INFORMATION SHEET
Location: Baltimore or Anne Arundel (circle one)

Client Name:_____
Last First M.I.

Address:_____

Legal Guardian Name: _____Relationship to Client: _____

❑ CHECK HERE IF CHILD IS COMMITTED TO DSS OR DJS (court order required on file)

Home Phone Number: _____Cell:_____Email Address:_____
❑Messages Ok ❑Please don't leave messages

D.O.B:_____Age___Sex_____Race:_____Marital Status_____S.S.#_____
MM/DD/YYYY

Highest Grade Completed_____Number of arrests in the last 30 days:_____Are you a Veteran?_____

PLEASEE CHECK THE APPROPRIATE OPTION:

❑Student
(Circle one): F/T or P/T School:_____Grade:_____

❑Unemployed ❑Receiving Disability ❑Looking for Work

❑Employed
(Circle one) F/T or P/T Employer:_____

*Primary Care Physician:_____
Name Address **Phone Number**

Allergies:_____

CURRENT MEDICATIONS CURRENTLY PRESCRIBED (please include dosage):

_____

_____

LIST TWO INDIVIDUALS TO BE CONTACTED IN THE CASE OF EMERGENCY:

1. Name_____ Tel: _____ Relation: _____

2. Name_____ Tel: _____ Relation: _____

Insurance Information

Insurance/Medical Assistance Number: _____ MCO: _____

I request the payment of authorized Medicaid/Medicare/Other Insurance Company benefits be made to me on my behalf to TIME OMHC, for any services rendered to me that the party who accepts assignment/physician. Regulations pertaining to Medicaid/Medicare assignment of benefits apply.
I understand my signature request that payment be made and authorizes release of medical information necessary to reimburse the claim. Item 9 of the HCFE-1500 claim form is completed; my signature authorizes releasing of the information to the insurance agency shown. In Medicaid/Medicare/Other Company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicaid/Medicare/Other Insurance Company charged, the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicaid/Medicare/Other Insurance Company.
I authorize the release of information to Value Options and the local Core Service Agency if I am a medical Assistance or Gray Zone client for the purpose of coordinating appropriate services.

_____ _____
Signature Date

CONSENT FOR TREATMENT

Client's Name: _____
I am the _____ Patient _____ Parent _____legally appointed guardian (court order required)
Other (Explain) _____
Location of Services: □ Baltimore □Anne Arundel County

- I voluntarily consent or give my consent to receive treatment and/or related services by TIME Outpatient Mental Health Clinic (TIME OMHC) which may be advised and/or recommended by the attending physician. I hereby request TIME Outpatient Mental Health Clinic and its qualified, clinicians, physicians, employees and agents (collectively TIME OMHC) to provide such as patient mental health and related medical services as are deemed medically necessary and appropriate.

- I understand that in the event of a medical or psychiatric emergency which may be life threatening, that it may become necessary for TIME Organization to render such emergency treatment and/or transfer myself or my child to a hospital for evaluation and/or treatment.

- I understand that all information concerning participation of myself/my child is confidential and that no information will be given without written consent from me.

- I agree that I have been fully oriented to the program's services and the treatment that is being provided to me. I have reviewed my rights and responsibilities as a patients and I am aware of the grievance process and the discharge/termination policy of this agency.

- In agreeing to receive services at TIME, I understand I shall assist in following the individualized treatment plan that has been developed or will be followed by TIME OMHC and shall ensure that all the scheduled appointments are kept.

- I am aware that an agent of my insurance company or other third party payer may be given information about services such as, cost, dates, and providers of services or treatments I have received.

- I understand it is my responsibility to cancel appointments within 24 hours if I am unable to keep the scheduled time allotted.

- I am aware that I may stop treatment with TIME at any time.

- I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this agency.

- I understand that if I am paying for services "out of pocket" that I am responsible for balances due.

RISKS AND BENEFITS OF MENTAL HEALTH TREATMENT

Receiving mental health services can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and/or helplessness. On the other hand, receiving mental health services has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific challenges and significant reduction in feelings of distress. However, there are no guarantees of what will be experienced while participating in mental health treatment. In either situation you will have the support of your therapist throughout the process.

CONFIDENTIALITY

All information given to or obtained by program therapist/ counselor/physician will be used only for your treatment/rehabilitation and administration of the program. Information may be released for the purpose of your treatment or rehabilitation services or if required by Federal Law or in response to legal investigations and court order. Information requested about you for any other purpose can only be released by your written consent.

By signing this document, I am acknowledging that I have full knowledge and understanding of the program, its requirements, and my rights, agree to participate according to the standards that have been set forth. I am in agreement and understanding of the intake process, program responsibilities, my responsibilities, and the termination process. I am also aware that I can choose to discontinue participation at any time. I have received A New Client Orientation manual that includes policies and procedures and I authorize the T.I.M.E Organization, Inc. to bill on my behalf for services.

Consent to Services:
The ❑ parent/guardian ❑ minor (16 years or older) ❑ adult consents to services?

_____ _____
Print Name **Date**

_____ _____
Signature **Relationship to Patient**

_____
Witness

5 DAY FACE TO FACE SCREENING ASSESSMENT

Client Name:	**DOB:**

Treatment Needs:

- ❑ Activities of Daily Living
- ❑ Anger/Temper/Conflict Resolution
- ❑ Assertiveness/Self-esteem
- ❑ Community Living
- ❑ Family/Marriage
- ❑ Finances
- ❑ Home/Housing
- ❑ Independent Living Skills
- ❑ Safety to Self/Others
- ❑ School Performance
- ❑ Sexual Issues
- ❑ Social Skills/Peer Interaction
- ❑ Substance Abuse Issues
- ❑ Coping Skills
- ❑ Trauma
- ❑ Medication Compliance Skills
- ❑ Vocational Skills
- ❑ Leisure Skills
- ❑ Work/Job Performance
- ❑ Legal Issues
- ❑ Money Management
- ❑ Dietary/Food Preparation
- ❑ Crisis Management Skills
- ❑ Physical Health

Available Resources:

_____

_____

Goals for Recovery:

_____

_____

Strengths:

_____

Entitlements:

- ❑ Client currently receiving entitlement benefits
- ❑ Client has independently completed application on _____
- ❑ Staff will assist the minor's parent or guardian to apply for entitlements by: _____
- ❑ Client refuses to disclose

FOR PRP SERVICES ONLY:

The parent/guardian or adult chooses to receive:

❑ only off-site PRP services ❑ only on-site PRP services ❑ both on-site and off-site PRP services

LEGAL GUARDIAN:

Is the client a child for whom courts have adjudicated their legal status?

❑ **Yes (Include copies of court orders or custody agreements)** ❑ No

Review of Somatic Status:

Does the client have any significant past or current medical problems?

❑ Yes (Document details in Assessment) ❑ No

Does the client's medical condition require somatic care follow-up?

❑ Yes (How often_____) ❑ No

Does the client have a primary care provider?

❑ Yes ❑ No (Indicate time frame for referral to a primary care provider)

CLIENT NAME:	
PARENT/GUARDIAN SIGNATURE:	**DATE:**
WITNESS SIGNATURE:	**DATE:**

Authorization to Use and Disclose Protected Health Information

NOTICE – PLEASE READ: I understand that each authorization signed below will remain in effect for **365** days after I sign and date the form. Each authorization may be withdrawn at any time in writing except to the extent that action has already been taken. Upon receipt of written revocation, further release of information shall cease immediately, except as allowed by law. Recipients of this information are forbidden to re-disclose this information without my specific authorization.

I understand that if I have authorized TIME to disclose my information to person who are not required by Federal or State law to keep the information confidential, these persons receiving my records may disclose my protected health information to other without my consent or authorization. TIME will not be responsible for the misuse or re-release of information by another individual, agency, or entity.

Notice To Recipient Of Information: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules **prohibit the recipient of the protected health information from making further disclosure of this information** unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Client Name:_____ **Date of Birth:**_____/_____/_____

I hereby authorize the TIME Organization to:

☐ **Disclose information** ☐ **request information** ☐ **exchange information**

With Name of Person or Entity: _____

Address:_____

Telephone/Fax:_____

INFORMATION TO BE USED/DISCLOSED/REQUESTED

Initial the following items needed:

	Diagnostic Assessment/ Intake		Psychological Evaluation Reports		Treatment Plan/ISP
	Progress Notes		Psychiatric Evaluation		Other Social History
	Physician's Orders		Court Reports/Records		Medication Records
	School Records/ Consultation		Laboratory Reports		Employment Records/Reports
	HIV and AIDS Status		**Drug and Alcohol Addiction Records**		Recent Physical Exam

Other (CLEARLY SPECIFY)_____

Purpose for Disclosure: ☐ Assist in Treatment Planning ☐ Continuity of Care

☐ Other (Specify)_____

I understand that I may withdraw this consent at anytime in the future as explained above and that this consent will expire in **365** days from the dates signed below, unless otherwise specified.

This consent will expire on ____/_____/_____ OR Upon discharge from services.

Signature: _____ Relationship: _____ Date:_____

Witness: _____ Date: _____

Mental Health Advance Directive

Notice: A Mental Health Advance Directive is a legal document. Before Signing any legal document, please read material Carefully and seek legal counsel.

Under Maryland law, it is the right of anyone sixteen (16) years of age or older to be involved in decisions about their mental health treatment.

The Advance Directive is designed to assist with the pre-planning process should an individual become incapacitated in making informed cognitive decisions.

(Initial Appropriate Responses)

I am sixteen (16) years of age or older
_____Yes _____No

_____
(Initials)

I currently have a Mental Health Advance Directive
_____Yes _____No _____Unsure

_____
(Initials)

I have provided a copy of my Mental Health Advance Directive to TIME Organization.
_____Yes _____No

_____
(Initials)

I was offered a Mental Health Advance Directive

_____Accepted _____Declined

_____
(Initials)

_____ _____
Client Name **Date**

TIME ORGANIZATION CLIENT ORIENTATION	
By my signature below, I certify that the statements listed below are true.	
☐	I have signed the 5 day face to face screening assessment
☐	I have been given a copy of TIME Organization's Client Handbook and Program Rules.
☐	I have received an explanation of and signed the Client's Rights form.
☐	I have received an explanation of the complaint and grievance process.
☐	I have received a description of different ways I can provide input into my services and provide feedback.
☐	I understand and have been given a copy of TIME Organization's Notice of Privacy Practices.
☐	I have reviewed client HIPAA agreement.
☐	I have been given an explanation of TIME Organization's confidentiality policies.
☐	I have been given an explanation of and signed the Consent for Treatment.
☐	I have been given information about behavioral expectations of clients and am aware that this information is also contained in the Client Handbook.
☐	I have been given information about criteria for being admitted to services, for being transitioned to a different service, and for being discharged.
☐	I have been informed about TIME Organization staff response if they identify potential risk to my well-being.
☐	I understand TIME Organization's hours of operation and how to access after-hour-services.
☐	I have received information about TIME Organization's standards of professional conduct.
☐	I have been informed about possible reporting and follow-up requirements for clients who are mandated (court-ordered) to services, regardless of discharge status.
☐	I have been assigned to my primary therapist/prp worker and have been given their contact information.
☐	I understand and have signed forms with description and explanation of financial obligations, fees, and any financial arrangements for services performed by TIME Organization.
☐	I understand TIME Organization's health and safety policies regarding: restraint/seclusion, use of tobacco products, legal and illegal drugs, prescriptions medication and weapons brought into any TIME Organization facility, program or activity.
☐	I understand the Program Rules and understand that the program may place restrictions on my customary rights and privileges, possible consequences of attitudes and behaviors, and that there will be ways to regain rights or privileges that have been restricted.
☐	I have been given a tour of the facility including: emergency exits, fire suppression equipment, first aid kits, emergency shelters, bathrooms, group therapy rooms.
☐	I have been asked if I have an advance directive, and have been offered education about this if I desire.
☐	I have been informed about the purpose and process of the screening and assessment.
☐	I have been informed about how my Treatment Plan will be developed; how I am expected to participate in the development of the plan and the achievement of my goals; the expected course of my treatment; how motivational incentives may be used; and expectations for legally required appointments, sanctions, or court notifications.
☐	I have been informed of the name of the person responsible for coordinating my services.
Assigned Individual Therapist/Coordinator:_____	
Client Printed Name: _____	
Client Signature: _____ **Date:** _____	