Welcome to White Marsh Psychiatric Associates, LLC for your care.

Please review the new patient information and complete all the forms. Please return them by fax, bring them to the office or mail them to:

White Marsh Psychiatric Associates, LLC
5024 Campbell Boulevard – Suite H
Baltimore, Maryland 21236
You could also fax them to 410-931-6694.

We will need these forms prior to your **telehealth visit, no later than the 2 days prior to your visit.** We may need to reschedule your appointment if we do not receive your paperwork. When mailing, please allow 5-7 days for the forms to be delivered.
For in-person visits, it is helpful for you to fill out the forms prior to your appointment and bring them with you to the visit. The forms will also be available in the office for in-person visits, and they can be completed prior to your appointment. If you need help or you have questions regarding these forms, please call us at 410-931-9280.

Notice of Privacy Practices -Attached is a pamphlet of our notice of privacy practices, philosophy of care, office hours and a listing of WMPA providers and services provided.

Registration page – please fill out in its entirety.

White Marsh Psychiatric Associates, LLC (WMPA) Policies Procedures and Consent- Please read the entire form and add your child's name to the second page, if the patient is your child. Please sign, state your relationship to the patient and date this form. Also, please have someone witness your signature by signing under your signature and give the date.

Office Policy - On the website, you will see a sample office policy. Later, we will give you an Office Policy specific for you/your child that will list your copays, co-insurance and or/deductible amounts. Your patient responsibility is due at the time of your service.

Addendum to Policy, Procedures, and Consents: Informed Consent for Telehealth Services –

If you want to have telehealth services, this Informed Consent authorizes us to contact you through your email address and/or cell phone number for the telehealth service. Please read this form in its entirety and complete the 2nd page including your cell phone number, the telephone carrier (e.g. Verizon) and your email address. Please add your printed name, patient or guardian signature and date. We also require an emergency contact and their relationship to the patient and a date.

I**nformed Consent for In-Person Services during Covid-19 Public Health Crisis-**
Please read this consent in its entirety and complete page 2 with the patient's printed name, signature, date and your provider's name and date.

Cross-Cutting Symptoms Measure – Clinical symptoms form for your provider. The age appropriate form – adult, guardian for ages 6-17, or self-rated form for ages 11-17 is enclosed. For adolescents, there may be two forms one for the guardian and one for the patient. These form(s) will be given directly to your clinician for in-person visits and can be returned to us to scan into our EHR for your telehealth appointment.

Please let us know your pharmacy for any medications that may be ordered for you:

Pharmacy name: _____ location: _____
Phone number: _____

Mail order pharmacy: _____ location: _____
Phone number: _____

We will also want a list of all the medications that you/your child are taking if you are being seen by a Certified Nurse Practitioner, Physician's Assistant or Psychiatrist.

We will need some forms signed electronically in the office at the time of your visit; or if you are doing telehealth, these forms will be signed at your next visit to the office.

5/10/22 FDD

WHITE MARSH PSYCHIATRIC ASSOCIATES, LLC

Patient Registration

Please print Patient Information

Today's date: _____ Referred by: _____

Patient's full name: _____ Patient's date of birth: _____ Sex: M F

Street address: _____ City: _____ State: _____

Zip: _____ Marital Status: S M W S D Race: _____ Ethnicity: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Employer: _____ Occupation: _____

Is the patient a child? ⬜ Yes ⬜ No College student? ⬜ FT ⬜ PT Year: _____

Responsible party's full name: _____ Street address: _____

City: _____ State: _____ Zip: _____ Alternate phone: _____

Primary care doctor: _____ Primary care doctor's phone: _____

Emergency contact: _____ Relation to Pt. _____ Phone: _____

⬜ I/my child can be reached at the above address and phone numbers.

⬜ An alternative means of communication is needed to reach us. Please contact me/my child at:

_____

Financial Responsibility

I understand that I am responsible for my/my child's entire fee. I will be responsible for a $50 payment for missed appointments unless I cancel an appointment 24 hours in advance**. I will call my insurance company to inform them of my choice to employ the services of White Marsh Psychiatric Associates, LLC, to obtain initial authorization (if needed) and to understand my benefits**. I further understand that the benefits quoted by my carrier are not guaranteed by my insurance company; therefore, they are not guaranteed by White Marsh Psychiatric Associates. LLC. I agree to pay all co-pays, deductibles, and self-payments at the time of service. **A $10 fee may be billed to me if my co-pay is not paid at the time of service.** Any services that are unpaid by my insurance carrier after 90 days or are later denied by my insurance carrier will be my responsibility; I will pay them when billed. Insurance payments or co-payments that I make directly will be deducted from my bill and noted on my monthly statement.

Finally, in the event that my account becomes delinquent and is forwarded to an attorney for collection, I am responsible for the attorney fees and all court costs.

_____

Signature of patient/patient's guardian Relationship Date

White Marsh Psychiatric Associates, LLC (WMPA) Policies, Procedures, and Consents

Appointments • Scheduling and being present for your appointments is crucial to your mental health care. In order to ensure adherence to treatment, all follow-up appointments should be scheduled as recommended by your provider and must be made within **six (6) months** of the previous appointment. If an appointment is not made within this time frame, you must go through the intake process again and your provider will be notified about your request to return to their care. We cannot guarantee that your provider will have an availability at that time.

Cancellations • Twenty-four (24) hours advance notice is required. Without 24 hours advance notice, you will be charged a $50 fee. This fee is due prior to your or your child's next visit.

Fees • Co-pays, self-payments, and payment for non-covered services are due at the time of service. Deductibles are due at the time of service unless you provide a statement from your insurance carrier showing your deductible has been met in full. Cash, checks, and debit/credit cards are accepted. There is a minimum charge of $15 for the completion of forms, and the return check charge is $35.00.

Insurance • We will submit your claims to your insurance carrier, and will make every effort to obtain accurate information about your benefits and limits of coverage. We must request that you contact your insurance carrier to obtain initial authorization and to understand your benefits. Co-pays and deductible amounts are not guaranteed to us when they are quoted from your insurance carrier; consequently, WMPA cannot guarantee them. You are responsible for your bill and/or your child's bill and you agree to pay any amounts that your insurance company does not pay.

Medications • Schedule the appointments that your prescriber recommends. It is your responsibility to contact the office staff and/or schedule and keep your next appointment before your medication runs out. Please allow at least five (5) days for your provider to refill your prescription.

Confidentiality • Information regarding your treatment will not be released unless there is:
1) your written consent,
2) an indication that clear and immediate danger exists,
3) a court order which directs the release on the information, or 4) disclosure of sexual abuse, physical abuse, or neglect of a child under the age of 18. The following consent allows us to provide information to your insurance carrier to ensure that your treatment is medically necessary and appropriate.
Your prescription may be sent with encrypted technology via the internet to your pharmacy.

We will protect your health care information. You have the right to review our Notice of Privacy Practices before signing this consent. Also, you have the right to revoke this consent at any time by notifying us in writing. The revocation will not affect any actions taken prior to the time you revoke it. You have the right to restrict the use of your health care information by informing us in writing of your wish to do so. However, we are no required to agree to any restrictions. If any restrictions are agreed upon, the agreement is binding at the time of use.

Consent to Release Information

I consent to the use and disclosure of my personal identifiable health information for treatment, payment, and health care operation purposes. Furthermore, I consent to the sharing of treatment information among my treatment providers if I am seeing more than one provider at WMPA. Also, treatment plans may be sent to managed care organizations to establish medical necessity for payment of care. I have received a copy of the WMPA Notice of Privacy Practices.

The psychiatrists and nurse practitioners at WMPA (the professional staff who prescribe medications) have chosen to participate in CRISP, a state-wide health information exchange program. This exchange will allow providers to access selected clinical information: emergency room and hospital evaluations and treatments, tests results (labs, EKGs, imaging results), pharmacy information, and medications prescribed. The only information released from WMPA will be you prescriber's name, your medical record number, and your patient demographic information – e.g., your name, date of birth, address, and telephone number. Easier access to this information will help your provider treat you and improve coordination of care.

You can opt out of participation with this health information exchange. Please see our Notice of Privacy Practices for details.

Consent for Examination and Treatment

We ask that the patient, parents, or legal guardian sign the following general consent to treatment. The patient, parent, or legal guardian may at any time decline specific recommendations.

I consent to have WMPA and its professional staff perform order examinations, psychotherapy, and/or related mental health treatments and to order medications when deemed medically necessary or advisable by licensed members of the professional staff for myself or my child _____ (Name of child, if applicable).

Termination of Treatment • WMPA reserves the right to terminate any treatment for failure to comply with treatment, unpaid balances, multiple missed appointments or late cancellations, failure to schedule follow-up appointments within the 6 months, or failure to comply with medical recommendations, such as obtaining laboratory tests. In the even that treatment is terminated, referrals to other providers will be made available.

By signing this statement, I agree to the policies, procedures, and consents described above.

Signature _____ Relation to Patient* _____ Date_____
*State relationship: Patients, Parent, or Legal Guardian

Witness _____ Relation to Patient* _____ Date_____
*State relationship: Patients, Parent, or Legal Guardian

White Marsh Psychiatric Associates, LLC
5024 Campbell Boulevard • Suite H • Baltimore • Maryland 21236

Phone 410 931 9280
Fax 410 931 6694

Office Policy

I understand that I am responsible for my entire fee. I authorize White Marsh Psychiatric Associates, LLC (WMPA) to bill my insurance company and receive compensation for services rendered. I further understand that the benefits quoted by my carrier are not guaranteed. I agree to pay all co-pays, deductibles, and non-covered services. Insurance payments or co-payments made to me directly should be forwarded to WMPA to be deducted from my bill. Since some insurance companies require pre-certification, I will call my insurance company to inform them of my choice to employ the services of White Marsh Psychiatric Associates, LLC. Finally, in the event that my account becomes delinquent and is forwarded to an attorney for collection, I am responsible for the attorney fees, collection fees, and all court costs.

I understand that a block of time has been scheduled for my visits with a provider at White Marsh Psychiatric Associates, LLC; in the event that I must cancel this appointment, 24 hours advance notice is necessary. *Without 24 hours advance notice, I will be responsible for a $50 payment for missed or late/cancelled appointments.*

Co-payments are due at the time of service.

Provider:

Insurance Carrier: Meritain

Initial co-payment: Date: 00/00/0000

Follow-up sessions:*

* Percentage co-pays or self-pay will vary with the visit code used.

Note:

Example Office Policy

Provider:

Insurance Carrier:

Initial co-payment: Date: 00/00/0000

Follow-up sessions:*

* Percentage co-pays or self-pay will vary with the visit code used.

Note:

Patient Name:

Signature:
Patient or Responsible Party/Relationship to Patient: (relationship to patient)

White Marsh Psychiatric Associates, LLC
5024 Campbell Blvd, Suite H
Baltimore, MD 21236

Addendum to Policy, Procedures, and Consents: Informed Consent for Telehealth Services

I understand that this informed consent for telehealth service is in addition to the general "Policy, Procedures, and Consents." In order to utilize telehealth services with providers at White Marsh Psychiatric Associates, LLC (WMPA) I must first be seen for evaluation face to face with my provider. Following that initial session my provider and I will determine if telehealth services are appropriate.

Definition of Telehealth
Telehealth involves the use of electronic communication to allow your provider at WMPA to conduct your appointment using interactive audio and video communications.
Telehealth includes the practice of psychiatry and psychological health care delivery, diagnosis, consultation, treatment, referral, education, and includes the transmission of potentially sensitive medical and clinical data.

I understand that I have the following rights with respect to telehealth services:

1. The laws that protect confidentiality of my personal information also apply to telehealth. As such I understand that the information disclosed by me during the course of my telehealth session is generally confidential. However, there are exceptions to that confidentiality including, but not limited to, reporting child abuse and/or neglect of a child under the age of 18, abuse of vulnerable adults, suicidal intent and plan, expressed threats directed at a specified victim, and where I make mental/emotional state a concern in legal issues.
2. I understand that I have the right to withdraw my consent to telehealth at any time. My withdraw of consent for telehealth will not impact my right to future care or treatment in other modalities of services (ie face to face)
3. I understand that telehealth has specific risks and consequences, including, but not limited to, information being disrupted/distorted by technical failures, information being interrupted by unauthorized persons, and the possibility that unauthorized individuals may gain access to my protected health information. WMPA takes all steps necessary to maintain the security of telehealth communication in accordance with applicable standards set forth by licensing bodies and government agencies.
4. I agree to provide an emergency contact and I am aware that my provider may discuss a safety plan specific to my telehealth treatment. Furthermore, I attest to knowing where the closest emergency room is to my specific location.
5. I understand that if my provider deems that telehealth is not the appropriate modality for my treatment, I will be able to see my provider for face to face sessions or I will be referred to another provider for treatment through other modalities. Furthermore, if I am currently seeing a provider for face to face services, my provider may also offer telehealth services and I am able to schedule sessions in either modality at my provider's discretion.
6. I will ensure that I have adequate technological skills to participate in the session. I assume responsibility for establishing a confidential environment and will not hold provider liable should confidentiality be breached due to my negligence. I can be assured that my provider will maintain a safe and secure confidential environment.

7. I understand that I may expect to notice improvements based on the access to my provider that telehealth services offer; however, no results can be guaranteed or assured.
8. I understand that my healthcare information may be shared with other individuals within WMPA for the purposes of scheduling and billing.
9. I understand that WMPA will make all efforts to submit your claim for telehealth services to your insurance carrier. WMPA cannot guarantee telehealth insurance benefits and I will need to be in contact with my insurance carrier to determine if telehealth services are covered. I assume the ultimate responsibility for my bill. I understand that co-pays, deductibles, and self-payment may apply, and I will be billed for applicable amounts.
10. I understand that if I am a minor, I will need permission from a parent or legal guardian to participate in telehealth sessions.
11. I understand that I may need to receive an email and/or text from my provider with access information to the telehealth session. I will respect the email and/or phone number of provider and will not utilize email and/or text for any other purpose other than to access my telehealth session. I authorize WMPA to contact me through text at _____(carrier:_____) or through email at _____ for the purpose of sending a link for my telehealth session.

Patient Consent to the use of Telehealth Services

I have read and understand the information provided above regarding delivery of services through telehealth. I was given an opportunity to ask any questions related to this document with my provider and my questions were answered to my satisfaction.

I have read this document carefully and understand the specific risks, benefits, and expectations related to the use of telehealth. I hereby give my informed consent to participate in the use of telehealth services for the treatment of myself or minor child.

By my signature below, I hereby state that I have read, understood, and agree to this informed consent.

_____

Patient Name Printed

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian Signature Date

_____ _____

Emergency Contact/Relationship Phone #

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

Given the fluid response to the COVID-19 pandemic and in keeping with the best practices set forth by the American Psychological Association (APA) and the Maryland Department of Health (MDH) the following contains important information about our decision (yours and mine) to resume/maintain in-person services. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an agreement between us.

Decision to Meet Face to Face

We've agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about going back to telehealth, we'll talk about it first and try to address the issue. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk).

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone
(you, me, our families, (my other staff) and other patients) safer from exposure, sickness and possible death. Your failure or refusal to adhere to these safeguards may result in our starting/returning to a telehealth arrangement.

- You will only keep your in-person appointment if you are symptom free.
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee.
- You will wait in our waiting room, if social distancing seating is available, or in your car until I am ready for your appointment.
- You will wash your hands or use hand sanitizer when you enter the building.
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.
- You will wear a mask in all areas of the office (I [and my staff] will too).
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking Hands) with me (or staff).

- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.
- You will take steps between appointments to minimize your exposure.
- If you have a job that exposes you to those who are infected, you will let me [and my staff] know.
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know.
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth.

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the virus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, (my staff) and all of our families safe from the spread of this virus. If you show up for an appointment and display symptoms of corona virus or have been told that you have been exposed to the corona virus within the past 14 day, I will require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details of the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements to the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

Patient Name: _____

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Provider