CLIENT
INTAKE PACKET

ESTD 2024

MY CHOICES, LLC.

MENTAL HEALTH

Intensive Outpatient Treatment and Recovery

Monday - Friday | 9 am - 5 pm

6065 HARFORD RD, BALTIMORE, MD 21214-1329
(410) 591 0495 | MYCHOICESBALT.ORG

ADMISSIONS INTAKE FORM

MY CHOICES, LLC.
MENTAL HEALTH

Client Name:		
Race		Gender
Social Security#	Date of Birth	Age
Street Address		
City	State	Zip
Telephone #		

Admission Date		
Level of Care	IOP	OP

Insurance Company
Medicaid #

Drug of Choice (Primary)	Age of First Use
Amount Used	Last Use
Prior Treatment Episodes	Years of Use
Method of Use	

CLIENT RIGHTS

MY CHOICES, LLC.
MENTAL HEALTH

You and your rights as a client are important. You have the right to fair, consistent, and professional treatment at our program. If you feel that your individual rights have been violated, you may use the grievance procedure.

The confidentiality/privacy of client records maintained by the program is protected by HIPPAA federal law as well as 42 CFR Part 2.

The following is a summary of non-HIPPA, 42 CFR part 2 clients rights as they pertain to your involvement with this program:

1. *You have the right to be treated with consideration, respect and full recognition of your human dignity and individuality.*
2. *You have the right to treatment, care and services that are adequate.*
3. *You have the right to not be physically or mentally abused by the program staff.*
4. *You have the right to be free from discrimination.*
5. *You have the right to be free from physical restraints.*
6. *You have the right to privacy and confidentiality.*
7. *You have the right not to participate in any experiential research unless fully informed and with written consent.*
8. *You have the right to fair and responsive treatment for the issues contained in your treatment diagnosis and treatment plan. You will participate in treatment planning.*
9. *You have the right to request a meeting with the Clinical Director to discuss issues which have not been addressed to your satisfaction by your individual counselor.*
10. *You have the right to exercise a grievance by the process outlined in your copy of the Client Grievance Procedure in the event you feel your rights have been violated.*
11. *You have the right to participate in any and all programs' services upon completion of the requirements for each service.*

CLIENT NAME	CLIENT SIGNATURE	DATE
WITNESS NAME	WITNESS SIGNATURE	DATE

INFORMED CONSENT FOR ASSESSMENT & TREATMENT

MY CHOICES, LLC.
MENTAL HEALTH

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CLIENT NAME	CLIENT SIGNATURE	DATE
WITNESS NAME	WITNESS SIGNATURE	DATE

ALTERNATIVE TREATMENT OPTIONS

MY CHOICES, LLC.
MENTAL HEALTH

As it is stated within the first page of this document, you have the right to receive treatment from another agency, at any time, tor any reason, at your own will and/or decision-less certain stipulations are applied through governmental entities such as law enforcement (i.e. probation, parole, pretrial, Department of Social Services, etc.). Whether it is through your own decision or based on the results and recommendations of an assessor, the following items are the various levels of care when regarding dierent treatment options that are available:

Opioid Maintenance: Long-term outpatient opiate substitute treatment program via Methadone, Buprenorphine, Naltrexone, Vivitrol, etc.
21 Day Methadone Detox: Outpatient medically-supervised opiate substitute treatment program.
Acute Detox: Medically supervised inpatient treatment for withdrawal from alcohol and other drugs.
Sub-Acute Detox: A non-medical detoxification program in a home-like environment.
Inpatient Treatment: An intensive program of individual and group counseling provided within a facility where members are required to reside for the duration of treatment.
Residential Treatment: A live-in environment where patients are provided with on-site clinical treatment through individual and group counseling applied support to learn independent living and varies in intensity regarding the amount of provided time o
Recovery House: A live-in environment that provides social, vocational and recreational activities that assists patients in the transition from acute detoxification treatment to community living.
Intensive Outpatient: An outpatient treatment facility that provides primarily group counseling and other services such as Buprenorphine, Naltrexone, Vivitrol treatment-and may additionally include Mental Health treatment services including individual/group therapy and psychiatric medication.
DUI Assessment: An assessment required, by the court, to determine the patient's extent of involvement with alcohol and other drugs.

I have been informed of alternative treat options and choose:

❒ To receive treatment
❒ Not to receive treatment
❒ To receive treatment at one of the following referrals for an listed treatment option

Referrals

- _____
- _____
- _____

My signature below dictates my consent and/or authorization to all the above sections, less any sections where I have selected to "OPT OUT." In the event that any of the sections have been opted out of, the signature below is not applicable to that/ those section(s).

_____	_____	_____
CLIENT NAME	CLIENT SIGNATURE	DATE
	_____	_____
	COUNSELOR SIGNATURE	DATE

HIPAA COMPLIANCE FORM

MY CHOICES, LLC.
MENTAL HEALTH

1. **My Choices, LLC.** shall not disclose or use Protected Health Information (PHI) in a manner that is inconsistent with HIPPAA regulations.
2. **My Choices, LLC.** agrees to maintain appropriate safeguards necessary to ensure that all Personal Health Information (PHI) is used or disclosed only as authorized under HIPPAA guidelines.
3. **My Choices, LLC.** agrees to mitigate to the extent practicable, any harmful effect that is known to be in violation of HIPPAA compliances.
4. **My Choices, LLC.** intends to create a chain of Trust Partner Agreement with respect to electronically exchanged data whereby all parties agree to protect the integrity and confidentiality of all PHI exchanged and proper consents to release information are signed by all parties involved.
5. **My Choices, LLC.** shall provide access to PHI to the subject of that information for inspection and/or copying or amendment as required by HIPPAA regulations.
6. **My Choices, LLC.** shall preside an accounting of disclosure of PHI to the subject after a written request of that information as required by HIPPAA regulations.

Communications with or about patient involving patient health information should be private and limited to those who need the information for treatment (Need to Know Basis). Payment and health care operation, health care operations and activities such as conducting medical records reviews, training health care professional and evaluating staff performance for the organization operations.

On *April 14, 2003*, the Health Insurance Portability and Accountability Act (HIPPAA) went into effect To comply with these federal regulations, **My Choices, LLC.**, needs to ensure the security of Protected Health Information (PHI) to their clients.

Please sign below acknowledging that you received a copy of these procedures at the time of admission.

CLIENT NAME	CLIENT SIGNATURE	DATE
WITNESS NAME	WITNESS SIGNATURE	DATE

Breaking HIPPAA's privacy or security rule can mean either a civil or criminal sanction. Civil penalties are fines of up to $100 for each violation.

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

MY CHOICES, LLC.
MENTAL HEALTH

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that l receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. *(I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during treatment and that I have the right to consent to or refuse such treatment).*

I understand that I can expect regular review of treatment to determine whethertreatment goals are being met I agree to be actively involved in the treatment and in the review process. No promiseshave been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time but agree to discuss this decision first with my provider.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it willemain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my provider is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations and discuss with your provider any questions or concems you may have.

By my signature below, I voluntarily request and consent to behavioral health assessment, care, treatment, or services and authorize my provider to provide such care, treatment, or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive.

By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity hasbeen offered to me to ask questions and seek clarification of anything unclear to me.

_____	_____	_____
CLIENT NAME	CLIENT SIGNATURE	DATE
_____	_____	_____
WITNESS NAME	WITNESS SIGNATURE	DATE

NOTICE OF PRIVACY PRACTICES

MY CHOICES, LLC.
MENTAL HEALTH
ESTD 2024

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 your provider may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

I understand that I can expect regular review of treatment to determine whethertreatment goals are being met I agree to be actively involved in the treatment and in the review process. No promiseshave been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time but agree to discuss this decision first with my provider.

I Under the Health Insurance Portability and Accountability Act of 1996 (*HIPAA, maintain the privacy of PHI and to provide you with notice of his or her legal dutes and privacy practices with respect to PHI. Your provider is required to abide by the terms of this Notice of Privacy Practices. Your provider reserves the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that your provider maintains at that time. Your provider will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or by providing one to you at your next appointment.

HOW YOUR PROVIDER 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 healthcare treatment and related services. This includes consultation with clinical supervisors or other treatment team members. Your provider may disclose PHI to any other consultant only with your authorization.

For Payment: Your provider may use and disclose PHI so that he or she can receive payment for the treatment services provided to you. Examples of payment-related activities are deciding 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, only disclose the minimum amount of PHI necessary for purposes of collection will be disclosed.

For Health Care Operations: Your provider may use or disclose, as needed, your PHI to support his or business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging other business activities. For example, your PHI may be shared with third parties that perform various business activities provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. Your PHI may be used to contact you to provide appointment reminders or information about treatment altematives or other health-related benefits and services.

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

Without Authorization: Applicable law and ethical standards permit your provider to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or;
- Necessary to prevent or lessen a serious an 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.

Verbal Permission: Your provider may 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.

CLIENT NAME	CLIENT SIGNATURE	DATE

MY CHOICES, LLC.
MENTAL HEALTH

YOUR RIGHTS REGARDING YOUR PHI:

You have the following rights regarding PHI maintained about you. To exercise any of these rights, please submit your request in writing to your provider:

Right of Access to Inspect and Copy: In most cases, you have the right to inspect and copy PHI that may be 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. Your provider may charge a reasonable, cost-based fee for copies.

Right to Amend: If you feel that the PHi your provider has about you is incorrect or incomplete, you may ask for it to be amended. although your provider is not required to agree to the amendment.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures that your provider makes of your PHI. Your provider 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 healthcare operations. Your provider is not required to agree to your request.

Right to Request Confidential Communication: You have the right to request that your provider communicate with you about medical matters in a certain way or at a certain location.
Right to a Copy of This Notice. You may ask your provider for a paper copy of this notice at any time.

COMPLAINTS:

If you believe your privacy rights have been violated, you may submit a complaint with the Federal Government. Filing a complaint will not affect your right to further treatment or future treatment. To file a complaint with the Federal Govemment, contact:

Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and the limits on ways my provider may use or disclose personal health information to provide service.

CLIENT NAME	CLIENT SIGNATURE	DATE

CLIENT CONSENT TO RELEASE INFORMATION FORM

MY CHOICES, LLC.
MENTAL HEALTH
ESTD 2024

Consent for the Exchange / Release of Confidential Information:

I,_____ (*Print Name*) & D.O.B: ___/___/____, Authorize: **My Choices, LLC.**, to disclose personal health information through written and electronic means to and from (2- way consent): **My Choices, LLC.**, (*Name of person or organization to which information is to be exchanged with*) the following information:

☐ Evaluation ☐ Treatment Recommendations ☐ Participation ☐ Progress in Treatment
☐ Urinalysis Results ☐ Billing Information ☐ Discharge Information
☐ Self-help Attendance ☐ Mental/Medical Health Information ☐ Other (Specify)

The purpose of this exchange as authorized in this consent is to support and monitor client's treatment progress, relevant needed information or coordination of care.

☐ I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 199S ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
☐ I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: 1 (one) year from date of discharge
or:_____ (*Specification of the date, event, or condition upon which this consent expires*).

☐ I understand that generally **My Choices, LLC.**, may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances, I may be denied treatment if I do not sign a consent form.

CLIENT NAME	CLIENT SIGNATURE	DATE

PROHIBITION OF DISCLOSURE This information has been released to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise specified by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules may restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

ACCIDENT WAIVER AND RELEASE OF LIABILITY FORM

MY CHOICES, LLC.
MENTAL HEALTH

- ☐ *I hereby assume all of the risks of participating in any activities associated with this treatment episode*, including by way of example and not limitation, any risks that may arise from inattention or inaccuracy on the part of the persons or entities being released from property owned, maintained, or controlled by them, or because of their possible liability without fault.
- ☐ I acknowledge that this Accident Waiver and Release of Liability Form will be used by **My Choices, LLC.** organizers of my treatment episode in which I will participate, and that it will govern my actions and responsibilities at said activity.

In consideration of my application and permitting me to participate in this treatment episode, I hereby act for myself, my executors, administrators, heirs, next of kin, successors, and assigns as follows:

(A) **I WAIVE, RELEASE, AND DISCHARGE** from any and all liability, including but not limited to, liability arising from the negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me including my traveling to and from this activity, *The following entities or persons*: **My Choices, LLC.** and/ or their directors, officers, employees and transportation providers;

(B) **INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE** the entities or persons mentioned in this paragraph from all liabilities or claims made because of participation in this treatment episode, whether caused by the negligence of release or otherwise.

- ☐ I acknowledge that **My Choices, LLC.** and their directors, officers, volunteers, representatives, and agents are NOT responsible for the errors, omissions, acts, or failures to act of any party or entity conducting transportation on their behalf.
- ☐ I hereby consent to receive medical treatment which may be deemed advisable in the event of injury, accident, and/or illness during this activity.
- ☐ I understand while participating in treatment, I may be photographed. I agree to allow my photo likeness to be used for any legitimate purpose by **My Choices, LLC.**

The Accident Waiver and Release of Liability Form shall be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law.

- ☐ I CERTIFY THAT I HAVE READ THIS DOCUMENT & I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY & A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

CLIENT NAME	CLIENT SIGNATURE	DATE

PATIENT'S RIGHTS AND RESPONSIBILITIES

MY CHOICES, LLC.
MENTAL HEALTH

We would like to assure you that we will do everything possible to make your treatment experience as comfortable and productive as possible. You can expect that you will always be treated with dignity and respect by all of those who work at this clinic and you may be assured that your human rights will be protected. This facility shall not deny any person equal access to its facilities or services based on age, race, color , religion, ancestry , sexual orientation, gender expression, national origin, ability to pay or disability.

If you have diculty reading your rights, please allow the staff to assist you.

As a patient at **My Coices, LLC.** you have the following rights and responsibilities under State and Federal Law:

A. All persons receiving services from **My Choices, LLC.** shall retain all rights, benefits, and privileges guaranteed by Federal, State, and local law, except those specifically lost through the due process of law.
B. Persons served have the right to live in the community of their choice without restraints on their independence, except those restraints to which all citizens are subject.
C. Persons served have the right to be treated with courtesy and dignity and are at all times entitled to respect for their individuality and the recognition that their strengths, abilities, needs, and preferences are not determinable based on a psychiatric diagnosis.
D. Persons served have the right to be notified of all rights accorded to them as recipients of services at the time of admission or intake, and in terms that he or she understands.
E. Persons served have the right to be treated in the least restrictive setting to meet their needs. Use of physical restraint will be limited to emergencies where there is a reasonable expectation that the situation would result in serious injury or death to the consumer or other persons in the environment.
F. Persons served have the right to receive services conducted in a manner reflecting quality professional and ethical standards of practice and shall be apprised of the organization's code of ethics/conduct.
G. Persons served to have the right to receive services without discrimination based on race, color, sex, sexual orientation, age, religion, national origin, domestic/marital status, political affiliation or opinion, veteran's status, physical/mental handicap, or ability to pay for services.
H. Persons served have the right to be treated in an environment free from physical abuse, sexual abuse, physical punishment, or psychological abuse by threatening, intimidating, harassing, or humiliating actions on the part of the staff.
I. Persons served have the right to be fully informed of the services to be provided, the right to consent to services, and the right to refuse services (except for legally mandated services) without fear of retribution or loss of rights.
J. Persons served have the right to privacy during facility visits. Individuals and/or group visits are permitted only when the purpose of the visitation is education or professional. Planning for outside visitors shall provide for limited interruption of consumer routine, therapeutic or rehabilitative programs, and related activities. Persons served will be given notice of such
K. Persons served have the right to confidentiality. Information may not be released without the consumer's written permission, except as the law permits or requires.
I. Persons served, or the consumer's legal guardians, have the right to review the consumer's record at any reasonable time upon request, including before an authorized release, and shall be afforded the assistance of an appropriate clinical employee in cases where a reasonable concern exists of a possibly handful effect to the consumer through the misinterpretation of information in the record.
M. Persons served, along with family or significant other(s), when appropriate, have the right to participate in their treatment and treatment planning. Persons served have a right to a complete explanation of the nature of treatment and any known or potential risks involved therein.
N. Persons served have the right to an individualized, written treatment plan to be developed promptly following admission, treatment based on the plan, periodic review and reassessment of needs, and appropriate revisions of the plan including a description of services that may be needed following discharge from services.
O. Persons served have the right to request and receive outside (other **My Choices, LLC.** employees) professional consultation regarding their treatment at their own expense.
P. Legally competent persons served have the right to refuse treatment, except in emergencies or other circumstances required by law. Persons served shall not be denied treatment, services, or referral as a form of reprisal, excepting that no individual provider shall be obligated to administer treatment or use methods contrary to his or her clinical judgment.
Q. Persons served shall have access to written information about fees for services and their rights regarding fees for services and will not be refused services due to an inability to pay.
R. Persons served have the right to an explanation if services are refused to them for any reason including admission ineligibility or continued care ineligibility and have the right to appeal such decisions.
S. Persons served have the right to informal complaint and/or formal grievance regarding practices or decisions that impact their treatment or status without fear or concern for reprisal by the organization or its staff and have the right to have this process communicated to them upon entry to services and throughout participation in services.
T. Persons served have the right to refuse to participate in research without loss of services and participate in research voluntarily only with full written informed consent.
U. Persons served have the right to access guardians, self-help groups, advocacy services, and legal services at any time. Access will be facilitated through the person responsible for the consumer's service coordination.
V. Persons served have the right to be treated in the least restrictive environment, be provided evidence-based information about alternative treatments, have access they are to their records, have equal access to treatment regardless of race-ethnicity, gender, age, and sexual orientation.

FINANCIAL POLICY

MY CHOICES, LLC.
MENTAL HEALTH

WE APPRECIATE THE OPPORTUNITY TO SERVE YOUR SUBSTANCE NEEDS. OUR GOAL IS TO PROVIDE YOU WITH THE BEST CARE AVALLABLE. TO ENSURE COMPLETE OPEN COMMUNICATION AND UNDERSTANDING OF THE INANCIAL ASPECTS OF THE CARE YOU RECEIVE WE HAVE INCLUDED THIS WRITTEN POLICY AS PART OF YOUR INFORMATIONAL PACKET.

Patient Payment Responsibility

We require payment at the time services are rendered, payable by Cash, Check, Visa, MasterCard, American Express or Discover. If we are participating providers with your carrier, we will bill covered services to your insurance company directly. Co payments, co-insurances, and deductibles as set by your benefit plan are due at the time of service, along with all non-covered services. All outstanding balances must be paid in full prior to proceeding with any new treatment pians.

Patient Insurance Notification

You must notify **My Choices, LLC.** of all insurance coverage (primary and secondary) prior to services rendered and of any changes in carrierof coverage while undergoing treatment at **My Choices, LLC.**

Pre-Authorization/Certification

Currently **My Choices, LLC.** participates with most major insurance carriers. Since insurance plans differ greatly, we do our best to verify insurance benefits on each new patient, although it is ultimately your responsibility to know your benefits as they pertain to our specialty. It is important to know that ***pre-authorization is not a guarantee of payment; benefits may be denied, or partial poyments recelved based on the stutus of your policy at the time of service.***

We provide financial counselors to assist you in understanding your financial responsibility. They will contact your insurance carrier regarding pre-authorizations and or pre-certifications. ***You cannot proceed with treatment until authorization is obtained and you have been notified by your financial counselor.***

Credits/Refunds

if there is a credit on your account, a review of the account will be performed, and the refund will be issued provided there areno outstanding claims due from your insurance carrier and all co-pays and co-insurances have been satisfied. Once determined refunds will be issued in the form of a check and can take up to 10 days. No exceptions.

Address Change

Please keep **My Choices, LLC.,** informed of any change in your address or phone numbers. This is especially important if you have biologicalmaterial stored with us.

Returned checks

There will be a $50.00 fee charged for each returned check.

CLIENT NAME	CLIENT SIGNATURE	DATE

EMERGENCY CONTACT FORM

MY CHOICES, LLC.
MENTAL HEALTH

Name:

_____

Emergency Contact Info:

(1) Name_____ Relationship_____

Address

_____ City,

State, ZIP _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Employer _____

(2) Name_____ Relationship_____

Address

_____ City,

State, ZIP _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Employer _____

Medical Contact Info:

Doctor Name:_____ Phone # _____

Dentist Name: _____ Phone # _____

☐ I have voluntarily provided the above contact information and authorize **My Choices, LLC.**, and its representatives to contact any of the above on my behalf in the event of an emergency.

_____	_____	_____
CLIENT NAME	CLIENT SIGNATURE	DATE

TELEHEALTH INFORMED CONSENT

MY CHOICES, LLC.
MENTAL HEALTH

TELEHEALTH IS HEALTHCARE PROVIDED BY ANY MEANS OTHER THAN A FACE-TO-FACE VISIT. TELEHEALTH SERVICES, SUBSTANCE ABUSE, MEDICAL, AND MENTAL HEALTH INFORMATION IS USED FOR DIAGNOSIS, CONSULTATION, TREATMENT, THERAPY, AND EDUCATION. HEALTH INFORMATION IS EXCHANGED INTERACTIVELY FROM ONE SITE TO ANOTHER THROUGH ELECTRONIC COMMUNICATIONS. TELEPHONE CONSULTATION, VIDEOCONFERENCING, TRANSMISSION OF STILL IMAGES, E-HEALTH TECHNOLOGIES. PATIENT PORTALS, AND REMOTE PATIENT MONITORING ARE ALL CONSIDERED TELEHEALTH SERVICES.

Patient must initial to acknowledge understanding:

I understand **My Choices, LLC.** is not responsible for breaches of confidentiality caused by a third party or by myself.

I understand that my counselor or group facilitator recommends engaging in telehealth services with me to provide substance abuse treatment.

I understand telehealth use is out of necessity and an abundance of precautions has originated.

I understand that my counselor is not liable for any technological difficulties of which my counselor has no control over. I further understand that my counselor doesn't guarantee that technology will be accessible or work as expected.

I understand that my counselor or I can terminate the telehealth session if it is determined by either myself or my counselor videoconferencing connections or safeguards are not adequate for the situation.

I have had a conversation with my counselor, at which time, I had the occasion to ask questions concerning services via telehealth. My questions have been answered to my satisfaction, and the risk, benefits and any reasonable alternatives have been reviewed with me at that time.

I understand that I am accountable for information security on my device, including, but not limited to my tablet, computer, or phone in my locale.

I understand that telehealth contains the transmission of my substance use disorder communication in an electronic or technology-supported format.

I understand that it is my obligation to ensure that virtual assistant, artificial intelligence devices including, but not limited to Echo or Alexa, will be disabled, or will be removed from the location where communication can be heard.

I understand that it is my obligation to inform my counselor of my location at the beginning of each therapy session. If I should for any reason change my location, it is my obligation to advise counselor or facilitator of change of locality.

I understand that all electronic medical communications carry some level of risk associated with the use of telehealth in a secure environment is reduced, there are still risk and are important to understand: Risks included, but not limited to:

- Despite reasonable efforts on behalf of my substance abuse provider, the transmission of substance abuse information could be disrupted or distorted by technical difficulties out of counselor's control.
- It is easy for electronic communication to be forwarded, interrupted or even changed without knowledge and despite taking reasonable measures.

I recognize I must take reasonable steps to protect myself from unauthorized use of my electronic communications by other.

I understand that electronic communication should never be used for emergency communications or urgent request. I understand emergency communications should be made to the providers office or to the existing emergency 911 services in my community.

I certify that I have read or have had someone from **My Choices, LLC.** read this agreement and I understand this agreement and all the blanks where filled in prior to my signature, with the opportunity to have questions answered to my satisfaction.

This electronic communication is between **My Choices, LLC., staff and program participant.*

CLIENT NAME	CLIENT SIGNATURE	DATE

AUTHORIZATION TO BILL INSURANCE

MY CHOICES, LLC.
MENTAL HEALTH

Check the following if understood:

- ☐ I understand, certify, and attest that I have sought evaluation, treatment, or medical advice from the staff at the clinic named above.
- ☐ I therefore authorize the medical staff and personnel to release my medical information to the insurance company for the purpose of determining and receiving benefits for medical bills.
- ☐ I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf.
- ☐ I understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required.
- ☐ I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

CLIENT NAME	CLIENT SIGNATURE	DATE

CAGE SMOKING ASSESSMENT

MY CHOICES, LLC.
MENTAL HEALTH

Circle YES or NO to the following:

Have you ever felt a need to cut down or control your smoking, but had difficulty doing so?

YES | NO

Do you ever get Annoyed or angry with people who criticize your smoking or tell you that you ought to quit smoking?

YES | NO

Have you ever felt Guilty about your smoking or about something you did while smoking?

YES | NO

Do you ever smoke within half an hour of waking up (Eye-opener)?

YES | NO

CLIENT NAME	CLIENT SIGNATURE	DATE

CRITERIA FOR SUCCESSFUL TRANSITION FROM INTENSIVE OUTPATIENT TO OUTPATIENT TREATMENT

MY CHOICES, LLC.
MENTAL HEALTH

- ☐ **Patient is free from illicit drugs for 90 days (about 3 months).**
- ☐ **Patients emotional behavioral and cognitive functioning is stable.**
- ☐ **Patient is functioning adequately in assessed life task areas.**
- ☐ **Patient has a supportive social system.**

CLIENT NAME	CLIENT SIGNATURE	DATE
	COUNSELOR SIGNATURE	DATE

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(410) 591 0495 | MYCHOICESBALT.ORG

ADVANCED CARE DIRECTIVES

MRN #: _____

MY CHOICES, LLC.
MENTAL HEALTH

Advanced care directives are specific instructions, prepared in advance, that are intended to direct a person's medical care if he/she becomes unable to do so in the future. Advanced care directives allow clients to make their own decisions regarding care they would prefer ta receive if they develop a terminal iliness or a life-threatening Injury. They can also designate someone the client trusts to make decisions about medical care if the client becomes unable to make (or communicate) these decisions.

Federal law requires hospitals, nursing homes, and other institutions that receive Medicare or Medicaid funds to provide written information regarding advanced care directives to all.consumers upon admission.

Advanced care directives can reduce:

- Personal worry;
- Futile, costly, specialized interventions that a consumer may not want;
- Overall health care costs;
- Feelings of helplessness and guilt for family;
- Legal concerns for everyone involved;

Examples of advanced.care directives include:

- Verbal Instructions: decisions communicated verbally by an individual to health care providers and family members.
- Organ donation: organ donor card can be carried in your wallet
- Living will: a written, legal document that conveys the wishes of a person in the event of a terminal iliness. Its peaks for the consumer who is unable to comnunicate *(State Laws vary and may be obtained by the State Bar Association, State Medical Association, State Nursing Association, and most hospitals/medical centers).*
- Special Medical Power of Attorney: A legal document that allows an individual to appoint someone else (proxy) to make medical or health care deaisions (only) in the event that the consumer becomes unable to communicate.
- DNR (do not resuscitate) order: This states that CPR is not to be performed if your breathing stops or your heart stops beating: This order may be written by the person's doctor after discussing the issue with the person (it possible), the proxy, or family.

Recommendations:

- If you choose to write up a living will or special medical power of attorney, check with specific state laws that apply.
- If you have a living will or special medical power of attorney, provide copies for your family members and health care providers. Carry a copy in your wallet, glove compartment of car; etc.
- Discuss your wishes with your tamily and your health care providers and plan ahead.

**Please note that these decisions can be changed at any time. However, if a living will is changed: everyone involved- including family or proxies --- and all health care providers, must be informed and new copies of instructions should be made and distributed.*

I am signing to verify that I reviewed and understand the informration above as well as understand that I cannot be discriminated against regarding having or not having an advanced directive.

Consumer ☐ does-or- ☐ does not have an advanced care directive.

_____	_____	_____
CLIENT NAME	CLIENT SIGNATURE	DATE
	_____	_____
	COUNSELOR SIGNATURE	DATE

GROUP RULES

MY CHOICES, LLC.
MENTAL HEALTH

1. One person speaks at a time. No side barring (talking).
2. Do not carry others private issues out of group. (What's said in group STAYS in group)
3. ALL PHONES MUST BE OFF AT ALL TIMES!! NO EXCEPTIONS (except for telehealth use)
4. Telehealth-All clients must be dressed appropriately
5. Respect one another
6. No one leaves the group during session.
7. You must use the restroom before group, and during break.

***ALL non-compliance to group rules may results in the following consequences.*

Consequences:

- 1st Violation: Verbal Warning
- 2nd Violation: Written Note
- 3rd Violation: Removal from group/ possible discharge

We are here to assist you into success, so therefore the rules and regulations must be put into place into place so that ALL goals and achievements are met.

▫ I have read, been orientated to and understand **My Choices, LLC.** policies regarding group practice.

CLIENT NAME	CLIENT SIGNATURE	DATE

EMERGENCY PROTOCOL

In emergencies, disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means. In emergency situations I will call **My Choices, LLC.** by phone and a contingency plan will be formulated.

At any time while unable to contact **My Choices, LLC.**, feel unsafe or at danger, I will contact;

- *Baltimore Crisis Response at Crisis Hotline at **410-433-5175**, 24 hours a day 7 days a week or;*
- *Anne Arundel County Crisis Response at Crisis Hotline at **410-768-5522**, 24 hours a day 7 days a week or;*
- ***911** if necessary*

Disruption of Service:

Should service be disrupted, I will contact **My Choices, LLC.**, for further guidance.

Client Communication:

It is my responsibility to maintain privacy on the client end of the transmission.

CLIENT NAME	CLIENT SIGNATURE	DATE

EMERGENCY EXIT FORM

MY CHOICES, LLC.
MENTAL HEALTH

I, _____ have been shown exits to use in the event of an ***emergency***, while I am receiving services at **My Choices, LLC.**. I am aware that in the event of an emergency, I agree to follow all directions given by staff members to assist me in getting out of the building in a safe and orderly manner.

_____	_____	_____
CLIENT NAME	CLIENT SIGNATURE	DATE
	_____	_____
	STAFF SIGNATURE	DATE

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TREATMENT AGREEMENT - CONSENT TO TREATMENT

I, _____ acknowledge that **My Choices, LLC.**, is allowing me to receive/acquire substance abuse treatment and counseling, in this program if I comply with the following:

1. *I will follow each phase of recovery and follow all rules that are required in each phase.*
2. *I will attend all program requirements (i.e. group and activities) as well as meet all requirements.*
3. *I must stay clean of all illicit drugs and submit random urinalyses upon request.*
4. *Treatment Fees are covered by Medicaid, I will not be charged for treatment as this is not **My Choices, LLC.**'s policy.*
5. *I must test negative for all drugs and alcohol. If I violate this rule, interventions will be implemented, and this could result in discharge from the program.*
6. *Following program rules as outlined in the client handbook. These rules will be discussed in orientation.*

Please make copies of all critical ID/Insurance cards

_____	_____	_____
CLIENT NAME	CLIENT SIGNATURE	DATE
	_____	_____
	STAFF SIGNATURE	DATE