COLUMBIA TREATMENT CENTER

5570 Sterrett Place, Suite 205, Columbia, MD 21044
Tele: 410.730.1333 Fax: 410.730.1559 Email: ctc@columbia-treatment.com

Terms of Treatment

Thank you for choosing Columbia Treatment Center for your counseling, education, and assessment needs. Our goal is to provide you with the best service possible to receive hope and healing. We look forward to working with you to improve your life and your relationships. As a Columbia Treatment Center client, it is important to realize that you have both rights and responsibilities. You are entitled to the following:

1. Be treated with respect and courtesy
2. Receive safe, considerate, and ethical care
3. Have your individual cultural, spiritual, and psychological needs respected
4. Have your privacy and personal dignity maintained
5. Be free from all forms of abuse, neglect, and harassment
6. Expect that information regarding your care will be treated as confidential
7. Receive treatment regardless of race, religion, sexual orientation, gender identity, disability, or any other form of discrimination prohibited by law
8. Expect reasonable continuity of care and to be informed of available and realistic care options when outpatient treatment is no longer appropriate
9. Understand your treatment plan, as well as the possible outcomes, risks, and benefits of your care, and be informed of any unanticipated outcomes
10. Be advised of program policies, rules, and regulations
11. Be aware of your program expectations
12. Know the names and titles of your counselors
13. See your medical records and have the information explained or interpreted as necessary, except when restricted by law
14. Review your bill and to have any questions or concerns adequately addressed
15. Be informed of the charges for services and available payment methods
16. Be involved in decisions concerning your care
17. Choose to have your family members and/or others involved in decisions about your care
18. Choose to exclude your family members and/or others from participating in decisions about your care
19. Discuss any treatment planned for you
20. Give your informed consent or informed refusal for treatment

For our services to be most effective, it is essential to have these services coordinated with other health care providers. Information will only be shared in accordance with Maryland Law and the Privacy Policies of this practice. For any person or institution that is not directly related to treatment, payment of services, or health care operations of this Practice, all protected health information will be kept confidential **UNLESS** you sign a release authorization.

This document is an agreement between Columbia Treatment Center and the Client and/or the Clients Guarantor. In consideration of the health care services provided to you or the Client and on all other accounts for future health care by this Practice, you agree as follows:

1. **CONSENT FOR TREATMENT.** You consent to mental health care as provided by Columbia Treatment Center. You understand that due to factors beyond our control, such benefits and desired outcomes cannot be guaranteed. A variety of treatment methods will be used to provide relief of your symptoms and to improve your coping and problem-solving skills. You agree to accept the risks that might result from non-compliance with our treatment recommendations.

2. **FINANCIAL AGREEMENT.** You agree to pay Columbia Treatment Center for services when they are rendered (all fees are non-negotiable). You may contact us to discuss our professional fees. Fees are standardized for all clients and program participants. We do not offer a sliding scale as we receive no public funding.

   Cash, check, and credit card payments are accepted; however, credit card payments may incur a 3% service charge.

3. **INSURANCE: OUT-OF-NETWORK PROVIDER.** Columbia Treatment Center does not participate in any insurance plan; we are considered an ‘‘out-of-network’’ provider. Most plans, however, offer out-of-network benefits. As a courtesy, the Columbia Treatment Center's administrative staff will provide upon request an itemized bill that you can submit to your insurance company. You may receive some reimbursement, but please check with your insurance company for further details.

4. **RETURNED CHECKS.** If a check has been returned for insufficient funds, Columbia Treatment Center will reverse the payment amount and add a $50.00 service fee to cover our costs.

5. **ATTENDANCE POLICY.** Columbia Treatment Center expects weekly, and on-time attendance from all clients enrolled in our treatment programs. Be punctual; we do not offer a grace period. We suggest entering your meeting room for individual or group treatment 15 minutes before the beginning of your appointment/group. Late entry will be counted as a missed appointment.

6. **MISSED OR CANCELLED APPOINTMENTS.** When you make an appointment, we reserve that time for you. When you miss or cancel your appointment, it takes away precious time the mental health provider could be spending treating another client. If you miss the group for any reason, you will be charged a $20 missed fee to hold your place in the group.

   If you must reschedule an evaluation or individual appointment, we ask that it is done at least 24 hours in advance of your appointment to avoid a rescheduling fee of $50.

7. **ABSTINENCE**. All programs at Columbia Treatment Center require abstinence from all non-prescribed drugs and alcohol. We will ask for random, observed urinalyses during your treatment, as indicated by your treatment plan. Urinalysis will normally be announced in group, though our administrative staff may also contact you given certain circumstances. You will be given 48 hours to report to our office to provide a sample. For each urinalysis, a $40 fee will be assessed to your account. We are required by many entities (courts, MVA, Parole and Probation, etc.) to prove that you have been clean and sober. If you do test positive, you are required to meet with our clinical staff for a re-evaluation ($85 fee) to discuss the terms of treatment.

8. **MINOR CLIENTS**. The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied

unless services have been approved by the parents (or guardians) and payment has been made before or at the time of service in accordance with item number 2 above.

9. **SPECIAL REQUESTS.** Columbia Treatment Center reserves the right to charge additional fees for special requests such as, but not limited to, telephone consultations, letters, billing summaries, transportation costs, and court appearances.

   What is included in the program:
   a. Your evaluation fee includes initial correspondence to the referral source.
   b. Progress and completion letters, there is no charge if you give us a minimum of five days' notice.

   What is not included in the program:
   a. MVA forms (these need to be filled out by a counselor and cost $75).
      *also applies to out-of-state DMV forms
   b. Rush Fees begin at $50 for expedited processing of evaluations, letters, or other correspondence. Depending on how much notice is given, these fees may increase.

10. **TERMINATION OF CARE**. We reserve the right to terminate care for any of the following reasons:

    a. Failure to follow treatment recommendations
    b. Outstanding balance
    c. No contact for the past 30 days or more
    d. Inconsistent attendance
    e. Dishonesty/misrepresentation of self
    f. Determination that Columbia Treatment Center is not the most appropriate treatment center for the client's needs. Should Columbia Treatment Center terminate care, we will provide you with alternative treatment sources.

11. **IN CASE OF EMERGENCY**. In the event of an emotional, behavioral, medical crisis, or life-threatening emergency, call 911 or go to the nearest emergency room. In urgent but non-life-threatening situations, contact Grassroots Crisis Intervention at 410-531-6677. A list of 24-hour crisis resources for clients living outside of Howard County can also be found on our website. Be advised that Columbia Treatment Center does not provide 24-hour crisis services, nor offer intervention services.

12. **CLIENT GRIEVANCE PROCEDURE**. Should you wish to file a formal complaint about any aspect of the Columbia Treatment Center program, or should you have any disagreement arise between you and your counselor, our grievance procedure is outlined below. Please be assured that filing a grievance will not reflect unfavorably on your participation in the program. Whenever possible, grievances should be resolved informally between you and your counselor. If you are not satisfied with the outcome or if you are filing a grievance for any other reason, you may put your complaint in writing and send it to the Director or their designee at ctc@columbia-treatment.com. The Director (or designee) will investigate the issue by gathering facts from all staff involved and the client and will find a satisfactory solution within five business days.

    If you are still not satisfied with the outcome after working with the Director, you may file a complaint with a third party outside of the agency.

    Howard County Bureau of Behavioral Health
    8930 Stanford Boulevard
    Ascend One Building
    Columbia, Maryland 21045
    (410) 313 6300

Telemental Health Informed Consent Form

I hereby consent to engage in telemental health with the clinical staff at Columbia Treatment Center (CTC) as part of my psychotherapy. I understand that "telemental health" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of mental health data, and education using interactive audio, video, or data communications. CTC provides secure private and HIPAA compliant teletherapy connection and complies with federal and state privacy laws.

I understand that I have the following rights with respect to telemental health:

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

The laws that protect the confidentiality of my medical and mental health information also apply to telemental health. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality.

I understand Columbia Treatment Center may contact my emergency contact and/or appropriate authorities in case of emergency.

I understand that there are risks and consequences from telemental health, including, but not limited to, the possibility, despite reasonable efforts on the part of my counselor, that: the transmission of my medical or mental health information could be disrupted or distorted by technical failures; the transmission of my medical or mental health information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or limited ability to respond to emergencies. CTC will notify all clients in the event of a data breach.

I understand that I may benefit from telemental health, but that results cannot be guaranteed or assured.

HIPAA 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, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, 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 posting a copy on our website, 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, or in the event of a payment dispute, we will only disclose the minimum amount of PHI necessary to inform the collection agency or justifiably support our case in the event of a dispute.

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 disclose 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. Following is a list of the categories of uses and disclosures permitted by HIPAA without authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order, or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order, or similar document, for the purpose of identifying a suspect, material witness, or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if 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.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt-out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also 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 at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

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.

- **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 is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are 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 or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **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. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **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 unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or another method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

- **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, 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.**

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Recording of a session conducted in person or via telehealth is prohibited in all cases. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, the progress of therapy, case notes, and summaries.

You agree to the above limits of confidentiality and understand their meanings and ramifications.

A copy of this notice will be available to you in your documents section of our Client Portal.

Electronic Payment Authorization

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Visa, MasterCard, American Express, Discover, Health Savings Account (HSA) and Flex Spending Account (FSA) credit cards. Service fees will be deducted from the designated account at the time services are rendered or when we receive notice from your insurance company that you have out of pocket expenses (copays, deductible amounts, or co-insurance amounts).

I authorize the payment of service fees using my credit, debit, HSA, or FSA card that was given to the administrative staff of Columbia Treatment Center and saved to my account with my permission.

Client Name: _____

Client Signature: _____ Date: _____