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 VI 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: the clinical director at 410-766-6624 or 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. You also have the right to receive a paper copy of this notice.

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 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 the following:
-Our Clinical or Program Director at 1406 South Crain Highway, Ste 104, Glen Burnie, MD 21061 or 410-766-6624.
-The Joint Commission at Office of Quality Monitoring, The Joint Commission, 1 Renaissance Blvd., Oakbrook Terrace, Illinois 60181
-You may also contact The Joint Commission by calling (800) 994-6610 or via email complaint@jcaho.org
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

Crisis and Resource Information for Clients

Maryland-Statewide Crisis Hotline- (800)422-0009

2-1-1 Maryland
Phone: 211
Website: http://www.211md.org
Area Served & Hours of Operation: Statewide 24/7

Anne Arundel County Crisis Response System
Phone: (410)768-5522
Website: http://www.aamentalhealth.org/pr_warmline.cfm
Area Served & Hours of Operation: Anne Arundel County 24/7
Provides mental health treatment, rehabilitation, and support to individuals and families.

Family Crisis Resource Center, Inc.
Phone: (301)759-9244 OR Text: (301)970-4242
Website: http://www.familycrisisresourcecenter.org/
Area Served & Hours of Operation: Statewide 24/7
Crisis and supportive counseling, crisis intervention, emotional support, information, and referral services to survivors of domestic violence and rape.

Client Information

Last Name:_____ **First Name**: _____ **Gender**: _____

Marital Status: _____ **Race**:_____ (i.e. Caucasian, Asian, Latin American)

Primary Language: _____ **Hispanic?: ( ) Yes ( ) No**

Address:_____**City/State/Zip**: _____

Cell #: _____ **Home #**:_____ **Email address: _____**

Client Social Security #: _____ **Date of Birth** (m/d/yr): _____

Employment Information (School, if student)

Employer/School Name: _____**Occupation**:_____

Work Phone: _____ **Address**: _____

City/State/Zip: _____

Responsible Party Information

☐ **Check here if responsible party is the same as above**

Last Name:_____ **First Name**: _____

Address: _____**City/State/Zip**: _____

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

Date of Birth (m/d/yr): _____ **Relationship to Client**:_____

Emergency Contact Information

Last Name: _____ **First Name**:_____ **Relationship to Client**: _____

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

Primary Care Physician & Pharmacy

Primary Care Physician:_____ **Phone #**:_____

Address:_____**City/State/Zip**:_____

Pharmacy: _____ Pharmacy Address: _____

Pharmacy Phone #: _____ Pharmacy Fax#:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MMHBS or insurance company to release any information required to process my claim.

Client/Guardian Signature: _____ **Date: _____**

Notice of Privacy Practices, Notice of Confidentiality, and Client Bill of Rights Receipts and Acknowledgement of Notices

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

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

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.)

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

Signature of Parent, Guardian, or Personal Representative: _____

Signature of Staff Member: _____

Advance Directive for Mental Health Treatment

Maryland law gives the right to anyone 16 years of age and over to be involved in decisions about their mental health treatment. The law states individuals have the right to make decisions in advance, including mental health treatment decisions, through a process called advance directive. The advance directive is designed to assist with pre-planning should an individual become unable to make informed decisions.

By signing below, I hereby acknowledge that I have been provided this information regarding advance directive and acknowledge that should I have additional questions about creating an advance directive for mental health treatment or providing the agency with a copy of my advance directive for mental health treatment I am able to reach out to my provider or Patient Care Coordinator.

Client/Guardian Signature: _____ **Date:** _____

Signature of Staff Member: _____

Insurance Information

Insurance Company:_____ **Phone**:_____

Member ID:_____ **Group #**:_____

Relationship to Subscriber:_____

(If other than self) Subscriber Name:_____

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 diagnostic 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 insurance company, you will be responsible for the full cost of each service.

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 you want to receive these services, knowing that you might have to pay for them yourself. Before you decide 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 must 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. l 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.

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.

Signature of client or person acting on client's behalf: _____ **Date**: _____

Payment Responsibilities and Credit Card Authorization Form

It is the responsibility of each client to have payment rendered for services. Clients are responsible for all co-pays and remaining balances following insurance reimbursement at the time of service. **All non-Medicaid and Medicare clients** (private insurance, self-pay etc.) must have a valid credit card on file while receiving services at MMBHS. MMBHS reserves the right to freeze access to services if two (2) or more payments have been missed. Services can resume only after the unpaid balance is zero and/or by completing a repayment plan with the accounting department. The accounting department can be reached at 410-766-6624.

As a courtesy to you, MMBHS will charge your credit card on file for the balance on your account. Please completed and sign this form to get started.
With this authorization, you authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card either once a month, or the day of your appointment, for the balance of your account. If this is a replacement authorization, the balance may be charged immediately. The charge will appear on your credit card statement.
If the credit card fails to authorize, or there is any other difficulty using this information to process the payment, this authorization will be removed from our records and information will be sent to the client requesting an alternative method of payment. If you choose to add another card, another authorization form will be required.

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other
Cardholder Name (as shown on card):_____

Card Number:_____

Expiration Date (mm/yy): _____ CVV (3 Digit code on back):_____

Cardholder ZIP Code (from credit card billing address):_____

Charge Monthly ☐ **OR** Charge after every appointment ☐

I, _____, authorize M & M Behavioral Health Solutions LLC. to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Client/Guardian Signature: _____ **Date:** _____

Signature of Staff Member: _____

Client Education

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 tests. 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.

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 if 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. I had the opportunity to ask questions to a counselor about the above material. If I want additional information on the above material, I know to request it from the agency.

Client/Guardian Signature: _____ **Date:** _____

Signature of Staff Member: _____

Medication Management Policy

At M&M Behavioral Health Solutions we strive to provide our clients with the best quality care possible. To ensure that you receive the necessary care, it is our company policy that clients seeking medication management are also actively following their treatment plan; this includes attending all medication and therapy appointments. If the client cancels, misses, or reschedules therapy appointments three times or more, as required by their treatment plan, 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. Clients enrolled in Substance Abuse treatment are also subject to being discharged if they miss 14 consecutive days worth of treatment. Clients enrolled in Mental Health treatment are subject to being discharged if they miss 30 consecutive days worth of treatment

Client/Guardian Signature: _____

Signature of Staff Member: _____

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.

Client/Guardian Signature: _____ **Date:** _____

Signature of Staff Member: _____

Social Media Policy

Friending
Staff at MMBHS do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). It is believed that adding clients as friends or contacts on these sites can compromise your confidentiality and respective privacy. It may also blur the boundaries of our therapeutic relationship.

Interacting
Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact MMBHS. These sites are not secure, and messages are not read in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with MMBHS in public online if there is an already established professional relationship. Engaging this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.
If you need to contact any staff member at MMBHS please contact the front desk at 410-766-6624 or connect2services@mmbhs.com

Location-Based Services
If you used location-based services on your phone or if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a client due to regular check-ins at our office on a weekly basis. Please be aware of this risk if you are intentionally “checking in,” from the office or if you have a passive LBS app enabled on your phone.

Consent for Electronic Communication

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) of 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 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 check choice:

Email communication is: ☐ Permitted unless otherwise appended on this document to be not permitted.
Text communication is: ☐ Permitted unless otherwise appended on this document to be 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 and Social Media.

Printed Name: _____
Signature: _____

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.

Consent for MMBHS Telehealth Services

What is telehealth? Telehealth is a way to visit with healthcare providers, such as your doctor, nurse practitioner, or therapist from any place, including your home. You do not need to go to the office.
How do I use telehealth? You talk to your provider by phone, computer, or tablet. You may use video or audio only platforms. MMBHS will provide you with the necessary links to connect your device with your therapist.
Can telehealth be bad for me? You and your provider will not be in the same room, so it may feel different than an office visit. Your provider may make a mistake because they cannot examine you as closely as at an office visit. (We do not know if mistakes are more common with telehealth visits). Technical problems may interrupt or stop your visit before you are done.
Will my telehealth visit be private? We will not record visits with your provider. If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you. Your provider will tell you if someone else from their office can hear or see you. We use telehealth technology that is designed to protect your privacy. If you use the Internet for telehealth, use a network that is private and secure. There is a very small chance that someone could use technology to hear or see your telehealth visit.
What if I want an office visit, not a telehealth visit? You can still schedule an office visit now. Office visits will require you comply with the local COVID-19 guidelines for that location.
What if I try telehealth and do not like it? If you decide you do not want to use telehealth again: contact the office at 410-766-6624 and say you want to stop telehealth services and schedule a different appointment type.
How much does a telehealth visit cost? What you pay depends on your insurance. A telehealth visit will not cost any more than an office visit.

If you sign this document, you agree that: We talked about the information in this document. We answered all your questions. You understand your options for scheduling telehealth appointments.

Client Name: _____ Date: _____

Client Signature: _____ 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 contracted 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, research 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 and understand the Tuberculosis Information & HIV/AIDS Fact Sheet.

☐ 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, understand, and agree to the Social Media & Electronic Communication Policy.

☐ I have read, understand, and agree to the Consent for Telehealth Services

☐ I have read, understand, and agree to the "Consent to Services" & "Risks & Benefits" as stated above.

☐ I understand that my provider(s) is a contracted individual.

*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.

Printed Name: _____

Client/Guardian Signature: _____ **Date:** _____

Authorization for Release of Personal Health Information and Medical Records

This release of information will allow another person, provider, or agency to access 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/Fax:_____

Personal Health Information to be disclosed: Verbal and written 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 upon my discharge from the agency. 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 Client:_____

Witness/Staff Signature:_____

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

Personal Representative's Name: _____
Relationship to Individual: _____

AUTHORIZATION TO DISCLOSE SUBSTANCE ABUSE TREATMENT INFORMATION FOR COORDINATION OF CARE

Name of Patient: _____
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:_____

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 following are the Maryland Medicaid Managed Care Organizations (MCOs).

FAX completed form to Optum Maryland: 1-855-293-5407 or
Mail to: Optum Maryland, Attn: ROI
10175 Little Patuxent Parkway
Columbia, MD 21044

Amerigroup Community Care Compliance Officer 7550 Teague Road, Suite 500 Hanover, MD 21076 (410)859-5800	MedStar Family Choice Compliance Officer 5233 King Avenue, Suite 400 Baltimore, MD 21237 (800)905-1722
Jai Medical Systems, Inc. 301 International Circle Hunt Valley, MD 21030 (888)524-1999	Priority Partners Compliance Officer 7231 Parkway Drive Hanover, MD 21076
Kaiser Permanente Compliance Officer 2101 East Jefferson Street Rockville, MD 20852 (301)816-2424	University of Maryland Health Partners (previously named Riverside Health of MD) 1966 Greenspring Drive, Suite 600 Timonium, MD 21093 (410)878-7709
Maryland Physicians Care 1201 Winterson Road, Suite 170 Linthicum, MD 21090 (800)953-8854	United Healthcare 10175 Little Patuxent Parkway Columbia, MD 21044 (800)487-7391
Aetna Compliance Officer 509 Progress Drive, Suite 117 Linthicum, MD 21209 (866)827-2710	