COLLABORATIVE COUNSELING CENTER

8820 Columbia 100 Parkway,
Suite 201
Columbia, MD, 21045
p. (443) 546-4000
f. (443) 546-4005

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: _____

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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Clinical Information Form

Patient Name: _____ Preferred Gender and Pronouns: _____

Why are you seeking help at this time? Please include mental health concerns.

_____

_____

_____

_____

_____

What are your goals for the current treatment/evaluation?

_____

_____

_____

Mental Health History

Past mental health treatment:
For example, outpatient therapy, medication management, residential or inpatient treatment, TMS, etc.

_____

_____

_____

Past mental health diagnoses: _____

Diagnoses and approximate date/age diagnosed: _____

Have you ever been prescribed medication for psychiatric treatment? (circle one) Yes No

Are you currently being prescribed medication for psychiatric treatment? (circle one) Yes No

If YES to either above, please fill out below to the best of your knowledge:
Include medication name, dose, start/end dates, side effects (if applicable) and reasons for stopping (if applicable)

_____

_____

_____

Medical Information

Primary Care Physician Name: _____

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Office Name: _____ Office Phone Number: _____

Other specialists providing you care: _____

Office name and phone number: _____

Please list any current medications and previous medications (include prescription and over-the-counter), excluding psychiatric medications:
Please include medication name, dose, length of treatment, start/end date, side effects (if applicable) and reason for stopping the medication.

_____

_____

Please list and describe any current or past medical diagnoses or conditions:

_____

_____

Do you have any allergies? (circle one) Yes No

If YES, please elaborate (what you are allergic to and reactions):

_____

_____

Social History

Marital Status: _____

Please note any current stressors in your life:

_____

_____

_____

Education/Employment History

Highest level of education completed: _____

Are you currently employed? (circle one) Yes No

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Consent for Care

I, the patient or patient's legal representative, hereby grant permission to Collaborative Counseling Center 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: _____

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:

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

Signature: _____ **Date:** _____

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Psychiatric Services: Informed Consent Policy and Procedures

The Collaborative Counseling Center's goal is to provide timely, effective and informed treatment. The prescribing of medication is one component of treatment to maximize the functioning of the person and is intended to be integrated, when possible, through an individualized plan of care through active involvement of the individual & parent/guardian when applicable. The following policy and procedures outline CCC's commitment to safe prescribing practices:

1. Psychiatric Services are MEDICAL services.
2. For all children under 16: Parents/Guardians MUST accompany their children to all appointments (in person and telehealth) to understand the risks/benefits of medication and provide informed consent.
    - If you are a kinship custodian (no legal guardianship), the child's parent must attend appointments or you must, in advance, provide CCC with a notarized statement that authorizes you to sign and consent for medical treatment of the minor in your custody.
3. Prior to receiving Psychiatric Services, patients may be requested to sign consents for collaboration with your Primary Care Physician (PCP), Pediatrician and/or other professionals prescribing your medication.
    - This applies to all adult, adolescents and child patients as needed.
    - This is considered best practice and in the best practice of your physical/somatic and behavioral health. Refusal to do so may limit the ability to prescribe certain medications.
4. During psychiatric appointments information about the use of medication and ongoing medication management will be clearly explained to include the following:
    - Dosing, possible side effects and alternatives considered.
    - Regular medication management visits will be conducted and required to ensure tolerance of the medicine, monitor side effects, consideration of medication alternatives, and discussions of efficacy and other patient concerns.
    - The length of treatment varies dependent on individual patient's needs.
    - Frequency of visits will be determined by the Psychiatrist in consultation with patient based on best practices, but not to exceed 6 months from the last medication management visit.
    - All refill requests must be made by calling the office during business hours (443) 546-4000.
    - Prescribers may consult a Prescription Drug Monitoring Program when prescribing medications at risk of misuse, abuse or diversion
    - In the event of an emergency related to medication prescribed:
        - If you are experiencing physical symptoms or reactions that require immediate intervention, please first call 911 or poison control at 1-800-222-1222 (National Service that connects you).
        - For questions or concerns during CCC business hours, call the office at (443) 546-4000 and the front office will assist you.
5. Psychiatric caseloads and appointments are at very high demand, and the following guidelines are used to maximize the benefit of this service for all patients served:
    - CCC requires a minimum of 48 business hours for cancellations to avoid being charged full fee for a missed visit, unless there is an expressed emergency.
    - If rescheduled, refills of medication will be provided to last until the next appointment.
    - To remain an active patient at CCC you must be seen within one calendar year. Patients who have not been seen in one year and wish to receive psychiatric services must schedule a new patient appointment for a psychiatric evaluation at new patient cost.
    - Reminder calls/texts/emails are provided as a courtesy, patients are expected to attend appointments as scheduled.

Initial to acknowledge receipt: _____

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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 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

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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.

Payment for Telehealth Services:

Collaborative Counseling Center will require clients to complete a Credit Card on File Form or accept payment at the time of scheduling. We will provide you with a receipt and HICF to submit to your insurance company.

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.

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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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 Center (CCC) whether created by CCC, 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 CCC 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** CCC may use information about you in order to provide you with proper medical treatment or services. Treatment is when a Clinician needs to provide, coordinate, or manage your healthcare and other services related to your healthcare. An example of treatment is when CCC consults with another healthcare provider, such as your primary care physician.
2. **For Payment** CCC 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, CCC 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. CCC 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** CCC may use and share information about you for administrative functions necessary to run our practice and promote quality care. Clinicians

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may share information with business associates who provide services necessary to run the practice, such as transcription companies or billing services. CCC will contractually bind these third parties to protect your information as your Clinician would. Also, CCC 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** CCC 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 CCC 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, CCC may 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:** CCC 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:** CCC 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. CCC will not release information without the written authorization of you or your legal representative, 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:** CCC 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, CCC 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

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of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.

6. **Public Health Risks:** CCC 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:** CCC 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 Center.

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 CCC. Your request must specify how or where you wish to be contacted. CCC 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

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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 CCC 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 CCC 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 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 CCC Clinician 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 CCC Clinician have 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 Center at (443) 546-4000.

4. **You have the right to amend confidential information.** If you feel that the information CCC 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, your request and a reason that supports your request must be made in writing and submitted to CCC. 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, CCC 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 no longer available to make the amendment. In such instances we would 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 would be permitted to inspect and copy
    d. Is accurate and complete
5. **You have the right to receive an 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 CCC. 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, CCC 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 and healthcare operations

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b. To individuals of confidential information about the
c. As a result of assigned authorization
d. For the practice's directory or to persons involved in your car
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, CCC 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, CCC has duties to protect your confidential information and inform you of changes to protection measures. CCC is required by law to maintain the privacy of confidential information and provide you with notice of CCC's legal duties and privacy practices with respect to such information. CCC is required to abide by the terms of this Notice currently in effect.

Changes to This Notice

CCC reserves the right to revise or change provisions on this Notice. CCC will make the new Notice provisions effective for all confidential information it maintains. CCC 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. CCC will mail updates of the notice to all active patients. Patients who are inactive at the time of mailing may receive an updated copy at their next scheduled appointment. A copy of the current Notice will be available throughout the practice. The Notice will contain the effective date on the top of the first page.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with CCC 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 CCC will be made only with your written permission. If you provide CCC 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, CCC 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.

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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) 546-4000 or by mail to:

Collaborative Counseling Center
8820 Columbia 100 Parkway, Suite 201
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Acknowledgement of Receipt of Notice of Privacy Practice

CCC 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) 546-5000, 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 Center
8820 Columbia 100 Parkway, Suite 201
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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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Acknowledgement of Receipt of Notice of Office Policies And Procedures

I have received a copy of Collaborative Counseling Center's 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**: _____

FOR INTERNAL USE ONLY
If you were unable to obtain an Acknowledgement of Receipt or unable to obtain a signature for the Acknowledgement of Receipt, please state the reason below. Please include your name.

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Insurance and Financial Policy

Brett I. Greenberger, M.D., P.C. ("Collaborative Counseling Center") is not contracted with any insurance carrier. Therefore:

1. All charges must be paid in full at the time of service.
2. Any contract that obligates your insurance carrier to pay for a portion of your healthcare is between you and your insurance carrier. Your insurance carrier has no relationship with Collaborative Counseling Center. We recommend that you contact your insurance carrier to verify your benefits and to understand how your insurance will reimburse you for services provided by our office.
3. As a service to you, our office will provide you with a completed medical claim form at the time of service so that you can submit a claim to your insurance carrier for reimbursement. We recommend that you contact your insurance carrier to verify claim filing instructions, and ask that you provide our staff with all necessary information.
4. MEDICARE: Collaborative Counseling Center has elected to "Opt Out" of Medicare. All patients who are enrolled in Medicare must sign the federally mandated "Private Contract" in order to receive services at our office. All services must be paid in full at the time of service, and neither Collaborative Counseling Center nor the patient may file a claim with Medicare for reimbursement as outlined in the "Opt Out" agreement.
5. It is your responsibility to obtain all referrals/authorizations required by your insurance plan.
6. We do not accept any payments from insurance companies.
7. We accept all major credit cards including Visa, Master Card, American Express, and Discover, and Check.
8. You will be charged the full session cost for appointments canceled or missed without 24 business hours' (Monday-Friday) notice and CCC will use your provided payment information. Your balance must be paid in full before another appointment can be scheduled or services provided.
9. Under Section 2799B-6 of the Public Health Service Act and its implementing regulations, health care providers, including Mental Health, are required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a group health plan or group or individual health insurance coverage, or a Federal health care program, or a Federal Employees Health Benefits (FEHB) program health benefits plan (uninsured individuals) or not seeking to file a claim with their group health plan, health insurance coverage, or FEHB health benefits plan (self-pay individuals) in writing (and may also provide it orally, if an uninsured (or self-pay) individual requests a good faith estimate in a method other than paper or electronically), upon request or at the time of scheduling health care items and services and upon request.
10. In the unlikely event that you default on payment for any amount due 60 days past the date of service, and all efforts have been made by CCC staff to contact you for payment, we will place your account in collections. (We may place your account in the hands of our attorney for legal action, if necessary, in addition to collections, and you will be charged an additional fee equal to the cost of collection, including attorney fees and court costs incurred as permitted by laws governing these actions.

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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f. (443) 546-4005

Insurance Out-of-Network Processing Form

Collaborative Counseling Center (CCC) uses a fee-for-service model and requires payment in full at the time of service. We do not process insurance claims; however, we are happy to provide all necessary documentation to patients and/or parents/guardians to submit claims on their own behalf.

Insurance Information:

Insurance Company: _____

Policy Number: _____

Group Number: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Relationship to Client: _____

I am submitting to my insurance for out of network reimbursement: (circle one) Yes No

You must provide a copy of the front and back of your insurance card.
Please email a copy of your insurance card to admin@collaborativecounselingcenter.com

Medicare patients: Medicare requires completion of the "Medicare Private Contract", which can be found at https://collaborativecounselingcenter.com/new-client-forms/

Disclaimer: The federal No Surprises Act aims to help clients understand health care costs in advance of care. Clients who do not plan to submit to their health insurance company have the right to request a Good Faith Estimate for future services rendered.

COLLABORATIVE COUNSELING CENTER

8820 Columbia 100 Parkway,
Suite 201
Columbia, MD, 21045
p. (443) 546-4000
f. (443) 546-4005

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 Center collects payment at the time of service. If we cannot process payment with the information provided, we will contact you for an alternative payment method.