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

Date:_____

Client Information Sheet

Client Information:

Name: _____

Address: _____

_____

Home Phone: _____ Cell Phone _____

Work Phone: _____ E-mail: _____

Date of Birth: _____

Preferred Pronouns: _____

In case of Emergency, contact: _____

Name and phone number of parent(s)/legal guardian(s):

Parent/legal guardian #1

Name: _____

Relationship to client: Self

Address (if different than client): _____

_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Parent/legal guardian #2

Name: _____

Relationship to client: Self

Address (if different than client): _____

_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Metropolitan Counseling Associates, LLC
Payment Policy
Effective September 17, 2018

PLEASE REVIEW THIS NOTICE CAREFULLY.

We understand that treatment is a significant investment of time, money and energy and we are committed to providing the highest quality services as cost effectively as possible. We make every effort to educate our clients and families about the financial aspects of treatment. This document will review our updated payment policy that will be effective April 1, 2015. It also includes important information about health insurance plans that we hope will help you maximize your benefits.

Please read this full policy carefully, and initial accordingly. Your signature on the third page of this document acknowledges your understanding of the policy and your agreement.

Payment Policy

Metropolitan Counseling Associates LLC (MCA) expects that all payment for services rendered be made at the time of service. Payment may be made by cash, check or credit card (Visa, MasterCard and American Express). If a cash or check payment is not made at the time of service, your signature on this document serves to authorize MCA to charge your credit card for services rendered.

_____ (please initial)

Credit Card Policy

In our efforts to avoid financially related disruptions to treatment and to address the reality that many services are provided to children and adolescents who are not financially responsible for their treatment; **we require that all clients and families keep a working credit card on file with our office**. The credit card information is kept securely in accordance with HIPPAA 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.

Please note that we process credit cards on a weekly basis. Therefore charges posted may not be consistent with the date of service and will be routinely posted within one week of services rendered.

_____ (please initial)

Invoices

Invoices are mailed monthly and document all services and payments that occur in the previous month. Clients may also request a billing invoice from their provider at the time of service. This document can be used to initiate reimbursement from third party payers and will also document the payment of cash or check. Credit card payments are reflected on the monthly invoice.

_____ (please 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.

_____ (please 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 clinical and financial practice.

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

Out of Network Providers:

An out of network, or non-participating provider is defined as a provider who is not contractually obligated to follow guidelines established by commercial insurance companies to

Verify patient benefits

- Pre-authorize services
- Submit claims
- Accept assignment of benefits
- Accept negotiated rates
- Submit supportive documentation for payment ***

***Commercial/ private health insurance companies cannot obtain psychotherapy notes without a patient's authorization. Furthermore, insurance companies are not permitted to condition reimbursement for services on receipt of such records. Although MCA does not release patient records directly to insurance companies, we will can support efforts to receive reimbursement by releasing patient records to a patient or responsible party with authorization.

_____ (please initial)

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,

Most health plans authorize services based on specific diagnostic criteria (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

***Both the Ascend Intensive Outpatient Program and the DBT Program have other financial factors we encourage you to speak with your provider about directly.

Reimbursement

MCA does not participate in network with any health insurance or third party payment plans. All of our billing and monthly invoices provide the information required by most third parties to secure out of network benefits.

_____ (please initial)

Any questions regarding billing and paperwork should be directed to our Billing office

301 654 7770 ext. 715 office@metcounseling.com

I _____ have read and understand the payment policy at Metropolitan Counseling Associates and agree to its terms.

_____ _____

Patient Signature Date

_____ _____

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

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

Client _____

Therapist _____

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

Authorization for Credit Card Use

Metropolitan Counseling Associates requires a credit card on file for all clients.

Please read, sign and date below:

I authorize Metropolitan Counseling Associates, LLC to use the credit card information that I have provided below to manually charge my credit card for mental health services provided through Metropolitan Counseling Associates, LLC to me and/or my child. I understand and accept that my credit card will be charged at the completion of any services rendered.

_____ _____
Signature Date

Please provide all of the information requested below:

_____ ◉ Visa ○ MC ○ American Express
Credit card number

_____ _____
Cardholders name as it appears on card Expiration date

_____
Cardholders billing address with zip code

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 ("HIPAA"), 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 HIPAA 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 HIPAA.

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 HIPAA.

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

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

Acknowledgement of Receipt of Privacy Practices

I have received a copy of Metropolitan Counseling Associates, LLC's Notice of Privacy Practices.

Name: _____

Address: _____

_____

_____ _____

Signature of Client/Client's Legal Guardian 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: _____

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

Release of Information

Client name:_____

I authorize _____
(Clinician's name)

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
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Bethesda, MD 20814
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Name:_____ Phone:_____

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for the purpose of treatment collaboration.

Client Signature:_____

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

Date: