MISO MEDICAL CENTER

CONSENT FORMS

Please fill out this information to the best of your knowledge. Only patient information is to go in patient sections of the form. Make sure you present your insurance card and driver's license to a staff member to receive a copy at this time.

DATE	

Patient Information:

LAST NAME		**FIRST NAME**		**M.I.**			
DOB		**AGE**		**SOCIAL SECURITY NUMBER**			
STREET ADDRESS		**APT./UNIT #**					
CITY		**STATE**		**ZIPCODE**			
HOME		**MOBILE**		**EMAIL**			

SMS/TEXT REMINDER? ☐YES ☐NO

Parent/Guardian: **If parent does not have legal custody, please provide custodial information* If Joint Custody: provide both parents information.* *PLEASE NOTE THAT SERVICES CAN NOT BEGIN UNLESS PROOF OF CUSTODY IS PROVIDED*

RELATIONSHIP							
LAST NAME		**FIRST NAME**		**M.I.**			
HOME ADDRESS							
PHONE #		**WORK #**		**EMAIL**			

RELATIONSHIP							
LAST NAME		**FIRST NAME**		**M.I.**			
HOME ADDRESS							
PHONE #		**WORK #**		**EMAIL**			

Primary Insurance Coverage *(If insured by TRICARE, please add the policyholder's SOCIAL SECURITY NUMBER to ensure benefits)*

INSURANCE COMPANY		**POLICY HOLDER**			
MEMBER ID		**GROUP NUMBER**			
POLICY HOLDER DOB		**RELATIONSHIP TO CLIENT**		**EFFECTIVE DATE**	

Secondary Insurance Coverage:

INSURANCE COMPANY		**POLICY HOLDER**			
MEMBER ID		**GROUP NUMBER**			
POLICY HOLDER DOB		**RELATIONSHIP TO CLIENT**		**EFFECTIVE DATE**	

General Patient Information:

PRIMARY CARE PROVIDER	
ADDRESS	

MISO MEDICAL CENTER

CONSENT FORMS

PHONE NUMBER		**FAX NUMBER**	

What is the purpose of your visit? *(Check all that apply)*

☐Evaluation ☐Second Opinion ☐Consultation ☐Medication management ☐Therapy

☐ Other: _____

What issues or concerns do you have which made you decide to seek help?

Are you currently on Medication? _____ *If yes, what kind*?

Preferred Pharmacy:

PREFERRED PHARMACY			
ADDRESS			
PHONE		**FAX**	

Emergency Contacts *(please provide information for those who may be contacted in case of an emergency)*:

NAME		PHONE		RELATIONSHIP	
NAME		PHONE		RELATIONSHIP	

EDUCATIONAL HISTORY:

What school does the patient attend?		**GRADE**	

Does the patient have an IEP? ☐Yes ☐No

Does the patient have a 504 plan? ☐Yes ☐No

Please check the accommodations your child receives:

☐ One on one aide ☐ Pull-out services ☐ Frequent breaks ☐ Extra test time

☐ Speech therapy ☐ Small class size ☐ Preferential seating ☐ Occupational therapy

☐ School counselor ☐ Social skills group ☐ Shortened assignments

Has the patient repeated a year? **☐Yes ☐No**

MISO MEDICAL CENTER

CONSENT FORMS

Does the patient have any behavioral issues at school? ☐**Yes** ☐**No**

Has the patient ever been suspended/expelled, or put in alternate placement? ☐**Yes** ☐**No**

Please check any of the symptoms below that identify/describe your child:

DEPRESSION	**MANIA**
☐ Depressed mood ☐ Irritability ☐ Crying for no reason ☐ Guilt ("it's all my fault") ☐ Hopelessness ("nobody can help me") ☐ Worthlessness ☐ Anhedonia (no energy, loss of interest in things he/she used to enjoy) ☐ Suicidal thinking ☐ Self-injurious behavior (cutting/hitting) ☐ Increased sleep	☐ Decreased need for sleep ☐ Elevated mood/grandiosity ☐ Appetite changes ☐ Inappropriate sexual behavior ☐ Too much energy ☐ Pressured speech ☐ Increase in goal-directed activities
ATTENTION	**ANXIETY**
☐ Inattentive ☐ Difficulty concentrating ☐ Easily distracted ☐ Can't follow multiple-step directions ☐ Hyperactive/difficulty remaining still ☐ Impulsive ☐ Interrupts often/can't wait turn ☐ Risk taker	☐ Excessive worry ☐ Somatic complaints (body) ☐ Nightmares ☐ Social anxiety/avoidance ☐ Difficulty separating from mom/dad ☐ Phobias ☐ Obsessions/compulsions ☐ School refusal
OPPOSITIONALITY	**CONDUCT DISORDER**
☐ Oppositional/defiant ☐ Argumentative ☐ Purposefully annoys others ☐ Easily angered ☐ Disruptive	☐ Truancy from school ☐ Destruction of property ☐ Stealing ☐ Lying ☐ Aggressive towards adults/kids ☐ Sets fires ☐ Violate curfew ☐ Runs away ☐ Cruel towards animals ☐ Bullies others/initiates fights
PSYCHOSIS	**AUTISM/PERVASIVE DEVELOPMENTAL DISORDER**
☐ Hallucinations (hearing voices or seeing things) ☐ Delusions (bizarre thinking) ☐ Paranoia (suspicious) ☐ Disorganized thinking	☐ Problems with speech ☐ Problems with social skills/interactions ☐ Limited or obsessive interests ☐ Repetitive behaviors *(flapping hands, rocking, pacing, humming, etc.)*

CONSENT FORMS

Description of Treatment Process

All clients will receive an initial evaluation from a licensed clinician in order to gather information about client's personal history and assess the client's treatment needs. At the time of intake, the treatment provider will discuss the therapeutic process with clients, including potential reactions to treatment; informed consent and confidentiality; and the client's rights and responsibilities. Clients have the right to discuss, with their provider, the options to the proposed treatment.

MISO Medical Center strives to provide clients with the best care possible. However, with any type of therapeutic services, there is a potential risk for discomfort. During the client's treatment, the provider will explain any potential risk or harm. MMC encourages clients to talk to their treatment provider if they are uncomfortable with the services being provided and to process their feelings with their provider.

Clients have a right to withdraw or decline treatment at any time. However, withdrawing from treatment may cause clients to regress and/or need additional support services. Clients have the right to speak to their treatment provider and/or the Executive Director regarding any grievances about their treatment or treatment provider.

Each client will collaborate with their therapist to create an initial and reoccurring treatment plan which includes short term goals; interventions; the client's needs, problems, and symptoms; and the service plan. Clients are offered the option to receive a copy of the treatment plan and are expected to participate in the development and achievement of goals.

Description of Services Available

MISO Medical Center **(MMC)** provides individual, group, family counseling, and psychiatric services. MMC counselors will use intervention techniques and behavior modification tools specific to each client, each goal, and each type of therapy.

Individual Therapy: One-on-one counseling, which will provide the client with an open space to share his or her feelings with an objective clinician.

Family Therapy: MMC works with the family to help them cope with the challenges of maintaining a child diagnosed with a mental disorder by providing family therapy. Family therapy sessions consist of the clinician interacting with the parent and child to help them interact in a positive manner and gain insight.

Group Therapy: This type of therapy is for adults as well as children/adolescent clients who are facing similar challenges. The group is facilitated by a licensed clinician.

Psychiatric Services: MMC's prescriber will conduct a psychiatric evaluation to determine if mental health medication is needed. The prescriber will prescribe medication and monitor the client's symptoms.

MMC strives to provide you with the best care possible. However, with any type of mental health service, there is a potential risk for side effects to the prescribed medication. During your visit, the prescriber will explain and provide you with information regarding your medication. Please keep this information handy, as it will be helpful to refer to if necessary.

CONSENT FORMS

TREATMENT CONSENT FORM

I, _____ hereby voluntarily consent for _____ to receive
(*Guarantor/ Guardian*) (*Client Name*)
consultative, diagnostic, and therapeutic services and/or procedures from MISO MEDICAL CENTER as listed below:

☐ Psychosocial Assessment ☐ Individual Therapy

☐ Family Therapy ☐ Group Therapy

☐ Medication Management ☐ Other Information: _____

I understand the benefits of each service as well as the alternative to recommended treatment. Unless specifically stated otherwise, this consent form expires upon completion of services from MMC.

The first 2 to 4 sessions are a time to evaluate whether the clinician is best person to provide the therapy services needed to meet your goals.

I further understand that I am free to withdraw this consent for services at any time without prejudice to receiving alternative services from MISO Medical Center. I may also be discharged from MMC if there is non-compliance with the agreed upon services.

I certify that the information I have reported regarding my insurance coverage is correct and further authorize the release of any necessary information to my insurance carrier for the purposes of processing my claim. I also permit a copy of this authorization to be used in place of the original and it may be retained on file.

If my insurance company or coverage changes in any way, it is up to me to inform **MMC** of these changes, and to obtain pre-authorization necessary for my continued care. I agree to take full responsibility for the fee for services rendered. Co-payments are due at the time of each visit.

I understand that I am responsible for any portion of the fee not covered by insurance such as:

- Yearly deductible if not met
- Missed or canceled appointments (unless I provide at least 24 hours' notice)
- Benefits used to their maximum in a calendar year or lifetime

I understand that the therapy session will last 45-50 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time.

If I become involved in court proceedings that require provider's time, I will be expected to pay for professional services in advance at a rate of $250.00 per hour. Services related to court proceedings include, but are not limited to: report writing, telephone calls, court/deposition appearances and travel time.

MDMA Patients are excluded from all out of pocket charges.

GUARDIAN SIGNATURE	DATE

14440 Cherry Lane Court. Suite 218. Laurel MD 20707
Email: misomedicalcenter@gmail.com
Tel: 301-747-0003 Tel: 240-729-0200 Fax: 301-547-7399
website: www.misomedicalcenter.com

CONSENT FORMS

Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client **cannot** be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults: If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, *the mental health professional is required to report this information to the appropriate social service and/or legal authorities*.

Prenatal Exposure to Controlled Substances: Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers *(when applicable)*: Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

These situations rarely arise. Should such a situation occur, I would make every effort to openly discuss what will need to occur before taking any action.

I AGREE TO THE ABOVE LIMITS OF CONFIDENTIALITY AND UNDERSTAND THEIR MEANINGS AND RAMIFICATIONS.

GUARDIAN SIGNATURE	
DATE	

Consent to Use and Disclose Your Health Information

This form is an agreement between you and Family Intervention.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information *(PHI)* about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let us use your information here and send to it others. *(Insurance Provider, General Practitioner, other Behavioral Health Provider).* The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. By signing this form, you are agreeing to let us use your information here and send it to others. By signing this form, you are acknowledging that you have received a copy of the MISO Medical Center Notice of Privacy Practices. Please read the Notice of Privacy Practices before you sign this Consent Form.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practice. If we do change it, you can get a copy by contacting our office at 240-918-3829, Mon. – Fri. 09:00 am – 06:00 pm or via email at misomedicalcenter@gmail.com.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wishes.

After you have signed this consent, you have the right to revoke it *(by writing a letter telling us you no longer consent)* and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

GUARDIAN SIGNATURE	**DATE**

CONSENT FORMS

PATIENT FINANCIAL TERMS AND CONDITIONS

(MDMA clients do not need to sign this form)

We are committed to providing you with the best possible care and services. If you have medical insurance, we are happy to assist you to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. **Unless this practice is a participating provider with your insurance plan, it is ultimately your responsibility to pay the provider for services rendered and to assure your insurance properly processes your claim and pays the provider.** If this provider does participate with your plan, your obligation is to remit all relevant insurance policy information to the provider at the time of service. **It is your responsibility to fully understand the terms and conditions of your insurance regarding the procedures for filing claims, what medical procedures and treatments you insurance does and does not cover, what amount, if any, your insurance will pay for medical services, and what your co-payment and deductible amount may be.**

Unless otherwise agreed upon by the provider, payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Amex, Discover. Returned checks will be subject to a $35.00 fee, and any outstanding balances older than 30 days will be subject to interest charges of 1.5% per month. In the unfortunate events collection procedures are required to collect an outstanding account balance, the patient shall be responsible for the reasonable cost (35% of the past due balance) of a collection agency, attorney, and/or court costs.

The undersigned hereby waives any defense he/she may have as to the Statue of Limitations barring future attempts to recover debts owed hereunder in the event of default.
We will gladly discuss your proposed treatments and charges and will answer any questions relating to your insurance.

You must realize, however, that **unless we are a participating provider with your insurance**:

1. Your insurance is a contract between you and the insurance company. We are not a party to that contract and therefore are not bound by its terms and conditions.
2. We are not bound by the fee payment structure of your insurance policy. You are responsible for whatever portion of our charges your insurance does not pay.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These charges are your responsibility.

We must emphasize that as a medical provider, unless we are a participating provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

By my signature, I indicate that I have read, understand and do hereby accept the terms of this agreement.

GUARDIAN SIGNATURE	***DATE***

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CONSENT FORMS

CANCELATION POLICY

I understand that I will be charged a fee if I fail to give at least 24-hour notice prior to cancelling my appointment.
I understand that I will be charged a NO-SHOW fee of $35 if I fail to show for my appointment.
I understand if I fail to keep appointments, fail to show to 3 scheduled appts. without notice I will be discharged from treatment.

FEES/COST PER VISIT

Court proceedings that require provider's time, will be expected to pay for professional services in advance at a rate of $250.00 per hour. Services related to court proceedings include, but are not limited to: report writing, telephone calls, court/deposition appearances and travel time. Rates vary $15.00-250.00 per hour.

90791 Initial Evaluation *(Intake):* $120	99204 Psychiatric Eval., *Mod. Complexity*: $162
90834 Individual Therapy *(45 min.):* $80-$100	99203 Psychiatric Eval., *Low Complexity*: $140
90837 Individual Therapy *(60 min.):* $85-$100	99215 Psych. Follow-up, *High Complexity*: $142
90847 Family Therapy *(45 min.):* $85	99214 Psych. Follow-up, *Mod. Complexity*: $108
90853 Group Therapy *(90-120 min):* $35-$50 *ea.*	99213 Psych. Follow-up, *Low Complexity*: $75

****Note**** **Medicaid clients are exempt from any financial obligations to Family Intervention Partners. Medicaid recipients will not be billed for any missed appointments and will not be charged for any services.**

PROCEDURE FOR DISCHARGE

Family Intervention Partners' discharge policy is explained and signed by the client and/or guardian at the time of admission. Based on a final assessment of the client's service needs as indicated in the medical record and the mutually agreed upon goals and community support systems, a discharge decision will be made accordingly.

Below is a list consisting of (but not limited to) conditions that would precipitate the discharge process:

- Satisfactory completion of goals
- Clinical rationale.
- Consumer voluntarily withdrawals from program.
- Issues related to compliance.
  - Noncompliance with treatment.
  - Constant lack of involvement or participation in the program.
  - **Consistent failure to keep scheduled appointments. (3 NO SHOWS)**
- Threatening, violent, or disrespectful behavior(s).
- If you do not attend or schedule services provided for one month.

Client Acknowledgement of Information

My signature below is acknowledgement that the following information was reviewed and explained to me during the intake process**:**

- ❖ Privacy (HIPAA) Laws
- ❖ Client Rights as participants
- ❖ Grievance Procedure
- ❖ Confidentiality of Records & Release of Information
- ❖ Description of Services offered
- ❖ Discharge Procedures

As a client or designee of the client, my signature below indicates that I understand the information above and that I agree to adhere to the policy, protocol and/or procedures to each of the items as listed as they relate to me at any given time as a participant in MISO Medical Center programs.

I _____ have read and understand the above information.

GUARDIAN SIGNATURE	***DATE***

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