

Bernard M. Raiche, Ed.D., LLC
2915-B Olney-Sandy Spring Road
Olney, Maryland 20832

Date of First Appointment: _____

Client's Name _____ **Date of Birth** ____/____/____

Client's Address _____

Home Telephone () _____ - _____ **Work Telephone** () _____ - _____

Mobile Telephone () _____ - _____ **E-mail address:** _____

Health Insurance Company _____

Member Number _____

Client Social Security Number: _____

If you have already obtained pre-certification please give pre-certification number and the number of sessions authorized _____

If client's insurance coverage is through another person (e.g. parent or spouse)

Insured's Name _____

Insured's Address _____

Insured's Telephone Number _____

Insured's E-mail Address _____

Insured's Date of Birth _____

Insured's Employer (if insurance is through employer) _____

Insured's Social Security Number: _____

Is client covered by a second health insurance policy? ____ Yes ____ No

If yes, please provide the information regarding the second insured and the second insurance policy on the back of this form.

Reason for visit: _____

Emergency Contacts (for children, please include information for parents not listed above)(Please include Name, Address, Telephone Number, and E-mail address):

How did you learn about my services (Check all that apply)?

- Referred by: _____
- www.raiche.net or www.raiche-counseling.com
- Your health insurance company - Name: _____
- Psychology Today website
- Help Pro (N.B.C.C.) website
- Help Starts Here (N.A.S.W.) website
- American Association of Marriage and Family Therapist website
- National Alliance for the Mentally Ill
- Montgomery County Access Center or Crisis Center
- Montgomery County Mental Health Association
- School Principal, Counselor, Teacher (Name and school) _____
- _____
- Brochure
- Other (Please specify) _____

If you are requesting a payment rate based on a sliding scale:

Have you applied for Medical Assistance? yes no

If yes, please provide proof of application

If yes and it has been denied, please provide a copy of the denial letter

If yes and it has been denied, please provide proof of income and family size

Bernard M. Raiche, Ed.D., L.C.S.W.-C.
2915-B Olney-Sandy Spring Road
Olney, Maryland 20832
301-404-4544

Consent for Mental Health Treatment
Agreement Regarding Payment for Services

Name of Client: _____ Date: _____

I agree to receive mental health services and to be treated by Bernard M. Raiche, Ed.D.

I am aware that billing and other information may be sent directly to my home in envelopes bearing the name of Bernard M. Raiche, Ed.D.

I understand that if during the course of treatment I reveal that I have been the victim of child abuse, or that I have abused a child, that information must and will be reported to the Child Protective Services.

I understand that if during the course of treatment I reveal that I am a danger to myself or to someone else, that appropriate action must and will be taken to protect me from self-harm or to protect others. That action may include initiating involuntary hospitalization, informing others who may be able to help protect me or who may be in danger from me, or notifying authorities.

I certify that the information given to me in applying for payment by Medical Assistance, Medicare or other third party payers is correct. I understand that I am responsible for any charges not paid by my health insurance plan.

I request payment of authorized benefits for services furnished to me by or in the name of Bernard M. Raiche, Ed.D. be made on my behalf. I assign and request that these benefits be paid directly to Bernard M. Raiche, Ed.D.

I authorize any holder of medical or other information about me to release to third party payers or their intermediaries or carriers or review agents having interest in this claim, any information needed to determine payment for these benefits or benefits for related services.

Client's Initials _____

Bernard M. Raiche, Ed.D., LLC
2915-B Olney-Sandy Spring Road
Olney, Maryland 20832

Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization

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

Without Authorization. Applicable law and ethical standards permit us 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 mandatory government agency audits or investigations (such as the social work licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission

We 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.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at [Insert Contact Information]:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that 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. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Bernard M. Riche, Ed. D., 3313 Megans Way, Olney, Maryland 20832 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is April 14, 2000

**Bernard M. Raiche, Ed.D., LLC
2915-B Olney-Sandy Spring Road
Olney, Maryland 20832**

**Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

Patient/Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Bernard M. Raiche, Ed.D.'s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Bernard M. Raiche, Ed.D. at 3313 Megans Way, Olney, Maryland 20832.

Signature of Patient/Client

Date

*Signature or Parent, Guardian or Personal Representative **

Date

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member

Date

Bernard M. Raiche, Ed.D., LLC
Clinical Social Worker - Psychotherapist

**Policy Regarding Missed Appointment or
Late Cancelled Appointment Fee**

When you make an appointment for counseling, that time is reserved especially for you. If you cancel that appointment without sufficient notice it is generally not possible to offer that time to someone else. As a result my time may be wasted. This situation is not fair to me because it means a loss of income. It is also not fair to other clients who may have wanted the lost appointment time. In order to discourage late cancellations or missed sessions, and to make up for the revenue lost, I am instituting the following late cancellation / missed session charge.

If you cancel or reschedule a session with me without giving 48 hours notice you will be charged a late cancellation fee of \$80.00. This fee will not apply if another client takes the appointment which you cancelled. If you do not cancel an appointment but do not attend that appointment you will be charged an \$80 missed appointment fee. I will not schedule you for a new appointment until the late cancellation or missed appointment fee has been paid.

The missed appointment or late cancelled appointment fee will not be covered by your health insurance, and will be your sole responsibility.

For your convenience I am accepting credit cards as a method of payment. If you wish you may complete the Credit Card Authorization Form. One option on that form allows you to have the charge for missed appointments or late cancellations billed to your credit card. If you do not select that option, then I will not schedule you for an additional appointment until you have made payment by check or cash.

Please sign below to confirm that you understand and accept this policy.

Thank you,

Bernard M. Raiche, Ed.D., LLC

By signing below I confirm that I understand and accept the Policy Regarding Missed Appointment or Late Cancelled Appointment Fees.

Signature

Print Name

Date

Bernard M. Raiche, Ed.D., LLC

Consent to Keep Information Disclosed by Children or Adolescents Confidential

Introduction

Generally parents have a right to know what a child or adolescent discloses in therapy. Clinically however it is important for children and adolescents to be able to disclose openly to their therapist knowing that what they disclose will be kept confidential, even from their parents. Often, if children or adolescents believe that what they disclose to their therapist will be re-disclosed to their parents, they will be unwilling to disclose in therapy. As a result therapy may be of little value to them.

For this reason you are being asked to consent to allow your child's therapist to keep information your child discloses confidential from you unless: (1) your child or adolescent agrees to allow the information to be re-disclosed, (2) it is necessary to re-disclose the information in order to protect the child or adolescent from harm, (3) it is necessary to re-disclose the information in order to protect others from harm or (4) re-disclosure is required under the law such as when a child reports that they have been abused or when disclosure is ordered by a court.

Your consent to allow your child's disclosures to be kept confidential from you is not a prerequisite to your child or adolescent receiving psychotherapy. But, in fairness to your child or adolescent, if you are not willing to consent that the information your child or adolescent discloses will be kept confidential, the child or adolescent will be informed that re-disclosure may be necessary if requested by their parents.

Consent

I consent to my child's therapist keeping information disclosed by my child or adolescent confidential, and understand that the information will not be disclosed to anyone, including me, without my child's permission. I understand that information my child discloses to his/her therapist will be disclosed to me if: (1) in the therapists opinion my child is in imminent danger of injuring himself/herself or injuring someone else, or (2) re-disclosure is required under a specific law or under a court order.

(Child/Adolescent's Name)

(Print Parent/Guardian Name)

(Parent or Guardian's Signature)

(Date)

Bernard M. Raiche, Ed.D., L.C.S.W.-C.
2915-B Olney-Sandy Spring Road
Olney, Maryland 20832
Tel: 301-404-4544
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br@raiche-counseling.com
www.raiche-counseling.com

Authorization to Disclose and/or Obtain Information

Complete this form if you wish me to share information with a school or other health care provider:

I, _____ [Insert Name of Patient/Client], whose Date of Birth is _____,

authorize Bernard M. Raiche, Ed.D. to disclose to and/or obtain from:

_____ the following information:

[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

- _____ Assessment
- _____ Diagnosis
- _____ Psychosocial Evaluation
- _____ Psychological Evaluation
- _____ Psychiatric Evaluation
- _____ Treatment Plan or Summary
- _____ Current Treatment Update
- _____ Medication Management
- Information
- _____ Presence/Participation in Treatment
- _____ Nursing/Medical Information
- _____ Toxicological Reports/Drug Screens
- _____ Educational Information
- _____ Discharge/Transfer Summary
- _____ Continuing Care Plan
- _____ Progress in Treatment
- _____ Demographic Information
- _____ Other _____
- _____ Other _____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose, please specify:

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Bernard M. Raiche, Ed.D. at 3313 Megans Way, Olney, Maryland 20832. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated: _____

Conditions

I further understand that Bernard M. Raiche, Ed.D. will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: _____

I will be given a copy of this authorization for my records.

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ Check here if patient/client refuses to sign authorization

Signature of Staff Witness Date