COLLABORATIVE COUNSELING *TMS*

5560 Sterrett Place, Suite 201
Columbia, MD, 21044
p. (443) 546-1100
f. (443) 546-4005

www.collaborativecounselingtms.com

Intake Forms Checksheet

Please read and complete each of the documents listed below as completely as possible. These documents are intended to be resources for you, as well as helpful aides to us for your care and treatment.

- New Patient Registration
- Collaborative Counseling TMS Notice of Privacy Practices and Policies
- Collaborative Counseling TMS Notice of Office Policies and Procedures
- Combined Acknowledgement of Receipt of Notice of Privacy Practices and Policies and Acknowledgement of Receipt of Notice of Office Policies and Procedures.
- Insurance and Financial Policy
- Consent for Care
- Authorization to Release or Exchange Information
- Credit Card on File Form
- Telehealth Consent Form

You may keep the Notice of Privacy Practices and Policies and Notice of Office Policies and Procedures for your reference. Please bring all other completed forms to your first appointment. Please feel free to request copies of any other forms.

Billing and patient accounts are administered by Collaborative Counseling TMS. You may contact us by phone at (443) 546-1100 or e-mail at avneet@collaborativecounselingtms.com

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New Patient Registration

General Information

Patient Name: _____ Patient Date of Birth: _____

Identified Gender: _____ Preferred Pronouns: _____

School and Grade and/or Employer: _____

Mailing Address: _____

Phone Number: _____ Email Address: _____

Medical and Referral Information

Complete Name of Primary Care Provider/Pediatrician: _____

Primary Care Provider's Telephone Number: _____

Name of Referring Provider and Phone Number: _____

Name of Pharmacy: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____

Parent/Guardian Information:

If patient is under 18

Parent/Guardian 1

Name: _____

Date of Birth: _____

Insurance Policy Holder: Yes No

Telephone Number: _____

Email Address: _____

Address: _____

_____

Parent/Guardian 2
If applicable

Name: _____

Date of Birth: _____

Insurance Policy Holder: Yes No

Telephone Number: _____

Email Address: _____

Address: _____

_____

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Appointment Reminders:

Collaborative Counseling Center provides appointment reminders via phone, email and/or text message. Please let us know how to communicate your reminders. Check all that apply:*

For your appointment reminders, which phone number/email would you like us to use? *

_____

Emergency Contact:

In the case of an emergency, if we are not able to get in contact with the parent/guardian, please include an emergency contact:

Emergency Contact Name: _____

Emergency Contact Relationship to Patient: _____

Emergency Contact Phone Number: _____

Emergency Contact Email: _____

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Consent for Care

I, the patient or patient's legal representative, hereby grant permission to Collaborative Counseling TMS to perform such examinations, medical, and therapeutic procedures as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, facsimile, and e-mail for my/the patient's diagnosis, treatment, payment, and healthcare operations.

I am aware that the practice of medicine and mental health services are not an exact science and that no guarantees or promises have been made to me as to the result of treatment or examination.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

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Patient Consent for a Medical Procedure Collaborative Counseling TMS Therapy

This is a patient consent for a medical procedure called Collaborative Counseling TMS Therapy®. This consent form outlines the treatment that your doctor has prescribed for you, the risks of this treatment, the potential benefits of this treatment to you, and any alternative treatments that are available for you if you decide not to be treated with Collaborative Counseling TMS Therapy.

The information contained in this consent form is also described in the "Collaborative Counseling TMS Therapy Patient Guide for Treating Depression" which is available from your doctor. Not all information in the Patient Guide is stated here, so you should read the guide and discuss any questions that you have with your doctor. Once you have reviewed the guide and this consent form, be sure to ask your doctor any questions that you may have about Collaborative Counseling TMS Therapy and its use in treating depression.

Dr. Brett Greenberger has explained the following information to me:

a. This treatment with Collaborative Counseling TMS Therapy is designed to relieve my current symptoms of depression.
b. TMS stands for "Transcranial Magnetic Stimulation". Collaborative Counseling TMS Therapy is a medical procedure. A TMS treatment session is conducted using a device called the Collaborative Counseling TMS Therapy System, which provides electrical energy to a "treatment coil" or magnet that delivers pulsed magnetic fields. These magnetic fields are the same type and strength as those used in MRI (magnetic resonance imaging) machines.
c. Collaborative Counseling TMS Therapy is a safe and effective treatment for patients with depression who have not benefited from antidepressant medications.
d. Specifically, Collaborative Counseling TMS Therapy has been shown to relieve depression symptoms in adult patients who have failed to receive satisfactory improvement from prior antidepressant medication in the current episode.
e. During a TMS treatment session, the doctor or a member of their staff will place the magnetic coil gently against my scalp on the left front region of my head. The magnetic fields that are produced by the magnetic coil are directed at a region of the brain that is involved with causing depression.
f. To administer the treatment, the doctor or a member of their staff will first position my head in the head support system. Next, the magnetic coil will be placed on the left side

of my head, and I will hear a clicking sound and feel a tapping sensation on my scalp. The doctor will then adjust the Collaborative Counseling TMS Therapy system so that the device will give just enough energy to send electromagnetic pulses into the brain so that my right hand twitches. The amount of energy required to make my hand twitch is called the "motor threshold". Everyone has a different motor threshold and the treatments are usually given at an energy level that is just above my individual motor threshold. How often my motor threshold will be re-evaluated will be determined by my doctor.

g. Once my motor threshold is determined, the magnetic coil will be moved to the left front region of my head, and I will receive the treatment as a series of TMS "pulses" that last about 4 seconds, with a "rest" period of about 11 seconds to 26 seconds between each series. The total treatment time typically lasts from 19 minute to approximately 40 minutes. I understand that this treatment does not involve any anesthesia or sedation and that I will remain awake and alert during the treatment. I will likely receive these treatments 5 times a week for 4 to 6 weeks (20 to 30 treatments), followed by a 6 treatment "taper" over 3 weeks. I will be evaluated by Dr. Brett Greenberger throughout my TMS treatment.
h. During the treatment, I may experience tapping or painful sensations at the treatment site while the magnetic coil is pulsing. These types of sensations were reported by about one third of the patients who participated in the research studies. I understand that I should inform the doctor or their staff if this occurs. The doctor or their staff may then adjust the treatment dose or make changes to where the coil is placed in order to help make the procedure more comfortable for me. I also understand that headaches were reported in half of the patients who participated in the clinical trial for the NeuroStar. I understand that both discomfort and headaches got better over time in the research studies and common over-the-counter pain medications such as acetaminophen may help if a headache occurs.
i. The Collaborative Counseling TMS Therapy System should not be used by anyone who is/has:
    1. Magnetic-sensitive metal in their head or within 12 inches (30 cm) of the NeuroStar magnetic coil that cannot be removed. Failure to follow this restriction could result in serious injury or death. These include but are not limited to: Cochlear implants, Aneurysm clips or coils, Stents Electrodes, Ferromagnetic implants in your ears or eyes, Bullet fragments, Other metal devices or objects implanted in the head, Facial tattoos with metal ink or permanent makeup
    2. Implanted stimulators in or near the head. These may including:
        - Deep brain stimulators
        - Cochlear implants
    3. Actively using illicit substances, including alcohol and cannabis misuse.

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j. The Collaborative Counseling TMS System should be used with caution in patients who have pacemakers or implantable cardioverter defibrillators (ICD) or are using wearable cardioverter defibrillators (WCD). Failure to follow this restriction could result in serious injury or death.
k. Collaborative Counseling TMS Therapy is not effective for all patients with depression. Any signs or symptoms of worsening depression should be reported immediately to your doctor. You may want to ask a family member or caregiver to monitor your symptoms to help you spot any signs of worsening depression.
l. Seizures (sometimes called convulsions or fits) have been reported with the use of TMS devices. No seizures were observed with use of the NeuroStar TMS Therapy System in clinical trials involving about 500 patients and over 15,000 treatments. Since the introduction of the NeuroStar TMS System into clinical practice, seizures have been rarely reported. The estimated risk of seizure under ordinary clinical use is approximately 1 in 30,000 treatments or 1 in 1000 patients.
m. Because the NeuroStar TMS Therapy system produces a loud click with each magnetic pulse I understand that I must wear earplugs or similar hearing protection devices with a rating of 30dB or higher of noise reduction during treatment.
n. I understand that although most patients who benefit from Collaborative Counseling TMS Therapy experience results by the fourth week of treatment, some patients may experience results in less time while others may take longer.
o. I understand that the symptom relief that I may receive from Collaborative Counseling TMS Therapy may be lost over time and I may need to take an antidepressant medication to help retain symptom relief. In clinical trials, 85% of patients retained benefit with antidepressant medication over 12 months. About one-third of these patients required some re-treatment with Collaborative Counseling TMS Therapy.
p. I understand that I may discontinue treatment at any time.

I have read the information contained in this Medical Procedure Consent Form about Collaborative Counseling TMS Therapy and its potential risks.

I have discussed my TMS treatment with Dr. Brett Greenberger who has answered all of my questions. I understand there are other treatment options for my depression available to me and this has also been discussed with me.

I therefore permit Dr. Brett Greenberger and his staff to administer this treatment to me.

Patient Signature: _____ Date: _____

Witness Signature: _____

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Insurance and Financial Policy

1. All co-pays and/or charges must be paid in full at the time of service.
2. CC TMS accepts most insurance plans. Any contract that obligates your insurance carrier to pay for a portion of your healthcare is between you and your insurance carrier. CC TMS, in collaboration with the client, will be in contact with insurance carriers to verify benefits and facilitate the reimbursement process for services rendered. Depending on the insurance plan, your financial responsibility for services rendered will vary based on deductibles and out of pocket maximums.
3. The benefits investigation and financial agreement provided to you by CC TMS is an estimate of your financial obligation, insurance payments are subject to change based on your policy's claim and benefit determination. The processing of the claims by your insurance company may change your amount owed. If the amount owed changes based on your insurance claims processed for services rendered, you are financially responsible for payment in full of the remaining balance owed.
4. CC TMS staff will obtain all referrals/authorizations on your behalf required by your insurance plan, including the clinical explanation for medical necessity. If it is necessary for insurance authorization and approval, CC TMS will request client assistance.
5. We accept all major credit cards including Visa, Master Card, American Express, Discover, Check and Cash payments.
6. A $50 fee will be charged for missed treatments without 24 hours' notice, with the exception of an emergency or other urgent matters. This fee must be paid in full before another appointment can be scheduled or services provided.
7. In the unlikely event that you default on payment for any amount due, we will place your account in the hands of our attorney for collection or legal action. You will then be charged an additional fee equal to the cost of collection, including attorney fees and court costs incurred as permitted by the laws governing these transactions. Once this occurs you will forfeit the opportunity to be treated in our practice.

By signing this document you are agreeing to pay for our services in full and acknowledge that you have read and fully understand its contents.

Signature: _____ Date: _____
(Parent or guardian, if patient is a minor)

Signature of Witness: _____ Date: _____

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Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Collaborative Counseling Centers' Psychiatrists and Mental Health Professionals to connect with individuals and families using interactive video and audio communications. Telehealth includes the practice of mental health care delivery, diagnosis, consultation, treatment, and referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth, for myself and/or my minor child:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. CCC utilizes secure, encrypted audio/video transmission software to deliver telehealth.
4. I understand that if my Provider believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of mental health services, and that despite my efforts and the efforts of my Provider, my condition may not improve, and in some cases may even get worse.
5. I understand the alternatives to mental health services through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or

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at the direction of my Provider, I may be directed to “face-to- face” mental health services.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present at the onset of the session, other than my Provider 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 medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.
8. I understand that my express consent is required to forward my personally identifiable information to a third party.
9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based mental health services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.
11. I understand that different states have their own regulations for the use of telehealth. CCC Providers will follow all guidelines for Maryland and their respective licensing boards.

Patient Consent to the Use of Telehealth:

I have read and understand the information provided above regarding telehealth, have discussed it with my Provider, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

The authorization below is given by the patient or on the patient’s behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

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Notice of Office Policies and Procedures

Purpose Of This Information

In order for Collaborative Counseling TMS to provide the best care possible, we want our patients to have as much pertinent information as possible. If you have any questions or concerns about the healthcare or business practices of this office, please feel free to discuss them with our Clinicians and Physicians.

Privacy And Release Of Information

Services you receive in this office are confidential, except in the circumstances listed below:

1. Threats of harm to self or others
2. Abuse of a child, vulnerable adult, or developmentally disabled person
3. A court order to release information
4. Subpoena of treatment records by an attorney. If you do not want this information released, you must obtain a protective order from the court within fourteen (14) days.
5. If you will be applying your health insurance benefits, we may be required to provide information to your health plan, including some or all of your record of treatment, in order for your carrier to pay for services. By signing the Acknowledgement of Receipt of Office Policies and Procedures form you consent to release of that information to your health plan. Psychotherapy notes are handled separately under HIPAA and have additional protections.
6. If you are party to child custody litigation at any time in the future, the court may order release of information about your treatment in this office.
7. In some instances, as provided by the state law of Maryland, information about your healthcare may be exchanged with other healthcare professionals involved in your treatment.

In circumstances other than these, CC TMS will not release information about your treatment without your authorization.

Emergency Contact

Messages left on voicemail are retrieved regularly and calls are returned as soon as possible. If you need more rapid attention for your own or someone else's safety, do not delay while waiting for a Clinician or Office Administrator to return your telephone call. In a mental health emergency, please call 9-1-1 or report to the nearest hospital emergency room.

Patient Records

An electronic record (file) is kept of services you receive in this office. You have a right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected. You may authorize in writing that copies of the record be released to entities you designate, at your expense, according to charges stipulated by the state law of Maryland. Under certain circumstances where seeing the record may put a patient or other person at risk, CC TMS may redact certain information in the record and/or require that you review the record in consultation with another healthcare provider. You may receive an accounting of non-routine uses and disclosures of your record. You may receive a free copy of

your record and a free accounting of non-routine disclosure(s) each year. Please contact Collaborative Counseling TMS to obtain these documents. We require your request to be in writing:

Collaborative Counseling TMS
5560 Sterrett Place, Suite 201
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If you have questions, please contact our office at (443) 546-1100.

Security Procedures

CC TMS makes reasonable efforts to prevent access and disclosure to unauthorized personnel. CC TMS keeps an ongoing log of potential risks and the physical and electronic safeguards implemented to limit these risks. CC TMS requires all of its clinicians and staff to abide by all applicable privacy regulations.

Insurance Benefits And Patient Responsibility For Fees

It is the patient's and the patient's guarantor's responsibility to work with the TMS Coordinator to discuss the financial obligations associated with this treatment. Patients may use insurance, pay a co-pay or pay in full for TMS Treatment. TMS Coordinator will work with you during the benefits eligibility process to determine benefits and determine cost of treatment and payment options. Only your health insurance plan can describe your benefits to you or verify provider eligibility. We will work with you to contact your health insurance plan directly for verification. The benefits investigation and financial agreement provided to you by CC TMS is an estimate of your financial obligation, insurance payments are subject to change based on your policy's claim and benefit determination. The processing of the claims by your insurance company may change your amount owed. If the amount owed changes based on your insurance claims processed for services rendered, you are financially responsible for payment in full of the remaining balance owed.

Fees And Payment

Payment is due in full at the time services are rendered as agreed upon with the patient, the TMS Coordinator and your insurance company and then outlined in your TMS Financial Agreement. Billing and patient accounts are administered by Collaborative Counseling TMS. Please telephone CC TMS directly with any questions or concerns about your account statement.

Unpaid Bills

It is important that you discuss with CC TMS any financial hardship that you may have. Doing so may allow us to arrive at a mutually agreeable payment plan that allows the continuation of your treatment. If this cannot be accomplished, seriously delinquent accounts may be referred to a collection agency and we may have to terminate our relationship as provider and patient. Information necessary to effect collection will be released to the collection agent. Should it become necessary to file suit in this context, you agree to pay reasonable attorney fees. A service fee of 3% will be charged on balances more than thirty (30) days past due.

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Late Cancellations And Missed Appointments

TMS Coordinator will work with you to determine a TMS schedule that best meets your needs. It is important that you attend your scheduled appointments. If you cannot be at your appointment time, we ask that you provide us at least 24 hours' notice (business days) so that we may plan accordingly. CC TMS may charge a fee for missed visits on a case by case basis.

Grievance Procedures And Complaints

If you have any questions or concerns about administrative or business matters in this office, please discuss them with the TMS Coordinator. We may involve the Clinical Director, Emily Greenberger, LCSW-C, if it would be mutually beneficial to do so.

If you have any questions or concerns about your treatment, you are encouraged to discuss them with your Clinician. In addition, or instead, the following avenues are available:

1. You may contact your health insurance plan or behavioral health benefit manager;
2. If you feel the problem is serious and/or you have not reached resolution through one of the avenues above, you can file a complaint with the Maryland Department of Health and Mental Hygiene. Contact information can be found on the DHMH website www.dhmh.maryland.gov
3. You may also file complaints regarding privacy practices to the Secretary of the U.S. Department of Health and Human Services.

Fees

TMS Treatment amounts vary by patient and insurance provider. TMS Coordinator will work with each patient to determine the cost of treatment solidified by a patient signed Financial Agreement.

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Notice of Privacy Practices and Policies

AS REQUIRED BY FEDERAL LEGISLATION, THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to all of the paper and electronic records of your care maintained by Collaborative Counseling TMS whether created by CC TMS, or records acquired from outside resources such as other clinicians involved in your care and laboratory reports.

Ways the Practice May Use and Disclose Your Information

The following categories describe ways that CC TMS shares your confidential information. Confidential information includes Protected Health Information (PHI) (information that could be used to identify you). Not every use or disclosure in a category is listed. However, all of the ways we are permitted to use and disclose information will fall within one of the following categories.

A. DISCLOSURES WHICH REQUIRE AUTHORIZATION

Psychotherapy notes are handled separately under HIPAA and have additional protections. Specifically, the regulations state that in most instances a practice must obtain an authorization for any use or disclosure of psychotherapy notes. No authorization is needed to carry out treatment, payment, healthcare operations, or the uses listed in routine situations. All other circumstances require a valid authorization from you for use and disclosure.

Confidential information may be released for payment and healthcare operations only to health insurance plans and their agents, as well as business associates of the practice. The definition of a health insurance plan does not include life insurance companies, automobile insurance companies, or workers' compensation carriers. These are not covered under HIPAA. If you would like information submitted to one of these companies, an authorization will be required, unless it is already mandated by state or federal law.

B. ROUTINE SITUATIONS

1. **For Treatment** CC TMS may use information about you in order to provide you with proper medical treatment or services. Treatment is when a Provider needs to provide, coordinate, or manage your healthcare and other services related to your healthcare. An example of treatment is when CC TMS consults with another healthcare provider, such as your primary care physician.
2. **For Payment** CC TMS may use and disclose information about you so that the treatment and services you receive may be billed and payment can be collected from you, an insurance company, or a third party (including a collection agency if

necessary). For example, on request, CC TMS may give your health insurance plan information about services you received at the practice, so your health insurance can pay my practice or reimburse you for the services. CC TMS may also tell your health insurance plan about a treatment you are going to receive, in order to obtain prior approval or determine if your plan will cover the treatment.

3. **For Healthcare Operations** CC TMS may use and share information about you for administrative functions necessary to run our practice and promote quality care. Providers may share information with business associates who provide services necessary to run the practice, such as transcription companies or billing services. CC TMS will contractually bind these third parties to protect your information as your Clinician would. Also, CC TMS may permit your health insurance plan or other providers to review records that contain information about you to assist them in improving the quality of service provided to you.
4. **Communicating with You and Others Involved in Your Care** CC TMS may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. In certain situations, I may share information about you with a friend or family member who is involved in your care or payment for your care unless you have requested that such disclosures not occur and the CC TMS is in agreement. Information disclosed will be directly relevant to such person's involvement with your care or payment related to your care. Whenever possible, this person will be identified by you. However, in emergencies or other situations in which you are unable to indicate your preference, CC TMSmay need to share information about you with other individuals or organizations to coordinate your care or notify your family.

C. SPECIAL SITUATIONS

1. **As Required By Law**: CC TMS will disclose information about you when required to do so by federal, state or local law. For example, CCC may release information about you in response to a valid court subpoena.
2. **Health Oversight Activities**: CC TMS may disclose information to a health oversight agency for activities authorized by law. For example, these oversight activities include: audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
3. For Judicial or Administrative Proceedings: If you are involved in a court proceeding, and a request is made for information about the professional services that you have received within the practice and the records thereof, such information may be privileged under state law. CC TMS will not release information without the written authorization of you or your legal representative,

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or in instance of issuance. This may also be the case in the instance of a court subpoena, which requires the provision of such information, which you have been properly notified. In response, you have not opposed the court subpoena within the legally specified format and timeframe, or in the instance of the issuance of a court order compelling me to provide Protected Health Information (PHI). This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

4. **To Avert Serious Threat to Health or Safety**: CC TMS may disclose your confidential mental health information to any person without authorization if they reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual. These disclosures may be to law enforcement officials to respond to a violent crime or to protect the target of a violent crime. For example, threats of harming another individual may be reported to appropriate authorities.
5. **Worker's Compensation**: If you file a worker's compensation claim with certain exceptions, CC TMS must make available at any stage of the proceedings, all PHI information in our possession that is relevant to that particular injury in the opinion of the Maryland Department of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.
6. **Public Health Risks**: CC TMS may disclose information about you for public health activities. These activities generally include, but are not limited to, the following:
    a. To prevent or control disease, injury, or disability
    b. To report child abuse or neglect
    c. To report adult and domestic abuse
    d. To report reactions to medications or problems with products
    e. To notify people of recalls of products they may be using
    f. 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
    g. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.
7. **Law Enforcement**: CC TMS may release information about you if asked to do so by a law enforcement official
    a. In response to a court order, subpoena, warrant, summons, or similar process
    b. To identify or locate a suspect, fugitive, material witness, or missing person
    c. If you are suspected to be a victim of a crime, generally with your permission

d. About a death we believe may be the result of criminal conduct
e. About criminal conduct at the hospital
f. In emergency circumstances involving a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

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Your Rights as a Patient

In addition to provisions by the practice to protect your confidential information, you are entitled to six (6) specific rights as a patient. Request forms are available for your assistance at Collaborative Counseling TMS.

1. **You have the right to request restrictions on certain uses and disclosures.** You have the right to request a restriction or limitation on the use and sharing of information about you for treatment, payment, administrative functions, or with individuals involved in your care. To request restrictions, you must make your request in writing to your Clinician. In your request, you must tell him/her: (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want it to apply. The Clinician is not required to agree to your request. If he/she does agree, the Clinician will comply with your request unless the information is needed to provide you with emergency treatment.
2. **You have the right to receive confidential communications.** You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or at a post office box. To request confidential communications, you must make your request in writing to CC TMS. Your request must specify how or where you wish to be contacted. CC TMS will not ask you for the reason and will seek to accommodate all reasonable requests.
3. **You have the right to inspect and obtain copies.** You have the right to review and obtain copies of information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does ***not*** include psychotherapy notes, information compiled in reasonable anticipation of a legal action or proceeding; and confidential information related to certain laboratory tests under Clinical Laboratory Improvement Amendments (CLIA). To inspect and copy information that may be used to make decisions about you, you must submit your request to CC TMS in writing. You may be charged a fee for the costs of copying, mailing or other supplies associated with your request. In the following circumstances CC TMS may deny your request to inspect and copy information:
    a. It is determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of you or another person

   b. The information makes reference to another person (unless the other person is a healthcare provider) and the CC TMS Provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to the other person
   c. The request for access is made by your representative and a CC TMS Provider has determined, in the exercise of professional judgment, that the provision of access to your personal representative is reasonably likely to cause substantial harm to you or another person. If you are denied access, you may request a review of the denial by another licensed medical practitioner. CCC will comply with the outcome of the review. If your request only concerns billing information, you may call Collaborative Counseling TMS at (443) 546-1100.

4. **You have the right to amend confidential information.** If you feel that the information CC TMS has about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the practice. To request an amendment, a reason that supports your request must be made in writing and submitted to CC TMS. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, CC TMS may deny your request if you ask to amend information that:
   a. Was not created by the practice, unless the person or entity that created the information is not longer available to make the amendment. In such instances we will consider the request
   b. Is not part of the information kept by or for the practice
   c. Is not part of the information which you be permitted to inspect and copy
   d. Is accurate and complete.
5. **You have the right to receive accounting of disclosures of confidential information.** You may ask to receive an accounting of certain disclosures made about you that were not related to the routine uses listed above. To request this list or accounting of disclosures, you must submit your request in writing to CC TMS. Your request must state a time period that may not be longer than six (6) years and indicate what format you want the list (for example, on paper or in an electronic file.) The first list you request will be free. For additional lists, CC TMS may charge you the cost of providing the list. CCC will notify you of the estimated cost involved and you may choose to withdraw or modify your requests because any costs are incurred. Disclosures do not have to be made when those disclosures are:
   a. To carry out treatment, payment, healthcare operations
   b. To individuals of confidential information about them
   c. As a result of assigned authorization
   d. For the practice's directory or to persons involved in your care
   e. For national security or intelligence purposes; or

f. To correctional institutions or law enforcement officials.

6. **You have the right to obtain a paper copy of this Notice upon request.** Even if you have requested an electronic copy, CC TMS will provide you with a paper copy of this Notice at your request.

Collaborative Counseling Center's Duties

In addition to your rights as a patient, CC TMS has duties to protect your confidential information and inform you of changes to protection measures. CC TMS is required by law to maintain the privacy of confidential information and provide you with notice of CC TMS's legal duties and privacy practices with respect to such information. CC TMS is required to abide by the terms of this Notice currently in effect.

Changes to This Notice

CC TMS reserves the right to revise or change provisions on this Notice. CC TMS will make the new Notice provisions effective for all confidential information it maintains. CC TMS will promptly revise and distribute the Notice whenever there is a change to the uses or disclosures, your rights, and our duties, or other privacy practices stated in this Notice. CC TMS will post updates of the notice to all active patients. Patients who are inactive at the time of the posting will receive an updated copy at their next scheduled appointment upon request. A copy of the Current Notice will be available throughout the practice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with CC TMS or with the Secretary at the Department of Health and of Human Services. All complaints must be submitted or verified in writing. You have specific rights under the Privacy Rule. You will not be penalized for filing a complaint.

Other Uses of Information

Other uses and disclosures of information not covered by this notice or the laws that apply to CC TMS will be made only with your written permission. If you provide CC TMS with specific permission to use or disclose information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, CC TMS will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that have already been made with your permission and that we are required to retain our records of the care that we provided to you.

COLLABORATIVE COUNSELING *TMS*

5560 Sterrett Place, Suite 201
Columbia, MD, 21044
p. (443) 546-1100
f. (443) 546-4005

www.collaborativecounselingtms.com

Privacy Officer
Emily Greenberger, LCSW-C is the Privacy Office for the practice. You may contact her with questions or comments by telephone at (443) 546-1100 or by mail to:

Collaborative Counseling TMS
5560 Sterrett Place
Columbia, MD, 21044

Acknowledgement of Receipt of Notice of Privacy Practice
CC TMS is required to provide you with a copy of this Notice and document your receipt. Please fill out an Acknowledgement of Receipt of Notice of Privacy after receiving this Notice. You may contact me with questions or comments by telephone at (443) 546-1100, or by mail at:

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Acknowledgement of Receipt of Notice of Privacy Practices And Policies

In order to comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices and Policies or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations.

I have received a copy of the Notice of Privacy Practices and Policies from:
Collaborative Counseling TMS
5560 Sterrett Place, Suite 201
Columbia, MD 21044

Patient Signature: _____ **Date**: _____

The authorization below is given by the patient or on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ **Relationship to Patient**: _____

Signature: _____ **Date**: _____

Acknowledgement of Receipt of Notice of Office Policies and Procedures

I have received a copy of Collaborative Counseling TMS' Notice of Office Policies and Procedures. I understand and agree to abide by them and consent to receive treatment. I understand and agree to abide by the late cancellation and missed appointment policy and the direct payment/fee for service policy.

Patient Signature: _____ **Date**: _____

The authorization below is given by the patient or on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ **Relationship to Patient**: _____

Signature: _____ **Date**: _____

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Authorization to Release or Exchange Information

Patient Information

Clients Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

Other Party

The provider, agency, family member and/or other entities

Name of Person/Organization: _____

Address: _____

Phone Number: _____

Information To Be Released

I hereby authorize Collaborative Counseling TMS to (please check all that apply)*

▢ Release Information to ▢ Gather Information from ▢ Exchange Information with

This information may consist of the following (please initial each line to which consent is given):

_____ Psychological test reports
_____ Psychiatric evaluation reports
_____ Periodic reports of psychotherapy
_____ Social History Data (family, education, employment, arrest, drugs, and alcohol)
_____ Medical Information
_____ Other (specify): _____

This information will be used (please initial each line to which consent is given):

_____ To determine appropriateness of treatment
_____ To develop a diagnosis and treatment plan
_____ To facilitate coordination of services
_____ At the request of the individual
_____ Other (specify): _____

Acknowledgment

I understand that no information may be forwarded by either party listed in this release to any other individual or agency without my written consent. I understand that this information may not be re-disclosed by its recipient. This authorization may be revoked at any time by my written statement except to the extent that authorized persons who are to disclose the information

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described above have already taken action in reliance on it. It is automatically revoked 30 days after the termination of the therapeutic relationship or under the following conditions:

This consent is given voluntarily, without coercion. Signing this form is not required to receive treatment/services
at Collaborative Counseling TMS.

Sign: _____ Date: _____

If the authorization above is given on the patient's behalf because the patient is either a minor or unable to sign, please specify who signed below:

Name: _____ Relationship to Patient: _____

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Credit Card Payment Form

Client Name: _____ Client Date of Birth: _____

Provider(s) Name: _____

Credit Card Type (Visa, MasterCard, AMEX, etc.): _____

Credit Card Number: _____

Security Code: _____ Expiration Date: _____

Name as it appears on the card: _____

Zip Code Associated with billing address: _____

Collaborative Counseling TMS collects payment as discussed in your financial agreement (if applicable). If we cannot process payment with the information provided, we will contact you for an alternative payment method.