Bernard M. Raiche, Ed.D., L.C.S.W.-C.
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 ____

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) _____________________

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
_____ 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 (even if I am now an adult and the abuse occurred when I was a child), or that I have abused or neglected 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 by 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 _________

I understand that if my treatment is not covered by Medical Assistance, Medicare, or under an agreement between a third party payer and Bernard M. Raiche, Ed.D., that the charges for services will be as follows:

Initial Assessment – Child or Adolescent	$190.00
Initial Assessment – Adult	$150.00
Individual Counseling / Psychotherapy	$110.00 per 50 minute session
Family or Couples Counseling	$110.00 per session
Individual Counseling / Psychotherapy	$ 55.00 per 25 minute session
Group Counseling / Psychotherapy	$55.00 per session
Telephone Counseling	$110 per 50-minute session
Instant Messaging Counseling	$110 per 50-minute session
E-mail Counseling	$55 for each 30 minute read/respond period

I understand that if I have health insurance coverage and am seeing Bernard M. Raiche, Ed.D. as an out of network or non-participating provider, that I will be responsible for payment. I understand that I will be provided with receipts that will include the information normally required by third party payers so that I can apply for reimbursement from my health insurance carrier.

I understand that there are risks associated with the counseling/psychotherapy process including the potential for the intensification of feelings or the deterioration of social relationships. I accept these risks in order to take advantage of the potential benefits from counseling and psychotherapy.

I understand that if I need to cancel an appointment I must call at least 24 hours before the scheduled appointment. I understand that if I do not I will be charged the full rate for the missed appointment unless that charge is prohibited by contract with my health insurance provider.

I understand that payment for services is due at the time the service is performed.

A copy of this signed statement shall act as the original, which will be kept at the office of Bernard M. Raiche, Ed.D.

Signature by Client or authorized representative Date

Witness Date

Revised 2/8/08

Bernard M. Raiche, Ed.D.
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.

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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, 2003.

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Bernard M. Raiche, Ed.D.
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**

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