JMJ HEALTHCARE SERVICES, LLC

OUTPATIENT MENTAL HEALTH CLINIC: CONSENT TO TREATMENT AND POLICIES

Payment Is Due at Time of Service: All co-pays, coinsurance or deductibles must be paid at the time of service. Balances owed from previous visits are expected to be paid in full at the time of your appointment. If a parent or another party takes responsibility for payment, the patient is still required to bring that payment to the appointment. **We accept Cash, Checks, Money Orders and Credit Cards. THERE WILL BE A $3 TRANSACTION FEE ON ALL CREDIT/DEBIT CARD TRANSACTIONS. Initials____**

Cancellations: When an appointment is scheduled, that time is reserved for you. A $60 fee will be charged for failure to cancel within 24h. Our answering machine is available to relay cancellations when the Office is closed. Emergencies may be excluded from this charge at the discretion of the Office Manager. **The $60 fee is also charged for No-Shows (not appearing for a scheduled appointment). NO EXCEPTIONS. Initials____**

Emergency Calls: If you are calling weekdays after 7PM or on the weekend, you will reach our answering machine. If you are experiencing an emergency, please hang up and contact crisis intervention or 911. If your call is not an emergency, please leave a detailed message expressing the nature of your call and someone will return your call the next business day. If you want your therapist/doctor to know that you are running late or unable to attend an appointment scheduled for that evening, please leave a message and our staff will periodically check our answering machine and notify your therapist/doctor as soon as possible. **Initials____**

Mandatory Check-Out at The Front Window: All Patients are required to check out at the front window to schedule an appointment for follow-up visits with your preferred provider. We realize this may result in having a line at the front window and will make every effort to minimize your wait time. We ask that you wait patiently and be respectful of the confidentiality of others in line. **Initials____**

Scheduling Appointments: Patients are responsible for scheduling their own appointments and keeping track of their treatment plan. Failure to consistently follow plan of care will result in removal from schedule. Patients with two (2) consecutive cancellations will be discharged. **NO EXCCEPTIONS. Initials____**

Same-day Appointments: Same-day appointments are not guaranteed and are only available if there is an opening. Appointments are available on a first come, first serve basis. **Initials____**

Insurance Benefits and Billing: Health insurance is a contract between you and your insurance company. For those companies with which we participate, we will file claims as a courtesy to our patients. However, *we cannot bill your insurance unless you provide a copy of your insurance card/virtual card and ID.* We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, coinsurance, covered charges, secondary insurance, etc., other than to supply information as necessary. If you choose to use your insurance benefits **YOU are responsible for calling your insurance company to obtain co-pay, deductible, and benefit information.** If you have an overpayment on your account, it will be credited to future visits. It is

your responsibility to be aware of your plan's annual visit limits, deductible amounts, percentage of charges your insurance will pay, and non-covered services. If requested, you will be provided with an invoice for services that contain all information necessary for you to bill your claims. **Initials____**

Minor Patients: In the case of divorced or separated parents, the person accompanying the child/children is responsible for payment at the time of service. If there is a court order in effect and payment is not made in advance by the party responsible per the court order, payment must be made at the time of service by the adult accompanying the minor and reimbursement will be the responsibility of the parties involved. **Initials____**

Lost or Misplaced Prescriptions: Due to increasing administration cost, there will be a $20 fee for lost or misplaced prescriptions. We will **NOT** rewrite lost or misplaced controlled substance prescriptions. **NO EXCEPTIONS. Initials____**

Prescription Refills: Prescription refills can only be fulfilled during regular business hours, 9am-6pm Monday through Friday. We will **NOT** accept refill requests on weekends or after business hours. Patients who have not been seen in over 30 days, must a provider to receive refills or change medications. **NO EXCEPTIONS. Initials____**

Medical Records, Letters and Completion of forms: JMJ charges a fee for medical records, letters and completion of forms which varies from $25 to $200 based on complexity. Please allow one week from the date the request was made for the information to be available. **Initials____**

Termination of the Physician or therapist Client Relationship: If you have **NOT** been treated by your preferred provider in 3 months or longer, you are no longer considered a patient, therefore no request for forms, documents or prescriptions will be honored. You must seek another psychiatrist by calling your insurance company to obtain further treatment. If you miss two (2) consecutive appointments **without notice, you will be discharged from JMJ. Initials____**

I CONSENT TO RECEIVE OUTPATIENT MENTAL HEALTH TREATMENT AT JMJ HEALTHCARE SERVICES, LLC. INCLUDING PSYCHIATRIC EVALUATION, INDIVIDUAL, GROUP, FAMILY COUNSELING AS WELL AS MEDICATION MANAGEMENT.

This is to certify that I have read and understand this document.

_____ _____

Signature of Responsible Party Date

_____

Print Name

JMJ HealthCare Services, LLC 3327 Superior Lane Suite 206 Bowie, Md. 20715

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND DIABETES CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

To Our Clients: We know that protecting your privacy is important. Therefore, JMJ HealthCare Services, LLC is dedicated to maintaining the privacy of your personal mental health information as part of providing professional care. We also are required by law to keep your information private.

We believe that you should know how we use this information here in this office, how we share it with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. Here are a few examples of what we have in place to protect your right to privacy and confidentiality:

1. Our clinical and administrative staff sign confidentiality statements. This affirms their commitment to protect your information.
2. We will use the information we collect about your mental health to provide you with **treatment**, and collect **payment** for our services, and for other health care operations. After you have read this notice you will have to sign a **Consent for Treatment Form** to let us use and share your information. **If you do not consent and sign this form, we cannot treat you**.
3. If we or you want to use or disclose (send, share, release) your information, we will discuss this with you and ask you to sign a **Consent to Release Information Form.**
4. Of course we will keep your mental health information private, but there are times when the law requires us to use or share it. Here are a few examples:
    1. When there is a serious threat to the safety and mental health of yourself, other individuals, or the public. We will only share information with a person or organization which is able to help prevent or reduce the threat.
    2. Some lawsuits and legal or court proceedings.
    3. If a law enforcement official requires us to do so.
    4. For Workers Compensation and similar benefit programs.

Your rights regarding your mental health information:

1. You can ask us to communicate with you about your mental health and related issues at a time or place that is convenient for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care, such as family members and friends, or the payment for your care. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the mental health information we have about you such as your medical and billing records. Contact our Program Director to arrange to see your records.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to amend your mental health information.
5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy from the Program Director
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Program Director and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the mental health care we provide to you in any way.

After you have signed this consent, you have the right to revoke it by writing a letter to our Program Director informing us that you no longer consent and we will comply with your wishes about using or sharing your information from that time on, but keep in mind that we may already have used or shared some of your information and cannot change that.

I **have received and understand the above notice concerning how my mental health and diabetes care information may be used and disclosed and how I can get access to this information.**

_____ _____

Signature of client or his/her guardian or personal representative **Date**

_____

Relationship to client

JMJ HealthCare Services, LLC

CONSENT FOR TREATMENT

Client's Name: _____ DOB:_____

JMJ HealthCare Services, LLC (JMJ) is an outpatient mental health. We provide individual, family and group counseling, medication management and mental health evaluations.

Treatment Agreement:

I agree to participate with JMJ HealthCare Services, LLC, and I understand that this treatment will be for me/my child's mental health and physical welfare. I understand that I have the right to have any medication or prescription recommendations explained to me in full and that I have the right to review medications with my psychiatrist or nurse representative.

I understand that I have the right to ethical and fair treatment without regard to my race, religion, ethnic origin, sexual orientation or color. I understand that I have the right to appeal any decision made in my/my child's treatment by first discussing it with my primary doctor or physician. I understand that if I am not satisfied with the determination of this appeal, I may then appeal to the Program Director. I understand that I may refuse treatment within 48 hours' notice. I understand that if I choose to refuse treatment or to rescind this agreement for treatment with JMJ, against medical advice, I will not hold JMJ accountable for any pain or suffering I/ my child may incur as a result of that refusal or cessation of treatment. I have been given a copy of Patient Rights Policy, Grievance Process and Discharge Policy for my review.

_____ _____ _____

Client/Parent/Guardian signature Relationship to Client Date

_____ _____

JMJ LLC Staff Signature Date

JMJ HealthCare Services, LLC

RELEASE OF INFORMATION

Consumer's Name: _____ DOB:_____

The confidentiality of Patients' records maintained by JMJ HealthCare Services, LLC is protected by Federal Law and regulations. The program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as a mental health or drug and alcohol substance abusing patient unless:

1. The patient consents in writing.
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in medical emergency or qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by this program is a crime. Suspected violations will be reported to appropriate authorities in accordance with Federal regulations.

Federal laws and regulations do not protect any information about a crime committed, or threat to commit crimes by a patient either at the program or against any person who works for JMJ.

I _____ have received and understand the above notice concerning my confidentiality rights at JMJ. I have also received a copy of this notice.

_____	_____	_____
Client/Parent/Guardian signature	Relationship to Client	Date

_____	_____
JMJ Staff Signature	Date

JMJ HealthCare Services, LLC

Client's Name: _____ DOB:_____

PATIENT'S RIGHTS POLICY

1. You have the right to receive appropriate treatment that restricts your personal liberty only to the extent necessary to your treatment or rehabilitation needs and applicable legal requirements.
2. You have the right to be protected from harm included but not limited to Mental, Physical and sexual abuse at the facility. All allegations of patient or client abuse by staff members must be reported to the local law enforcement agency.
3. You have the right to an individualized treatment or rehabilitation plan.
4. You have the right to participate, in a manner appropriate to your condition, in the development and periodic review of your treatment or rehabilitation plan.
5. You have the right to receive treatment or rehabilitation as stated in your individualized treatment or rehabilitation plan.
6. You have the right to be told in appropriate terms of:
    a) The contents and objectives of treatment or rehabilitation;
    b) The nature and significant possible negative effects of treatment or rehabilitation;
    c) The name, title and role of staff members who are directly responsible for carrying out your treatments or rehabilitation, and when appropriate;
    d) Other treatments, services or providers of mental health services.
7. You have the right to have access to your treatment records and the right, with written permission, form your attorney to have access to your records. In the event your physician believes that it would be harmful to you to read your record, you have the right to a written summary of those sections of the record in which your physician believes might be harmful.
8. You have the right to refuse medication.
9. You have the right to refuse to participate in physically intrusive research.
10. You have the right, prior to admission, to an explanation in terms and language that you can understand of the admission and discharge policies.
11. You have the right prior to admission, to an explanation of your rights in terms and language that you can understand, and to have a list of your rights posted in a prominent place in the facility.
12. You have the right, prior to admission, to an explanation, in terms and language that you can understand, of any charges and fees that you will be required to pay.
13. You have the right to an aftercare plan.
14. You have the right to privacy in our offices. Clients should be able to talk to their treatment coordinator in private and know that the information they supply will not be given out without their permission in writing. Any observers to the treatment will be identified and present only with the client's permission. All records are confidential and protected by federal laws and regulations, they do not protect any information about a crime committed by a client, either at the program or against any person who works for the program. Also, they do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate State or Local Authorities (SEE §42 u.s.c.290dd-3 and 29cee-3 for Federal Laws and §42 CFR Part 2 for Federal Regulations).
15. You have the right to file a grievance if you are not satisfied with the treatment or rehabilitation that you receive.

GRIEVANCE PROCESS

1. In the event you have any grievances, you may personally through or in combination with other persons, present grievances and recommend changes in policies and services on behalf of yourself or others without fear of reprisal, interference, coercion or discrimination.
2. A grievance may be initiated verbally and must be confirmed in writing by the Program Director.
3. The grievance will be forwarded by the Program Director for review.
4. The Director will review the report of the supervisor, clinician or AD HOC committee and report in writing to the advisory board.
5. All the above steps will be completed within 14 working days.
6. If needed, the written response will include an assessment of any factors contributing to the grievance, and proposed remedies, if any, to prevent a recurrence of problems.

DISCHARGE POLICY

An Individual Treatment Plan (ITP) will be developed by the client and the treatment coordinator. The ITP outlines long and short-term goals designed to address issues bringing the client to treatment. When these goals have been successfully attained or there is evidence of successful progress to attainment, the treatment coordinator and client will negotiate a plan of discharge with a clear date of termination. If alternative treatment is sought or a different choice of treatment is requested, the client will be discharged. The client may be readmitted at any time with a new intake process. The treatment coordinator will make referrals for necessary resources needed for the client after discharge and will document in the client's record.

I have been informed of and agree to my rights to medical care as stated above. I have been informed of and agree to the policies and procedures for submitting a grievance. I have been informed of and agree to the policy for being discharged from JMJ, LLC. I understand the rights to medical care, policies and procedures, and the discharge policy as explained to me. If there is any portion of the rights, policies and procedures or the discharge policy which require further explanation, I understand that I am free to request explanation and assistance now or in the future.

_____ _____ _____
Client/Parent/Guardian signature Relationship to Client Date

_____ _____
JMJ Staff Signature Date

Name of Client: _____Male ___ Female ____

DOB: _____ Age: _____ Cell/Work Phone: _____

Home Phone: _____Address: _____

Relationship to Client: ☐Parent ☐Legal Guardian ☐Self ☐Other: _____

SSN: _____Insurance Provider: _____

Insurance ID #_____ Policy Holder: _____DOB: _____

Is client covered under any other health insurance plan? ☐ No ☐ Yes, if so please provide us with your secondary insurance: _____

Referral Source: (Name of Person): _____ Phone: _____

Address: _____

Consumer's Primary Care Physician: **_____** ***Phone:*** **_____**

Address:

_____

****Health alert (any known drug allergies or adverse reactions)***

_____

Alternate Emergency Contact:

Name: **_____**

Relationship: **_____**
Address: **_____**

Daytime Phone: **_____** ***Evening Phone:*** **_____**

I understand that in the event of any emergency, attempts will be made to contact any of the above for the purpose of notification. It is my preference that such treatment is provided by the above physician. I also freely give consent to JMJ to release to the above physician pertinent information relevant to such treatment.

_____ _____
Client/Parent/Guardian Signature Date

_____ _____
JMJ Staff Signature Date

JMJ HealthCare Services, LLC

Client/Guardian:

It is very important that we provide the highest quality of service. Therefore, it is also very important that we maintain clear communication to prevent misunderstandings. Please carefully

read the following information about our **cancellation/no show policy; our hours of operation and on-call emergency procedures:**

1. It is very important that you come to your appointments on a regular basis. You (or your child's) sessions are reserved for you. If you do not keep your appointments, progress in treatment will suffer. We expect to be notified of cancellations at least 24hrs in advance.

2. We discharge clients after 2 consecutive "No Shows."

3. The program operates Monday – Friday from 9:30 am to 7:00 pm. On-call and emergency services are provided through a live "answering service." A staff member is on-call in the evenings and on the weekends by cell phone. The cell number can be accessed by calling the program's main number @ 240-206-8345.

Emergency procedures are available 24/7. For immediate help in an emergency, **please call the Prince George's County Crisis Response System @ 301-429-2185.** If you or someone is experiencing a life-threatening emergency, 911 should be called immediately.

Please do not hesitate to talk to the Medical Director or your preferred provider about any problems or concerns you may be experiencing with the services provided. We will discuss your concerns with you with the hope that the issue can be resolved.

Thank you for choosing **JMJ HealthCare Services, LLC** as your provider we look forward to working with you.

I_____ have read and understand the above notice regarding the program's cancellation/no show policy; hours of operation and on-call emergency procedures

_____ _____

Signature of Client (or guardian) Date

_____ _____

JMJ Staff Signature Date