as·cend : *v.* To go or move upward; rise, advance.

Ascend is a three stage program with a minimum of a three month commitment to the program.

Stage I : Intensity
Goal identification
Making connections

Stage II: Progress
Implementation of tasks to reach goals
Tracking progress

Stage III: Ascent
Transitioning out
Attaining goals
Maintaining Progress

Weekly Schedule:

Monday:		Wednesday:		Thursday:	
9:30-10:45	Process Group	9:30-10:45	Narrative	9:30-10:45	Process Group
11:00-12:00	Goals	11:00-12:00	Yoga	11:00-12:00	Life Skills
12:00-12:30	Lunch	12:00-1:00	Lunch	12:00-1:00	Lunch
12:30-2:00	Art	12:45-2:00	DBT	1:00-2:00	Training w/Kim
				2:15-3:00	Wrap-up

Friday:
15 minute Parent weekly wrap-up call

*The content of the curriculum for the Life Skills components of the Ascend Program will flex to accommodate the majority of the participants in the Ascend program.

Metropolitan Counseling Associates, LLC
7201 Wisconsin Ave., Suite 700
Bethesda, MD 20814
301-654-7770 phone/fax

Client Information Sheet

Client Information:

Name: ____

Home Address: ____

____

Home Phone: ___________________ Cell Phone: ___________________

Work Phone: ___________________ E-mail: _______________________

Date of Birth: ___________________

In case of Emergency, contact: _______________________________

Name and phone number of parent(s):

Parent #1

Name: ____

Relationship to client: mother father step-mother step-father other

Address (if different than client):____

____

Home Phone: __________________ Cell Phone:___________________

Work Phone: __________________ E-mail:______________________

Parent #2

Name: ____

Relationship to client: mother father step-mother step-father other

Address (if different than client):____

____

Home Phone: __________________ Cell Phone:___________________

Work Phone: __________________ E-mail:______________________

ASCEND THERAPY CONTRACT

Schedule and Return Phone Call Practices

The Ascend program meets Mondays (9:45-2:00), Wednesdays (9:30-2:00) and Thursdays (9:30-3:00). On Thursdays between 9:30-3pm clients generally see the Ascend psychiatrist for medication monitoring. A weekly 15-20-minute summary phone call to parents will be made on Fridays. Individual therapy and family therapy are scheduled separately from the blocked group times above.

Crisis Procedure

Please note that the Ascend treatment team does not provide 24 hr./7 day/ week care. The team will not respond to crisis texts. If there is a crisis, the procedure is to call the Montgomery County Crisis Center at 240-777-4000, the DC Access Helpline at 888-793-4357 or 888-7-WE-HELP or go to your nearest emergency room. Please also leave a voice mail for your individual therapist and psychiatrist informing he/she about the nature of the crisis.

Initial:_________

Collaboration with Outside Treatment Providers

While clients are in the Ascend program, all mental health services must be provided by members of the Ascend team. Clients are encouraged to return to their current psychiatrist and Individual therapist once they complete the program. While in the program, if the client wants outside providers to receive progress updates, the client can make a request to the Ascend Clinical Coordinator. At least 4 weeks prior to discharge from the Ascend program, clients need to schedule an appointment with their psychiatrist. The Ascend psychiatrist does not continue to provide any services (clinical/med management) post discharge. If clients want to continue working with their Ascend individual or family therapist after completion of the program, that option can be explored. Referrals for outside psychiatry and therapy are provided upon request.

Initial:___________

Initial Intake Process

The initial intake/assessment is done in three parts: First, a 1-hour meeting with the client. Second, see psychiatrist to gather client medical history, family medical history and current medication regime. And third, a 1-hour meeting with the parents. Time will also be spent speaking with all relevant previous therapists and psychiatrists as well as reviewing any relevant testing or reports available. Should clients not be deemed ready for this specific level of care, the Intake Coordinator will work with the client and/or the client's family to identify the appropriate treatment options. The fee for the intake process ranges from $500-$800 depending on the time needed to conduct a thorough assessment.

Initial:___________

Fee Schedule

Fees are divided into a two-part bill; one part for insurance reimbursable services, one part for non-insurance reimbursable services. Insurance reimbursable services will be billed through MCA on a standard itemized bill. MCA does not bill insurance directly, nor are we a participant of any insurance carrier. We do provide a billing statement with all relevant insurance codes to accommodate submission to insurance by our clients. Payment by credit card is expected at the end of each week.

These services include:	Rate:	CPT Code:
• Process Group Therapy (2x/week)	$85/group	90853
• Art Therapy (1x/week)	$85/session	90853
• Goals Group (1x/week)	$60/group	90853
• Dialectical Behavior Therapy (1x/week)	$85/group	90853
• Narrative Therapy	$60/group	90853
• Lunch Group (1x/week)	$60/session	90853
• Wrap Up Group	$60/group	90853
• Initial Treatment Planning Meeting	$300/session	90847
• Follow-up 30 min Treatment Planning(1x/month)	$200/session	90785
• Individual Therapy (minimum 1x/week*)	$175/session	90834
• Family Therapy (varies)*	$200/session	90847
• Required Parent Group (2x/month)	$60 per family	90849
• Discharge Treatment Team Mtg (45mins)	$250/session	90847
• Medication Management (4x/month)* 99214/99213/90833	$150-300/session	

* Frequency and duration of medication management, individual and family therapy varies from client to client. After the client's 1st month in Ascend, an initial treatment team meeting will be scheduled to include the client, parents, and the Ascend team, during which initial impressions and assessment will be shared and a specific treatment plan will be created.

Non-insurance reimbursable services will be billed through MCA on a separate itemized bill. These services are a package fee of $650/month. Payment by credit card is expected on the first business day of each month.

These services include

- Ascend Yoga (1x/week)
- Weekly Summary Phone Call (1x/week)
- Life Skills (1x/week)
- Strength Training (1x/week)
- Individual Educational/Vocational Services are billed weekly based upon use. They do not carry a CPT code and are therefore not insurance reimbursable.

If an Ascend client has substance abuse issues she may be referred to a substance abuse group or individual substance abuse counseling that will take place outside of the Ascend day and may be required to participate in Ascend.

- Substance Abuse $100/group 75 minutes 90853
  $130/session 60 minutes 90834

Clients who have trauma as part of their clinical picture may choose to participate in a trauma group outside of Ascend hours.

- Trauma Group $100/group 75 minutes 90853

* Crisis Management is billed as needed at a rate of $35/10 minutes with CPT code 90839.
* Phone time (whether crisis or non-crisis) with a client, her family or between clinicians is billed at a rate of $35/10 minutes.

Initial: _______

Regarding Payment

All services will be billed through MCA on a standard itemized bill. MCA does not bill insurance directly, nor are we a participant of any insurance carrier. We do provide a billing statement with all relevant codes (CPT, Diagnosis, Clinical/License Number, MCA Tax ID, etc) to accommodate submission to insurance by our clients. Payment by credit card is expected at the end of each week for services rendered for that week.

Metropolitan Counseling Associates, LLC. accepts Visa, MasterCard, and American Express. For Ascend clients, use of a credit card is the only acceptable means of payment. All clients are required to keep a credit card on file. A credit card authorization form is attached to this contract.

Initial: _______

Metropolitan Counseling Associates, LLC
Payment Policy
Effective April 1, 2015

PLEASE REVIEW THIS NOTICE CAREFULLY.

Credit Card Policy

The credit card information is kept securely in accordance with HIPPA policies and will only be used in accordance with written authorization on this form.

If a credit card on file ceases to work and disrupts agreed upon payment, we will contact you within 48 hours. We require a new working credit card within 5 business days. After 5 business days, all treatment will be discontinued until a new working credit card is on file.

Initial: ____________

Delinquent Accounts

Unfortunately, there are times where despite best efforts accounts become past due and "delinquent." This document serves as written notice and signed consent (alongside our HIPPAA policy statement) that we are authorized to use your personal information to secure payment through either collections or court proceedings.

Initial: _______________

Healthcare Information

Our decision to practice independent of third party health plans "out of network" is a reflection of our need to protect the integrity of our practice and clinical decision-making. We understand that this can create additional financial challenges for families.

In the effort to help you secure the most reimbursement and financial support possible we would like to give you the following information:

Pre-Authorization

Many health plans require pre-authorization for mental health or behavioral health services. A contractual group working with your primary health plan often manages these benefits. We strongly recommend that all clients contact their health insurance at the time of seeking treatment to clarify the specific requirements to access out of network benefits. MCA is not responsible for acquiring pre-authorization for treatment, however we will gladly complete any necessary paperwork we are provided to facilitate this process. Please ask your health plan to guide you and give you information regarding the specific paperwork and where it is required to be sent and give this information to your direct provider.

Most health plans authorize services based on specific diagnostic criteria (ICD 9 or ICD 10) and procedural codes (CPT). Diagnosis cannot be given prior to beginning treatment but can be provided after 1-2 initial meetings. Pre-authorizations that require this information are routinely applied 30 days retroactively in accordance with this reality.

It may be helpful to know the following psychotherapy procedural codes when you are investigating your health benefits.

Initial Evaluation 90791

Individual Counseling 90832, 90834, 90837

Family Counseling 90846, 90847

Group Counseling (including Art therapy and DBT) 90853

Multi-Family Group (DBT) 90849

Initial: _______

Any questions regarding billing and paperwork should be directed to our Financial Manager, Sondra Brassel at 301 654 7770 ext. 715 or you can email her at: brassels@metcounseling.com

Attendance/Cancellation Policy

Clients in the Ascend program are expected to attend all components of the program each week. If a client misses six days, for any reason, he/she will be discharged. We require 48-hour notification of any extended trips or vacations. If we receive less than 48 hours' notification, you will be changed for the missed days.
Unless you give 24 business hours' advance notice, failure to keep your Individual therapy, family therapy, psychiatry or educational/vocational appointment renders the time unusable. If you are unable to keep your appointment, or wish to reschedule, please notify us as far in advance as possible. IN ANY EVENT, YOU WILL BE BILLED THE FULL FEE FOR ANY MISSED APPOINTMENT NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE OR 1 BUSINESS DAY IN ADVANCE FOR EITHER A MONDAY APPOINTMENT OR AN APPOINTMENT DIRECTLY FOLLOWING A HOLIDAY.

Initial: _______

Regarding Inclement Weather

Despite the fact that we practice in Montgomery County, we have decided to follow the Washington, DC Public Schools weather cancellation plans. If the DC Public Schools are closed for any weather-related reason the Ascend program will be closed. If DC Public Schools are delayed the Ascend program will be open at the normally scheduled time. If your appointment is on a non-school day and the weather is inclement, the above cancellation policy is no longer in effect. Clinicians and clients together decide whether or not a given appointment should be kept.

Initial: _______

Regarding Court-Involved Cases

For clients in counseling, our policy is to not testify in court, or release information about client's services (other than dates of sessions, length of sessions, attendance at sessions, and fee information) to an attorney, custody evaluator appointed to court related issues, or any other officer of the court. Our professional opinion is that releasing such information about a client's services jeopardizes the well-being of the client and sabotages the therapeutic relationship.

Initial: _______

Ascend Program sponsored by
Metropolitan Counseling Associates, LLC
7201 Wisconsin Ave., Suite 700
Bethesda, MD 20814
(301) 654-7770
Tax ID #20-2833850

THERAPY CONTRACT SIGNATURE PAGE

I have read the attached therapy contract. I understand and agree to comply with the policies as they are described and I acknowledge receipt of a copy of this contract.

_______________________________________ _______________
Clinician's Signature Date

_______________________________________ _______________
Client Signature Date

_______________________________________ _______________
Parent Signature Date

_______________________________________ _______________
Parent Signature Date

This document will be kept on file and a copy can be made for you at your request.

Ascend Program sponsored by
Metropolitan Counseling Associates, LLC.
7201 Wisconsin Ave., Suite 700
Bethesda, MD 20814
301-654-7770
Tax ID #20-2833850

Authorization for credit card use

I authorize Metropolitan Counseling Associates, LLC to use the credit card information that I have provided below to charge my credit card for all Ascend related services provided to me and/or my child. I understand and accept that my credit card will be charged at the end of the week that services were rendered.

____ ____________________
Signature Date

Please provide all of the information requested below:

____ Visa MC AmEx
Credit card number (circle one)

____________________________________ ______________ ____________
Cardholders name as it appears on card Expiration date Card Code

____
Cardholders billing address with zip code

Client Code of Conduct

Ascend Intensive Outpatient Services is a voluntary program. Once admitted, participants will attend all treatment components. In addition:

- I will be on-time for all scheduled appointments. If, by chance, I am running late, I will contact Joy Martini at 301-674-4917 to let her know that I am running late. A call from my parent is not a substitute.
- I will not attend the program under the influence of drugs or alcohol.
- I will not use drugs or alcohol with fellow program participants or former Ascend clients for the entire duration of my time in the Ascend program.
- I will respect peers' privacy and confidentiality by not discussing any group matters outside of the program.
- I will not engage fellow program participants in any self-destructive behavior.
- I will actively participate in all aspects of Ascend. (i.e. sharing, active listening, attending, staying awake, completing assignments, medication compliance). I understand that even if I am physically present, if I am not actively present as described above, I will receive 1/3 of an absence.
- I understand that all members of the treatment team will communicate regularly about all matters relevant to my treatment.
- While in treatment, any outside contact with group members becomes relevant to the group treatment and may be addressed by any group member at any time.
- If I miss six (6) days from the Ascend Program, for any reason, I will be discharged. If I miss more than three (3) treatment days in the first 30 days from when I begin the program, I will be discharged.
- If I miss any scheduled individual, family therapy, or educational/vocational appointments with any treatment team member without 24 hour notice, that will count as 1/3 of an absence.
- I will refrain from using my cell phone while in groups.
- If I am more than 5 minutes late, I will wait in the lobby until the group ends before joining the others. If I am late 3 times, it will count as a full day absence.

* Non-compliance is grounds for discharge at the treatment team's discretion.

Client Signature____ Date_____________

Ascend Team Member Signature_____________________________ Date_____________

Family Participation Agreement

We agree to actively support our young adult's treatment goals and progress by the following:

- Participation in an initial 1-hour treatment planning conference.
- Participation in family therapy in accordance with treatment plans.
- Participation in intake process.
- Participation in 45-minute discharge meeting at the end of treatment.
- Parents are required to attend a 2x monthly parent group. The group will meet from 8:00 am - 9:00 am on Thursdays at the Ascend office. Only one parent is required to attend from each family but both are welcome.

Client
Signature____date________________

Parent
Signature____date________________

Metropolitan Counseling Associates, LLC
7201 Wisconsin Ave., Suite 700
Bethesda, MD 20814
301-654-7770

Release of Information

Client name:____

I authorize: Ascend Program of Metropolitan Counseling Associates, LLC to exchange information with:

Parent names:_______________________________

Phone:______________

Address:____

for the purpose of treatment collaboration.

Client Signature:____

Parent/legal guardian signature
(if client is under 18):_______________________________________

Date:________________________

Metropolitan Counseling Associates, LLC
7201 Wisconsin Ave., Suite 700
Bethesda, MD 20814
301-654-7770

Release of Information

Client name:____

I authorize: Ascend Program of Metropolitan Counseling Associates, LLC to exchange information with:

Name:_______________________________ Phone:______________

Address:____

for the purpose of treatment collaboration.

Client Signature:____

Parent/legal guardian signature
(if client is under 18):_______________________________________

Date:_________________________

Metropolitan Counseling Associates, LLC
7201 Wisconsin Ave., Suite 700
Bethesda, MD 20814
301-654-7770

Release of Information

Client name:____

I authorize: Ascend Program of Metropolitan Counseling Associates, LLC to exchange information with:

Name:_______________________________ Phone:______________

Address:____

for the purpose of treatment collaboration.

Client Signature:____

Parent/legal guardian signature
(if client is under 18):_______________________________________

Date:_________________________

Metropolitan Counseling Associates, LLC
7201 Wisconsin Ave., Suite 700
Bethesda, MD 20814
301-654-7770

Regarding Internet Use Between Clients/Guardians of Clients & MCA

Please be aware that any e-mail communication between clients/guardians and MCA Mental Health Providers is not guaranteed to be secure/confidential. Thus, if you choose to communicate about clinical matters with an MCA Mental Health Provider by means of e-mail, doing so is at your own risk. MCA will not communicate with clients via e-mail unless a written Release of Information that acknowledges the risk to confidentiality is signed and dated. Furthermore, e-mail and text messages cannot be used to cancel appointments.

I give permission to communicate with Metropolitan Counseling Associate, LLC. Via e-mail.

Signature: ____

Print Name: ____

Parent/Guardian of: ____

Date: ____

Recommendations to Maximize
Insurance Reimbursement

Ascend Intensive Outpatient Services is not a hospital affiliated program and is not accredited by the Joint Commission (JCAHO). We do not participate as an in-network provider with any health insurance plan. The decision not to contract in-network is in effort to protect our ability to offer a comprehensive treatment program that meets the unique clinical needs of our participants.

Most out-of-network benefits offer limited coverage for intensive treatment. Many policies have a "daily rate" for day treatment that may not apply to intensive outpatient services. To maximize your potential reimbursement, we recommend the following.

1. Prior to your young adult beginning Ascend, contact your insurance company and ask if out-patient mental health treatment requires pre-authorization. If so, provide MCA with information and required forms.
2. Ask if your insurance company requires regular treatment plans and if so, how often?
3. Learn the details of your insurance coverage for outpatient mental health services. Each plan is different even within the same insurance company. If you are familiar with your coverage, it will help you maximize the amount you are reimbursed.

   a. Prior to beginning treatment, ask your insurance company about their reimbursement rates for the following CPT Codes so you know what to expect:
      90853 (group), 90834 (individual), 90846 (family w/o patient), 90847 (family w/patient), 90785, 90791, 90792 (psychiatry intake), 99213, 90833 (weekly psychiatry); 90849 (Multi-Family Group); 90839 (Crisis Management)

   b. Ask if they will reimburse for multiple services on a single day? Such as, multiple 90853's or a combination or 90853 and others listed above.

4. Please let us know if your insurance company requires diagnostic information prior to invoicing.

Ascend/Metropolitan Counseling Associates, will not submit insurance forms directly to your insurance company. We have learned that insurance companies vary greatly in their acceptance and processing of our invoices. We will work with you to create an invoice that meets your insurance companies requirements for reimbursement. But, you are responsible for filing and following up with your insurance company. We are happy to answer any of your insurance companies questions to assist in making this process as smooth as possible. To do so and be HIPPA compliant, we require an up to date signature on our privacy policy contract.

Metropolitan Counseling Associates, LLC
Notice of Privacy Practices
Effective April 1, 2015

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

PLEASE REVIEW THIS NOTICE CAREFULLY

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPPA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection. This information will be used to secure payment through a private collection company or the court of law.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPPA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As social workers, psychologists, and professional counselors licensed in Maryland it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with HIPPA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPPA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may be used for research purposes. All information shared with researchers will be de-identified; no link between your PHI and your name will be released to researchers.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 5942 Hubbard Drive, Rockville, MD 20852:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person. Records are maintained for 6 years from the date of last treatment contact, or 6 years from the age of majority, whichever is later.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request. If you wish to have emails sent with encryption, please notify your therapist.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 5942 Hubbard Drive, Rockville, MD 20852 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is February 2015.

____ ______________________

Patient Signature Date

____ ______________________

Guardian/ Parent (If patient is under 18 years old) Date