CENTER FOR BEHAVIORIAL HEALTH, LLC
COLUMBIA ADDICTIONS CENTER

5570 Sterrett Place, Suite 205, Columbia, MD 21044
Tele: 410.730.1333 Fax: 410.730.1559 Email: cac@columbiaaddictions.com

Date: _____________

Client Name:___________________________________ Date of Birth:___________

Address:____

City:_____________________________ State:__________ Zip:___________

Home #:__________________________ Cell #:____________________________

E-mail: ___________________________

Emergency Contact Person: ____

Relationship: ____

Phone # ____

What is the primary purpose of today's visit? _______________________________

Do have another mental health or substance abuse provider at this time? ________

Name:_____________________________ Phone #___________________________

Pharmacy Name & Phone if you are here to see one of our physicians

Name:_____________________________ Phone #___________________________

Do you have any current substance related legal charges? ____________________________

Who referred you to us? ____

Were you referred to a specific provider?_______________________________

Client Contract

Welcome to our practice. This document includes important information regarding our professional services and your rights and responsibilities as a patient.

Patient Rights

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law designed to limit the use and disclosure of your Protected Health Information (PHI). In accordance with HIPAA, your PHI will not be released to any entity without your express written consent.

Contacting your Clinician

Clinicians are often not immediately available by telephone, as they are at most time meeting with patients. The administrative staff member taking your call may be able to answer your questions and will leave a detailed message for your clinician. Every effort will be made to return your call within 12-24 hours.

Cancellation Policy

If you are unable to attend your scheduled session, it is important that you call. **We require at least 24 hours advanced notice for cancellations of individual appointments, or the full fee of the appointment will be charged.**

Fees

All fees are due at the time of service. If payment is not current, we are under no obligation to deliver services.

Consent

By signing below I understand that I am voluntarily presenting for services. I acknowledge that I am responsible for all charges in connection with care and treatment rendered. I have read this form; I understand and agree to the contents of this form. I acknowledge receipt of the Privacy Practices.

______________________________	______________________________
Client (or Parent) Signature if a minor	**Date**

Consent for the Release of Confidential Information

____

(Circle One: Spouse, Parent, Attorney, Probation Officer, Counselor, Physician, Other/Please State)

PLEASE ENTER ONLY ONE NAME ABOVE; A SEPARATE FORM MUST BE COMPLETED FOR EACH PERSON TO WHOM YOU ARE ALLOWING INFORMATION TO BE RELEASED

FULL RELEASE

☐ I authorize Columbia Addictions Center to release information to, and to obtain information from, the person or organization I have written above.

-OR-

LIMITED RELEASE

☐ I authorize Columbia Addictions Center to release ***only*** the following information to the person or organization I have written above:

_____Appointment Dates/Times

_____Account Balance

_____Initial Evaluation

_____Progress, Attendance, Completion and Discharge Reports

_____Urinalysis or Breathalyzer Results

Signed by: _______________________________ ________________________

Signature of Patient or Legal Guardian — Relationship to Patient

_______________________________ ________________________

Print Patient's Name — Date

This authorization will be valid for one year unless I otherwise specify.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.