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TAGHI MODARRESSI CENTER FOR INFANT STUDY: SECURE STARTS
UNIVERSITY OF MARYLAND SCHOOL MENTAL HEALTH PROGRAM
www.umaryland.edu

University of Maryland SMHP Referral Form

Student's Name: _____ Grade: _____ Date: _____

Home Room Teacher: _____ Referral Source: _____

Pupil ID No. (PIF#): _____ Race: _____ Gender: ☐ Male ☐ Female

Reason for referral:

Please check all that apply and write a brief description of your concerns

☐ Academic Concerns ☐ Behavioral Concerns ☐ Attendance Concerns ☐ Social Concerns ☐ Emotional Concerns

Please include family/guardian contact information (if available):

Child lives with: *check all that apply*

☐ Both Parents ☐ One Parent ☐ Mother ☐ Father
☐ Grandparent(s) ☐ Foster Care ☐ Other caregiver: _____

1st Caregiver's Name: _____ Age: _____ Employment: _____

2nd Caregiver's Name: _____ Age: _____ Employment: _____

Legal Guardian (if different from above): _____

Name of individual to be contacted: _____

Address: _____

Work Phone: _____ Home/Cell Phone: _____

Has the parent/guardian been notified of this referral? ☐ Yes ☐ No

Please rate the urgency of this request:

☐ Not Urgent ☐ Moderately Urgent ☐ Very Urgent

We appreciate your referral! Thank you!!

To be completed by SMHP clinician: Date Received: _____

Outcome (detailed below): ☐ Appt. Scheduled ☐ Referred Out

Disposition:

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Welcome to University of Maryland School Mental Health Program (SMHP)

Mission and Services:
Through the provision of school mental health services, the University of Maryland School Mental Health Program (SMHP) seeks to enhance the learning environment of the Baltimore City Public School System (BCPSS) by removing the barriers to learning and actively promoting the social-emotional-behavioral well-being of students. The SMHP staff is dedicated to creating a safe and nurturing learning environment in which students and families are able to rapidly access a range of culturally sensitive and effective prevention and therapeutic services that promote wellness and academic success using a person and family centered approach. Services provided to elementary, middle and high school youth include:

- Individual Counseling
- Group Counseling
- Family Counseling
- Case Management
- Family Activities/Events
- Classroom Presentations/Activities
- School-wide Activities
- Classroom Behavior Support
- Teacher/School Staff Consultation
- Mental Health Screening and Assessment
- Home Visits (as needed)
- Psychiatric Consultation including Telepsychiatry
- Crisis Management
- Attendance and Support at Team Meetings
- Resource Sharing and referrals as needed

If you have special needs or concerns, we are happy to work with you to make needed accommodations. The following guidelines will help us work together as an effective team.

What is Person and Family Centered Care?
The UM SMHP views Person and Family Centered Care as a collaborative approach to prevention and treatment services that highlights the importance of a child and/or families involvement in their care. The UM SMHP has committed to resources that ensure the planning, delivery and evaluation of our program is driven by patients and families and work towards the most successful outcome for you and your family. Our program values the patient and family by focusing on strengths and abilities. Our treatment plans involve patients and families and view the patient and family as an equal partner in the treatment process. In order to grow, we believe patients and families need a supportive and healthy environment. You are welcome to contact our program leadership if at any time you do not feel this philosophy is being utilized and we welcome your feedback through your treatment process.

Program Hours: Therapy appointments are available based on the counselor's individual schedule at given school sites. Please speak with your school counselor to determine their office hours-these vary by school. Medication management appointments are scheduled through the school counselor and are typically held on Tuesdays. If you cannot make your appointment, please call to cancel and reschedule.

Phone Contact: Please contact the SMHP counselor at your school to determine the best way to reach him/her. When leaving a message, please state:

- Your name,
- Your child's name,
- The best way to reach you, and
- How we can best assist you.

Medication Refills or Prescription needs: Medication refills are discussed during medication management appointments. It is the parent/guardian's responsibility to notify the counselor if a refill is needed and provide feedback on a child's response to medications. For urgent medication needs, please contact your child's counselor.

Medication Cost Assistance: There are currently no copays for Medical Assistance. If you are self-paying or have private insurance and are struggling to meet your copays, please speak to your clinician and psychiatrist. There are a few pharmacies that offer discounted medications. Walmart's $4 prescription list: https://www.walmart.com/cp/$4-prescriptions/1078664 and Target's $4 and $10 Generic Medication List: https://tgtfiles.target.com/pharmacy/WCMP02-032536_RxGenericsList_NM7.pdf

Telepsychiatry Services: Telepsychiatry is the delivery of Psychiatry services using Video Teleconferencing (VTC). This service is similar to Skyping or using FaceTime. This service may be used at your school site and your clinician will provide additional details if it may be included in your treatment.

On-Call Procedure: In the event that a counselor needs to be contacted and they are not at your child's school site, please contact the SMHP on-call number 410-328-5881. This option is available 8:30 am-5:00pm. If a request for services is made at another time than the scheduled appointment, a wait may be entailed until a counselor is available to see you. For emergency treatment, after hours, go to or call the nearest hospital emergency room and/or call 911.

Emergency or Urgent Care: In case of an emergency please use your local emergency system (see chart below for local care options or ask us for emergency services information). Crisis intervention services will be provided to patients' who need to be seen on an emergent or crisis oriented basis. If you child presents or reports risk to themselves or others, clinicians will respond appropriately following all agency clinical procedures and mandated reporter laws.

We are committed to supporting your efforts to help your child stay safe and develop his/her full potential. When managing potential crises, please keep the following guidelines in mind:

- Be prepared. Talk with your therapist about ways to prevent crises and support your family. It helps to plan ahead.
- Keep in touch, schedule and keep regular mental health treatment appointments. Call ahead to reschedule. Treatment works if you use it regularly.
- If your child is taking medication, keep track of when you need a refill.
- Keep a journal about your concerns including steps you have taken to assist your child. Be safe and healthy.
- Be ready to call for help. Enlist help from family and friends. Know your community resources. Use your supports.
- Take Action
    - Stay calm
    - Reduce noise and stressors (i.e. turn off T.V., loud music, etc.)
    - Make sure all children in your care are safe
    - Don't threaten
    - Get help if needed

Emergency Numbers
****For life threatening emergencies please use 911****

Psychiatric Urgent Care Numbers	
Anne Arundel County	410-768-5522
Baltimore City	**410-433-5175**
Baltimore County	410-931-2214
Carroll County	1-800-422-0009
Frederick County	211 or 301-662-2255
Harford County	410-638-5248 – 410-588-1017 (Pager)
Howard County	410-531-6677
Montgomery County	240-777-4000
Sheppard Pratt Urgent Assessments	410-938-4357
Sheppard Pratt Scheduled Crisis Intervention Program	410-938-5302
Maryland Youth Crisis Hotline	1-800-422-0009

For Child Protection Emergencies contact the local child protection team where the maltreatment occurred.

Revised 3.21.19

- *Baltimore City: 410-361-2235*
- *Baltimore County: 410-853-3000*
- *Anne Arundel County: 410-421-8400*
- *Howard County: 410-872-4203 after hours: 410-313-2929*
- *Carroll County: 410-386-3434 (Baltimore area: 410-876-2190)*

Additional Resources:
Maryland Youth Crisis Hotline: 1-800-422-0009
House of Ruth 24 Hotline (Domestic Violence): 410-889-7884
The Family Tree (Family Stress Line): 1-800-243-7337
Maryland Poison Control: 1-800-222-1222

Complaint and Grievance Policy: It is our hope that all complaints and grievances are resolved through communication with the primary clinician. However, if this is not possible, grievances should be directed to the Program and/or Executive Director to resolve the grievance. The administrative team will respond to grievances and inform each family of the outcome. If revisions are made to the care plan as a result of a grievance or to this grievance policy, families will be notified immediately. Any unresolved grievances will additionally be reported to program funders, including BHS-B. If you feel your grievance is not begin addressed you may contact Faculty Physicians Inc. (FPI), by phone, 667-214-1492 on their "We Care Line' or by email, wecare@fpi.umaryland.edu. We appreciate and take seriously all concerns of our patients and families.
Website link for additional grievance directions:
https://docs.google.com/document/d/1Urh1v9a1PaWwNeC36V6HYJqRpLlhWgcj-VwyL7gSKCk/edit?usp=sharing
Nancy Lever, PhD, University of Maryland School Mental Health Program, Executive Director
Phone: 410-706-4974

Comments, Compliments and Your Satisfaction:
We love to hear from our patients and families and your feedback helps us improve services. If you would like to provide feedback feel free to contact our Program Director, Jennifer Cox, at jfcox@som.umaryland.edu. Additionally, your clinician may periodically request that you complete a satisfaction survey that will be reviewed by the SMHP Leadership Team. You may also request a satisfaction survey at any time during your treatment. All responses are confidential.

Important Rules and Regulations:
- Patients/families are responsible for their behavior while attending sessions. Foul language, fighting and unruly behavior will result in possible removal from the office. No loitering, weapons, tobacco, or illegal drugs including alcohol are allowed at any time. You are responsible for keeping all prescription and over the counter medication secure and within your possession. Under no circumstances will threatening or disruptive behavior be tolerated.
- Patients need to respect the privacy of their own treatment and that of others. The treatment of others who are known to you should not be discussed.
- Seclusion and restraint will not be used by any University of Maryland, SMHP clinician or trainee.

Discharge/Transition Policy:
A child/youth may be released from the services offered by the University of Maryland School Mental Health Program for the following reasons:
1.) Transition to another level of care has been discussed and agreed upon by the Treatment Team (patient and family are part of the Treatment Team)
2.) Treatment goals are met.
3.) Non-adherence with program requirements (the parent/legal guardian has not had contact with the clinician within 90 days). Program expectations are discussed with parent/legal guardian during admissions. If the patient requires additional services after discharge, the clinician will assist the patient family in the referral process.
4.) The parent/legal guardian does not participate in and sign treatment plans, as required.
5.) The treatment team (including guardian and patient) believes the child may be better served by another agency
6.) The patient receives an IEP that includes counseling services (some exclusions apply).

Program expectations are discussed with parent/legal guardians during admissions. If the child and family require additional services after discharge, the SMHP will assist the family in the referral process.

Advanced Directives for Mental Health:
Students who are 18 and older will receive, verbally and in writing, information regarding making an advanced directive for mental health services.

Changes: Please keep us updated of important changes, such as new phone numbers, addresses, doctors, insurances, etc.

We look forward to working with you and your child.

Center for Infant Study/School Mental Health Program
University of Maryland, Baltimore
School of Medicine
Division of Child and Adolescent Psychiatry
701 West Pratt Street, 4th Floor/737 W. Lombard Street, 4th floor
Baltimore, MD 21201
410-328-5881
Fax: 410-328-3522 CIS/410-706-0984 SMHP

http://umm.edu/programs/psychiatry/services/special-programs/child-and-adolescent-psychiatry/outpatient-services/school-mental-health-program

The University of Maryland School Mental Health Program (SMHP)
Acknowledgment of Receipt of Documents

I hereby acknowledge that I have received a copy of the documents listed below from the University of Maryland, SMHP:

- University of Maryland, SMHP Welcome letter which includes:
  - Description of Services
  - Program Hours and On-Call Procedures
  - Discharge Procedures
  - Emergency or Urgent Care Services
  - Complaint and grievance processes
  - Advanced Directives (16 years old and older)
  - Rules and Regulations

Advanced Directives for Mental Health:

☐ Yes ☐ No I am 18 years old or older. (If yes, proceed to next statement. If no, you may skip this section.)
☐ Yes ☐ No I have received information verbally and in writing regarding making an advanced directive.
☐ Yes ☐ No I currently have an advanced directive for mental health services (continue below based on patient response):
☐ Yes- My advanced directive can be found in this file.
☐ No- I would like to develop an advanced directive with my counselor. Developing an advanced directive for mental health will become a treatment goal in my Individualized Treatment Plan.
☐ No- I decline the offer to develop an advanced directive for mental health services.

Patient Name: _____

Name of Parent (Guardian): _____

Please check if you are the legal guardian of the child seeking treatment ☐ Yes ☐ No
*(if you checked "**No**" please do not complete this form, instead talk with one of our staff to find how to get the needed consent)*

Relationship to patient: _____

Signature of Parent (Guardian): _____

Date: _____

Witness Signature and Credentials: _____

Date: _____

If you would like additional family or social supports to be involved in this child's treatment, please indicate below.
******Release of information must be signed by guardian******

Name	Phone number	Date of Birth *must be 18 years of age or older	Release of Information Signed? (yes/no)

Revised 3.21.19

University of Maryland School Mental Health Program

In collaboration with the Baltimore City Public School System (BCPSS) and Behavioral Health Systems-Baltimore (BHSB), the University of Maryland School Mental Health Program (SMHP) provides a full continuum of prevention and intervention services to BCPSS elementary, middle, and high school youth. Services through the SMHP include:

Individual Counseling

Group Counseling

Family Counseling

Case Management

Family Activities/Events

Classroom Presentations/Activities

School-wide Activities

Classroom Behavior Support

Teacher/School Staff Consultation

Mental Health Screening and Assessment

Home Visits (as needed)

Psychiatric Consultation

Attendance and Support at Team Meetings

Resource Sharing

University of Maryland School Mental Health Program

Consent for Mental Health Services, Assessment Collection and Reporting

_____(Guardian initials) By initialing, I give consent for my child to receive mental health services through the University of Maryland's School Mental Health Program (SMHP). I understand that these services may include individual, group and/or family sessions, teacher/staff consultation, as well as other services and activities (see attached).

_____(Guardian initials) By initialing, I give consent for teacher, youth and caregiver assessments to be collected as part of the SMHP's effort to inform and guide my child's treatment and ensure the quality of services.

_____(Guardian initials) By initialing, I give consent for results of assessments and other quality improvement measures to be shared with the University of Maryland and funders of SMHP services. Results will only be shared as a group report to approved stakeholders.

All records pertaining to school mental health services are the property of the SMHP and will be kept confidential (i.e. they will not be released without parent/legal guardian permission unless mandated by law). Should you choose not to agree to assessment reporting, your child's treatment will not be impacted in any way. Furthermore, I understand I can revoke this consent at any time by providing the request in writing to my school counselor.

Patient's Last Name First Name Middle Name	**DOB**
Signature of parent/legal guardian	**Date**
Printed Name of parent/legal guardian Relationship	**Phone Number**
Street Address Suite/Apt. City State Zip	**Work Number**
Therapist/Witness	**Date**

☐ **Please check if student is over 16 years of age. This student may be seen as a SMHP case only and will complete the above parent/legal guardian information.**

☐ **Please check if student is 18 years of age or older. This student may be enrolled as a CIS case and will complete the above parent/legal guardian information.**

School Mental Health Program

University of Maryland

UM School Mental Health Program Tele Mental Health Services

"TELE"

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

School Mental Health Program
737 W. Lombard Street
4th Floor
Baltimore, MD 21201
410-706-6895
http://schoolmentalhealth.org

Please contact the mental health clinician in your child's school for additional information on our program and services.

Quick Facts About "Tele"

- Tele allows you/your child to talk with a mental health provider via the internet– similar to Facetime
- Tele software is HIPAA compliant to protect your privacy
- You will not be recorded
- Tele sessions may involve interactive online tools to learn skills
- Tele allows for more frequent visits and follow-up with your psychiatrist and/or your provider
- Your psychiatrist can write prescriptions and have them sent to your pharmacy
- Families have reported they are happy using tele mental health services
- Your feedback will be used to make the tele experience is great!

UM School Mental Health Program Telepsychiatry

Overview

The University of Maryland, School Mental Health Program offers Tele Mental Health services to students and families enrolled in it's school-based mental health program. This technology is easy to use and allows more flexibility and frequent contact with your psychiatrist and mental health provider. Below are answers to **Frequently Asked Questions** about tele.

What is VTC?

VTC stands for Video Tele Conference (or "tele"), which allows people in different locations to communicate by video over the internet.

Am I being recorded? How would I know?

No, **our tele session are never recorded**. However, it is possible to record sessions using tele. You would know that you are being recorded if you saw a blinking red dot in the teleconferencing meeting window/ computer screen.

Where is my psychiatrist/mental health provider located?

During tele appointments your providers may be located in a private office at the University of Maryland- near the University of Maryland Hospital– or in their homes. Ask your provider for a "tele tour" of the space.

Is it safe and secure?

Yes, tele is safe, secure, and private. The computers and software we use are overseen by the University and meets all HIPAA and privacy standards.

Who will be part of a tele session?

The psychiatrist, clinician, student and parent/guardian and any important people involved in the treatment may be in the session. Family members and those important to you or your child's treatment are encouraged to also attend sessions, as appropriate.

How do I attend a tele appointment?

It's easy! Your provider will tell you how to download the App and then he/she will send you an appointment link. When it's time for your session, just click the link to join the meeting

What if I don't like using tele?

If you do not like using tele, you can choose not to use this service. Let us know your preference and we will work to identify the best option possible for your child and family.

What if the internet or power is out when we try to use tele?

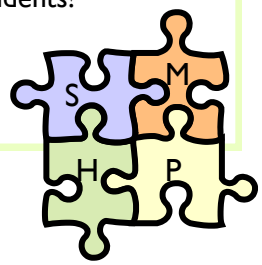
In the event of an internet outage during tele, your clinician will work with the information technology department to restore the operations of tele ASAP or will help you problem solve about your internet. If internet cannot be restored, then your appointment can be rescheduled for a later date or you can switch to the phone for the rest of the session.

Can I see the psychiatrist on tele and get medication the same day?

Our psychiatrist have the ability to e-prescribe to your pharmacy. Most prescriptions can be picked up at your pharmacy within hours. Be sure to verify your pharmacy information with your providers.

How else does UM use Tele?

Tele can be used for consultations with teachers and other school staff, student support team or IEP meetings, and for educational presentations for school staff and students!



University of Maryland Center for Infant Study/School Mental Health Program
Department of Psychiatry/Psychiatry Associates, P.A.
Client Consent to Participate in Telemental Health (In-home)

Herein, the term "Telemental Health Provider" or "Mental Health Provider" may refer to any therapist/counselor, psychiatrist or mental health trainee providing services to me/my child through the University of Maryland, Center for Infant Study/School Mental Health Program (CIS/SMHP).

1. I understand that my Mental Health Provider, has recommended the use of telemental health to enhance and/or provide services. Telemental health is the use of video conferencing equipment and tele platforms to provide mental health services such as therapy and/or medication consultation. The benefit will be improved access to mental healthcare without physically coming into the Mental Health Provider's office. This can be helpful during times of social distancing and during the regular course of my care as it allows more flexibility for and access to appointments.

2. I understand that the Mental Health Provider will use audio- and video- communications to interact with me/my child. My Mental Health Provider has explained to me how the video teleconferencing technology will be used during the tele session. I understand that I/we will not be in the same room/facility as the Mental Health Provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I am aware that the University of Maryland CIS/SMHP is using state-of-the art technology to best protect my confidentiality during the session. I understand that my Mental Health Provider or I can discontinue the telemental health session if it is felt that the videoconferencing connections are not adequate and may elect to use the telephone in order to continue the session. Furthermore, I understand that if I/my child opts to participation in tele-GROUPS, there is an added risk to privacy as other group members (and potentially those in others' homes) may see and hear what is being transmitted, including images and sounds on the screen and in the background.

4. I understand that I will provide me/my child with a computer, smartphone or tablet in order to facilitate the connection and I agree that on my end, the site chosen for the session will be the most private/confidential location possible. I further agree that only those involved in the session will be present in this location/room and that I/my child will divulge any other individuals present and that my child's Mental Health Provider has the right (1) to ask non-involved individuals to leave the room; and/or (2) terminate or reschedule the session based on non-compliance of the request.

5. The laws that protect the confidentiality of my/my child's medical information also apply to telemental health. I understand that my/my child's healthcare information may be shared with other individuals for scheduling purposes. In the event of technical malfunction, there may be a need for technicians from University of Maryland to be present during the session, I and/or my child will be informed. I further understand that I have the right to request the following: (1) omit specific details of my/my child's or our family's personal history that are sensitive; (2) ask non-clinical personnel to leave the room during the session; or (3) terminate session at any time.

6. Documentation related to the session will be kept in my University of Maryland medical chart- the same as face-to-face sessions.

7. In line with Maryland Annotated Code Courts and Judicial Proceedings Article § 10-402., which contains the Maryland wiretap law, at no time will sessions be recorded.

8. In the event of an emergency, I understand that a crisis plan will be developed between myself and my child's Mental Health Provider ahead of time. As caregiver/guardian, I agree to be immediately available by phone or in-person during telemental health sessions. In the event I cannot, I will provide contact information for someone authorized to act in my behalf.

9. I understand that my child must be in the state of Maryland to receive telemental services and that I will be asked to disclose my/my child's location at the start of telemental sessions.

10. I understand that if my mental health provider or I feel that I would be better served by another form of mental health services (i.e. face-to-face), I will be referred to a provider who can offer such services in my area during times of social distancing.

11. **Client & Caregiver/Guardian Responsibilities**
    a. I will identify a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
    b. I agree to use the phone and/or video-conferencing platform selected for our virtual sessions, and the mental health provider will explain how to use it.
    c. I will use a computer, tablet or smartphone with video capability during the session, when possible.
    d. I understand it is important to be on time. If I/my child needs to cancel or change the appointment, I will notify the mental health provider **at least 24 hours in advance by phone or email**.

I have read this document carefully, reviewed the Client and Caregiver Responsibilities, and understand the risks and benefits of the telemental health session. I have had my questions regarding the session explained.

I hereby consent to participate in a telemental health under terms described herein.

Name of client	**DOB**
Signature of caregiver/legal guardian	**Date**
Printed Name of caregiver/legal guardian	**Phone Number**
Email of caregiver/legal guardian	
Name of emergency contact	**Phone number**
Relation of emergency contact to client	**Email**

Revised 4.15.2020

SMHP CONSENT TO PARTICIPATE IN A TELEMENTAL HEALTH EVALUATION/FOLLOW-UP

Patient's Name: _____

1. I understand that my school mental health clinician, _____, has recommended

a TeleMental Health (TMH) evaluation and/or follow-up with Dr. _____.

2. I understand that the telepsychiatrist will use audio and video communications to interact with me, my child and/or to consult with my school clinician.

3. My school mental health clinician has explained to me how the video conferencing technology will be used during the consultation. I understand that this consultation will not be the same as a face-to-face mental health/healthcare visit due to the fact that I will not be in the same room as the mental health care provider I am seeing.

4. I understand that if my provider or I feel that I would be better served by another form of mental health services (i.e. face-to-face) I will be referred to a provider who can offer such services in my area.

5. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I am aware that the University is using state-of-the art technology to best protect my confidentiality during the session. I understand that my school mental health clinician or I can discontinue the TMH session if it is felt that the videoconferencing connections are not adequate and may elect to use the telephone in order to continue the session.

6. The laws that protect the confidentiality of my medical information also apply to TMH. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than the telepsychiatrist and school mental health clinician in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my child's or our family's personal history that are sensitive to me; (2) ask non-clinical personnel to leave the room during the TMH session; and/or (3) terminate the consultation at any time.

7. I have had the alternatives to a TMH evaluation/follow-up explained to me, and in choosing to participate in a TMH session, I understand that some parts of the visit may be conducted by individuals at my location such as the school mental clinician in coordination with the telepsychiatrist.

8. In the event of an emergency, I understand that a crisis plan will be developed between my school mental health clinician and the telepsychiatrist and an effort will be made to have the school mental health clinician and other school staff address the crisis and to arrange transportation to the nearest emergency room if the crisis cannot be managed.

9. My provider may ask me and/or my child to fill out satisfaction surveys during the course of treatment. I understand that these surveys are optional and if I/my child elect not to participate in these surveys this will in no way compromise my eligibility in the TMH program.

10. I have read this document carefully, and understand the risks and benefits of the teleconferencing evaluation and/or follow-up. I have had my questions regarding the visit explained.

I hereby consent to participate in a TMH visit under the terms described herein.

_____	_____	_____
Patient's/parent/guardian signature	Date	Time
_____	_____	_____
Witness signature	Date	Time

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Emergency Information Form

Date Completed/Date of Registration _____
Patient Name: _____ DOB: _____
SSN: _____ MA#: _____
Gender of Patient: ☐ Male ☐ Female Phone: _____
Address: _____

Parent (Legal Guardian) Name: _____
Relationship to Patient: _____
Address: _____
Phone: (w) _____ (h) _____ (c) _____

Parent (Legal Guardian) Name: _____
Relationship to Patient: _____
Address: _____
Phone: (w) _____ (h) _____ (c) _____

Parent (Legal Guardian) Name: _____
Relationship to Patient: _____
Address: _____
Phone: (w) _____ (h) _____ (c) _____

Primary Care Provider*: _____
Address: _____
Phone: _____ Fax: _____

If a patient does not have a primary care provider, this will be a treatment goal on the initial treatment plan.

Two additional people to contact in case of emergency (not residing in the same home as the patient*):
Name: _____
Address: _____
Phone: _____
Relationship to child: _____

Name: _____
Address: _____
Phone: _____
Relationship to child: _____

☐ The parent/guardian was unable to identify an additional emergency contact. Reason: _____

In cases referred by Department of Social Services, such as Child Protective Services or Foster Care, the agency social worker and supervisor may be listed above

Does your child have any allergies?	☐ **No** ☐ **Yes (explain):**
Does your child take medication?	☐ **No** ☐ **Yes (explain):**
Does your child have any health problems?	☐ **No** ☐ **Yes (explain):**
What was the date of your child's last physical exam:	

Signature of Parent (Guardian): _____ Date: _____

Emergency Information form revised 6.28.17

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

FACULTY PHYSICIANS, INC.
UNIVERSITY OF MARYLAND PSYCHIATRY ASSOCIATES, P.A.
UNIVERSITY OF MARYLAND DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY
TAGHI MODARRESSI CENTER FOR INFANT STUDY: SECURE STARTS
UNIVERSITY OF MARYLAND SCHOOL MENTAL HEALTH PROGRAM

Financial Information Form

Date:_____ ☐ New Patient ☐ Update

Patient:

School:_____

Patient's Last Name: _____ Patient's First Name: _____

DOB: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ Zip:_____

Phone (home): _____ (cell): _____

Patient SSN: ☐ Not available ___ ___ _____

Patient Primary Care Provider: ☐ Pt does not have a PCP _____

Person Responsible for the Bill:

Name: _____

DOB: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ Zip: _____

Phone (home): _____ (cell): _____ (work): _____

SSN:_____

Relationship to Patient: ☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other

Insurance Information:

Medical Assistance #:_____ **MCO Name:** _____

I hereby authorize the release of any medical or other information necessary to process this claim. I also request payment of government or other insurance benefits either to myself or to the party who accepts assignment on this claim. I authorize payment of medical benefits to the physician or non physician practitioner for services provided to me.

Signed:_____ Date: _____
Patient/Parent/Guardian

PATIENT RIGHTS AND RESPONSIBILITIES

University of Maryland Faculty Physicians, Inc. is committed to providing patients with the highest quality care.

You have the right to…

- Considerate, respectful and compassionate care regardless of age, gender, race, national origin, religion, sexual orientation or disabilities.
- A reasonable response to requests for care.
- Information from your care provider to decide about treatment and procedures, except in emergencies.
- Assessment and prompt treatment of pain and other symptoms.
- Know if your treatment is part of a research study.
- Refuse treatment as allowed by law. Your care provider will tell you the effects of refusing treatment.
- Expect full consideration of your privacy and confidentiality in care discussions, examinations and treatments.
- Review your medical records and have them explained, unless restricted by law.
- A safe and secure environment.
- Sign language or foreign language interpreter services. We will make every effort to provide an interpreter as needed.
- Participate in decisions about your care, treatment and services provided and include your family members or friends, with your permission.
- Make an advance directive, appointing someone to make health care decisions for you if you are unable. If you do not have an advance directive, we can provide you with information.
- Discuss concerns with your care provider, nursing staff, or a member of our management team.

To help us provide the safest care to you and all of our patients, here are your responsibilities…

- Provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer, when it is required.
- Inform the practice of any special needs prior to your appointment
- Keep appointments, be on time for appointments or provide a 24 hour notice if you are unable to keep your appointments.
- To ask questions when you do not understand information or instructions. If you believe you can't follow through with your treatment plan, you are responsible for telling your care provider. You are responsible for outcomes if you do not follow the care, treatment and services plan.
- Treat all staff and other patients with courtesy and respect. Please be mindful of noise levels and privacy. You are also responsible for the behavior of those accompanying you during your visit.
- Make arrangements for paying your bills. Ask questions about your bill as soon as possible.

Your signature below represents your commitment and acknowledges our commitment to work collaboratively with your care providers to achieve optimal care.

_____ _____

Signature Date

Relationship of Person Signing (if other than Patient): _____

Thank you for choosing us for your health care needs.

**Must be updated annually

Division of Child
& Adolescent Psychiatry
Center for Infant Study/
School Mental Health Program

CIS/SMH CARF Patient Rights

The CIS/SMH program is committed to providing you with the best possible behavioral health care. If you have special needs, we are happy to work with you to make needed accommodations. Each patient receiving services from our team, has the right to the following:

1. Privacy and confidentiality;
2. To be treated with consideration, respect, and full recognition of the patient's human dignity and individuality;
3. To receive treatment, care, and services that are adequate, appropriate, person and family-centered and in compliance with relevant state, local, and federal laws and regulations;
4. To not be physically or mentally abused by the program staff;
5. To be free from discrimination;
6. To be free from physical restraints;
7. To be free from financial or other exploitation;
8. To be free from humiliation, retaliation and neglect;
9. To not participate in any experimental research unless fully informed and with written consent;

In addition

10. Patient's right to grieve program decisions include, but are not limited to:
    a. Discharge; and
    b. Change in status;
11. Investigation and resolution of alleged infringements of rights of the person served.

Patient Name: _____

Name of Parent (Guardian): _____

Relationship to patient: _____

Signature of Parent (Guardian): _____

Date: _____

Witness signature: _____

Date: _____

Taghi Modarressi Center for Infant Study: Secure Starts
University of Maryland School Mental Health Program
Division of Child and Adolescent Psychiatry
University of Maryland, Baltimore
701 West Pratt Street, 4th Floor
Baltimore, MD 21201
410-328-5881
410-328-8552 (fax)

UNIVERSITY of MARYLAND FACULTY PHYSICIANS, INC.

Faculty Practices of the
University of Maryland School of Medicine

NOTICE OF PRIVACY PRACTICES ("NPP")

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.

Effective Date: September 23, 2013

SCOPE OF OUR PRIVACY PRACTICES: This NPP describes the privacy practices of University of Maryland Faculty Physicians, Inc. and its affiliated faculty practice groups listed on the last page of this NPP (collectively, "**FPI**"), the University of Maryland School of Medicine ("**SOM**"), and all healthcare professionals, employees, staff, students, volunteers and other personnel whose work is under the direct control of FPI and/or the SOM.

All FPI and SOM entities, individuals, sites and locations follow the terms of this NPP. In addition, these entities, individuals, sites and locations may share protected health information or "PHI" with each other, and with facilities affiliated with the University of Maryland Medical System Corporation, including the University of Maryland Medical Center ("**UMMC**") and the University of Maryland Rehabilitation & Orthopaedic Institute ("**ROI**") as part of an Organized Health Care Arrangement, for treatment, payment, or health care operations purposes as described in this NPP and otherwise permitted by law. Note, FPI, SOM, UMMC and ROI are separate legal entities, and each maintains its own medical record and billing systems. For this reason, you may need to contact FPI, SOM, UMMC and/or ROI separately to request copies of your medical record.

HOW WE MAY USE & DISCLOSE YOUR PHI: We are committed to protecting the privacy and security of your PHI. In this NPP, we describe different ways that we use and disclose such PHI, which may include, without limitation, information about your diagnosis, treatment, test results, and billing information. Not every use or disclosure will be listed, but all of the ways we are permitted to use and disclose information will fall in one of the categories listed. Sometimes special laws govern the use and disclosure of certain types of very sensitive PHI, such as mental health, substance abuse, and HIV/AIDS information.

For Treatment Purposes. We may disclose your PHI to physicians, nurses, technicians, students, or other individuals who are involved in taking care of you. For example, we may share your PHI to coordinate the different things you need, such as prescriptions, lab work, x-rays and follow-up care. To the extent permitted by law, we also may disclose your PHI to individuals outside FPI, the SOM, UMMC and ROI who may be involved in your medical care (such as family members, home health agencies and others providers of services that are part of your care).

For Payment. We may use and disclose your PHI to an insurance company or third party payor so that the treatment and services you receive from us may be billed to and paid by them. For example, we may need to give your health plan information about services you received so that your health plan will pay us or reimburse you for the services, or to obtain prior approval to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose your PHI for administrative and operational purposes. These uses and disclosures are necessary for our operations, and to make sure that all of our patients receive quality care. For example, we may use your PHI to review our treatment and services and to evaluate our performance in caring for you.

Health Information Exchange (HIE). A Health Information Exchange, or HIE, is a way of sharing your PHI among participating physician offices, hospitals, labs, radiology centers, and other medical care providers through secure, electronic means. The purpose is so that each of your participating caregivers can have the benefit of the most recent information available from your other participating caregivers when taking care of you. We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a Maryland-wide HIE. As a participant in CRISP, we may share and exchange information that we obtain or create about you for treatment and public

health purposes, as permitted by law. This exchange of PHI can provide faster access to critical information about your medical condition, improve the coordination of your medical care, and assist medical care providers and public health officials in making more informed treatment decisions.

You may opt-out of CRISP by calling CRISP at 1-877-952-7477, or by submitting a completed Opt-Out Form directly to CRISP by mail, fax, or through the CRISP website at www.crisphealth.org. When you opt-out of participation in CRISP, medical care providers will not be able to search for your PHI through CRISP while treating you. However, even if you opt-out, your PHI will remain in the exchange. Specifically, your physicians or other treating providers who participate in CRISP will still be able to receive your lab results, radiology reports, and other data sent directly from CRISP that they may have previously received by fax, mail, or other electronic communications. Public health reporting in accordance with law, such as the reporting of infectious diseases to public health officials, will also continue to occur through CRISP even if you decide to opt-out.

Appointment Reminders. We may contact you about an appointment for treatment or medical care. This may be by mail, telephone, answering machine, email or text message.

Treatment Alternatives, Benefits and Services. We may contact you about possible treatment options or alternatives and other health-related benefits and services.

Fundraising. FPI may disclose to the SOM Office of Development the following PHI for fundraising purpose without an Authorization: (1) demographic information (name, address, contact information, age, gender, or date of birth); (2) dates of health care provided to you; (3) Department of service; (4) name of the treating physician; (5) outcome information; and (6) health insurance status. Fundraising materials you may receive will contain the option to opt-out of future fundraising communications. The opt-out method will not be burdensome to you.

Business Associates. There may be some activities provided for FPI or SOM by outside businesses that perform work on our behalf under a contract that requires appropriate safeguards for PHI, such as medical transcription services, billing services, and collection agencies. We may disclose your PHI to our business associates so they may perform the job we have asked them to do.

Individuals Involved in Your Care or Payment for Your Care. We may release your PHI to family members, personal representative, or other persons who are involved in your medical care or help pay for your care, provided the PHI is directly relevant to such other person's involvement. Unless you object, in the event of a disaster we may provide information about you to a disaster relief organization so it can notify your family of your condition and location.

Deceased Persons. We may disclose PHI to family members or others involved in a decedent's healthcare or payment for care when the disclosure is relevant to their involvement and not inconsistent with the decedent's previously expressed wishes that are known to us. Also, PHI of persons deceased for more than 50 years will no longer be considered PHI and therefore will not be regulated under HIPAA.

Research. Under certain circumstances, without your authorization, we may use and disclose your PHI to researchers if the research has been approved through a special review process designed to protect patient safety, welfare, and the confidentiality of participants. This process might be used, for example, to conduct records research, when researchers are unable to use de-identified information and it is not practicable to obtain research participants' authorization. We also may disclose PHI to researchers if:

- We have received representations from the researcher, either in writing or orally, that the use or disclosure of PHI is solely to prepare a research protocol or for similar purposes preparatory to research, that the researcher will not remove any PHI from FPI or SOM, and that the PHI for which access is sought is necessary for the research purpose. This provision might be used, for example, to design a research study or to assess the feasibility of conducting a study; or

- We have received representations from the researcher, either in writing or orally, that the use or disclosure being sought is solely for research on the PHI of decedents, that the PHI being sought is necessary for research, and, at the request of FPI or SOM, documentation of the death of the individuals about whom information is being sought.

In certain circumstances, we must obtain your authorization to use or disclose your PHI to researchers. Such authorization must be in writing, and we may combine such authorization with any other type of written permission, for example, a consent form to participate in such research study or an authorization for a different research study.

As Required By Law. We will disclose your PHI when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to help prevent or lessen the threat.

Organ and Tissue Donation. We may release PHI to organizations that handle and monitor organ procurement, donation and transplantation.

Military & Veterans. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your PHI for workers' compensation or work site safety laws such as OSHA and similar programs.

Public Health Activities. We may disclose your PHI for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to notify the Food and Drug Administration of reactions to medications or problems with products; to notify individuals of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence if the patient agrees or we are required or authorized by law to do so.

Health Care Oversight Activities and Registries. We may disclose PHI to a health care oversight agency for activities authorized by law, such as investigations, inspections, and licensure, and to patient registries for conditions such as tumor, trauma and burns.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct at the offices or clinics of FPI or SOM; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors or Morticians. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release PHI about our patients to funeral directors or morticians as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law, for example, to provide protection to the President.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official as authorized or required by law.

Directory. We may use or disclose your PHI (name, location, condition described in general terms, and religious affiliation) in a directory when you are receiving treatment at our facilities, and, for directory purposes, we may disclose such PHI to members of the clergy or, except for religious

affiliation, to persons who ask for you by name. We will inform you in advance of such use or disclosure and give you the opportunity to agree to or prohibit or restrict the use or disclosure.

Immunizations. We may use or disclose your PHI to provide proof of immunization to a school that is required by state or other law to have such proof. A parent, guardian or other person acting in loco parentis of the individual, if the individual is an unemancipated minor, must agree to the disclosure.

YOUR RIGHTS REGARDING YOUR PHI:

Authorization. We will not use or disclose your PHI for any purpose that is not listed in this NPP without your written authorization. Uses or disclosures of PHI requiring an authorization (in most circumstances) include, for example, the use or disclosure of psychotherapy notes, the use or disclosure of PHI for marketing (except communications made face-to-face or communications in the form of a promotional gift of nominal value), and the exchange of PHI in return for remuneration from the recipient unless permitted under HIPAA. Other types of uses or disclosures not described in this NPP require an authorization. If you authorize us to use or disclose your PHI for another purpose, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your PHI, or about how to revoke an authorization, contact your treatment provider. You may not revoke an authorization for FPI or SOM to use and disclose your information to the extent that FPI or SOM has taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other laws may allow the insurer to continue to use your information to contest claims or your coverage.

Right to Inspect and Copy. You have the right to inspect and copy your PHI that we have in our health and billing records, except for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, or PHI that may not be disclosed under the Clinical Laboratory Improvements Act of 1988. If you want to review or receive a copy of these records, you must make the request in writing to your treatment provider. We may charge a fee for the cost of copying, mailing and other supplies related to your request. You are not entitled to a copy upon demand, but rather, we will generally have thirty (30) days to respond. Under limited circumstances, your request may be denied, or you may instead receive a summary of the undisclosed portion of the medical record, such as when requesting certain psychotherapy notes or during ongoing clinical trials. In some cases, if your request is denied, you may request that the denial be reviewed.

If you request a digital copy of certain electronic PHI or direct us in writing to transmit a copy to another person/entity, we will try to produce the information in the format requested if readily producible. To protect the integrity of our systems, we will not allow any portable devices, such as your personal key drives, access to our systems. Consequently, we may not be able to accommodate all preferred methods of delivery, but we will do our best to supply a reasonable electronic alternative to meet your needs. IF YOU REQUEST AN ELECTRONIC COPY, WE HEREBY EXPRESSLY DISCLAIM ALL DUTIES AND RESPONSIBILITY FOR THE SECURITY AND PROTECTION OF SUCH INFORMATION ONCE TRANSMITTED TO YOU, AND WE HAVE NO CONTROL OVER ACCESS TO THAT INFORMATION AFTER THE TRANSMISSION TO YOU THEREOF. ALL PHI MAINTAINED BY US WILL CONTINUE TO BE SECURED AND PROTECTED AS REQUIRED BY APPLICABLE LAW.

Right to Amend FPI or SOM PHI. If you believe that the PHI that FPI or SOM has about you is incorrect or incomplete, you may request an amendment. You must request this amendment in writing to your treatment provider stating the reason why you believe the information is not correct or complete. We will act on your request within sixty (60) days of receipt of the request. We may extend the time for such action by up to thirty (30) days, if within the initial sixty (60) days we provide you with a written explanation of the reasons for the delay and the date by which we will complete action on the request. FPI or SOM may deny your request for an amendment and will tell you why the request was denied, your rights to submit a statement disagreeing with the denial, and an explanation of how to submit the statement.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures made of your PHI for the six (6) years prior to the date of your request. This accounting will not include disclosures FPI or SOM made for treatment, payment, health care operations, disclosures you authorized, certain disclosures to national security, correctional or law enforcement

personnel, disclosures made to you, or incidental disclosures. To request an accounting of disclosures made by FPI or SOM, you must submit your request in writing to your treatment provider. Your request must state the name or names of your treatment provider, and a time period that may not be longer than six (6) years and may not include dates before April 14, 2003. We will act on your request within sixty (60) days of receipt of the request. We may extend the time for such action by up to thirty (30) days, if within the initial sixty (60) days we provide you with a written explanation of the reasons for the delay and the date by which we will complete action on the request. If you request more than one accounting in a twelve-month period, you will be charged for the costs of providing subsequent accountings after the initial accounting, which we will provide at no charge.

Right to Request Restrictions. You have the right to request that (i) we restrict the disclosure of your PHI to health plans if you or someone else paid for the relevant care in full outside of your health plan coverage; (ii) your treatment provider give you a paper prescription instead of an electronically transmitted prescription; (iii) we restrict how we use or disclose your PHI. With respect to Subsection (iii), we will consider your request, but we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law. To request restrictions, you must make your request in writing to your treatment provider. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply. FPI and SOM do not have the authority to bind each other to any restrictions to which FPI or SOM may agree, so you will need to make requests for restrictions to both FPI and SOM.

Right to Request Confidential Communications. You have the right to request that FPI or SOM communicate with you about health matters in a certain way or at a certain location. For example, you can ask that FPI or SOM only contact you at work or by mail. To request confidential communications, you must make your written request to your treatment provider, specifying how or where you wish to be contacted. FPI and SOM will not ask you the reason for your request, and will accommodate all reasonable requests. If you request that your PHI be transmitted directly to another person designated by you, your written request must be signed and clearly identify the designated person and where the copy of the PHI is to be sent.

Right to a Paper Copy of This NPP. You have the right to a paper copy of this NPP. You may ask us to give you a copy of this NPP at any time.

Right to Breach Notification. FPI will notify you if there is breach of your unsecured PHI by us or our business associates or subcontractors.

CHANGES TO THIS NPP: We are required to abide by the terms of the NPP currently in effect. We reserve the right to change this NPP. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future. FPI and SOM will post a copy of the current notice in the locations where you receive services and on our website at http://www.fpi.umaryland.edu/.

QUESTIONS ABOUT YOUR PRIVACY RIGHTS & COMPLAINTS

For questions about your privacy rights, or to report a complaint:

Contact persons are listed below for **University of Maryland Faculty Physicians, Inc.** and the **University of Maryland School of Medicine** to (i) address questions you may have regarding your privacy rights; and (ii) to report complaints if you believe your **privacy rights** have been violated. All complaints must be submitted in writing. You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint**.

If you have questions about your medical care, please contact your treatment provider directly. The numbers below are only for matters relating to the privacy and security PHI.

University of Maryland
Faculty Physicians, Inc.
Director of Legal Affairs & Privacy
250 W. Pratt Street, Suite 901
Baltimore, MD 21201

FPI HIPAA Hotline #: 410-328-8011
FPIHIPAAPrivacy@fpi.umaryland.edu

University of Maryland
School of Medicine
Privacy Official
100 North Greene Street, Room 214
Baltimore, MD 21201

SOM HIPAA Hotline #: 410-706-0337
SOMHIPAAPrivacy@som.edu

University of Maryland Faculty Physicians, Inc.

List of Affiliated Clinical Practice Groups Subject to this NPP:

1. University of Maryland Anesthesiology Associates, P.A.
2. University of Maryland Dermatologists, P.A.
3. University of Maryland Emergency Medicine Associates, P.A.
4. University of Maryland Family Medicine Associates, P.A.
   d/b/a University of Maryland Family & Community Medicine
5. University of Maryland Physicians, P.A.
   d/b/a University of Maryland Medical Group
   d/b/a University of Maryland Cardiology Physicians
6. University of Maryland Neurology Associates, P.A.
7. University of Maryland Neurosurgery Associates, P.A.
8. University of Maryland Obstetrical and Gynecological Associates, P.A.
9. University of Maryland Oncology Associates, P.A.
10. University of Maryland Eye Associates, P.A. (Ophthalmology and Visual Sciences)
11. University of Maryland Orthopaedic Associates, P.A.
12. University of Maryland Orthopaedic Trauma Associates, P.A.
13. University of Maryland Otorhinolaryngology–Head & Neck Surgery, P.A.
14. University of Maryland Pathology Associates, P.A.
15. University of Maryland Pediatric Associates, P.A.
16. University of Maryland Psychiatry Associates, P.A.
17. University of Maryland Radiation Oncology Associates, P.A.
18. University of Maryland Diagnostic Imaging Specialists, P.A.
19. Shock Trauma Associates, P.A.
20. University of Maryland Surgical Associates, P.A.
21. Maryland Medicine, P.A.
22. University Imaging Center, LLC
23. University of Maryland Community Physicians

UNIVERSITY of MARYLAND
FACULTY PHYSICIANS, INC.

Faculty Practices of the
University of Maryland School of Medicine

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the

HIPAA 2013
Notice of Privacy Practices

from
University of Maryland Faculty Physicians, Inc. (FPI),
FPI's affiliated Clinical Practice Groups and/or
the University of Maryland School of Medicine

_____ _____
Signature of Patient or Patient's Authorized Representative Date

_____
Print Patient Name or Name of Patient's Authorized Representative

_____
Relationship of Person Signing (if other than Patient)

If NOT signed, please indicate reason:

_____

This acknowledgment is effective 9/23/13 and replaces earlier versions.

UNIVERSITY of MARYLAND FACULTY PHYSICIANS, INC.
Faculty Practices of the University of Maryland School of Medicine

AUTHORIZATION TO RELEASE/REVIEW MEDICAL RECORD INFORMATION

University of Maryland Faculty Physicians, Inc. and the affiliated physician practice groups listed on the following page (collectively, "**FPI**") release patient medical record information in compliance with FPI's Notice of Privacy Practices. Completion of this Authorization gives FPI permission to obtain/release/disclose the following patient's information.

Patient's Last Name _____ First Name _____ Middle Initial/Name _____ Maiden or Other Name (if any) _____

Address _____ Suite/Apt. # _____

City _____ State _____ Zip Code _____

Date of Birth _____ XXX-XX- _____ Last 4 digits of Social Security # Telephone # _____

Release Information From:	***Release Information To:***
Name: _____	Name: University of Maryland, Psychiatry Associates, SMHP
Address: _____	Address: 701 W. Pratt St. Baltimore, MD 21201
Phone: _____ Fax: _____	Phone: 410-328-3522 Fax: 410-706-0984

For complete medical record and/or billing records, check below:

☐ Complete copy of medical record*** ☐ Billing records

For specific information, but not the complete medical record, check below:		***Purpose of disclosure:***
☑ Laboratory/pathology records	☐ Drug and alcohol treatment information	☑ Request of Patient
☐ X-ray/radiology records	☐ Behavioral or mental health records	☑ Treatment/Continued Care
☐ Consultation reports	☐ HIV/AIDS	☐ Insurance/Disability Application
☐ Abstract/Summary	☐ Other Immunization & lead records; Last physical; Other information pertaining to treatment	☐ Legal
☐ Pharmacy/prescription records		☐ Other _____

If FPI has records from other providers, || **I do** ☐ / **I do not** ☑ || wish to have those records released per this Authorization.
If neither box is checked those records will be provided if the request is for a complete copy of the medical record.

For the date(s) of service from: _____ to: _____

****If the patient's complete medical record contains any information relating to behavioral and/or mental health care, alcohol and drug abuse, HIV/AIDS, sexually transmitted diseases, and/or genetics you are hereby authorizing disclosure of this information.*

This Authorization is voluntary. FPI may not condition treatment, payment, enrollment, or eligibility for benefits on the signing of this Authorization. This Authorization can be revoked in writing at any time as provided in FPI's Notice of Privacy Practices. Such revocation will not cover disclosures made previously in reliance on this Authorization. FPI, its employees, officers, directors, agents and staff are released from legal responsibility or liability for the release of the information in accordance with this Authorization. Medical record information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. ***A fee may be charged for processing this request.*** *This Authorization will expire one (1) year from the date signed unless a sooner date, event, or condition is specified: _____.*

I have read the above and fully understand the terms and conditions of this Authorization.

Signature: **X** _____ Date: _____

Print Name: _____ Phone # if not Patient: _____

If not signed by Patient; please note authority to act for Patient and attach proof (other than parent):

☐ Parent with parental rights	☐ Court appointed guardian ☐ Registered kinship care relative	☐ Medical power of attorneys/appointed health care agent ☐ Court appointed personal representative of deceased

This Authorization will expire one (1) year from date signed- Update Annually

UNIVERSITY of MARYLAND
FACULTY PHYSICIANS, INC.

Faculty Practices of the
University of Maryland School of Medicine

University of Maryland Anesthesiology Associates, P.A.
University of Maryland Dermatologists, P.A.
University of Maryland Diagnostic Imaging Specialists, P.A.
University of Maryland Emergency Medicine Associates, P.A.
University of Maryland Eye Associates, P.A.
University of Maryland Family Medicine Associates, P.A.
(d/b/a University of Maryland Family and Community Medicine)
University of Maryland Neurology Associates, P.A.
University of Maryland Neurosurgery Associates, P.A.
University of Maryland Obstetrical and Gynecological Associates, P.A.
University of Maryland Oncology Associates, P.A.
University of Maryland Orthopaedic Associates, P.A.
University of Maryland Orthopaedic Trauma Associates, P.A.
University of Maryland Otorhinolaryngology-Head & Neck Surgery, P.A.
University of Maryland Pathology Associates, P.A.
University of Maryland Pediatric Associates, P.A.
University of Maryland Physicians, P.A.
(d/b/a University of Maryland Medical Group)
(d/b/a University of Maryland Cardiology Physicians)
University of Maryland Psychiatry Associates, P.A.
University of Maryland Radiation Oncology Associates, P.A.
University of Maryland Surgical Associates, P.A.
Shock Trauma Associates, P.A.
University Imaging Center, LLC

UNIVERSITY of MARYLAND FACULTY PHYSICIANS, INC.
Faculty Practices of the University of Maryland School of Medicine

AUTHORIZATION TO RELEASE/REVIEW MEDICAL RECORD INFORMATION

University of Maryland Faculty Physicians, Inc. and the affiliated physician practice groups listed on the following page (collectively, "**FPI**") release patient medical record information in compliance with FPI's Notice of Privacy Practices. Completion of this Authorization gives FPI permission to obtain/release/disclose the following patient's information.

Patient's Last Name | First Name | Middle Initial/Name | Maiden or Other Name (if any)

Address | Suite/Apt. #

City | State | Zip Code

Date of Birth | XXX-XX- Last 4 digits of Social Security # | Telephone #

Release Information From:	***Release Information To:***
Name:	Name: University of Maryland, Psychiatry Associates, SMHP
Address:	Address: 701 W. Pratt St. Baltimore, MD 21201
Phone: Fax:	Phone: 410-328-3522 Fax: 410-706-0984

For complete medical record and/or billing records, check below:

☐ Complete copy of medical record*** ☐ Billing records

For specific information, but not the complete medical record, check below:		***Purpose of disclosure:***
☐ Laboratory/pathology records	☐ Drug and alcohol treatment information	☑ Request of Patient
☐ X-ray/radiology records	☐ Behavioral or mental health records	☑ Treatment/Continued Care
☐ Consultation reports	☐ HIV/AIDS	☐ Insurance/Disability Application
☐ Abstract/Summary	☐ Other _____	☐ Legal
☐ Pharmacy/prescription records		☐ Other _____

If FPI has records from other providers, || **I do** ☐ / **I do not** ☑ || wish to have those records released per this Authorization.
If neither box is checked those records will be provided if the request is for a complete copy of the medical record.

For the date(s) of service from: _____ to: _____

****If the patient's complete medical record contains any information relating to behavioral and/or mental health care, alcohol and drug abuse, HIV/AIDS, sexually transmitted diseases, and/or genetics you are hereby authorizing disclosure of this information.*

This Authorization is voluntary. FPI may not condition treatment, payment, enrollment, or eligibility for benefits on the signing of this Authorization. This Authorization can be revoked in writing at any time as provided in FPI's Notice of Privacy Practices. Such revocation will not cover disclosures made previously in reliance on this Authorization. FPI, its employees, officers, directors, agents and staff are released from legal responsibility or liability for the release of the information in accordance with this Authorization. Medical record information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. ***A fee may be charged for processing this request.*** *This Authorization will expire one (1) year from the date signed unless a sooner date, event, or condition is specified: _____.*

I have read the above and fully understand the terms and conditions of this Authorization.

Signature: **X** _____ Date: _____

Print Name: _____ Phone # if not Patient: _____

If not signed by Patient; please note authority to act for Patient and attach proof (other than parent):

☐ Parent with parental rights	☐ Court appointed guardian ☐ Registered kinship care relative	☐ Medical power of attorneys/appointed health care agent ☐ Court appointed personal representative of deceased

This Authorization will expire one (1) year from date signed - Update Annually

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

FACULTY PHYSICIANS, INC.
UNIVERSITY OF MARYLAND PSYCHIATRY ASSOCIATES, P.A.
UNIVERSITY OF MARYLAND DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY
TAGHI MODARRESSI CENTER FOR INFANT STUDY: SECURE STARTS
UNIVERSITY OF MARYLAND SCHOOL MENTAL HEATLH PROGRAM

CONSENT FOR RELEASE OF INFORMATION

Student Name: _____ Date of Birth_____

Address _____

Home Telephone #: _____ Mobile Telephone #: _____

Check and complete the appropriate section:

☐ As the parent/legal guardian of the above-named student, I, (fill in parent/guardian name on line) _____, acknowledge that the student will receive services from Faculty Physicians, Inc., University of Maryland Psychiatry Associates, P.A. and University of Maryland School Mental Health Program (collectively, "FPI") on-site at the student's home school.

☐ I, the above-named student, acknowledge that I will receive services from Faculty Physicians, Inc., University of Maryland Psychiatry Associates, P.A. and University of Maryland School Mental Health Program (collectively, "FPI") on-site at my home school.

I authorize U\FPI to release to and receive from the Baltimore City Public School System medical/school information (the "Records"). I understand that such Records may contain health information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment as well as educational records, immunization records, suspensions/office referral data, attendance data, referrals to the Child Study Team and other student service teams, and written and verbal communication with school staff related to mental health intervention.

In addition, I authorize FPI to release identifying student information to Baltimore City's Public School System's Division of Research, Evaluation, and Accountability and Behavioral Health Systems-Baltimore (BHSB) to support program accountability and quality improvement activities.

I understand that the Records will be released and received for the purpose of treatment and quality improvement activities.

FPI, its employees, officers and medical staff are released from liability for the release of information in accordance with this consent.

Signature of patient or parent/guardian _____

Relationship to Student _____

Date _____

Witness _____

(*This consent is valid one year from the date of signature*)

737 West Lombard Street, 4th Floor, Baltimore, MD 21201 • 410-706-6895 • 410-706-0984 fax

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Consent to Treatment

I consent to mental health care, which encompasses outpatient or school-based treatment, routine diagnostic assessment, therapy and medical treatment, case management and psychiatric rehabilitation services, and emergency psychiatric and medical care if necessary.

I have received and had explained to me the Patient Rights, discharge policy and rules and regulation of the programs within the Division of Child and Adolescent Psychiatry.

Patient Name: _____

Name of Parent (Guardian): _____

Please check if you are the legal guardian of the child seeking treatment ☐ Yes ☐ No

(if you checked "No" please do not complete this form, instead talk with one of our staff to find how to get the needed consent)

Relationship to patient: _____

Signature of Parent (Guardian): _____

Date: _____

Witness signature: _____

Date: _____

Taghi Modarressi Center for Infant Study: Secure Starts
University of Maryland School Mental Health Program
Division of Child and Adolescent Psychiatry
University of Maryland, Baltimore
701 West Pratt Street, 4th Floor
Baltimore, MD 21201
410-328-5881
410-328-8552 (fax)

Advance Directive for Mental Health Treatment

Maryland Department of Health and Mental Hygiene

Behavioral Health Administration

Larry Hogan, Governor
Boyd K. Rutherford, Lt. Governor
Van T. Mitchell, Secretary, DHMH

NOTICE: *This is an important legal document.*
Before signing this document, you should know these important facts.

Introduction

Maryland law gives the right to anyone 16 years of age and over to be involved in decisions about their mental health treatment. However, a parent or guardian of a person under the age of 18 years may authorize treatment, even over the objection of the minor. The law also notes that at times, some persons are unable to make treatment decisions. Maryland law states that you have the right to make decisions in advance, including mental health treatment decisions, through a process called advance directive. An advance directive can be used to state your treatment choice or can be used to name a health care agent, who is someone that will make health care decisions for you.

A. If you are a person with a mental illness, this document provides you the chance to take part in a major way in your mental health care decisions when you are not able to. This document allows you to express your consent or refusal to medications for your mental illness and other health care decisions, including use of seclusion and restraints. Please know that Maryland law allows a health care provider to override your refusal for medication for a mental disorder in limited situations if you are involuntarily committed to a psychiatric hospital.

B. This document may be completed by any individual 18 years of age and has not been determined to be not capable of making an informed decision. An advance directive may be oral or written. If written, it must be signed and dated. Two witnesses must also sign the document. The health care agent may not be a witness. And, at least one witness may not be a person who is knowingly entitled to benefit by your death, for example inherit money, insurance benefits. The witnesses must sign the document stating that the person making the directive is personally known them and appears to be of sound mind.

C. If you wish to guide your health care providers on what treatment you wish to have if you should become unable to give consent, and you DO NOT WANT A HEALTH AGENT, fill out the form titled "Advance Directive for Mental Health Treatment". If you want an agent to make the choice for you, fill out the form **"**Appointment of Health Care Agent." You may fill both forms if you want an agent to make the choices and you also want to assist in those choices. If the directive is made orally, it must be made in the company of your attending physician and one witness.

D. You can also make an advance directive naming a person as your health care agent, to make mental health decisions when you are not able to do so. The agent must make choices in line with any desires you have expressed in this document, or if your wishes are not expressed and are not known by the agent, the agent must act in good faith in what he/she believes to be in the best interest for you. It is your job to inform the agent that the agent has been named in your advance directive, and to make sure he/she agrees to be your agent. It is important that your health care agent be informed about your mental illness and the decisions you have made in this form. It is highly recommended that you discuss the contents of this form with your family and close friends and your mental health providers.

E. The Office of the Attorney General has issued an opinion that a healthcare agent may sign an individual into a facility, including a psychiatric hospital. If you wish your healthcare agent to be able to make this choice, you should so specify.

F. Maryland law allows giving a medication for the treatment of a mental disorder over the person's expressed wishes, or placing a person in seclusion or restraints against the person's expressed wishes, under certain conditions.

Advance Directive for Mental Health Treatment

I (*name*) _____being an adult, and emotionally and mentally able to make this directive, willfully and freely complete this health care advance directive to be followed if it is determined by two physicians that I am not able as a result of a psychiatric or physical illness to assist in my health care treatment. (The second physician may not be involved in my treatment). It is my intent that care will be carried out despite my inability to make choices on my own behalf. In the event that a guardian or other decision-maker is chosen by a court to make health care choices for me, I intend this document to take priority over all other means of discovering intent while able.

The usual symptoms of my identified mental disorder may include:

I direct my health care providers to follow my choices as set forth below:

Medications for treatment of my mental illness:

If I become unable to make informed choices for treatment of my mental illness, my wishes regarding medications are as follows:

I may be allergic to the following medications:

Medication	**Reaction**

The following medications have been helpful in the past and I would agree to them if prescribed:

Initial all that apply:

I agree to the performance of all tests and other means to identify or assess my mental health.

I agree to the performance of all tests and other means to check how well the medications are working and their effect on my body, i.e. blood tests.

I specifically do not agree with dispensing the following medications, or their own brand-name, trade name or generic equal.

Medication	***Reasons for not agreeing***

I agree with dispensing all medications prescribed by my treating psychiatrist, unless listed above.

Admission to and continuation of Mental Health Services from a facility other than an inpatient hospital.

Check one

☐ I do not have a preference about receiving mental health services from a facility or other provider than a psychiatric hospital, i.e., clinic, PRP, mobile treatment.

☐ I agree to receive services from a facility, which is not a hospital.

☐ I do not agree to receive mental health services from a provider or facility other than a hospital.

Conditions/ Limits:

Other Choices

If I am unable to make informed decisions about my mental health choices, my wishes regarding other information or options are listed below:

Release of Records

I authorize the release of (check one):

☐ any and all mental health records

☐ the following mental health record / records of the following providers:

to:

_____

(*name of person records may be released to)*

Appointment of Health Care Agent

I select the following person as my agent to make health care choices for me:

Name _____

Address _____

Work Number _____ *Home Number* _____

If this agent is unable, unwilling, or elsewhere engaged to act as my agent, then I select the following person to act in this role:

Name _____

Address _____

Work Number _____ *Home Number* _____

My agent has full power and right to make health care choices for me:

☐ Just in regards to the instruction above.

☐ If my wishes are not expressed above, and my wishes are not otherwise known to my agent, or if my wishes are unknown or unclear, my agent is to make health care choices for me with my best interest in mind, to be determined by my agent after reviewing the benefits, burdens, risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.

The authority of my agent is subject to the following conditions and limits:

My agent has full power and right to:

1. Request, receive and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and the right to disclose this information.

2. Employ and release my health care providers.

3. Approve my admission to or release from any facility (other than psychiatric hospital or unit), nursing home, adult home or other supervised housing or medical care facility.

Check One:
My agent

☐ **HAS**

☐ **HAS NOT**

the power and authority to approve my admission to or release from a psychiatric hospital or unit.

Check one:
My agent's powers and rights become active:

☐ when my attending physician and a second physician decide that I am unable to make well-versed choices regarding my health care;

OR

☐ when this document is signed.

My agent shall not be responsible for costs of care based just on this agreement.

_____ _____

Date *Signature*

The above named person signed or acknowledged signing this advance directive in my company and based upon my personal study appears to be a capable person.

_____ _____

Witness name *Witness signature*

_____ _____

Witness name *Witness signature*