ADVANCED BEHAVIORAL HEALTH, INC.

Client Data Form

CLIENT INFORMATION

Patient Name: _____ DOB: _____

SS #: _____ Gender: _____ Marital Status: _____

Address: _____

Home #: _____ Cell #: _____

Employer: _____ Work #: _____

Race: ☐ White ☐ African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander

☐ American Indian ☐ Alaskan Native

Ethnicity: ☐ Hispanic ☐ Not of Hispanic Origin Are you a veteran? ☐ No ☐ Yes

How did you hear about us? _____

Who is financially responsible for this bill? _____

Address: _____

Phone #: _____ Relationship to Patient: _____

If Patient is a Minor

Mother's Name: _____ Cell#:_____ Work#:_____

Home Address: _____

Father's Name: _____ Cell#:_____ Work#:_____

Home Address: _____

Legal Guardian's

Name:_____Cell#:_____Work#:_____

Home Address: _____

INSURANCE INFORMATION

Primary Insurance: _____

Benefit/Eligibility Phone Number(s): _____

Policy/ID #: _____ Group #: _____

Policy Holder: _____ Relation to Patient: _____

SS #: _____ DOB: _____ Employer: _____

Secondary Insurance: _____

Benefit/Eligibility Phone Number(s): _____

Policy/ID #: _____ Group #: _____

Policy Holder: _____ Relation to Patient: _____

SS #: _____ DOB: _____ Employer: _____

REASON FOR APPOINTMENT

☐ Hyperactivity/Impulsivity ☐ Sleep Disturbance ☐ Anxiety

☐ Oppositional Defiant ☐ Mood Disturbance ☐ Depression

☐ Hearing Voices/Hallucinations ☐ Anger Problems ☐ Family Conflict

☐ Other: _____

Are you required by court/probation/parole to have this treatment? ☐ No ☐ Yes

Is this treatment related to an accident or injury? ☐ No ☐ Yes

Is this treatment related to a legal claim? ☐ No ☐ Yes

PAST HISTORY

Have you ever been INPATIENT at a psychiatric facility? ☐ No ☐ Yes

If yes, where and when? _____

Have you ever been in OUTPATIENT treatment? ☐ No ☐ Yes

If yes, where and when? _____

Have you ever been INPATIENT for a substance abuse problem? ☐ No ☐ Yes

If yes, where and when? _____

Have you ever been in OUTPATIENT for a substance abuse problem? ☐ No ☐ Yes

If yes, where and when? _____

Signature: _____ Date: _____

Printed Name: _____ Date: _____

Witness: _____ Date: _____

ADVANCED BEHAVIORAL HEALTH, INC.

Brief Medical Survey/History

Patient Name: _____ DOB: _____

	No	Yes	
Do you have a source of regular medical care?	☐	☐	Doctor Name: _____ Phone #: _____
Have you had a physical exam In the last year?	☐	☐	Date: _____ Doctor Name: _____
Have you had any major surgeries?	☐	☐	If Yes, explain: _____
Do you take any medication regularly?	☐	☐	Medication Name: Prescribed by:
Do you have any ongoing medical problems?	☐	☐	If yes, explain: _____
Are you allergic to any medications?	☐	☐	If yes, explain: _____

Are you experiencing:	No	Yes	Explanation
Shortness of breath?	☐	☐	
Chest pain?	☐	☐	
High/Low blood pressure	☐	☐	
Heart burn, nausea/vomiting	☐	☐	
Bowel/Bladder problems	☐	☐	
Muscle or Joint pains	☐	☐	
Headaches	☐	☐	
Seizures	☐	☐	

For Female Patients:			
Problems with menstruation?	☐	☐	
Are you pregnant?	☐	☐	

ADVANCED BEHAVIORAL HEALTH, INC.

CONSENT FOR EMERGENCY CONTACT

Primary Medical Doctor

Name: _____ Telephone: _____

Address: _____

1st Emergency Contact

Name: _____ Telephone: _____

Address: _____

Relationship to the client: _____

2nd Emergency Contact

Name: _____ Telephone: _____

Address: _____

Relationship to the client: _____

3rd Emergency Contact

Name: _____ Telephone: _____

Address: _____

Relationship to the client: _____

I give Advanced Behavioral Health, Inc. permission to contact any of the above-named people in the event of a medical or other emergency, thereby disclosing participation in mental/behavioral health treatment.

Signature: _____ Date: _____

Printed Name: _____ Date: _____

Witness: _____ Date: _____

ADVANCED BEHAVIORAL HEALTH, INC.

PCP Coordination of Care

Primary Care Doctor: _____ Patient Name: _____

Address: _____ DOB: _____

Phone: _____

Fax: _____

Authorization for Release of Confidential Information

I understand that my records are protected under HIPAA and cannot be disclosed without my written consent unless otherwise provided for in HIPAA guidelines. I have been informed of the type of information being released, the benefits and disadvantages (if any), and I understand that treatment services are not contingent upon my decision to sign this release. I also understand that I may revoke this consent any time except to the extent that action has been taken in reliance on it and that in any event, this consent expires upon discharge from treatment.

I request and authorize you and Advanced Behavioral Health, Inc. to exchange information about me/my child.

Signature: _____ Date: _____

----------Office Use----------

Dear Doctor _____,

The above-named patient is receiving behavioral health services from our practice. We would appreciate sending us the following information to aid in our treatment of the patient.

- Report of last physical exam, most recent lab results and any other information you feel is appropriate.

A behavioral health diagnosis of _____ has been given and the patient is currently prescribed the following medications: _____.

We are providing the following services: ☐ Medication Management ☐ Individual Psychotherapy ☐ Family Psychotherapy ☐ Other: _____

Thank you for your assistance with this patient. Please feel free to contact us in the future if you have any questions or require any information.

Sincerely,

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH AND/OR ACADEMIC INFORMATION

Patient/Student Information

Name: _____ Birthdate: _____

Address: _____ Phone Number: _____

Release of Information

I hereby authorize: ☐ Advanced Behavioral Health, Inc.

☐ Other provider/facility Name: _____

to release health information from: ☐ Medical record ☐ School record ☐ Verbal health and/or academic information by service provider of the above name patient/student for the following purpose: ☐ Provision of services ☐ Continuum of care ☐ Legal

☐ Other: _____

To: _____

Phone Number: _____ Fax Number: _____

For treatment dates: _____

TYPE OF ACCESS AUTHORIZED:

☐ Copies of the record
☐ Inspection of the record
☐ Verbal communication

SELECT PORTIONS OF THE RECORD:

☐ Discharge Summary ☐ History & Physical ☐ Labs/Medical Tests ☐ Consultation
☐ Psychosocial History ☐ Medication List ☐ Educational Records ☐ School Visitation
☐ Other: _____

This authorization will expire on year from the date signed for records below unless specific expiration event or condition is named here: _____. For verbal communication, this authorization will expire upon discharge. The authorization covers only treatment for the dates specified above. I understand that I have the right to refuse to sign this authorization for release of protected health and/or academic information. I understand that authorizing the disclosure of this information is voluntary. I need not sign this form to assure treatment. I understand that I may inspect the information to be used or disclosed, as provided in 45 CFR 164.524.

- I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as described within this document.
- I understand that this authorization may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I may withdraw this authorization by notifying, in writing, the above specified provider/program/facility.
- I acknowledge that the material authorized for release may contain alcohol, chemical dependency, psychiatric, HIV testing or results, or AIDS information.
- I understand that health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2.
- If these records contain information from another provider, this information will not be disclosed unless the other provider has not prohibited this, it is permitted by law, and you check the following box: ☐
- I understand that, once information is released, this facility cannot prevent the recipient from further disclosing the information.

This facility is released and discharged of any liability and the undersigned will hold the facility harmless for complying with this "Authorization for Release of Protected Health and/or Academic Information".

Signature of Patient/Student: _____ Date: _____

Signature of Parent/Guardian/
Authorized Representative: _____ Date: _____

Fees/charges will comply with all laws and regulations applicable to release of information

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

ADVANCED BEHAVIORAL HEALTH, INC.

INSURANCE SIGNATURE ON FILE

Patient's Name: _____ DOB: _____

INSURANCE COVERAGE

I request that payment of authorized commercial insurance benefits or insurance secondary to primary insurance be made directly to **Advanced Behavioral Health, Inc.** for any services provided to me by that provider of service. I understand that I am financially responsible for charges not covered by this authorization. I authorize any holder of medical information to release to my insurance company or its agents any information, which may be necessary to determine benefits payable for related services.

_____ _____

Patient/Subscriber Signature Date Signed

_____ _____

Witness Signature Date Signed

_____

ADVANCED BEHAVIORAL HEALTH, INC.

Financial Agreement

ADVANCED BEHAVIORAL HEALTH, INC: FINANCIAL AGREEMENT

We are pleased that you have chosen Advanced Behavioral Health, Inc. for your care. Our goal is to provide you with the highest level of excellent service.

Insurance:

If we participate with your insurance company, we will submit claims on your behalf to your primary and secondary insurance carriers for reimbursement – unless we have received prior notification of non-covered services. It is the responsibility of the patient (guarantor) to provide information regarding insurance coverage including a copy of the insurance card at the time of **each appointment.**

Co-payments are due **at the time of service** – unless prior arrangements have been made in advance. All co-insurance and deductibles are your financial responsibility and payment is due within 10 days of the date you receive a statement from Advanced Behavioral Health, Inc.

For your convenience we accept Visa, Discover, MasterCard, American Express or money orders.

It is requested that you notify us 24 hours in advance when canceling a scheduled appointment. We reserve the right to charge a fee of $95.00 for any appointment canceled or broken without a 24-hour notice.

Past due accounts are subject to a $25.00 monthly late fee. Payments not received within 60 days of statement date may be sent to a collection agency/attorney. You will be responsible for all collection cost incurred, including attorney's and court fee, if applicable.

We care about our clients and will work with you if you are experiencing financial hardship. Please speak with your provider if you find yourself in this situation. We may be able to work on a payment plan to avoid further collection proceeding. However, if your account is assigned to a professional collection agency/attorney, you will no longer be able to receive services from the providers at Advanced Behavioral Health, Inc. until the account is settled. In addition, any future services rendered will require payment in full at the time of each service provided.

Insurance authorization and assignment of benefits/consent to treatment:

I hereby consent to Advanced Behavioral Health, Inc. releasing my health information for the purposes of treatment, payment and healthcare operations. I also agree to assign payment(s) from my insurance carrier to Advanced Behavioral Health, Inc. for services rendered to me and/or my dependents. I understand that I am responsible for all amounts not covered by my insurance, as well as applicable co-insurance and deductibles.

_____ _____

PRINTED NAME OF PATIENT DATE

_____ _____

SIGNATURE OF PARTY FINANCIALLY RESPONSIBLE/PARENT/GUARDIAN DATE

Welcome to Advanced Behavioral Health, Inc.

CLIENT HANDBOOK

NON-DISCRIMINATION POLICY

The services and facilities of Advanced Behavioral Health, Inc. are operated on a non-discriminatory basis. This policy prohibits discrimination on the basis of race, color, age, sex, national origin, marital status, disability, sexual orientation, economic situation, religion or political affiliation with service delivery.

GENERAL INFORMATION

Who We Are:

Advanced Behavioral Health, Inc. is a multi-disciplinary team of mental health professionals, including psychiatrists, psychologists, psychiatric nurses and therapists, who have a wide variety of specialties. As needed, access to other resources such as Laurel Hospital and Children's Hospital can be arranged. These resources include inpatient and partial hospitalization programs.

What You Can Expect at Your First Visit:

On the day of your first visit you will be asked to fill out a number of forms. Some of these forms are for our business records, so it is important to **have your insurance card(s) with you**. If your mental health benefits are through a managed care organization, you must have authorization from your insurer in order to have an appointment with a clinician.

Treatment begins with an evaluation. You will meet with a clinician who will ask you about the problems for which you are seeking help. The clinician will determine the services you need and whether our outpatient clinic will be able to provide those services. If we are able to serve you, the clinician will use the information you have provided and based on what wellness and recovery goals you feel you or your child wants to accomplish while with us, we will create a treatment plan with you. Although the goals and objectives we create with you will be measurable and time-specific there is no set time for the course of treatment as you or your child's needs may change as times goes on and we may need to modify treatment goals and objectives according to your needs and desires.

As soon as we possibly can after the start of treatment, we will begin to talk with you about your or your child's various needs after discharge from our services. We want to make sure we do everything we possibly can to ensure that your recovery continues after you leave us. Every effort will be made to provide you with brief and efficient treatment. The clinician doing your evaluation may continue as your therapist for ongoing treatment, may recommend another clinician with a different specialty to be your therapist, or may recommend some other type of approach for your difficulties. If we are not able to assist you, we will attempt to refer you to another source of care.

Appointments:

We will make every effort to arrange appointment times that are at your convenience. In the event that you must miss a scheduled appointment, **please call the office at least 24 hours in advance**.

What Kind of Treatment Might be Recommended?

Individual Therapy: This type of treatment, in which you meet alone with your therapist, is what most people traditionally associate with therapy. However, other approaches, such as group therapy and/or medication, are becoming the treatment(s) of choice in many cases.
Family or Couples Therapy: In such treatment, the focus is on the relationships involved and finding new solutions to old problems.
Medications: Often a person's problem involves chemical imbalances. For example, some types of depression are related to the way brain chemistry affects mood. In such instances, taking specially prescribed medication may be very helpful.
Other Means of Treatment: Treatment is not just what you do in the therapist's office. It may be suggested that you undertake outside activities such as reading, journal keeping, attending self-help groups, nutrition, exercise, talking to a dietician, practicing desirable new behaviors, etc.

What Kinds of Clinicians Are There?

Psychiatrist (M.D.): This is someone who has graduated from medical school and has completed residency training in psychiatry. Only physicians can prescribe medications.
Psychologist (Ph.D. or Psy.D.): Someone who has graduated from a doctoral program in psychology and completed and approved internship.
Social Worker (LCSW-C): A person who has graduated from a master's level program in social work and has completed a period of post-graduate supervision.
Clinical Nurse Specialist (RN, CS): A graduate of a master's level program in nursing specializing in psychiatry and has completed a period of post-graduate supervision.
Professional Counselor (LCPC): A person who has graduated from a master's level program in clinical psychology or counseling and has completed a period of postgraduate supervision.

How Do You Get the Most from Your Treatment?

Attend Scheduled Appointments: It is necessary to be present to receive the treatment if you want it to be effective.
Speak Honestly: You are not there to please the therapist; you are there to identify your problems and to work on them. Therefore, in order to receive the greatest benefit from treatment you need to be very open and honest in talking about your feelings, thoughts and your behavior, even if you view it as "bad" or "shameful".
Risk Trying Things the Clinician Suggests: Often treatment involves some proposed changes. For example, suggestions could include speaking up and being more assertive, listening more, being less aggressive, getting a physical exam or a blood test, completing homework assignments, etc. Also, therapy usually involves suggested alternatives in how you think about yourself and the world. Change is difficult, but by you seeking help you are indicating that some changes might be useful to you. Talk with your therapist if you are having difficulty pushing yourself to replace old behaviors with new ones.

Length of Treatment:

No one can accurately predict exactly how long it will take to meet your treatment goals. Some problems can be addressed in one or two sessions while others may take longer. Your insurance benefits may help determine the length of treatment since many health plans offer treatment for crisis-oriented, brief therapy only. It may be best to define very focused goals and plan a short course of therapy targeted to those goals.

Managed Care:

Most health insurance coverage today is "managed". Some of the organizations providing managed care are Magellan, Beacon Health, Kaiser, Optum, United Behavioral Health, Cigna Behavioral Health plus many others. These and similar organizations usually require that services to their subscribers be authorized in advance. It is your responsibility to track your authorized visits and notify your therapist, in advance, if further authorizations are needed. Any services provided to you without authorization will be your financial responsibility. Managed care organizations require therapists to provide the Utilization Review Committees with reports containing diagnostic, symptomatic and treatment plan information before authorizing continued benefits. Some managed care organizations or HMO's have their own network of providers. If our outpatient center does not have a provider who is a member of that network, we will not be able to provide services to you except on a self-pay basis. You will need to call your insurance company to find out who to contact for services.

Emergencies:

If you have an emergency situation where you feel an urgent need to talk to a professional, contact the Advanced Behavioral Health, Inc. office. If the outpatient clinic is open and your therapist is present, she/he will return your call. When the clinic is closed, in case of an emergency, contact 911 or the Prince George's County Crisis Response System at 301-927-4500, the Baltimore County Crisis Responses System at 410-576-5097 or the Montgomery County Crisis Response System at 240-777-4000. *(This procedure is not to be used to discuss matters that can be handled at your next scheduled therapy session nor should it be used to obtain medication refills.)* Once you're with a licensed healthcare professional or medical personnel have that person call * and the on-call physician will return the call in a timely manner. However, if you feel that the situation is life threatening and requires immediate assistance, you should always go the nearest emergency room.

Health and Safety Policies:

Emergency Drills

Advanced Behavioral Health, Inc. is required to conduct emergency drills, which may require evacuation from our building if you are on the premises. Please be prepared to exit the building promptly.

Use of Seclusion or Restraint

Advanced Behavioral Health, Inc. forbids the use of seclusion and restraint in its programs.

Use of Tobacco Products

Advanced Behavioral Health, Inc. is a tobacco-free environment. The use of any tobacco product and e-cigarette is forbidden on site.

Illegal or Legal Substances Brought onto Premises

Advanced Behavioral Health, Inc. is a drug-free setting. Illegal substances are forbidden in the organization's facility. Over the counter medications may be brought on site but their presence should be reported to staff.

Prescription Medication

Prescription medications may be brought on site but their presence should be reported to staff.

Weapons

You may not bring weapons onto Advanced Behavioral Health, Inc.'s facility.

Inclement Weather

The decision to close the outpatient clinic will be made by the Director. Clients are encouraged to call the office at 301-345-1022 to ascertain if the office is open or closed. If needed, clients can call the outpatient clinic on the next business day to reschedule their missed appointment. There will be no charge for the missed visit or for a cancellation due to inclement weather.

Advance Directives

Upon entering into services with Advanced Behavioral Health, Inc. we would hope that you would inform us of any advance directives that you have established with other treatment providers. Advance directives are interventions that you wish to be carried out if you were to experience a serious physical or mental illness or have a serious accident. If you would like the staff of Advanced Behavioral Health, Inc. to help you develop a set of advance directives we would be happy to do so.

Further Assistance:

Our reason for being here is to help you. Please feel free to ask questions about these matters or any other pertaining to your treatment here.

CLIENT RIGHTS AND RESPONSIBILITIES

As a client of Advanced Behavioral Health, Inc. you have the right to:

1. The confidentiality of your protected health information.
2. Privacy.
3. Freedom from:
    a. Abuse.
    b. Financial or other exploitation.
    c. Retaliation.
    d. Humiliation.
    e. Neglect.
4. Access to:
    a. Information pertinent to you in sufficient time to facilitate your decision making.
    b. Your own records.
5. Informed consent or refusal or expression of choice regarding:
    a. Service delivery.
    b. Release of information.
    c. Concurrent services.
    d. Composition of the service delivery team.
    e. Involvement in research projects, if applicable.
6. Access or referral to:
    a. Legal entities for appropriate representation.
    b. Self-help support services.
    c. Advocacy support services.
7. Adherence to research guidelines and ethics if and when you are involved in a research project.
8. Investigation and resolution of alleged infringement of rights.
9. Know that parent and legal guardians are responsible for children 16 years and under. All procedures regarding client rights and confidentiality apply to them.
10. Other legal rights as prescribed by the state and federal governments.

As a client of Advanced Behavioral Health, Inc. you have the responsibility to:

1. Work with your clinician to plan your treatment and decided on the goals of your treatment.
2. Work to accomplish your treatment goals. This includes taking medication as prescribed. Be honest with your clinician(s) in discussing anything related to your problems.
3. Tell your therapist and psychiatrist how your medications make you feel. Tell them about the side effects from any medications you take.
4. Give correct information to the staff about your family income, your employment and your health insurance coverage. Immediately tell the administrative staff whenever there is a change in any of these.
5. Pay your fees at the time of your visit. Discuss any problems with your fees with the administrative staff.
6. Keep your appointment and be on time since your appointment time is set-aside for you. If you are late, the time available for your session will be shortened. If you are more than 15 minutes late your therapist or doctor may not be able to see you at all. If you know that you will be delayed or that you will not be able to keep your appointment, please call. You may be charged for any sessions that you miss without giving 24 hours' notice.
7. Let your clinician know if you are not doing well or if you are feeling worse.
8. Talk with your clinician if you are thinking about stopping your treatment. You may be ready to handle things on your own, or you may be facing a difficult spot in treatment and need some additional help dealing with it.

If you have any questions or concerns about these Right and Responsibilities, please speak with your clinician or the administrative staff. If they are not able to address your concerns, you may contact the Clinic Director, Vera Kurdian at (301) 345-1022 extension 7015

Ways You Can Provide Input

We encourage clients and their families to provide input about the services you receive from Advanced Behavioral Health, Inc. The following are just a few of the ways that you can provide input to us about any aspect of your services:

- Make Suggestions to your counselor, therapist or doctor. They will be taken seriously.
- Respond to our regular satisfaction surveys. We will post a summary of the results.
- If you are dissatisfied with any aspect of the care we provide to you or your family member, please fill out and submit a complaint form. We will investigate your complaint thoroughly and will not retaliate for the filing of the complaint. We will provide you with a written response to your complaint.
- Consider joining our Advisory Board. It meets regularly to discuss issues important to all served by Advanced Behavioral Health, Inc.

GRIEVANCE PROCEDURES

STEP 1

If clients or family members have grievance or complaint concerning their treatment, bill or any other issue they are first directed to discuss it with their therapist. They have the right to be seen within five working days. If the issue cannot be resolved to their satisfaction at this level, or they are unwilling to speak to the therapist for whatever reason, the next step may be taken.

STEP 2

If discussion with the therapist does not resolve the issue, the client/family is then directed to voice the grievance to the Program Director. This request must be in writing and should include the client name, date of complaint, the nature of the complaint and steps that have been taken to resolve the problem. Clients who are unable to prepare the written statement can request that the Program Director assign a staff member who is not involved in the problem to assist in writing the complaint. They have the right to a written response within five working days of receipt of the request.

STEP 3

If the above steps do not resolve the problem, the client or family may appeal to the Director of the Prince George's County Department of Family Services, using the same written format as previously described. The Director will review the problem, meet with client, if needed, and prepare a written response within 10 working days. One copy of the response will be given to the client or family, with additional copies given to the Program Director, who will review the case and document their opinion concerning the situations.

Names and Address of Contact for Grievances

Vera Kurdian
Outpatient Program Director
1003 West 7th Street
Frederick, MD 21701
Phone: 301-345-1022 extension 7015

L. Christina Waddler, Director
Prince George's Co. Dept. of Family Services
Mental Health Authority Division
5012 Rhode Island Ave Room 114
Hyattsville, MD 20781
Phone: 301-985-3890

CODE OF ETHICS

Overview

The Code of Ethics provides guidelines for decision-making that is reflective of the moral principles and core values of the organization. The Code is intended to promote high standards of service delivery and business conduct. Advanced Behavioral Health, Inc. employees are required to adhere to this Code as well as any Code of Ethics pertaining to professional affiliations. All new employees are oriented to the Code of Ethics during orientation to the agency and are given a copy of the Code. It is also available to other stakeholders upon request.

Advanced Behavioral Health, Inc.'s philosophy is based upon recognition of basic human rights and the treatment of all persons with dignity and respect. The underlying premise is that no person shall be subject to discrimination on the basis of disability (physical, developmental or mental), gender, age, race, religion, sexual orientation, ethnicity, marital status, socio-economic status or political affiliation. Services will center on individual needs and encompass social, physical, spiritual and psychological aspects of each individual.

Definitions

Confidentiality: Information received or observed about a person served, or about an employee that is held in confidence and only disclosed when properly authorized or legally and/or professionally obligated to do so.
Ethics: The principles of conduct governing an individual or group; concerns for what is right or wrong, good or bad, and with moral duty and obligation.
Stakeholders: All those who have a vested interest in an issue. Within Advanced Behavioral health, Inc. it may include the person with disabilities, their family members, advocates, staff, other agencies, funding sources, employers, regulatory bodies and the general community.

Ethical Responsibility in the Delivery of Services to People Supported

- To maintain the best interests of the person supported and advocate for those interests as circumstances require.
- To folder self-determination and to encourage individuality accepting each person as unique and valuable.
- To maintain confidentiality.
- To be supportive and non-judgmental.
- To protect the people supported from abuse and/or neglect and avoid participation in practices that are disrespectful, degrading, intimidating, psychologically damaging or physically harmful to clients.

Ethical Responsibility to the Agency

- To work towards achieving the mission of Advanced Behavioral Health, Inc.
- To assist Advanced Behavioral Health, Inc. in providing the highest quality of service, acknowledging that personal, interpersonal and societal circumstances may change.
- To be knowledgeable of, and abide by, Advanced Behavioral Health, Inc. policies and procedures.
- To maintain confidentiality concerning information obtained in the course of providing services, and make disclosures only with the consent of service users, or, where required to do so by the order of a court.
- To promote a positive image of Advanced Behavioral Health, Inc. in the community through friendly, respectful and cooperative interactions.

Ethical Responsibility in Marketing Services

- To reflect accurately the policies/positions of Advanced Behavioral Health, Inc. in public statements and to avoid any possible misrepresentation of personal opinion as society policy/position.

Ethical Responsibility to the Community and Taxpayer

- To foster a spirit of cooperation with other service agencies, education programs and volunteer organizations involved in community living services.
- To maintain a commitment to high standard of service, continuing quality improvement and prudent financial stewardship.
- To deal with others, both inside and outside Advanced Behavior Health, Inc. based on unquestionable integrity, open communication, social responsibility and proactive safety conscientiousness in addition to a commitment to high quality, continuing improvement and the best use of fiscal resources.
- To behave in full and complete compliance with all applicable laws and regulations: In addition, our dealings with others will be based on complete candor, cooperation, honesty and mutual respect.
- To ensure Advanced Behavioral Health, Inc. property or the property owned by the people we support will not be used in order to obtain personal benefit. This ethics policy prohibits employee theft, fraud and embezzlement or misappropriation of property belonging to Advanced Behavioral Health, Inc. or the people supported, another employee or any associate or supplier of Advanced Behavioral Health, Inc.
- To report financial results in accordance with generally accepted accounting, principles. Those reports will fairly present financial position and operating results.
- To purchase supplies from reputable suppliers who will treat our society and employees with respect. Advanced Behavioral Health, Inc. shall interact with their suppliers in an open, honest and timely manner. Such communication will create positive partnerships that will benefit the overall operation.
- To use suppliers of goods and services on the basis of price, quality and service only. In selecting suppliers, we also will be mindful of our commitment to supporting businesses that hire people with disabilities. No employee may profit personally from a relationship with a supplier.
- To be respectful corporate citizens in the community, we will participate in activities within the community for the betterment of the community.
- To acknowledge limitations in knowledge and competence.
- To not use drugs or alcohol prior to, or during work.
- To maintain standards of safety through the use of appropriate equipment, clothing and procedures.

Ethical Responsibility to Colleagues

- To establish and maintain relationships of mutual respect, trust, courtesy and cooperation with colleagues.
- To foster a culture in which excellence in practice is pursued in all activities.
- To act as a team member, supporting other members of the team by maintaining consistent standards and by offering and receiving support, especially in crises.
- To maintain clear, open communication with individuals, team members and management.
- To not engage in sexual harassment or other forms of personal harassment towards any person served, colleagues, manager or stakeholders.
- To offer both positive feedback and constructive criticism.

Ethical Responsibility in Human Resources

Pursuant to Human Rights Legislation, Advanced Behavioral Health, Inc. provides equal employment opportunities to qualified individuals able to fulfill the job description regardless of disability, race, ethnicity, religion, gender, socio-economic status, marital status, sexual orientation, national origin, political affiliation, age or status. Harassment and misconduct are unacceptable behaviors for all employees of Advanced Behavioral Health, Inc.

- To ensure employees work time is a resource committed to service delivery and not diverted to personal pursuits.
- To ensure employees receive recognition for dedication to society and services.
- To clearly define the service that Advanced Behavioral Health, Inc. has the mandate and capacity to deliver.
- To maintain the overall goal of building communities that best meet the needs of people with developmental disabilities with a cooperative approach to promoting our services.
- To ensure other services are not denigrated as part of our own marketing.
- To promote a positive, respectful image of people with developmental disabilities.

Ethical Responsibility to the Profession

- To maintain membership in relevant regulatory bodies and other relevant practitioner associations.
- To ensure the knowledge and skills of professional staff are used to the greatest advantage in service delivery.
- To ensure that neither the standards nor practices of the organization nor the job description and performance expectations of the profession conflict with the profession's regulatory and ethical requirements.

Ethical Responsibility as an Employee

- To maintain high personal standards of professional conduct, avoiding any acts that may bring the profession or service into disrepute or which may diminish the trust or confidence of any stakeholders.
- To avoid conflict of interest situations.
- To refuse any gift, favor or compensation which might be influential or perceived to be influential in obtaining preferential consideration.
- To carry our professional duties and obligations with integrity and objectivity and to recognize how personal values, opinions, experiences, limitations and biases can affect personal judgement.
- To maintain appropriate boundaries between personal and professional relationships.

All allegations of violations to Advanced Behavioral Health, Inc. ethical codes may be reported to the Clinic Director without fear of retaliation.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED (shared) & HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFUELLY

Purpose of the notice: This notice of privacy practices describes how we may share your "protected health information" (PHI) to carry our treatment, payment, health care operations and for other purposes that are permitted or required by law. It also describes your rights to see and control your PHI.

Advanced Behavioral Health, Inc. is required by law to:

- Make sure PHI is kept private.
- Give you notice of our legal duties and privacy practices that affect your PHI.
- Follow the terms of the notice that is currently in effect.

Definitions:

Protected Health Information: Medical information that identifies you or may provide a basis for identifying you, including demographic information. Your PHI relates to your past, present or future physical or mental health condition and related health care services. Advanced Behavioral Health, Inc. is required by law to keep records of care that is provided to you.

You/Your: Any person receiving a health-related service through Advanced Behavioral Health, Inc. If the subject of the PHI is a minor, patient means the parent (unless subject to a limiting court decree or custody agreement) or authorized legal representative(s).

Designated Record Set: One's individual medical and billing records; i.e. your medical and billing records are a "designated record set".

Treating Clinician: The individual primarily responsible for providing the patient's mental health services at Advanced Behavioral Health, Inc.

Medical Record: A record of clinical services provided. The medical record is part of the designated record set.

Patient: Any person receiving a health-related service through Advanced Behavioral Health, Inc.

Who Will Follow This Notice:

- Any Advanced Behavioral Health, Inc. health care professional authorized to enter information into your medical record.
- All Advanced Behavioral Health, Inc. departments and units that have access to PHI.
- All Advanced Behavioral Health, Inc. employees and staff that have access to PHI.
- Any Advanced Behavioral Health, Inc. volunteer who is permitted to provide you services or assistance and volunteers providing Advanced Behavioral Health, Inc. operational services assistance.

How We May Use & Share PHI About You: These categories describe different ways that Advanced Behavioral Health, Inc. may use and share you PHI. For each category, we will explain what we mean and try to give you some examples. Not every use in a category will be listed. However, all of the ways Advanced Behavioral Health, Inc. is permitted to use and disclose information will fall within one of the categories.

- Treatment: Advanced Behavioral Health, Inc. will use and share your PHI to provide, coordinate or manage your health care and related services. We may use and disclose your PHI to tell you about, or recommend possible treatment options or alternatives that may be of interest to you. We may share PHI about you with:

- Health care practitioners such as doctors, nurses, technicians, student trainees, or other personnel who are involved in taking care of you at Advanced Behavioral Health, Inc.
- Different departments of Advanced Behavioral Health, Inc. in order to coordinate the different things you need, such as prescription, lab work and x-rays.
- People outside of Advanced Behavioral Health, Inc. who may be involved in your medical care after you leave our program, such as referrals to aftercare placement or providers outside of Advanced Behavioral Health, Inc. who are treating you.

- Payment: Advanced Behavioral Health, Inc. will use your PHI to obtain payment for health care services provided. This will include contacting your health insurance plan to get approval for payment of recommended psychiatric services. Your insurance company will be contacted to determine eligibility for benefits, to review services for medical necessity, and to undertake utilization review activities. This may also include sharing information with others, such as Medicare or Medicaid for the purposes of obtaining payment.
- Healthcare Operations: Advanced Behavioral Health, Inc. may use and share your PHI to support healthcare operations. For example, we may use PHI to review our treatment and to evaluate the performance of our staff in caring for you. This helps make sure all of our patients, clients and residents receive quality care and services. We may also combine PHI about many patients and clients to decide what additional services Advanced Behavioral Health, Inc. should offer, what services are not needed and whether certain treatments are effective. We may also share information with health care practitioners such as doctors, nurses, technicians, student trainees, and other personnel for review and learning purposes. We may also share your PHI with Health Oversight Agencies for activities authorized by law such as audits, inspections, licensure, and government benefits programs, the Mental Hygiene Administration and/or their Core Service Agency.
- Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services: Advanced Behavioral Health, Inc. may use your PHI to remind you that you have an appointment for treatment or services. We may also tell you about possible treatment options that may be of interest to you, such as drug treatment services offered at Partners in Recovery, clinical research studies, or services to address domestic violence.
- Individuals Involved in Your Care or Payment for Your Care: With your agreement, we may share your PHI with a family member, relative, close friend, or any other person you identify. Only information that directly relates to that person's involvement in your health care will be shared. If you are unable to agree or object, we may share information, if based on professional judgment we determine that it is in your best interest. In addition, in the event of a disaster, we may share PHI related to your status and location with your family and/or organization assisting in disaster relief effort.
- Research: In special cases, we may use and share your PHI for research purposes. For example, a research project may compare the health and recovery of all patients who received one medication to those who received a different medication for the same condition. However, all research projects must be approved through an institutional review board. This process evaluates a proposed research project and its use of medical information.

- The patients' need for privacy is balanced with the researcher's need for medical information. The institutional review board will review and set rules for using PHI before any information is released. If you volunteer to participate in a research study, the consent forms you sign to participate in the research study will inform you of any special uses to be made of your PHI.

- As Required by Law and Public Health Activities: Advanced Behavioral Health, Inc. may use or share your PHI to comply with local, state or federal law. Only information that is required will be released. Examples of this would include reporting for public health activities; notification of abuse, neglect or domestic violence; health oversight activities; judicial and administrative proceedings; and law enforcement.
- To Avert a Serious Threat to Health or Safety: Advanced Behavioral Health, Inc. may use and share PHI about you when, in our judgement, necessary to prevent a serious threat to your health and safety, or to the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- Workers Compensation: Your PHI may be disclosed to comply with workers' compensation laws and other similar legally established programs. These programs provide benefits for work-related injuries or illness.

Your Rights Regarding PHI About You: You have the following rights regarding the PHI we maintain about you:

- Right to see and copy PHI: For as long as we keep your PHI, you have the right to see and get a copy of your PHI that is contained in your designated record set.
    - To read & copy PHI you must write to the Medical Director. To read a copy of your designated record set you must write the Medical Director.
        - If you request a copy of the information, we may charge a reasonable fee for the associated cost of copying and mailing your request.
        - In certain limited situations, we may deny your request to read and copy your PHI. In some circumstance, you may have the right to have this decision reviewed, and the decision to deny access may be reversed.
- Right to a List of Disclosures: You have the right to receive a list describing specifically who has received PHI about you during the last year. There are certain restrictions and limitations. This list will not include those who have received PHI for treatment, payment or healthcare operations, as described in this notice of privacy practice. It will also not include those who have made inquiry of a facility directory, or family member or friends involved in your care, or to who notification was given.
    - To request this list, contact Advanced Behavioral Health, Inc.'s Director.
        - The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost of providing this list.
- Right to Request Restrictions: You have the right to request that we limit how we use and disclose your PHI. We are not legally required to agree to your request.
    - If we do agree, we will limit the information, unless it is needed to provide you emergency treatment.
    - To request restrictions, you must make your request in writing to your treating clinician for each admission and/or registration for services. Your request must list (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) who may not receive information.
- Right to Choose Confidential Communications: You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

- Right to Amend your PHI: You have a right to amend by adding to your PHI in your designated record set for as long as we keep this information. To request to add information, your request must be in writing to the Department of Medical Records where you received treatment. You must include a reason for your request. If your request is not in writing or does not include a satisfactory reason, we may deny your request to amend by adding to your designated record set. In addition, we cannot permit you to amend information that:
    - Was not created by us.
    - Is not part of the PHI kept by or for Advanced Behavioral Health, Inc.

- Is not part of the information, which you would be, permitted to inspect and copy.
- Is accurate and complete.
- If we should deny your amendment request, you have the right to insert in the record a concise statement of the reason you disagree with the record.
- To Request confidential communications, you must make your request in writing to your treating clinician.
- Your request must list how or where you wish to be contacted.
- You do not have to give a reason for your request.
- We will accommodate reasonable requests.

- Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of notice.
  - You may obtain a copy of this notice by contacting the Advanced Behavioral Health, Inc. Director.
- Changes to this Notice: We have the right to change this notice. We have the right to make revised or changed notice effective for PHI we already have about you, as well as any PHI we receive in the future.
- Other Uses of PHI: Other uses of PHI not covered by this notice or the laws that apply to us will be made only with your written permission. If you give us permission to use or share PHI about you, you may take back that permission and we will no longer use PHI about you for reasons covered by your written authorization. We are unable to take back your permission, we have already made with your permission. Also, you are unable to take back a permission to share PHI if it was to permit the sharing of your PHI to an insurance company as a condition of obtaining coverage, to the extent that other law allows the insurer to contest claims or coverage. We are required to keep records of the care that we provided to you.
  - To take back your permission you must make your request in writing. Send your request to the Advanced Behavioral Health, Inc. Director.
    - Written permission to use or share PHI about you is not a condition of receiving treatment.
- Complaints: If you believe your privacy rights have been violated, you may file a complaint with the local Core Service Director. All complaints must be made in writing. You will not be penalized for filing a complaint.
  - Core Service Agencies:
    - Baltimore County: Baltimore County Department of Health, Bureau of Behavioral Health, 6401 York Road, Third Floor, Baltimore, MD 21212. Phone: 410-887-3828. Director: Kimberly Cuthrell.
    - Frederick County: Mental Health Management Agency, 22 South Market Street, Suite 8, Frederick, MD 21701. Phone: 301-682-6017. Director: Pippa McCullough.
    - Montgomery County: Department of Health & Human Services, 401 Hungerford Drive, 1st Floor, Rockville, MD 20850. Phone: 240-777-1400. Behavioral Health Planning and Management: Scott Greene.
    - Prince George's County: Behavioral Health Services Prince George's County Core Service Agency, 9314 Piscataway Road, Clinton, MD 20735. Phone: 301-856-9500. Division Manage: L. Christina Waddler.

ADVANCED BEHAVIORAL HEALTH, INC.

I have received a copy of Advanced Behavioral Health, Inc.

Acknowledgement of Receipts of Rights, Responsibilities and Grievances
Acknowledgement of Receipt of Notice of Privacy Policies
Acknowledgement of Receipt of Financial Agreement

Patient's Name: _____

Signature: _____

Date Received: _____

Signature of Parent/Guardian/Authorized Representative:

_____

Relationship to patient: _____

Date Received: _____

ADVANCED BEHAVIORAL HEALTH, INC.

Medicare Payment Authorization

PLEASE READ CAREFULLY AND SIGN:

MEDICARE PATIENTS ONLY:

I authorize Advanced Behavioral Health, Inc. to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that I am responsible for the deductible, coinsurance, and any non-covered services as determined by Medicare.

Patient Signature:_____Date:_____

Medicare Supplemental Insurers' MEDIGAP Assignment of Benefits:

Section 4081 of the Omnibus Budget Reconciliation Act of 1987 provides an additional participation incentive for participating physicians by providing payment directly for assigned Medicare Supplemental (MEDIGAP) insurance benefits.

I understand my signature gives authorization for my physician to bill claims directly to my recognized MEDIGAP insurance carrier and for payments to be received directly. This allows for medical information to be forwarded to the insurance carrier as necessary.

The explanation of Medicare Benefits received from Medicare will display the following message to notify you that a claim has been submitted to your MEDIGAP carrier: "Because you are assigned MEDIGAP benefits, information regarding your claim will be sent to your private insurer within 30 days. " I also understand that any deductibles, coinsurances, and non-covered services will be my responsibility.

Patient Signature:_____Date:_____

Witness Signature:_____ Date:_____