Chesapeake Bay
Psychological Services LLC

Dear New Client or Parent:

Thank you for scheduling an appointment at Chesapeake Bay Psychological Services. At your earliest convenience, please read the instructions below, review and complete the enclosed forms, contact us with any corrections, and return these forms via e-mail or bring them to the first appointment.

Before the first appointment: If you will be relying on insurance to help pay for services, to ensure that we have your correct information, please ***review the appointment and insurance information we have on file for you***. That information is attached if you received these forms by mail or e-mail. It is also available online at www.chesapeakebaypsychological.com. If any of the information is incorrect or missing, as soon as possible, please call (410-604-0226), fax (877-643-0126), or email us (billing@chesapeakebaypsychological.com) with the correct information. Doing so will allow us to verify benefits, copayment amounts, preauthorization, and our participation in the insurance network, so that you will not have to pay in full for the first appointment. Also, ***please note that payment is due at each appointment*** unless otherwise agreed.

Bring to the first appointment:

- The enclosed forms, completed
- Copies of any records you may wish the clinician to review
- The client's insurance card, if insurance is to be used
- Payment in the form of cash, check, or credit card
- Driving directions below

Chesapeake Bay Psychological Services is a small private practice with limited support staff. Please understand that while your clinician may not be available often by telephone, you will have your clinician's undivided attention at each appointment. We look forward to working with you.

Sincerely,

Catherine M. Smithmyer, PhD

Catherine M. Smithmyer, Ph.D., Director, Licensed Psychologist

Directions from Kent Narrows/the Eastern Shore: Traveling Westbound from Kent Narrows on Route 50/301, take Exit 37 (the last exit before the Bay Bridge) and merge RIGHT onto Route 8/Romancoke Rd towards Stevensville. Take the first LEFT at the traffic light onto Skipjack Parkway (at the sign for the Chesapeake Bay Business Park). At the stop sign, turn LEFT onto Log Canoe Circle. Take the first LEFT (at the sign marked Bridge Office Center), and make an immediate LEFT into our parking area. Look for the CBPS sign on the door of the first building on the LEFT, at 155 Log Canoe Circle. **Directions from Stevensville and the Bay Bridge:** Traveling Eastbound from the Bay Bridge on Route 50/301, take exit 37 and turn LEFT at the light onto Route 8/Romancoke Rd. On Route 8, proceed through one light and turn LEFT at the second traffic light onto Skipjack Parkway (at the sign for the Chesapeake Bay Business Park). At the stop sign, turn LEFT onto Log Canoe Circle. Take the first LEFT (at the sign marked Bridge Office Center), and make an immediate LEFT into our parking area. Look for the CBPS sign on the door of the first building on the LEFT, at 155 Log Canoe Circle.

Scheduling after the first appointment: Please consider scheduling your future therapy appointments online; many people find this to be a great convenience. To schedule online:

- At www.chesapeakebaypsychological.com, click the "Schedule Online" tab, then click "Returning Client."
- Enter your username and password, then click "Login." (Please do not use the "Quick Sign Up" or "Enrollment" tabs, or you will create a new account, and your existing appointments will not show up in it.)
- Use your existing login (or contact us if you have forgotten it). If you received this form via e-mail, your login information is in the e-mail. If you received this form by mail, your new login is:
  Username: _____ Password: _____ .
- When scheduling, take care not to schedule "continued therapy" appts for dates prior to your first "New Client" appt.
- Online, you may view, schedule, and cancel appointments and change your username and password, if desired.

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Insurance Information Form

Client Information (Person clinician is treating)

Last name: _____ First name:_____ Middle: _____

Date of birth: _____ Gender*: _____ Social security number: *(optional)*_____

FT Student /Unemployed/Disabled /Retired /Homemaker (Or) Occupation:_____

Employer: _____ Employer's Address: _____

Primary Insurance Information

Primary Insurance Company: _____ Group #:_____

Member, Subscriber, Recipient, or ID #: _____ Insurance Telephone#:_____

Primary Policy Holder: Relation to client: □ Self (if self, skip to Secondary Insurance Information Below)
□ Spouse or domestic partner Parent Other: _____

Last name: First name: Middle: _____

Address: _____City: _____ State:_____ ZIP:

Best phone number: _____ Other phone: _____

Date of birth: _____Gender*: _____ Social security number: *(optional)* _____

FT Student /Unemployed/Disabled /Retired /Homemaker (Or) Occupation: _____

Employer: _____ Employer's Address: _____

Secondary Insurance Information

Secondary Insurance Company, if any: _____ Group #:

Member, Subscriber, Recipient, or ID #: _____ Insurance Telephone#: _

Secondary Policy Holder: Relation to client: □ Self (if self, skip to Authorization to Release section below)
□ Spouse or domestic partner Parent Other: _____

Last name: First name: Middle: _____

Address: _____ City: _____ State: _____ZIP:

Best phone number: _____ Other phone: _____

Date of birth: _____ Gender*: _____ Social security number: *(optional)* _____

FT Student /Unemployed/Disabled /Retired /Homemaker (Or) Occupation: _____

Employer: _____ Employer's Address: _____

Other Health Insurance: I certify that the information above is complete and current; the client has no other insurance coverage. **Authorization to Release Medical Information to Insurer(s):** Federal regulations allow Chesapeake Bay Psychological Services (CBPS) to disclose information from client records in order to obtain payment for services provided. I consent to such permitted disclosures (such as sending to the insurance company information required for payment).

Assignment of Benefits: For services provided to the client listed above, I hereby assign the relevant insurance benefits to CBPS.

_____ Date: _____

Signature of adult client, guardian, or other responsible party

Printed Name: _____

***Gender is requested because it is a required item on insurance claim forms**

CBPS Services Agreement

Client name:_____ DOB:_____

Welcome to Chesapeake Bay Psychological Services (CBPS). Before the first appointment, please read this document carefully, as it contains important information about our policies and services. At the first appointment, please ask any questions you may have about our policies or services. You must sign this agreement in order to receive services.

Confidentiality and Disclosure

When a client receives mental health services, the law protects the privacy of the client's communications to the clinician and the resulting medical records. The clinician may not reveal or release that information to anyone without the written authorization of the client and/or the client's guardian, except when disclosure is allowed or required by law. When a disclosure is required, the clinician will make reasonable efforts to discuss it with the client before taking action. Most of the provisions explaining when the law allows or requires disclosure are described in the notice of privacy practices; *thisform provides additional information and examples but does not replace the notice ofprivacy practices*. In the following situations, the clinician may be allowed or required to release information without the client's specific authorization, or the client may be required to authorize a disclosure in order to receive services:

Disclosure is allowed for certain treatment, payment, and healthcare operations

- Health care providers such as CBPS are allowed to disclose information to your health insurance company in order to obtain payment, unless you choose to pay for services directly.
- CBPS is allowed to disclose information as necessary to its business associates who have agreed to comply with privacy (HIPAA) laws. These business associates may include, for example, an answering and scheduling service, a collection agency, and a bookkeeping service. Information disclosed is the minimum necessary to carry out treatment, payment, and healthcare operations.
- Clinicians are allowed (and sometimes required by professional ethics) to seek consultation from other professionals about specific cases, although client identity is kept confidential.

Disclosure is sometimes required by law or professional ethics

- If a clinician has any reason to suspect possible past or present abuse or neglect of a child or vulnerable/elder adult, the clinician is always required by law to make a report to the appropriate authority.
- If a client presents a danger to oneself or others, the clinician is required by law and professional ethics to take action to mitigate the danger; such action often includes disclosing information. For example, the clinician may be required to warn the person endangered, contact law enforcement, inform family members, or attempt to ensure that the client is admitted to a hospital.
- If CBPS is served with a valid subpoena or court order to release information or records, disclosure may be required by law.
- Certain legal proceedings could result in disclosure. For example, when a plaintiff places his or her mental status at issue in a lawsuit, the defendant may have the right to obtain the plaintiff's mental health records and the testimony of the plaintiff's current or former mental health provider. Similarly, if a client files suit against a mental health provider, information about the client may be disclosed by the defendant. In child custody cases and child protection cases, an attorney appointed by the court to represent the child may authorize the release of the child's mental health records or the provider's testimony. This document should not be construed as legal advice: if you expect to be involved in litigation, you should consult with your attorney to determine what information might or might not be disclosed in court.

Disclosure is sometimes inherent to the service(s) provided

- The client's authorization to disclose information may be required for some services to be properly provided. For example, some psychological evaluations may require the psychologist to contact the client's other health care providers for information.
- When services such as therapy or an evaluation are requested or ordered by a third party, such as a court or social service agency, the client's agreement to receive those services indicates agreement that requested information (such as evaluation results or compliance with therapy) will be disclosed.
- In order to participate effectively in family therapy or group therapy, clients are often expected to disclose information to the family or the group. A client's agreement to participate in family therapy or group therapy indicates an agreement that information disclosed may be discussed among family members or group members. Family members and group members are asked to keep such information confidential, but the discretion of family members and group members cannot be guaranteed.

Minors' Rights to Confidentiality

Although the law generally allows parents access to their minor children's medical records, mental health records may legally be withheld from parents when the clinician believes that releasing records would be harmful to the child. Moreover, most children and especially teenagers will participate in therapy more effectively if they are allowed to discuss some matters with the therapist in confidence. Therefore, when providing therapy to minors, we ask that parents agree that the therapist will respect the privacy of information shared by the child in confidence, except information that parents need to protect the child from life-threatening danger.

On the other hand, parental involvement is important to the assessment and treatment of children, so parents should share information regularly with the therapist, and should expect to receive information about the progress of the child's treatment.

Our Services and Policies

The Nature of Psychological and Psychiatric Services
Psychological and psychiatric services, including psychotherapy, medication management, and psychological testing, take many forms, depending upon many factors such as the client's age, health, presenting symptoms, diagnosis, and the clinician's training and preferences. Psychologists who provide testing services may choose from a wide variety of published psychological tests, and most therapists use techniques from several different therapeutic models. These models include, for example, behavioral, cognitive-behavioral, interpersonal, psychodynamic, supportive, solution-focused, and family systems models. Clients should feel free to ask questions about what techniques or tests may be used at CBPS as well as what others may be available elsewhere.

Regardless of the tests, therapy techniques, or medications used, the effectiveness of psychological and psychiatric services depends not only upon the skill and efforts of the clinician, but also upon the efforts of the client, and upon collaboration between clinician and client. For example, therapy will be most effective for clients and families who make an active effort to work on matters discussed in therapy, both during the therapy session and outside of therapy. Medications will be most effective if taken as prescribed. Likewise, results of psychological tests will only be valid if the client completes the test with sincerity. If a client has concerns, questions, or disagreement with the clinician about approaches used, the client should openly discuss such issues with the clinician to resolve any misunderstanding or difference of opinion.

Ultimately, psychological and psychiatric services offer both benefits and risks. Benefits may include receiving an accurate diagnosis, reducing specific symptoms, and reducing distress. With regard to risks, all medications have some risks, and many therapy clients experience a temporary increase in distress when focusing on problem areas. Due to the multitude of factors that influence the outcome of psychological and psychiatric services, we cannot guarantee that our services will yield positive or intended results. However, most people who seek psychological and psychiatric services report those services to be helpful.

Information about Therapy Services
Therapy services are typically provided in sessions that last 40-55 minutes in duration. Therapy is usually scheduled once per week, but may be scheduled more or less often as appropriate. In the first few sessions, the client (and parents of a minor client) and the therapist discuss the presenting problem, symptoms, background history, and so forth. Together, they formulate a treatment plan and begin therapy. Thus, several sessions may pass before the client begins to experience the benefits of therapy. If at any time the therapist or client feels that a different therapist would be more helpful, the advisability of getting a second opinion or transferring to a new therapist should be discussed.

Especially for children and adolescents, family therapy is often recommended. Different family therapy approaches involving different combinations of family members may be used. As with individual therapy, the treatment plan will be formulated collaboratively. Parents and children should feel free to express their feelings about who should be included in family sessions.

Information about Psychiatric Services
Currently, psychiatric services that CBPS offers include psychiatric evaluation and medication management for adult patients only, provided by a certified registered nurse practitioner who has a specialty in psychiatric mental health. The initial appointment may be up to one hour in length, whereas follow-up appointments are typically 15 to 30 minutes in length. Patients are typically seen frequently until the new medication regimen has proven effective, and less frequently thereafter. Because psychiatric services at CBPS do not include psychotherapy, our medication management patients are encouraged to see different clinician (typically a psychologist or clinical social worker) for therapy.

Information about Psychological Evaluation Services
Psychological evaluation services, provided by a psychologist or a qualified professional under the supervision of a psychologist, are typically requested by clients or their physicians in order to guide treatment. For example, a physician may refer a client for psychological testing in order to determine whether or not the client has ADHD and needs treatment for it. Evaluation services of this type are most often provided in one or two appointments of varying length after the initial consultation session. Such evaluations often consist of a review of pertinent records, rating scales completed by the client and others, and one-on-one psychological testing. Afterward, the psychologist provides a detailed written interpretive report and a feedback session in which results of the evaluation are explained to the client. If the client has insurance coverage for psychological testing, the psychologist can sometimes ask the insurance company to "preauthorize" payment for the portion of the evaluation for which the insurance company agrees to provide benefits.

Clients are sometimes referred by attorneys, courts, or social services agencies for psychological evaluation services in order to provide information that may be needed in the courtroom. For example, CBPS can provide mental injury evaluations and child custody evaluations. Such evaluations tend to be highly specialized, time-consuming, and costly because, in addition to meeting standard practice guidelines, they must also be designed to meet forensic guidelines and to withstand legal challenges to the extent practicable. They are seldom covered by insurance. If more information is needed about such specialty evaluation services, please ask.

Information about Consultation Services
Consultation services may vary widely depending upon the nature and extent of consultation needed. At CBPS, our clinicians are available for consultation regarding areas of psychology or psychiatry in which they have training and expertise. For example, a client might seek consultation regarding how to obtain appropriate mental health services for a friend about which the client is concerned. A private school or employer might seek consultation regarding crisis intervention after a tragedy. Parents might seek consultation regarding their child's need for educational accommodations in gradeschool or college. Divorced parents might seek consultation to resolve parenting differences. We can also make referrals to other experts as appropriate.

Additional Information Regarding Services for Children
Children must be accompanied by a parent or guardian at each appointment unless the parent, child, and therapist agree otherwise in advance. Parents will need to participate in most or all of the initial session; thereafter, parent participation will depend upon the service to be provided and the treatment plan. An initial session with parents *only* is sometimes advisable, especially for young children. If including the child in the initial session is likely to be harmful to the child (by exposing the child to a discussion that may be upsetting or of an adult nature), please leave us a message regarding those concerns and do *not* bring the child to the session.

Supervision of Children
Children under the age of 12 (and older children who are not able to manage themselves in the waiting room) may not be left unsupervised in the waiting room. Thus, parents should not bring additional children to the appointment unless those children are to be included in the session or unless the parent is not to be included in the session.

Contacting the Office between Appointments
Clients may call 410-604-0226 to schedule appointments or may schedule appointments online at the website. In a clinical emergency, our receptionist and/or the answering service will make every effort to contact one of our clinicians when the office is closed. However, CBPS is not an emergency facility and is not able to provide emergency services. Clients experiencing a true emergency involving danger to the client or others should seek emergency services at the nearest hospital emergency room or by calling 9-1-1.

Dual Relationships
A "dual relationship" occurs when a clinician providing therapy or other psychological services to a client has some other type of personal or business relationship with the same client. Some dual relationships have the potential to cause problems—for example, by affecting the clinician's objectivity or the effectiveness of the therapeutic relationship. If a client is aware of a dual relationship that could present a problem, the client should inform the clinician immediately.

E-mail Permission
While e-mail is a convenience for many of our clients, we cannot guarantee its security. Please indicate whether you wish to receive e-mail from us that may contain private health information, including e-mail reminders of your appointments.

☐ Yes, I wish to receive e-mail reminders of appointments and/or other e-mails that may contain private health information, and I am aware that the security of e-mail is not guaranteed.

E-mail Address: ☐ do not change ☐ change to:_____

☐ No, please remove/omit my e-mail address from the system. I understand that I will not receive e-mail reminders of appointments.

Please note that even if you check "No" above, if you send us e-mail that contains private health information (such as information about appointments, symptoms, or mental health concerns), by doing so, you imply that we have permission to respond with e-mail containing private health information.

Signed Agreement

You may revoke your consent to this agreement in writing at any time, but the revocation cannot be retroactive and can only take effect when received. CBPS retains the right to disclose information in order to seek payment for services already rendered. A revocation of this agreement in no way diminishes the client's responsibility to pay for services received or costs already incurred.

Your signature below indicates that you have had the opportunity to read this agreement in its entirety (or to have it read to you), that you consent to this agreement, and that you have been offered or given a copy of the Notice of Privacy Practices: Maryland Notice Form. If you are a parent or guardian consenting to services for a minor child, your signature also attests that the child's other parent or legal guardian does not object to these services. If you have reason to believe that the other parent or guardian may object, please notify us immediately.

First Client/Guardian Signature: _____
Printed Name: _____ Date:_____
Second Client/Guardian Signature, if applicable: _____
Printed Name: _____ Date:_____

Chesapeake Bay Psychological Services LLC

Telephone: 410-604-0226 Facsimile: 877-643-0126
www.chesapeakebaypsychological.com

Fee Agreement

Client name:_____DOB:_____

Clients or their guarantors are expected to pay for services at the time those services are received. If you anticipate difficulty paying on time, please notify our office immediately to discuss payment arrangement options. For services that are expected to be covered by insurance, applicable deductibles and copayments must be paid at the time services are received. If preauthorization is required by the insurer, the client should call the insurance carrier prior to the first appointment to obtain preauthorization. CBPS will submit claims to most companies on behalf of our clients. However, clients and their guarantors retain full responsibility to pay for all services rendered, including services not covered by insurance and claims denied by the insurer. Some of the services listed below are not covered by most insurance policies, including the missed appointment charge.

Rates for services at Chesapeake Bay Psychological Services are currently as follows, but are subject to change:

Service	Non-prescribing Clinician Rate	Prescribing Clinician Rate
Initial appointment, typically 45-60 minutes	$200	$300 (or $250 if less complex)
Medication follow-up, typically 15-30 minutes	N/A	$200 ($100 or $150 if less complex)
Individual or family therapy, typically 45-55 min.	$160 ($120 if brief)	N/A
Extended therapy session	$40 per quarter hour	N/A
Consultation, up to one hour	$200	$300
Psychological evaluation	$160/hour or flat fee	N/A
Court or other appearance, per hour scheduled and driving time, plus mileage (at standard mileage rate):		
	$200/hour	$300/hour
Most telephone contacts >5 minutes	$40 per quarter hour	$60 per quarter hour
Most requested documentation	$40 per quarter hour	$60 per quarter hour

The following services are included at no charge: brief telephone contacts (up to 5 minutes), telephone contacts with other providers, medical record review, contacts with insurance companies, documentation requested by insurance companies, submission of claims to primary and secondary (but not tertiary) insurance companies.

Other Fees	CBPS Rate
Copying of records	$0.75/page
Missed appt without 24 hrs notice	***$65** (may be waived in case of unforeseen illness/emergency)*
Returned check charge	$25/check
Collections costs	35% of any delinquent balance, plus any legal costs

- Chesapeake Bay Psychological Services offers reduced rates based upon clinical needs and financial status. Please inquire in advance.
- Please note that clients will be charged for court appearances and legitimate requests for information or documentation regarding services they have received at CBPS, even if a different party issues the subpoena or requests the information or documentation.
- Parents, please note that our office cannot mediate disagreements between parents over financial responsibility for services provided to a child. Payment is due at the time of service; parents must resolve differences over payment for services in advance. In the case of an outstanding balance, the parent(s) who signed this fee agreement will be held responsible.
- Treatment will be terminated for clients who have missed 3 appointments in one year without 24 hrs notice and without payment, including clients whose insurer (such as Medicaid) prohibits CBPS from charging clients for missed appointments.
- ***Payment is due at the time of service. Guarantors who do not bring or send in payment at the time of service must complete the CBPS Credit Card Authorization Form, which is providedfor your convenience.***

You may revoke your consent to this agreement in writing at any time, but the revocation cannot be retroactive, and in no way diminishes your responsibility to pay for services already received or costs already incurred.

Responsible Party/Guarantor Signature: _____

Printed Name: _____ Today's Date:_____ Date of birth:_____

Address if different from client: _____ City: _____ State:_____ ZIP:_____

Relationship to client: _____ Primary phone: _____ Secondary phone: _____

Chesapeake Bay Psychological Services LLC

Telephone: 410-604-0226 Facsimile: 877-643-0126
www.chesapeakebaypsychological.com

Notice of Privacy Practices: Maryland Notice Form

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

Client Name: _____ **Date**: _____

I. Uses and Disclosures for Provision of Services, Payment, and Health Care Operations

We maintain a record of *protected health information (PHI)* on each individual who obtains services at our practice. We can *use* or *disclose* this PHI 1) for the *provision of services, payment, and health care operations* purposes, 2) with your *written authorization*, or 3) under circumstances outlined in Section III below. To help clarify these terms, here are some definitions:

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

II. Uses and Disclosures Requiring Authorization

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

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

III. Uses and Disclosures without Authorization

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

- *Child Abuse* – If we have reason to suspect that a child has been sexually or physically abused, or is subjected to abuse or neglect, we must report this suspicion to the appropriate authorities. This applies regardless of when the alleged abuse occurred or whether the alleged abuser is still alive.
- *Adult and Domestic Abuse* – we may disclose protected health information regarding you if we reasonably believe that you are a victim of vulnerable adult abuse, neglect, or exploitation.
- *Health Oversight Activities* – If we receive a subpoena from an official Maryland agency because they are investigating our practice, we must disclose any PHI requested by the agency.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated by a third party, or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to us a specific threat of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm.

IV. Client's Rights and Practitioner's Duties

Client's Rights:

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

Practitioner's Duties:

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

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Dr. Catherine Smithmyer, at the telephone number and address above.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

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

This notice is effective July 1, 2006.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by mail or in person at one of your visits to our practice.

I acknowledge receipt of this notice:

Date: _____

Signature of adult client, guardian, or other responsible party

Printed Name:

Chesapeake Bay Psychological Services LLC

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www.chesapeakebaypsychological.com

Standard Credit Card Agreement

Payment is due at the time of each appointment, in the form of cash, check, credit, or debit card. If you prefer to pay by credit or debit card, we ask that you complete this agreement. Doing so will relieve your clinician from having to request your card at each session, thus saving time in your appointments.

Client name: _____ DOB: _____

Cardholder name as it appears on card: ☐same as above ☐Other:_____

Credit card number:_____Expiration date:_____

Cardholder billing address:_____

Cardholder telephone number: _____

Cardholder e-mail address (optional): _____

For FSA or HAS Cards only:

☐ This is a Flexible Spending Account (FSA) or Health Savings Account (HSA) card and:

☐has no grace period and should not be charged for any services provided after December 31st.

☐has a grace period sending ___/___/____ (no later than March 15th) and should not be charged for services provided after the grace period ends

☐ has a run-out period and should not be charged for services provided in the current calendar year (and grace period, if any) after the run-out period ends on ___/___/____.

☐ I am not sure about the grace and/or run-out period; I will let CBPS know before December 31st or I will provide another form of payment promptly after December 31st.

Except as limited elsewhere on this form, I agree that Chesapeake Bay Psychological Services may charge the credit or debit card listed above for any balance due on this account at time of service or thereafter until authorization is revoked in writing. Such charges may include, but are not limited to deductibles, copays, and/or coinsurance required by my insurance policy (if any).

☐Please contact me first if the amount to be charged exceeds $ _____ .

☐Please contact me first if the amount is due to an insurance denial (other than copay, coinsurance, or deductible)

I understand that I am not required to sign this agreement in order to receive services at CBPS.

Cardholder/Authorized Signature: _____Date:_____

Chesapeake Bay Psychological Services LLC
Telephone: 410-604-0226 Facsimile: 877-643-0126

Authorization to Release Information To/From Primary Care Physician

Client name:_____ DOB:_____

I hereby authorize the disclosure of my individually identifiable health information, as follows:

The Persons/Organizations indicated below are authorized to RELEASE and/or RECEIVE the information:

Chesapeake Bay Psychological Services

Primary Care Physician: _____

Primary Care Physician's Phone Number: _____

Purpose: Coordination of Services

Specific description of information to be released:

Any and all information pertinent to mental health treatment

- I understand that this authorization will expire one year from the date signed.
- Please note: I am not required to sign this authorization in order to receive services at CBPS.
- I understand that this authorization is revocable except to the extent that action has been taken in reliance upon it. To be effective, any revocation must be received in writing by the party I have authorized to release the information.
- I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations.

Client/Guardian Signature:_____

Printed Name: _____ Date: _____

Chesapeake Bay
Psychological Services LLC

Medication List

Client Name: _____ Date of Birth: _____ Date Completed:

Please list all Medications you are currently taking, including prescriptions, over-the-counters, herbals, and vitamins/minerals/dietary supplements. Be sure to tell your clinician at each appointment about any medication changes.

MEDICATION NAME	DOSAGE	HOW OFTEN	REASON FOR MEDICATION	HOW TAKEN, IF NOT ORALLY

Prescribers: 1._____ 2. _____