HIPAA Notice of Privacy Practices

I 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.

II. DEFINITION

By law *MMBHS* is required to insure 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.

III. 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:

A. To provide treatment or services;
B. For health care operations (i.e., case consultation, quality control, accreditation processes, etc.);
C. To obtain payment for treatment or services.
D. In cases where a client is served in more than one *MMBHS* program;

III. When required by federal, state, or local law:
  A. If we become aware that you may be a danger to yourself or a reasonably identifiable other;
  ii. If we become aware of/suspect child abuse or neglect
  iii. If we become aware of/suspect abuse or neglect of a vulnerable adult
  iv. If we are court ordered to testify or to submit our records to the court;

IV. 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;
V. 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;
VI. For research or educational purposes;
VII. For Workers' Compensation purposes;
J. Appointment reminders and health related benefits or services;
K. 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.
L. If disclosure is otherwise specifically required by law;

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the right:

A. To see and get copies of your PHI at the cost of no more than $ .25 per page. 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.
B. 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 *MMBH S* is legally required or permitted to make.
C. To choose how your PHI is sent to you. (i.e., sent to your work address instead of home address, cell phone vs. home phone, etc.) We are obliged to agree to your request provided that we can do so without undue inconvenience.
D. 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.
E. To receive a paper or email copy of this notice.

V. 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.

VI. 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 VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about *MMBHS* privacy practices, no retaliatory action will be taken against you.

VII. 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: Tracey McMullen at Tracey.Mcmullen@yahoo.com

M & M Behavioral Health Solutions, LLC

REGISTRATION FORM (Please Print)

PATIENT INFORMATION

Last Name: _____ First Name: _____ Client #: _____

Marital Status: ___ Married___ Single___ Widowed___ Divorced___ Child Race:_____ (i.e. Caucasian, Asian, Latin American)

Primary Language: _____Ethnicity: _____ (i.e. Japanese, Chinese, Hispanic, German, Irish, American)

Address: _____ City/State/Zip: _____

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

Patient Social Security #:_____/_____/_____ Date of Birth: (m/d/yr) _____/____/_____ Gender: M F

EMPLOYMENT INFORMATION (SCHOOL, IF STUDENT)

Employer / School Name: _____ Occupation: _____ Work Phone: _____

Address: _____ City/State/Zip: _____

RESPONSIBLE PARTY INFORMATION

____ ***Check here if responsible party is same as above***

Last Name: _____ First Name: _____ Social Security #:_____/_____/_____

Address: _____ City/State/Zip: _____

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

Date of Birth: (m/d/yr) _____/____/_____ Relationship to Patient: _____

EMERGENCY CONTACT PERSON

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

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

PRIMARY CARE PHYSICIAN

Primary care physician: _____ Phone #: _____

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. 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: _____

Insurance Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____

Date of Birth: _____ SSN: _____

Insurance: _____ Phone: _____

Member ID: _____ Group #: _____

Relationship to Subscriber: _____

Subscriber's Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____

Date of Birth: _____ SSN: _____

*BE ADVISED THAT BY SIGNING FOR US TO BILL YOUR INSURANCE COMPANY YOU UNDERSTAND THAT AUDITORS FROM THAT COMPANY HAVE THE RIGHT TO COME IN, INSPECT AND READ YOUR FILE. ALL YOUR DIAGNOSITIC INFORMATION IS SUBMITTED TO THEM AFTER EACH SESSION. CONFIDENTIALITY IS NOT PRESERVED WHEN INSURANCE COMPANIES ARE BILLED. IF YOU DO NOT WISH FOR US TO BILL YOUR INSURAANCE OMPANY YOU WILL BE RESPONSIBLE FOR THE FULL COST OF EACH SERVICE.

Client Signature:_____ Date:_____

---------- **FOR OFFICE USE ONLY** ----------

Provider Name: _____

Phone: _____ NPI: _____ Tax ID: _____

Address: _____

City: _____ State: _____ Zip + 4: _____

Diagnosis: _____

Claim # : _____ Medical Record#: _____

Prior Auth # (if needed) : _____

M & M Behavioral Health Solutions, LLC
1412 N. Crain Highway, Suite 1B
Glen Burnie, Maryland 21061
(P) 410-766-MMBHS (6624)
(F) 410-766-0240
www.MMBHS.com

Consent to Treat

1. I _____ give permission for **M & M Behavioral Health Solutions, LLC** to give me mental health treatment. I have been advised of any and/or all risks and benefits of treatment.

2. I allow **M & M Behavioral Health Solutions, LLC** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **M & M Behavioral Health Solutions, LLC** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my provider.
   - I have the right to transfer to another provider at any time.
   - I have the right to have a copy of my medical records after submitting written request.

_____ _____
Patient's Signature Date

_____ _____
Parent or Guardian Signature (for children under 18) Date

_____ _____
Print name Date

Anne Arundel County Provider Network

A group of agencies working together to provide and coordinate Services

AUTHORIZATION FOR RELEASE OF INFORMATION

RELEASE FOR COORDINATION OF CARE AUTHORIZATION

RE: NAME (Please Print)_____ DATE OF BIRTH_____

The purpose of this form is to allow me to choose how my services are coordinated. I understand that this is my decision to make and that I can change my mind. If I change my mind, I need to make a written request to cancel this consent. This request will go to the agency or program's Medical Record or Health Information Department for processing. I also understand that I can ask a staff member to assist me with this process. If I have a legal guardian, my guardian may sign or cancel this consent on my behalf.

By checking yes, I am allowing these providers to communicate and exchange information needed to coordinate and continue care, treatment and services. If I check no, I do not want the information exchanged with that provider.

Yes	No	Provider/ Agency Name	Yes	No	Provider/ Agency Name
☐	☐	**Residential Rehabilitation Program:** Arundel Lodge, Omni, PTS and/or Vesta	☐	☐	**Hospitals/Inpatient** AAMC, BWMC, Laurel Regional, other
☐	☐	**Fire Department:** Anne Arundel County, Annapolis City	☐	☐	**Police:** Anne Arundel County, Annapolis City
☐	☐	**Shelter:** Lighthouse Shelter, Sarah's House, Arundel House of Hope	☐	☐	**Detention Facilities:** Jennifer Road and Ordnance Road
☐	☐	**Psychiatric Rehabilitation Program:** Arundel Lodge, ASG, Care Connection, Foundations, Omni, PDG, PTS, Vesta	☐	☐	**Crisis Response System Services:** including mobile visits, phone contacts, interventions
☐	☐	**Case Management:** Community Residence, PDG	☐	☐	Department of Social Services
☐	☐	Mental Health Provider_____	☐	☐	Family Member _____
☐	☐	Anne Arundel County Core Service Agency	☐	☐	**Crisis Beds:** Psy Ki, Mosaic, SMCN, Safe Journey
☐	☐	Anne Arundel County Partnership for Children, Youth and Families	☐	☐	Department of Juvenile Services
☐	☐	School: _____	☐	☐	**Anne Arundel County Health Department**
☐	☐	Other: Please describe:			

INFORMATION REGARDING THE ABOVE NAMED INDIVIDUAL FOR THE PURPOSE OF:

Coordination of Care and Entitlement Eligibility

INFORMATION RESTRICTED TO: Attendance, services received, compliance with recommendations, diagnosis, medications and side effects (if clinically necessary) with individual treatment plans, testing results, applications, previous providers, treatment plans, discharge summaries, and after care plans.

This permission expires automatically at the end of one year unless otherwise stated, but may be revoked by the patient's written request at any prior time except to the extent that action has been taken on it. Parent or legal guardian must sign in the case of a minor child (under age 18 for outpatient mental health services and under 18 for other medical and health services) unless an otherwise minor child is emancipated or permission is not necessary due to protection under the Minor Right Law.

BEFORE SIGNING - PLEASE READ CAREFULLY AND ASK QUESTIONS IF YOU HAVE ANY:

Patient/Parent/Legal Guardian Signature Date

Agency Completing This Form Date

Witness Signature Date

Release Valid Through

M & M Behavioral Health Solutions, LLC

1412 Crain Highway North, Suite 1B, 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 described 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:

Name:_____

Address:_____

Telephone:_____

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 will 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 messages 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 patient's 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 of 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: **Permitted** **Not Permitted**

_____ *Text communication is:* **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 _____

Notice of Privacy Practices
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, or 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 of attorney, healthcare surrogate, etc.)

□ Patient/Client refused to acknowledge receipt:

_____
Signature of Staff Member Date

Medication Check

Name:_____ **Birthday:**_____ **Today's Date:** _____

Please fill out the following in as much detail before your appointment

List all meds you are taking:

Name of med: *Dose:* *times a day* *time of day taken*

_____

_____

_____

_____

Are you taking the meds as prescribed ☐ yes ☐ no
If no, how are you taking them:_____

Since the last visit, have any of the following symptoms/side effects been present? ***Check all that apply***

☐ blurred vision	☐ chest pain	☐ dizziness	☐ difficulty falling asleep
☐ dry mouth	☐ shortness of breath	☐ headaches	☐ waking up frequently
☐ nausea	☐ excessive bruising	☐ skin rash	☐ nightmares/vivid dream
☐ upset stomach	☐ pain in joints	☐ bleeding gums	☐ wakes/can't go back to sleep
☐ vomiting	☐ excessive sweating	☐ increased thirst	☐ excessive sleep
☐ constipation	☐ night sweats	☐ frequent urination	☐ daytime fatigue
☐ diarrhea	☐ sexual changes	☐ numbness	☐ tics/abnormal behaviors
☐ ears ringing	☐ seizures	☐ tremor	☐ other_____

_____

How often are you using:
Caffeinated products (coffee, tea, pop):_____
Alcohol:_____
Marijuana or other chemicals:_____

Please rate the following:

Sleep	☐ worse	☐ poor	☐ fair	☐ good	☐ improving
Appetite	☐ worse	☐ poor	☐ fair	☐ good	☐ improving
Energy level	☐ worse	☐ poor	☐ fair	☐ good	☐ improving

Response to meds. ☐ don't feel any different ☐ poor, side effects or other problems noted
☐ fair, could be better ☐ good ☐ pleased with response

Are you having any suicidal/homicidal thoughts? ☐ no ☐ yes **explain:**_____
Do you have a plan for suicide/homicide? ☐ no ☐ yes **explain:**_____

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Beck Anxiety Scale

Date:_____

		Not at all	Mildly (it did not bother me much.)	Moderately (It was very unpleasant but I could stand it..)	Severely (I could barely stand it.)
1	Difficulty breathing	0	1	2	3
2	Difficulty sleeping at night	0	1	2	3
3	Dizzy or lightheaded	0	1	2	3
4	Face flushed	0	1	2	3
5	Faint	0	1	2	3
6	Fear of dying	0	1	2	3
7	Fear of losing control	0	1	2	3
8	Fear of the worst happening	0	1	2	3
9	Feeling hot	0	1	2	3
10	Feelings of choking	0	1	2	3
11	Hands trembling	0	1	2	3
12	Heart pounding or racing	0	1	2	3
13	Indigestion or discomfort in abdomen	0	1	2	3
14	Nervous	0	1	2	3
15	Numbness or tingling	0	1	2	3
16	On edge	0	1	2	3
17	Racing thoughts	0	1	2	3
18	Shaky	0	1	2	3
19	Sweating (not due to heat)	0	1	2	3
20	Terrified	0	1	2	3
21	Unable to relax	0	1	2	3
22	Unsteady	0	1	2	3
23	Wobbliness in legs	0	1	2	3
				Total Score:	