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 if needed, and return these forms via fax or e-mail or bring them to the first appointment.

Before the first appointment: ***Please note that payment is due at each appointment (including copays/deductibles).*** If you will be relying on insurance to help pay for services, we suggest that you verify your coverage, benefits, and provider network with your insurance company prior to your appointment. Also, if you did not provide us with your complete insurance information when scheduling, please call (410-604-0226), fax (877-643-0126), or email us (admin@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.

Bring to the first appointment:

- The enclosed forms, completed
- ***Parents:*** The most recent custody order, if any
- 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 often be available 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
Maryland 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. You may schedule online at www.chesapeakebaypsychological.com.

Chesapeake Bay Psychological Services LLC

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

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

Chesapeake Bay
Psychological Services LLC

Standard Credit Card Agreement

Payment is due at the time of service, in the form of cash, check, credit, or debit card. It is our policy to require clients (except those with Medicaid) to keep a credit or debit card on file with us, either as the main form of payment or as a backup. This policy allows our clinicians to see clients when our receptionist is unavailable, to treat children and adolescents when parents are unavailable, and to keep appointments with clients who forget to provide payment. If your account is current and you feel the need to ask the director for an exception to this policy, please email your reasons to admin@chesapeakebaypsychological.com.

Client name:_____ DOB: _____

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

Credit card number:_____ Expiration date:_____

For your protection, after your credit card information is entered into our secure system, we have access to only the last 4 digits of your card number, and we redact and shred the original copy of this form.

Please use this card as my: ☐ main form of payment ☐ backup only

Cardholder billing address:_____

Cardholder telephone number:_____

Cardholder e-mail address (optional):_____

For FSA or HSA cards only:

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

- ☐ has no grace period and so should not be charged for any services provided after December 31st.
- ☐ has a grace period ending ____/____/____ (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 be not 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 if the amount to be charged exceeds $_____.
☐ Please contact me if the amount is due to an insurance denial (other than copay, coinsurance, or deductible).

OR

☐ I have emailed admin@chesapeakebaypsychological.com to request an exception to the policy.

Cardholder/Authorized Signature: _____ Date: _____

☐ This client has Medicaid and so is not required to provide a credit card.

Chesapeake Bay
Psychological Services LLC

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

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: _____

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; *this form provides additional information and examples but does not replace the notice of privacy 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.

Additional Notes:

- CBPS therapists keep healthcare records of each therapy session in a secure electronic medical record (EMR) system. All patient information is documented and stored securely—for example, images of artwork created in art therapy are stored in the EMR.

- Clients have a right to decline treatment and to decline the recording of treatment for research or review by other person(s); CBPS does not record video or audio of treatment without first obtaining client permission.

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 may request information about the progress of the child's treatment.

Our Services and Policies

The Nature of Psychological Services
Psychological services, including psychotherapy and psychological testing, take many forms, depending upon many factors such as the client's age, health, 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, client-centered, interpersonal, psychodynamic, solution-focused, art therapy, play therapy, attachment-based, 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 techniques used, the effectiveness of psychological 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. 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 services offer both benefits and risks. Benefits may include receiving an accurate diagnosis, reducing specific symptoms, and reducing distress. Risks may include a temporary increase in distress when focusing on problem areas. Due to the multitude of factors that influence the outcome of psychological services, we cannot guarantee that our services will yield positive or intended results. However, most people who seek psychological services report those services to be helpful.

Information about Psychological Evaluation Services (if currently provided by CBPS)
Psychological evaluation services, provided by a psychologist or a qualified professional under a psychologist's supervision, are typically requested by clients or healthcare providers in order to guide treatment, or sometimes by courts or other agencies in order to provide information that may be needed in the courtroom. Evaluation services may involve multiple appointments and information-gathering, but always begin with an initial consultation to discuss/determine the purposes, requirements, and cost of the evaluation.

Information about Therapy Services
Depending upon the therapist's training and the client's concerns, diagnosis, and preferences, therapy services available at CBPS may include individual therapy, family therapy, school-based therapy, teletherapy, art therapy, and play therapy, among others. 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 or approach would be more helpful, the advisability of changing the treatment plan, getting a second opinion, or transferring to a new therapist should be discussed. If we anticipate that ongoing services will be interrupted, we will notify and work with the client to arrange for continued care, including transfer or referral to another appropriate provider if needed.

Family Therapy
We provide family therapy for clients of all ages when support from family members is needed for effective treatment, and/or when improving family relationships can help the client's condition. In family therapy, different combinations of family members may be included. Family members are free to express their feelings about who should be included. As with individual therapy, the treatment plan will be formulated collaboratively. For children, parent involvement in therapy is usually essential. Family therapy provided to treat a client's condition is usually covered by insurance, whereas counseling focused solely on improving a relationship rather than treating an individual's condition may not be covered.

As a form of individual healthcare, family therapy's top priority is the treatment of an individual patient's diagnosed condition. Thus, in the course of family therapy, only one member of the family is diagnosed and treated. Other participants in family therapy may or may not benefit, but they are not formally assessed, diagnosed, or treated by the therapist. Because they are not the patient, they do not typically have the same rights as the patient—such as the right to confidentiality, or the right to obtain copies of the patient's medical

record. If a participant needs therapy themselves, they must schedule it separately, usually with a different therapist. At times, the boundary between the roles of participant and patient can seem unclear, so if questions arise, family members are encouraged to discuss the matter with the patient's therapist.

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. 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. Clients in crisis when our clinicians are unavailable should call Eastern Shore Mobile Crisis at 888-407-8018.

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 and Phone/Text Permissions
Your signature below indicates that, if/when you provide CBPS with your email address or phone number, including in our online scheduler or by emailing us, you agree to receive email, phone calls, and/or text messages from us that may contain scheduling, payment, or other private health information, with the understanding that the security of email and text messages cannot be guaranteed. Regarding clinical matters, please schedule an appointment rather than emailing us. To withdraw your agreement to receive email or appointment reminders from us, please notify us in writing.

Concerns/Complaints: Clients/families with any concerns about their experience at CBPS are asked to please contact our director, Dr. Catherine Smithmyer, if the concerns are not resolved by other staff. Dr. Smithmyer may be reached indirectly via our website, or directly via our phone system.

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.

PARENTS PLEASE NOTE: 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

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	**Rate***
Initial appointment, typically 45-60 minutes	$225
Individual or family therapy, typically 45-55 min.	$180 ($135 if brief)
Extended therapy session	$45 per quarter hour
Consultation, up to one hour	$225
Psychological evaluation	$250/hour or flat fee
Court or other appearance, per hour scheduled plus one hour minimum prep time, plus driving time & mileage (at standard mileage rate):	$250/hour
Most telephone contacts >5 minutes	$45 per quarter hour
Most requested documentation	$45 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	**Rate***
Copying of records	$6.50 or the actual cost of labor for copying, supplies, postage, and preparation of any explanation or summary.
Missed appt without 24 hrs notice	***$69*** *(may be waived in case of unforeseen illness/emergency)*
Returned check charge	$35/check
Collections costs	35% of any delinquent balance, plus any legal costs

*Note: Clients with Medicaid are not charged for covered services, returned check fees, or prohibited fees, which currently include fees for missed appointments, completing forms/reports, mail, phone calls, or copies of records requested by a licensed provider.

- 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 provided for 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

Medication List

Client name:_____DOB: _____Date: _____

Please list all current medications, including prescriptions, over-the-counter medications, herbals, and vitamins/minerals/dietary supplements. Be sure to tell your clinician at each appointment about any medication changes.

Medication Name	Dose	How often	Reason	Prescriber's Name