taken or used. This includes methadone and vitamins.
- Keep medications locked and secure.
- For minor clients: ensure medication is monitored by a responsible adult.

Discharge Policy: Thrive reserves the right to close a client's services at any time. Reasons for discharge include:

- Failure to complete general, safety, or medication related responsibilities. Successful completion of goals or client no longer is experiencing mental health symptoms that meet criteria for a qualifying diagnosis.
- A clinical recommendation that a client needs more intensive services (i.e. an IOP or residential placement).
- If the primary focus of treatment is or becomes out of the scope of services provided by Thrive Behavioral Health (e.g. Substance Abuse/Use, Autism Spectrum Disorder, Eating Disorders), then this agency will refer to an appropriate provider and may have to end services.
- A client has not attended an appointment within the last 60 days or has been unable to be reached for 60 days.
- Client and therapist cannot find an appropriate place to meet for therapy sessions.

If a client is discharged, the program will notify a client in writing by sending a letter to the last known address and will provide the client with a list of other resources in the area where the client can seek treatment. The client may reapply for services after 90 days & request to have their case reviewed to determine (if the client is eligible to return and resuming services is appropriate). If a client has been sent a discharge letter already, the client will not be granted a therapist or prescriber transfer.

Program Hours: Thrive office hours are from 9 to 5:30pm on Monday and Thursday, 9 to 5pm on Wednesday, 9 to 3pm on Friday and extended evening hours on Tuesday from 9 to 6:30pm. Thrive therapists generally work normal business hours, but individual therapists may work additional hours depending on need and availability.

Program Description: Thrive offers both clinic and off-site services in the state of Maryland. The Thrive off-site program provides mental health services to adults, children, and families in their homes and in the community. Thrive also provides school based mental health services. Thrive will offer support in finding transportation to psychiatric appointments when available. Therapy entails, at times, discussing emotional, painful & age appropriate topics. This includes but is not limited to past/current abuse, neglect, trauma, self-care, wellness, and birth control options.

Communication: Off-site therapists typically communicate with clients through cell phone and text messaging. Text messages must be limited to scheduling of appointments and/or appointment attendance. Any communication besides information related to appointment scheduling must be done during session or through a phone call. Failure to comply may result in a referral to another treatment setting.

Therapeutic Session Times:
Thrive clinicians offer the following types of appointments and may vary upon clinical necessity, schedules, and client availability. Full Individual and Family sessions ranging from 38- 60 minutes (Adults only a full family therapy session), Brief Individual and Family Sessions ranging from 17-37 minutes, and Group Therapy for 3 or more Individuals ranging from 38-52 minutes.

Helpful Information – Thrive Copy Page 3

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: _____

Insurance/ Non-payment Policy:

- I certify that the client (myself or my child) does not have private insurance.
- I certify that the client (myself or my child) does not have Medicare.
- I understand that I will be responsible for any fees the insurance company does not reimburse, that Thrive will not be aware of the fee until after the insurance company has been billed, and that Thrive will inform me of fees once Thrive has been informed.
- I understand that any insurance issues I may have are between me and my insurance company, not THRIVE.
- I authorize payment directly to THRIVE of the insurance benefits otherwise payable to me.
- I understand that if I have not provided accurate information, Thrive may charge me the normal and customary fee as determined at the time services are provided and that I am responsible for these fees.
- If insurance coverage changes at any time, it is my responsibility to notify Thrive of the changes. I will immediately inform the therapist if the client:
    a. Has his/her medical assistance is "cut off" or is no longer active
    b. Has active private insurance (usually through a job or a relative's job) or acquire Medicare
    c. Applies for disability (as this may result in the client receiving Medicare)

Family and Natural Support Involvement:

- Thrive Behavioral Health recognizes the importance of a support system in one's life. Thrive encourages on-going communication with a client's support system, as appropriate, particularly in regard to identifying preferences, needs, strengths, and supporting goal progress.
- For adult clients, Thrive welcomes, but does not require, the participation from family members, friends, faith leaders, and/or others involved in supporting a client's progress towards goals.
- For child, adolescent, and teenage clients, Thrive emphasizes the importance of family involvement in treatment. It is expected that caregivers/guardians participate in family therapy on a consistent basis. Family therapy can support the child, adolescent, and/or teen in making progress through a wide range of interventions. These interventions include: goal planning and progress review, identifying and supporting use of healthy coping skills, fostering positive communication and boundary setting, recognizing strengths that can be built upon, identifying positive supports or resources, and completing safety planning.
- Thrive reserves the right to discontinue services if unable to come to a mutually agreeable treatment plan regarding family involvement in services. Thrive is unable to provide services to minors whose parents have not reviewed and signed treatment plans throughout treatment. Clients who are 16 or 17 may consent to mental health treatment in the state of Maryland, but Thrive requires the participation of parent/guardian in order to prescribe psychotropic medication.

Attendance Policy: If you need to reschedule an appointment, you will contact your therapist at least 24 hours before the scheduled appointment. It is considered a no show or missed appointment if you:

- Give less than 24 hours' notice for an appointment you are not going to attend
- Are more than 10 minutes late to psychiatry or therapy appointments
- If you are not at the agreed upon meeting place and do not respond to attempts to contact you
- Do not show for your appointment

You also acknowledge that you understand that the following will lead to immediate discharge:

- Missing 3 or more appointments in a 6-month period
- Missing a psychiatric evaluation or reevaluation
- Missing 2 psychiatry appointments in 6 months

THRIVE BEHAVIORAL HEALTH
MEETING PEOPLE WHERE THEY ARE

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Millersville, MD 21108
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☐ **12501 Prosperity Dr Suite 235**
Silver Spring, MD 20904
Fax (240) 641-8042

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

Client Name: _____ Date of Birth: _____

Medications Policy: It is Thrive policy that no Benzodiazepine prescriptions will be written for new or returning clients. Thrive typically refers back to previous prescriber for tapering from benzodiazepines. Thrive does not write refills for lost or stolen prescriptions or medications. Clients must be present and seen for a prescription to be written. Legal guardians and caregivers are expected to be present for appointments.

First Therapy Appointment Policy: Your primary therapist will contact you within 2 weeks. If you do not hear from someone, please contact your Intake Therapist. If you do not respond and attend an appointment within 30 days of your intake, then we will assume you are no longer interested in services and your case will be closed. If this is the case, you may contact your insurance company or one of the crisis numbers on the front of this page in order to seek services elsewhere.

I have received a written copy and a verbal explanation of the following policies and agree, consent, and understand the terms/conditions of the:

• HIPAA Privacy Policy • Crisis Plan • Client Rights • Grievance Policy • Client Responsibilities • Program Hours • Program Description	• Therapeutic Session Times • Discharge Policy • Insurance/Non-Payment Policy • Attendance Policy • Medications Policy • First Therapy Appointment Policy

_____ _____

Adult Client or Parent/Guardian of Minor Client Date

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MEETING PEOPLE WHERE THEY ARE

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Client Name: _____ Date of Birth: _____

Helpful Information – Client Copy Page 1

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Client Rights: Clients have the right to be treated respectfully, to know your condition and progress, to participate in your treatment planning and be offered a copy, request your mental health records unless the treatment team determines it would cause harm to release them, to end your services at any time, and to know the nature and side effects of treatments. You are able to request a one-time therapist transfer if you feel that you are not therapeutically connecting with them. You may also request a one-time prescriber transfer if one is available in your location. Once the discharge process has started, transfer requests will no longer be granted.

Grievance/Feedback Policy: If you are unhappy with how you have been treated or have a concern, we welcome you to let us know how we can improve our program and services. As such, please follow these steps:
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Client Name: _____ Date of Birth: _____

Helpful Information – Client Copy Page 2

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- Client and therapist cannot find an appropriate place to meet for therapy sessions.

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Client Name: _____ Date of Birth: _____

Helpful Information – Client Copy Page 3

Insurance/ Non-payment Policy:

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- I understand that I will be responsible for any fees the insurance company does not reimburse, that Thrive will not be aware of the fee until after the insurance company has been billed, and that Thrive will inform me of fees once Thrive has been informed.
- I understand that any insurance issues I may have are between me and my insurance company, not THRIVE.
- I authorize payment directly to THRIVE of the insurance benefits otherwise payable to me.
- I understand that if I have not provided accurate information, Thrive may charge me the normal and customary fee as determined at the time services are provided and that I am responsible for these fees.
- If insurance coverage changes at any time, it is my responsibility to notify Thrive of the changes. I will immediately inform the therapist if the client:
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- Give less than 24 hours' notice for an appointment you are not going to attend
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- If you are not at the agreed upon meeting place and do not respond to attempts to contact you
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You also acknowledge that you understand that the following will lead to immediate discharge:

- Missing 3 or more appointments in a 6-month period
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Client Name: _____ Date of Birth: _____

Helpful Information – Client Copy Page 4

Medications Policy: It is Thrive policy that no Benzodiazepine prescriptions will be written for new or returning clients. Thrive typically refers back to previous prescriber for tapering from benzodiazepines. Thrive does not write refills for lost or stolen prescriptions or medications. Clients must be present and seen for a prescription to be written. Legal guardians and caregivers are expected to be present for appointments.

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I have received a written copy and a verbal explanation of the following policies and agree, consent, and understand the terms/conditions of the:

• HIPAA Privacy Policy • Crisis Plan • Client Rights • Grievance Policy • Client Responsibilities • Program Hours • Program Description	• Therapeutic Session Times • Discharge Policy • Insurance/Non-Payment Policy • Attendance Policy • Medications Policy • First Therapy Appointment Policy

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Client Name: _____ Date of Birth: _____

HEALTH INSURANCE PORTABILITY and ACCOUNTABITLITY ACT [HIPAA]
NOTICE OF PRIVACY PRACTICES

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

Definitions of terms:
When we say "you" in this Notice we refer to the patient or research participant who is the subject of the medical information. When we say "we", "our", "us", "THRIVE", or "Thrive" we refer to one or more of the THRIVE organizations. When we say "medical information", or "health care information", we include information that identifies you and tells about your past, present, or future physical or mental health condition and the provision of the health care provided to you.

Safeguarding your protected Health Care Information:
Thrive Behavioral Health (THRIVE) is committed to protecting your health care information. In order to provide treatment, THRIVE will ask for certain health information and the health information will be put into your medical record. The medical record usually contains your symptoms, examination and test results, diagnosis, and treatment records provided by your therapist and or psychiatrist. That information, referred to as your health medical record, and legally regulated as health information may be used for a variety of purposes. THRIVE is required to follow the privacy practices described in this Notice, although THRIVE reserves the right to change our privacy practices and the terms of the Notice at any time. A new copy of the notice will be provided upon your request from THRIVE.

How THRIVE may use your Protected Health Care Information:
THRIVE employees will only use your health care information for purposes related to your treatment. For uses beyond what THRIVE normally does, THRIVE must have your written authorization unless the law permits or requires it. The following are some examples of our possible uses and disclosures of your health care information.

Uses and disclosures relating to treatment, payment, or health care operations:
For Treatment: THRIVE may use or share your health care information to approve or deny treatment and to determine if your medical treatment is appropriate. For example, THRIVE providers may need to review your treatment plan with your health care provider for medical necessity and coordination of care. We may disclose medical information about you to doctors, nurses, therapists, students, or other persons involved in your health care treatment.

Payment: THRIVE may use and share your health information in order to bill and collect payment for your health care services and to determine your eligibility to participate in our services. For example, your health care provider may send claims for payment of medical services rendered for you, in order to receive payment or to reimburse you for services.

Health Care Operations: THRIVE may use and share your health care information to evaluate the quality of services provided, or to our state and federal auditors. Your medical information also may be used or disclosed to comply with law and regulation, accreditation purposes, patients' claims, grievances or lawsuits, health care contracting relating to our operations, legal services, business planning and development, business management and administration, the sale of all or parts of THRIVE to another organization, underwriting and other insurance activities to operate the THRIVE organization.

Other uses and disclosures of health care information required or allowed by law:

Appointment reminders: We may contact you to remind you that you have an appointment with a provider.

Treatment Alternatives: We may contact you to tell you about or recommend possible treatment options or alternatives that may interest you.

Health-related benefits and services: We may contact you about benefits or other services we provide.

Information purposes: Unless you provide us with alternative instructions, THRIVE may send appointment reminders and other program materials to your home.

Required by law: We will disclose medical information about you when required to do so by federal or state law.

Public health disclosures: THRIVE may disclose medical information about you for public-health purposes. These purposes generally include the following: *Preventing or controlling disease (such as cancer or tuberculosis), injury or disability; *reporting vital events such as births and deaths; *reporting child abuse or neglect; *notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading disease or condition; *notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading disease or condition;

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Client Name: _____ Date of Birth: _____

*notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading disease or condition; *notifying the appropriate government authority as authorized or required by law if we believe a patient has been the victim of physical or sexual abuse, neglect or domestic violence. **Health oversight activities**: THRIVE may disclose your health care information to other divisions in the department and other agencies for oversight activities required by law. Examples of these activities are audits, inspection, investigations and licensure.

Coroners, Medical Examiners, Funeral Directors and Organ Donations: In most circumstances THRIVE may disclose health care information relating to a death to, coroners, medical examiners, or funeral directors, and to authorized organizations relating to organ, eye, or tissue donations or transplants.

Research Purposes: In certain circumstances, and under supervision of our Institutional Review Board or other designated privacy board, THRIVE may disclose health care information to assist in medical research. Your medical information may be important to further research efforts and the development of new knowledge.

Avert threat to health or safety: In order to avoid a serious threat to health or safety, THRIVE may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lesson a serious and imminent threat to your health and safety of the public or another person.

Protective services for the U.S. President and others: As authorized or required by law, we may disclose medical information about you to authorized federal officials so they may conduct special investigations or provide protection to the U.S. President, other authorized persons or foreign heads of state.

Military: If you are a member of the armed forces, we may release medical information about you to military authorities as authorized or required to by law.

Families, friends or others included in your care: Unless you say no, THRIVE may release your medical information to anyone involved in your medical care or payment of your care. Such people include family members, friends, or any individual you identify. THRIVE may also share health information with people to notify them about your location, general condition or death.

Workers Compensation: THRIVE may disclose health care information to workers compensation programs that provide benefits for work-related injuries or illnesses without regard to your fault. These programs provide benefits for work-related injuries or illness.

Patient Directories: The health care plan under which you are enrolled does not maintain a directory for disclosures to callers or visitors who ask for you by name. Your name will not be identified to an unknown caller or visitor without authorization from you.

Legal proceedings, lawsuits and other legal actions: We may disclose medical information to courts, attorneys and court employees when we get a court order, subpoena, discovery request, warrant, summons or other lawful instructions from those courts or public bodies and in the course of certain other lawful, judicial or administrative proceedings or to defend ourselves against a lawsuit brought against us.

Law Enforcement: If asked to do so by law enforcement, and as authorized or required by law, we may release medical information:
* to identify or locate a suspect, fugitive, material witness or missing person;
* about a suspended victim of a crime if, under certain limited circumstances, we are unable to obtain the persons agreement;
* about a death suspected to be the result of criminal conduct;
* about criminal conduct at THRIVE
* in case of a medical emergency, to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Other uses of medical information:
Other uses and disclosures of medical information not covered by this Notice will be made only with your written authorization. If you provide us authorization (permission) to use or disclose medical information about you, you may revoke (withdraw) that authorization (permission), in writing, at any time.

CRISP:
We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org.

THRIVE BEHAVIORAL HEALTH
MEETING PEOPLE WHERE THEY ARE

Phone (410) 780-5203

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

Client Name: _____ Date of Birth: _____

Your rights regarding medical information about you:

Right to request restrictions: You can request a restrictions or limitation on the health care information THRIVE uses or discloses about you. THRIVE will accommodate your request if possible, but it is not legally required to agree to the requested restriction. If THRIVE agrees to a restriction, THRIVE will follow it, except in emergency situations.

Right to request Confidential Communications: You can request that THRIVE communicate w/you about medical matters in a certain way or a certain location.

Right to request a disclosure: You have the right to request that we disclose your medical information for reason not provided in this Notice. For example, you may want your lawyer to have a copy of your medical records.

Right to Inspect and Copy: With certain exceptions (such as psychotherapy notes, information collected for certain legal proceedings, and medical information restricted by law) you have a right to see your health care information upon written request. If you want copies of your health information, you may be charged a fee for copying, depending on your circumstances. You have a right to choose what portions of your information you want to have copied, and to have prior information to the cost of copying.

Right to request Amendment: You may request in writing that THRIVE correct or add to your health record. THRIVE may deny the request if THRIVE determines that the health information is 1) correct and complete; 2) not created by us and/ or nor part of our records; 3) not permitted to be disclosed. If THRIVE approves the request for amendment, THRIVE will change the health information and inform you, and will inform others that need to know about the change in your health care information.

Right to an accounting of disclosures: You can request a list of disclosures made of your health information six years prior to your request. Exceptions are health information that has been used for treatment, payment, and operations. In addition, THRIVE does not have to list disclosures made to you, based on your written authorization, provided for national security, to law enforcement officials or correctional facilities. There will be no charge for up to one aforementioned list each year.

Right to paper copy of this notice: You have the right to receive a paper copy of this Notice and/or electronic copy by email upon request.

Questions or complaints:
Please contact the office at 410-780-5203

THRIVE will take no retaliatory action against you if you make such complaints.
Effective Date: February 15, 2017 and replaces earlier versions.