HIPAA Notice of Privacy Practices

1. It is *M&M Behavioral Health Solutions, LLC known here as 'MMBHS*' legal duty to safeguard your protected health information (PHI) and inform you of our 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 it carefully.
2. DEFINITION
   By law *MMBHS* is required to ensure that your PHI is kept private. The PHI constitutes information created or noted by *MMBHS* that can be used to identify you. It contains data about your past present, or future health or condition, the provision of health care services to you, or the payment for such health care.
3. HOW *MMBHS* WILL USE AND DISCLOSE YOUR PHI
   MMBHS may use and disclose your PHI for the following reasons on a "need to know" basis:
   - To provide treatment or services.
   - For health care operations (i.e., case consultation, quality control, accreditation processes. etc.).
   - To obtain payment for treatment or services.
   - In cases where a client is served in more than one *MMBHS* program.
   - When required by federal. state. or local law:
     - If we become aware that you may be a danger to yourself or a reasonably identifiable other.
     - If we become aware of/suspect child abuse or neglect
     - If we become aware of/suspect abuse or neglect of a vulnerable adult
     - If we are court ordered to testify or to submit our records to the court:
   - For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, we may need to give the county coroner information about you.
   - For specific government functions. *MMBHS* may disclose PHI of military personnel and veterans under certain circumstances. We may disclose PHI in the interests of national security or assisting with intelligence operations.
   - For research or educational purposes.
   - For Workers' Compensation purposes.
   - Appointment reminders and health related benefits or services.
   - Disclosures to family, friends. or others. *MMBHS* may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.
   - If disclosure is otherwise specifically required by law.
4. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI
   You have the right:
   - A To see and get copies of your PHI at the cost of $20.00 Requests must be made in writing. You will receive a response within 30 days of *MMBHS* receiving your written request. If denied, reasons for the denial will be provided to you. Processing of record requests can take up to 6 weeks.
   - To request limits on uses and disclosures of your PHI. While your request will be considered, *MMBHS* is not legally bound to agree. You do not have the right to limit the uses and disclosures that *MMBHS* is legally required or permitted to make.
   - To choose how your PHI is sent to you. (i.e., sent to your work address instead of home address.) We are obliged to agree to your request provided that we can do so without undue inconvenience.
   - To amend your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request (in writing) that the existing information is corrected, or the missing information is added.
   - To receive a paper or email copy of this notice.
5. ELECTRONIC COMMUNICATION
   MMBHS staff are trained to limit electronic communication of client information whenever possible. If you choose to communicate with your service provider electronically (i.e., email, text messages, cellular phones, etc.) you will be asked for written permission to do so. Please also be aware of the security risks involved in this type of communication.
6. HOW TO COMPLAIN ABOUT *MMBHS* PRIVACY PRACTICES
   If you believe your privacy rights have been violated or if you object to a decision made about access to your PHI. you are entitled to file a complaint with the person listed in Section 7 below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue SW. Washington, DC. 20201. If you file a complaint about *MMBHS* privacy practices, no retaliatory action will be taken against you.
7. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES
   If you have any questions about this notice or any complaints about *MMBHS* privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Jasper Nance at director.mmbhs@mmbhs.com.

Notice of Confidentiality and Client Bill of Rights

Confidentiality and Privacy

The confidentiality of client records maintained by M&M Behavioral Health Solutions is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § l32d et seq., 45 CPR. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § C.F.R. Part 2. Generally, M&M Behavioral Health Solutions may not say to a person outside of the program that you attend the program, nor disclose any information identifying you as an alcohol and/or drug user or behavioral health client or disclose any other protected information except as permitted by federal law.

Federal Law permits M&M Behavioral Health Solutions to disclose information without your permission:

1. Pursuant to an agreement with a qualified service organization/ business associate.
2. For research, audit, or evaluation.
3. To report a crime committed on property of or against M&M Behavioral Health personnel.
4. To medical personnel in a medical emergency.
5. To appropriate authorities to report suspected child or elder abuse and/or neglect.
6. To appropriate authorities if the client poses an imminent danger to self or others.
7. As allowed by a court order.

Before M&M Behavioral Health Solutions can use or disclose any information about your health in a manner which is not described above, we must first obtain your specific written consent allowing such disclosure. Any such written consent may be revoked by you in writing.

Client Bill of Rights

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. M&M Behavioral Health Solutions is not required to agree to any restriction you request, but if it does agree then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means. M&M Behavioral Health Solutions will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by M&M Behavioral Health Solutions, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal, or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information in M&M Behavioral Health Solutions records, and to request and receive an accounting of disclosures of your health related information made by M&M Behavioral Health Solutions during the six years prior to your request. This release/disclosure of your information does not include individual progress notes as allowed by law. You also have the right to receive a paper copy of this notice upon request.

A. In accordance with Title 6 of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title 9, Section 10800, and Americans with Disabilities Act of 1990, each person receiving services from an alcoholism or drug abuse recovery or treatment facility, shall have rights which include, but are not limited to, the following:

1. The right to confidentiality as provided for in Title 42, Code of Federal Regulations, Part 2 and HIPAA and the right to receive this privacy notice.
2. To be accorded dignity in contact with staff, volunteers, board members, and other persons. You have the right to have your rights explained to you in simple terms, in a way you can understand within 24 hours admission, which can help in decision making.
3. To be accorded safe, healthful, and comfortable accommodations to meet the client's needs. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
4. To be free from verbal, physical, emotional abuse, inappropriate sexual behavior or contact, exploitation, humiliation, harassment, and/or neglect.
5. To be informed by the program of the procedures to file a grievance (without fear of retaliation) or appeal discharge.
6. To be free from discrimination based on ethnic group identification, culture, sexual orientation, religion or spiritual beliefs, age, gender, skin color, socioeconomic status, language, or disability.

7. To be accorded access to his or her file and the right to own the information within his or her file with the exception of psychotherapy notes.
8. The right to request corrections of erroneous and/or incomplete information.
9. The right to decline participation in any research or be treated by staff in training.
10. The right to prohibit re-disclosure of client information.
11. The right to request transmittal of communications in an alternative manner.
12. The right to obtain an accounting of disclosures.
13. The right to express preferences regarding counselor or service provider.
14. Fiduciary abuse of participants is prohibited.
15. To be free from any marketing or advertising publicity without written authorization.
16. The right to provision of services will be responsive to the participants' social support and legal advocacy needs, when necessary.
17. The right to be free from intrusive procedures (strip searches or pat downs).
18. If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law). You have the right not to receive unnecessary or excessive medication.
19. You have the right to accept or refuse treatment after receiving this explanation.
20. You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
21. You have the right to be told about the program's rules and regulations before you are admitted. You also have the right to be told what is to be expected of treatment.
22. You have the right to be told before admission:
    - the condition to be treatment.
    - the proposed treatment.
    - the risks, benefits, and side effects of all proposed treatments and medication.
    - other treatments that are available and which ones, if any, might be appropriate for you; and
    - the expected length of stay.
23. You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing the plan. You also have the right to meet with staff to review and update the plan on a regular basis.
24. You have the right to be told in advance all estimated charges and any limitations on the length of service of which M&M Behavioral Health Solutions is aware.
25. You have the right to receive an explanation of your treatment and/or your rights if you have questions while you are in treatment.

B. For residential sites, the Client Bill of Rights shall also include:

1. You have the right not to be restrained or placed in a locked room by yourself unless you are a danger to yourself or others. You have the right to communicate with people outside of M&M Behavioral Health Solutions. This includes the right to have visitors, to make telephone calls, and to send and receive mail. This right may be restricted on an individual basis by the Clinical Director or Program Director if it is necessary for your treatment or security, but even then you may contact an attorney, the Maryland Department of Health and Mental Hygiene at any reasonable time. If a client's right to free communication is restricted under the provisions of this paragraph, the Clinical Director or Program Director will document the clinical reasons for the restriction and the duration of the restriction in the client record. The Clinical or Program Director will also inform the client, and, if appropriate, the client's consenter of the clinical reasons of the clinical reasons for the restriction and the duration of the restriction.
2. If you consented to treatment, you have the right to leave M&M Behavioral Health Solutions requesting discharge unless a physician determines that you pose a threat of harm to yourself or others.

C. Each participant shall, review, sign, and be provided at admission, a copy of the participant rights specified in A1 through A25 above. The program shall place the original signed bill of rights in the client's record.

D. The provider shall post a copy of this document in a location visible to all participants and the general public.

E. Follow-up after discharge cannot occur without a written consent from the client.

F. Any program conducting research using clients as subjects shall comply with all federal regulation for protection of human subjects (Title 45. Code of Federal Regulations 46.) However, you have the right to refuse to take part in research without affecting your regular care.

M&M Behavioral Health Solutions Duties

M&M Behavioral Health Solutions is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. We are required by law to abide by the terms of this notice. M&M Behavioral Health Solutions reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. Revised notices will be posted in the office and on our websites, as well as given to all active clients.

Complaints and Reporting Violations

You may complain to the Secretary of the United States Department of Health and Human Services at 200 Independence Avenue S.W., Washington, DC, 20201, to the Maryland Department of Health and Mental Hygiene at 201 West Preston Street, Baltimore, MD, 21201, and to M&M Behavioral Health Solutions Clinical or Program Director (at the address below) if you feel that your privacy rights have been violated under HIPAA. M&M Behavioral Health Solutions will take no retaliatory action against you if you file a complaint about our privacy practices.

Contact

If you have questions about this notice or any complaints, please contact our Clinical or Program Director at 1406 South Crain Highway, Ste 104, Glen Burnie, MD 21061 or 410-766-6624. Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurred.

Effective Date: January 1, 2016

List of the Maryland Medicaid Managed Care Organizations (MCOs)

Aetna Compliance Officer 509 Progress Drive, Suite 117 Linthicum, MD 21209 (866)827-2710	**Amerigroup Community Care** Compliance Officer 7550 Teague Road, Suite 500 Hanover, MD 21076 (410)859-5800
Priority Partners Compliance Officer 7231 Parkway Drive Hanover, MD 21076	**Maryland Physicians Care** 1201 Winterson Road, Suite 170 Linthicum, MD 21090 (800)953-8854
United Healthcare Community Plan 10175 Little Patuxent Parkway Columbia, MD 21044 (800)487-7391	

Please keep the first 4 pages for your records.

Notice of Confidentiality and Client Bill of Rights (*Pages 2-4*)

Acknowledgement: I hereby acknowledge that I received a copy of this notice.

Client Name: _____ **Date:** _____

Client Signature: _____ **Date:** _____

Signature of Staff Member: _____ **Date**: _____

Notice of Privacy Practices (*Page 1*)

Receipts and Acknowledgement of Notice

Patient/Client Name: _____ **DOB:** _____

Social Security Number: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer.

Signature of Patient/Client: _____ **Date**: _____

Signature of Parent/Guardian/Personal Representative: _____ **Date**: _____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual, (power or attorney, healthcare surrogate, etc.)*_____

☐ **Patient/Client refused to acknowledge receipt:**

Signature of Staff Member: _____ **Date:** _____

*Use of Client Photos

MMBHS uses client photos within the context of the electronic medical records system as an additional identifier for medical records. These photos follow the same regulations as written medical records. Clients may choose to opt out of having their photo stored with their medical record by notifying the administrative staff.

M & M Behavioral Health Solutions, LLC

REGISTRATION FORM (Please Print)

PATIENT INFORMATION

Last Name: _____ First Name: _____ If Minor, Parent Name:_____

Marital Status (*Circle one*): Married – Single – Domestic Partner - Widowed - Divorced - Child Gender: M F Other: _____

Primary Language: _____ Race: _____ (i.e. Caucasian, Asian, African American) Hispanic? Y N

Address: _____ City/State/Zip: _____ Homeless? Y N

Cell #: _____ Home #: _____ Work #: _____

Patient Social Security #: _____/_____/_____ Date of Birth: (m/d/yr.) _____/____/_____ Veteran: Y N

EMPLOYMENT INFORMATION (SCHOOL, IF STUDENT)

☐ Check if unemployed Employer / School Name: _____ Occupation: _____

How long employed/Grade?_____ Address: _____ City/State/Zip: _____

INSURANCE INFORMATION

Insurance:_____ Member ID:_____ Group Number:_____

Address:_____ City/State/Zip:_____ Subscriber Name/Relationship:_____

EMERGENCY CONTACT PERSON

Last Name: _____First Name: _____ Relationship to patient: _____

Home #: _____ Work #: _____ Cell#: _____

PRIMARY CARE PHYSICIAN

Primary care physician: _____ Phone #: _____

Address:_____ City/State/Zip: _____

PHARMACY INFORMATION

Pharmacy Name: _____Phone Number: _____ Fax #:_____

Address:_____ City/State/Zip: _____

The above information is true to the best of my knowledge. I am authorizing my insurance benefits to be paid directly to the provider. I understand that I may become financially responsible for any balance due, and any balances owed are due prior to receiving services. I also authorize M & M Behavioral Health Solutions, LLC (MMHBS) or the insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

Optum Additional Demographic Data Capture

Please complete the following if you have <u>ANY form of Maryland Medicaid/State Funded Insurance</u>, as this information is needed to guarantee authorization & coverage. <u>*If you have Medicare or other Private Insurance, you do not need to complete this form*</u>.

1) Would you prefer to be called by anything other than your legal name? _____
2) Please list any previous names (*maiden name, legal name change, etc.*) _____
3) Mailing address (*if different than physical address on file*) _____
4) Living situation? (*Circle one*): Homeless Residential/Independent Community Institution Other: _____
5) US Citizen? **YES** **NO** Maryland Resident? **YES** **NO**
6) Do you have a legal guardian? (*If so, please list the guardians first and last name, address and phone number*)

   _____
7) How well do you speak English? (*5 years or older*) **VERY WELL** **WELL** **NOT WELL** **NOT AT ALL**
8) Do you need assistance with communicating in English? **YES** **NO**
9) Do you speak any other language than English at home? **YES** **NO**
10) Primary Source of Income? _____
11) Highest level of Educational? _____
12) Currently pregnant? **YES** **NO** **N/A**
13) Arrest status/history? (*number of arrests within the last 30 days?*) _____
14) The number of times you have attended a self-help group in the last 30 days. _____

Questions regarding disabilities or accommodations needed: *(please circle yes or no)*

15) Are you deaf or do you have serious difficulty hearing? **YES** **NO**
16) Are you blind or do you have serious difficulty seeking, even when wearing glasses? **YES** **NO**
17) Because of a physical, mental, or emotional condition, do you have serious difficulty, remembering or making decisions? (*5 years or older*) **YES** **NO**
18) Do you have serious difficulty walking or climbing stairs? (*5 years or older*) **YES** **NO**
19) Do you difficulty dressing or bathing? (*5 years or older*) **YES** **NO**
20) Because of physical, mental, emotional conditions do you have difficulty doing errands alone such as visiting doctor's offices or shopping? (15 years or older) **YES** **NO**

Advanced Beneficiary Notice

NOTE: You need to make an informed decision about receiving these services

There is always the possibility that your insurance company may not pay for these services. Insurance companies do not always cover mental health treatments. The fact that your insurance company may not pay for these services does not mean that you should not receive the treatment.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why your insurance company may not pay.
- Ask us how much these services will cost you (Estimated cost $150.00) in case you have to pay for them yourself or through other means.

☐ **OPTION 1: YES. I want to receive these services for mental health treatment.**
I understand that my insurance company may decide not to pay for these services. Please submit my claim to the insurance company. I understand that you may bill me for services and that I may have to pay the bill while my insurance company is making its decision. If my insurance company does pay, you will refund to me any payments I made to you that are due to me. If my insurance company denies my claim. I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other means that I have. I understand I can appeal my insurance company's decision.

☐ **OPTION 2: NO. I have decided not to receive these services.**
I will not receive these services. I understand that if my insurance company denies the claim that I will have to pay for the service out of pocket. I elect at this time to forgo services even though you have indicated to me that treatment would be beneficial to me at this time. I understand that I may return at any time to reconsider receiving mental health treatment.

Signature of client or representative: _____ **Date**:_____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health Information on this form may be shared with them. Your health information which the insurance company sees will be kept confidential by them as required by HIPAA laws.

M & M Behavioral Health Solutions, LLC

1406 Crain Highway South, Suite 104, Glen Burnie, MD 21061 (P)410-766-6624 (F) 410-766-0240

Authorization for Release of Personal Health Information and Medical Records

This release of information will allow another person and/or provider to access and/or exchange your medical information. (This includes health information, which is any information that relates to your past, present, or future physical or mental health or medical condition.) I authorize the disclosure of my personal health information as describe below. I understand that this authorization is voluntary.

I hereby give permission to M&M Behavioral Health Solutions, LLC to release information to and/or obtain information from the following:

Information is released to: _____

Address: _____

Telephone/Fax: _____

Personal Health Information to be disclosed: Verbal, written and electronic communication of ALL records/pertinent information needed for the purpose of rehabilitation, treatment, services and the complete continuation of care for the consumer.

Right to revoke: I may revoke this authorization at any time except to the extent that action has been taken. If I do not revoke it, this authorization with expire one year after the date on which signed. To revoke this authorization, I will contact the Program Director/Coordinator and make a written request to cancel consent.

I, _____, DOB:_____ SS#:_____ have had full opportunity to read the contents of this authorization and I confirm that the contents are consistent with my direction to the person named above. I understand that, by signing this form, I am confirming my authorization that the above-named person(s) or organization may use and/or disclose nonpublic personal health information described in this form.

Signature of Consumer: _____ Date: _____

Witness: _____ Date: _____

**If a personal representative, on the behalf of this individual signs this authorization, complete the following:

Personal representative's Name: _____

Relationship to Individual: _____

Consent for Electronic Communication

Client Name: _____ **DOB**: _____

This form, when completed and signed by you, authorizes your therapist/MMBHS staff to release and/or exchange protected information from your clinical record using electronic mail (e-mail) or other forms of electronic communication.

ASSUMPTIONS

– E-mail/text messages can be immediately broadcast worldwide and be received by many intended and unintended recipients.
– E-mail and other forms of electronic communication are not "secure" means of communication.
– Recipients can forward e-mail or text messages to other recipients without the original sender's permission or knowledge.
– Users can easily misaddress an e-mail message or text message.
– E-mail or text message may be altered and is easier to falsify than handwritten or signed documents.
– Backup copies of e-mail or text messages may exist even after the sender or the recipient has deleted his/her copy.
– E-mail or text messages containing information pertaining to a patients diagnosis and/or treatment constitutes a part of the patient's medical record. All e-mail and text messages may be discoverable in litigation regardless of whether it is in a patient's medical record.
– Messages transmitted via e-mail or text messages may not be picked up in a timely fashion. To avoid unnecessary delays in the transmission of important information, do not use e-mail or text messages to send urgent messages.

**Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and may no longer be protected by the HIPAA privacy rule. You have the right to revoke this authorization, in writing, at any time by sending such written notification to the MMBHS business address. Your revocation will not be effective to the extent that MMBHS staff have taken action in reliance on the authorization or if this authorization was obtained as a condition obtaining insurance coverage and the insurer has a legal right to contest a claim. If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.

_____I(we) understand the assumptions stated above and understand that electronic communication (text, email, cell phone) is not a secure means of communication. I am aware that the provider may decline to communicate via electronic communication based upon the nature of the medical information. I give permission for MMBHS to use electronic communication as a means of communication regarding my care. I understand that I may withdraw this authorization at any time by notifying MMBHS administrative staff or my therapist in writing.

Please initial on line and circle choice:
_____Email communication is, unless otherwise appended on this document to be: **Permitted** **Not Permitted**
_____Text communication is, unless otherwise appended on this document to be: **Permitted** **Not Permitted**

This provider does not use any communication made through social media sites, such as Facebook, Twitter, Instant Messaging, LinkedIn, etc.

By signing below, I understand and agree to the above stated policy regarding electronic communication.

Signature: _____ **Date**: _____

M&M Behavioral Health Solutions

Medication Management Attendance Policy

At M&M Behavioral Health Solutions, we strive to provide our clients with the best quality care possible. In order to ensure that you receive the necessary care, it is our company's policy that clients seeking medication management are also actively involved in therapy treatment and attending with a therapist at least once a month. If the client cancels, misses, or reschedules therapy appointments three times or more, they will not be permitted to see a prescriber until they see their therapist first. Otherwise the client will be discharged, and referrals will be provided.

All clients are expected to adhere to the company policy. If you have any questions, please feel free to speak with a client care coordinator.

Thank you.

Client Signature: _____ **Date:** _____

Urine Drug Testing

As a client at M&M Behavioral Health Solution all clients are required to participate in random supervised drug screening. Once clients have been requested by a staff member to provide a urine sample for drug testing the client must not leave the property and provide the sample within 2 hours. Failure to do so will result in the event as being documented as a refusal.

- Clients with a positive drug test will be required to have a substance abuse evaluation to further determine treatment needs.
- Two or more drug test refusals may result in being discharged from the agency.
- It is the responsibility of the client to ensure that all medications are current and on file with the agency. This includes all MAT programs i.e. methadone, suboxone
- Clients that do not have insurance covered laboratory services will be responsible for the $40 cost of the drug screen. Additional testing cost may also result for drug testing in addition to the initial screen.

Print Name: _____

Client Signature: _____ **Date**: _____

Staff Signature: _____ **Date:** _____

Tuberculosis: General Information

What is TB? Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine. A person with TB can die if they do not get treatment.

What Are the Symptoms of TB? The general symptoms of TB disease include feelings of sickness or weakness, weight loss, fever, and night sweats. The symptoms of TB disease of the lungs also include coughing, chest pain, and the coughing up of blood. Symptoms of TB disease in other parts of the body depend on the area affected.

How is TB Spread? TB germs are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. These germs can stay in the air for several hours, depending on the environment. Persons who breathe in the air containing these TB germs can become infected; this is called latent TB infection.

What Should I Do if I Have Been Exposed to Someone with TB Disease? People with TB disease are most likely to spread the germs to people they spend time with every day, such as family members or coworkers. **If you have been around someone who has TB disease, you should go to your doctor or your local health department for testing.**

How Do You Get Tested for TB? There are two tests that can be used to help detect TB infection: a skin test or TB blood test.

How is TB Disease Treated? TB disease can be treated by taking several drugs for 6 to 12 months. It is very important that people who have TB disease finish the medicine, and take the drugs exactly as prescribed.

I read and understand the materials presented to me and I had the opportunity to ask questions to a counselor about the above material. I understand I can request additional information on the above material

Client Signature: _____ **Date**: _____

Counselor/Staff Signature: _____ **Date**: _____

HIV/AIDS FACT SHEET

HIV is a virus spread through certain body fluids that attacks the body's immune system, specifically the CD4 cells, often called T cells. Over time, HIV can destroy so many of these cells that the body can't fight off infections and disease. These special cells help the immune system fight off infections. Untreated, HIV reduces the number of CD4 cells (T cells) in the body. This damage to the immune system makes it harder and harder for the body to fight off infections and some other diseases. Opportunistic infections or cancers take advantage of a very weak immune system and signal that the person has AIDS.

What Is HIV? HIV stands for *human immunodeficiency virus*. It is the virus that can lead to *acquired immunodeficiency syndrome*, or AIDS, if not treated. Once you get HIV you have it for life. HIV attacks the body's immune system, specifically the CD4 cells (T cells), which help the immune system fight off infections. Untreated, HIV reduces the number of CD4 cells (T cells) in the body, making the person more likely to get other infections or infection-related cancers. These opportunistic infections or cancers take advantage of a very weak immune system and signal that the person has AIDS, the last stage of HIV infection. No effective cure currently exists, but with proper medical care. HIV can be controlled. The medicine used to treat HIV is called antiretroviral therapy or ART. If taken the right way, every day, this medicine can dramatically prolong the lives of many people infected with HIV, keep them healthy, and greatly lower their chance of infecting others. Today. someone diagnosed with HIV and treated before the disease is far advanced can live nearly as long as someone who does not have HIV.

What Is AIDS? AIDS is the most severe phase of HIV infection. People with AIDS have such badly damaged immune systems that they get an increasing number of severe illnesses, called opportunistic infections. It is very important to take steps to reduce your risk of transmission. Some groups of people in the United States are more likely to get HIV than others because of many factors, including the status of their sex partners, their risk behaviors, and where they live.

To make an appointment for free HIV testing in AA county, call 410-222-7382.

I read and understand the materials presented to me. **YES** **NO**

I had the opportunity to ask questions to a counselor about the above material. **YES** **NO**

I want additional information on the above material I know to request it from the agency. **YES** **NO**

Client Name: _____ **Date**: _____

Counselor/Staff Name: _____ **Date**: _____

Consent to Services

Consent to Services: I voluntarily consent that I will participate in a behavioral health treatment (*e.g. psychological or psychiatric*) by staff from M&M Behavioral Health Solutions (MMBHS). MMBHS employs staff members with a variety of Maryland approved licenses and expects each individual clinician to practice within their scope of practice. Treatment may be provided by a licensed counselor, a psychologist, a psychiatric nurse practitioner, a psychiatrist, or an individual supervised by any of the professionals listed. If you are seen by a supervised individual, please be aware your information may be shared with their supervisor. Additionally, MMBHS allows interns from academic institutions and clinicians in need of clinical supervision, provided on site, to engage in agency business and access records with the same capacity as independent clinicians. Clients may opt out from these services by contacting the clinical director. Services may include interviews, assessments or testing, psychotherapy, and/or medication management.

Risks & Benefits: Behavioral health treatment has both benefits and risks. Risks may include experiencing uncomfortable feelings because the process often required discussing difficult aspects of one's life. However, treatment has been shown to have benefits. It often leads to a significant reduction in feelings of distress, increased satisfaction in relationships, greater awareness and insight, increased skills and resolutions to specific problems. A small number of clients may not improve because of treatment or may terminate before it is clinically indicated. It is important to keep your clinician advised of any difficulty you may encounter during your treatment.

Expiration of Consent: This consent will expire at the time of discharge from behavioral health services from MMBHS.

Attestation of Informed Consent: Information regarding our policies and procedures is provided as part of this informed consent. Please review these documents carefully and check below. Your check mark indicated that you have read, understand, and agree to the information provided in each of the policies and procedures.

- ☐ I have read, understand and agree to the Notice of Privacy Practices and have been offered a copy.
- ☐ I have read, understand and agree to the Client Bill of Rights and have been offered a copy.
- ☐ I have read, understand and agree to the Advanced Beneficiary Notice.
- ☐ I have read, understand and agree to the Electronic Communication Policy.
- ☐ I have read, understand and agree to the Medication Management Policy.
- ☐ I have read, understand and agree to the Urine Testing Policy.
- ☐ I have read and understand the Tuberculosis Information.
- ☐ I have read and understand the HIV/AIDS Fact Sheet.

*****I have read and understand the above information and have had all rules and policies above explained to me. I have had an opportunity to ask questions about this information, and I consent to behavioral health treatment through MMBHS as outlined above. If applicable, I attest that I am designated representative and have the right to consent for the treatment of this client.

_____	_____	_____
Client Signature	**Client Name(Print)**	**Date**
_____	_____	_____
Staff/Counselor Signature	**Staff/Counselor Name(Print)**	**Date**

Family and Recovery Environment Assessment

☐ *Check here and sign/date at the bottom to opt out of completing this form*

	Questions	Yes	No
1.	Would you like to receive information about how chemical dependency affects families?		
2.	Did you grow up in a household where 1 or more family member's alcohol use had a negative impact on the family?		
3.	Would you like to receive information about Al-Anon and/or other 12-step and other self-help programs?		
4.	Do you have a family member who is currently in need of substance abuse treatment?		
5.	Do you believe that the support of you family members can help you refrain from alcohol and/or drug use?		
6.	Would you be interested in setting up a meeting with your primary counselor and family member about substance abuse?		
7.	Would you like to receive information about how to deal with family issues in recovery?		
8.	Did you grow up in a household where 1 or more family member's drug abuse had a negative impact on the family?		
9.	Do you currently reside with a family member or relative whose active drug and/or alcohol use has a negative impact on your efforts to maintain abstinence or sobriety?		
10.	Are your family members supportive of your efforts to abstain from alcohol and/or drug abuse?		
11.	Can you talk to your family members about your participation in methadone maintenance treatment?		
12.	Have you ever suffered from any type of physical, emotional, or sexual abuse by a family member that would make it unsafe for you to involve them in your treatment?		
13.	Would you like to set up a meeting with a family member(s) to discuss how substance use can impact the family?		
14.	Would you like to bring in a family member to discuss how your substance use may have impacted them?		
15.	If you have children under the age of 18, are you comfortable discussing your involvement in treatment?		
16.	Could your primary counselor or treatment team be helpful in talking to your family members about your current involvement in treatment?		
17.	Are you currently interested in receiving some family counseling and/or therapy?		
18.	Do you have any concerns about a family member's current drug or alcohol use?		
19.	Do you what you family or a member of you family involved in any aspect of your treatment?		
20.	Is there a need for an interpreter and/or supports or special services needed to engage your family member in treatment?		
21.	Do you want or need support and/or treatment services to address how your substance misuse may have impacted your own children and loved ones?		

_____ _____

Client Signature **Date** **Counselor/Staff Signature** **Date**

AUTHORIZATION TO DISCLOSE SUBSTANCE ABUSE TREATMENT INFORMATION FOR COORDINATION OF CARE

Name of Patient: _____ DOB: _____

Address: _____

Phone Number: _____ Medical Assistance Number: _____

Section 1: Purpose of Authorization

This Authorization to disclose is for the purpose of permitting the Maryland Medical Assistance Program (the Medicaid program), my substance use treatment provider, and any other providers identified in this form to coordinate my care so that it is more beneficial to me. By giving my consent, my Medicaid Managed Care Organization and any other providers specifically identified on this form will have access to information about substance use treatment I am receiving, which will help avoid conflicts in medication or treatment and improve the care I am receiving. By giving this consent, I may also gain access to other care management services offered through the Medicaid program.

Section 2: Name of Substance Use Treatment Provider:

M & M Behavioral Health Solutions
1406 Crain Hwy S. Suite 102 & 104
Glen Burnie, MD 21061
Phone: (410)766-6624 & Fax: (410)766-0240

Section 3: Duration and Revocation of Authorization

This authorization will expire one year from the date I sign it. I may revoke this authorization at any time by notifying the Maryland Medicaid Program's Administrative Services Organization, Optum Maryland, either orally or in writing at the address below; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed. To revoke the authorization, notify Optum at:

Optum Maryland
10175 Little Patuxent Parkway
Columbia, MD 21044
Phone: 800-888-1965
Fax: 855-293-5407

Section 4: Authorization

I hereby authorize my substance use treatment provider to disclose to the Maryland Medicaid Program (including its administrative services organization, Optum Maryland), claims and authorization data resulting from the treatment, for purposes of coordination of my care. If you want to identify the kind or amount of information that you are authorizing for disclosure, you may do so here:

_____

I also authorize the Maryland Medicaid Program (including Optum Maryland) to re-disclose my claims and authorization day to the Medicaid Managed Care Organization in which I am enrolled, and with any additional health care providers listed on this form below, for purposes of coordinating my health care.

I further authorize my substance use treatment provider to disclose medical records requested by my MCO's patient care coordination team, for purposes of coordinating my care.

I understand that the information that may be disclosed as a result of this authorization may not be re-disclosed to any entity other that those entities identified in this authorization.

I also understand that, for two years following the date of my signature, I have the right to find out who in the MCO actually saw my information.

I have been provided a copy of this Authorization.

Patient Signature: _____ **Date:** _____

Additional health care provider(s) with whom information about by care may be shared:

Name: _____

Address: _____

Name: _____

Address: _____

* NOTE: If you are signing as the member's Legally Authorized Representative, attach a copy of the legal document(s) granting you the authority to do so. Examples are health care power of attorney, a court order, guardianship papers, etc. ***The List of Maryland Medicaid Managed Care Organizations (MCOs)*** *can be found on* *Page 4*.

FAX completed form to Optum Maryland: 1-855-293-5407 or

Mail to: Optum Maryland, Attn: ROI

10175 Little Patuxent Parkway

Columbia, MD 21044