15480 Annapolis Rd• Bowie, MD • 20715

info@themodalitiesgroup.com • www.themodalitiesgroup.com

CONSENT FOR TREATMENT

Welcome to TMG.
This document contains important information about the services and policies of TMG. Please review the information carefully, sign the document, and discuss any questions with your therapist.

Confidentiality
Policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. It is the policy of TMG to protect the privacy of every client to the maximum extent possible. Generally, information about you or services furnished to you will not be released without your prior written consent. There are, however, some circumstances which require the disclosure of information without your consent, such as when:

a) mandated by state or federal law due to suspicion or knowledge of child abuse and/or neglect or elder abuse and/or neglect,
b) there is an imminent risk or serious threat of physical harm to self or to others, and
c) specifically ordered by a court of law.

In accordance with the quality assurance standards set by our governing body, your file may be reviewed to ensure record keeping compliance. Also, your therapist may anonymously discuss your treatment with a supervisor to ensure the provision of quality care. All TMG supervisors and staff are obligated to follow laws of confidentiality.

Cancellation Policy
TMG requires 24-hour notice in the event you need to cancel or reschedule your appointment. To cancel or reschedule your appointment contact your therapist by calling his / her direct dial phone number, email, or calling our main number.

Appointments that are canceled or missed without the 24-hour notice will be billed to your account in the amount of $85. Insurance does not reimburse for missed appointments; therefore, you are responsible for full payment of this fee. Please discuss with your therapist any questions about the cancellation policy.

Messages
If you need to contact your therapist outside of your scheduled appointment, you may contact him / her by calling the direct dial phone number, or emailing. Messages are reviewed by the following business day. If you experience a mental health crisis, please review the section on emergencies below. Please discuss with your therapist any questions about how he / she handles messages.

Emergencies
Please discuss with your therapist how to handle emergencies. If you experience a mental health crisis outside of a session there are several resources for help. Maryland's Helpline is available 24/7 to provide support, guidance, and assistance. Please call 211 and select option 1, text your zip code 898-211, or visit 211MD.org. Alternatively, you may go to the nearest Emergency Room or call 911.

Fees and Insurance
Payment is expected at the time of your appointment. TMG accepts the following payment options: HSA, FSA, MasterCard, Discover, American Express and Visa.

TMG accepts the following insurance: Maryland Medicaid, Magellan, Carefirst/BCBS, Cigna, United Healthcare as in-network, and other insurance as out-of-network, please contact our office to confirm. If you select to use your insurance, we will assist you in answering basic questions about your benefits, as well as submit claims on your behalf. You will need to provide your current insurance identification card and your government issued ID prior to your initial appointment. Your plan may include deductibles, co-insurance, and co-pays. Ultimately, you are responsible for payment and understanding your insurance policy.

The standard fee is $190 for an initial appointment, and $175 for ongoing appointments. TMG requires timeliness of payments; overdue accounts may result in formal collection procedures.

Client Rights
All clients of TMG maintain their rights to the following:

Personal Rights

1) The Client must be treated with dignity and respect, free from any verbal, physical, emotional or sexual abuse.
2) The Client has the right to have staff make fair and reasonable decisions about treatment and care.
3) The Client may not be filmed, taped or photographed unless he/she agrees to it.

Treatment and Related Rights

1) The Client must be provided prompt and adequate treatment and services appropriate for them.
2) The Client must be allowed to participate in the planning of their treatment and care.
3)
No treatment may be given to the client without written, informed consent, unless it is an emergency to prevent serious physical harm to self or others, or a court orders it.
4) The Client must be informed in writing of any costs of care and treatment for which he/she or relatives may have to pay.

Record Privacy and Access
1) See HIPAA Privacy Practices notice.

Grievances
TMG aims to provide all our clients with high-quality mental health care that will offer hope and healing. In the event you are dissatisfied with the services you or your loved one receive, you retain the right to advocate for on your/their behalf.

For clinical complaints, the procedures are as follows:
Step 1: Clients are encouraged to talk with the therapist to see if the complaint can be responded to and resolved at that level.
Step 2: If the client and therapist cannot achieve satisfactory resolution to the complaint, the client may contact the Executive Director my calling the main number and requesting to speak with the Director or his/her designee.

For administrative or financial complaints, the same set of procedures apply, with an additional step:
Step 3: The client may present a written statement describing the complaint to the Executive Director who will respond to the complaint within 10 business days.

Termination of Services
Clients have the right to end treatment at any time. Please notify your therapist of your desire to complete therapy. She/he may request to have a final session with you to allow for therapeutic termination and to provide aftercare planning. Services through TMG may be terminated for a variety of other reasons, including but not limited to:

- there is mutual agreement by the client and therapist to end services
- the client does not return for treatment or reschedule for 30 days
- the therapist decides to discontinue treatment because it is no longer effective or because the client does not comply with treatment recommendations
- the client is engaged in residential or inpatient treatment (i.e. hospitalization) and does not expect to return to treatment
- TMG therapists may use their clinical judgment to determine a client needs to be referred to another clinician or to another provider organization to ensure appropriate treatment
- TMG reserves the right to terminate with a client who has violated cancellation policies to the point that it has become disruptive to their treatment and/or to the therapist's schedule

Please note that clients are still responsible for making payments on all balances after they have ended treatment, no matter the circumstances. Clients are welcomed to return to treatment with TMG if and when it is appropriate.

Client Consent

My signature below indicates that I reviewed this document, agree to the policies, and authorize the services. I accept financial responsibility for payment of services received, and for payment of late cancellations. If I use insurance to pay all or a portion of the charges, I hereby authorize the release of information necessary to process insurance claims filed on my behalf. I acknowledge that I am financial and legally responsible for the full payment of charges for services received in the event my health insurance policy does not cover my claim. I am 18 years of age or older or I have legal custody of this minor child(ren).

Client Name (Print: _____

Client Signature: _____ **Date:**_____

Custodial Parent or Guardian Signature: _____ **Date:**_____

Notice of 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.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record**

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

- **Ask us to correct your medical record**

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

- **Request confidential communications**

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

- **Ask us to limit what we use or share**

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- **Get a list of those with whom we've shared information**

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

- **Choose someone to act for you**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes
- In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

- **Treat you**

We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

- **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Help with public health and safety issues**

We can share health information about you for certain situations such as: Preventing disease, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.

- **Do research**

We can use or share your information for health research.

- **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

- **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services

- **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

This notice is effective 11/1/2021. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

15480 Annapolis Rd• Bowie, MD • 20715

info@themodalitiesgroup.com • www.themodalitiesgroup.com

This is to acknowledge that I have received

TMG's Privacy Notice

Name _____

Signature _____

Date _____

15480 Annapolis Rd• Bowie, MD • 20715

info@themodalitiesgroup.com • www.themodalitiesgroup.com

Appointment Reminders

TMG offers the option to receive an appointment reminder the day prior to your scheduled appointment by email (up to 2 email addresses) and/or by phone (only 1 phone number permitted). If you choose the reminder by phone, you have the option of a text message or a computer-generated voice message.

Please select **ONE** of the following options:

☐ **TEXT REMINDER (*only one type of phone reminder can be provided*):**

☐ **Text Message:** I authorize TMG to send text message appointment reminders to me on my provided cell phone number. Text message charges from my cell phone provider may apply.

Cell phone number to send text messages to: (_____) _____ - _____

☐ **Decline Text Message:** I do not authorize TMG to send text message appointment reminders to me on my provided cell phone number.

☐ **Email message:** I authorize TMG to send an email message appointment reminders to me on my provided email address.

Email address(es) to send reminder messages to (up to 2):

_____

_____

☐ **None of the above:** I will remember my appointments on my own.

I understand that Late Cancellation and No-Show appointment fees will apply if I cancel my appointment with less than 24 hours' notice.

Appointment information is "Protected Health Information" under HIPAA. By signing, I give my permission to receive appointment reminders as selected. My signature indicates that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services if applicable. I understand that this authorization can only be revoked in writing.

Printed Name	Signature	Date

15480 Annapolis Rd• Bowie, MD • 20715

info@themodalitiesgroup.com • www.themodalitiesgroup.com

EMAIL CONSENT

CLIENT INFORMATION	
CLIENT NAME:	DATE OF BIRTH:
EMAIL ADDRESS:	

TMG will use reasonable means to protect the confidentiality of Protected Health Information (PHI) as defined in the Health Insurance Portability and Accountability Act (HIPAA) sent and received through email. However, because of the risks outlined below, TMG **cannot guarantee the security and confidentiality of email communications and will not be liable for improper disclosure of confidential information** that is not caused by TMG's intentional misconduct.

The risks of email communication include, but are not limited to:

- Email can be copied, circulated, forwarded, and stored in electronic files;
- Email, whether accidentally or intentionally, can be broadcast worldwide immediately and received by many unintended recipients;
- Email is easier to falsify than handwritten or signed documents;
- Backup copies of email may exist even after the provider or client has deleted his or her own copy;
- Employers and online services may have a right to archive and inspect emails transmitted through their systems;
- Passwords providing access to email can be stolen and misused, or host systems can be compromised, leading to unauthorized disclosure of personal information;
- Email can be intercepted, altered, forwarded, or used without written authorization or detection;
- Email may not be answered in the time frame expected by the sender.

After reviewing the risks of email communication, you may authorize (client initials next to selected method):

_____ Encrypted email communication, a secure method, or
_____ Unencrypted email communication, an unsecure method.
_____ None; I do not consent to email communication

If you authorize a method of email communication, you acknowledge and agree to the following:

- I understand that TMG will read and respond to email communication as promptly as possible; however, a specific turnaround time is not guaranteed. Thus, I will not use email for emergencies or other time-sensitive matters.
- I acknowledge that some or all information sent or received via email may concern my diagnosis and/or treatment. Email may be included in my medical record or forwarded internally to other TMG staff as necessary for diagnosis, treatment, payment, and other business purposes. Electronic information will not, however, be forwarded to independent third parties without my prior written consent, except as authorized or required by law.
- I understand that communication via unencrypted email is not secure and, therefore, TMG cannot guarantee the confidentiality of electronic PHI.
- I understand that TMG and its representatives are not liable for breaches of confidentiality caused by any third party or myself.
- I understand that I may, at any time, revoke my consent for email communications, in writing.
- Unless revoked in writing, this authorization will expire upon the date on which I terminate care with TMG and its providers.

I hereby acknowledge that I have read and fully understand the information provided in this Email Consent.

_____ _____
Client Signature Date

RIGHT TO REVOKE

I request that my provider no longer use email to communicate with me.

_____ _____
Client Signature Date

_____ _____
Provider Signature Date