My Mental Health, LLC
www.MyMentalHealthTMS.com
Phone: 443.354.1200 Fax: 410.553.0019

1600 Carin Hwy South,Ste 503,Glen Burnie MD, 21061
8865 Stanford Blvd,Ste121, Columbia MD, 21045
1829 Reisterstown Rd,Ste 460, Pikesville MD, 21208
218 North Washington St, Ste 050, Easton MD, 21601

Welcome to My Mental Health LLC. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner. With this letter, we have the following for you to complete and review.

- New patient packet
- Please bring a copy of your Photo ID, Insurance card and competed patient packet with you the day of your visit.

If you have any questions, please give the office at call at 443-354-1200

Please note that this appointment is to complete an assessment and appropriateness for our practice and not a grantee of future care. If we are unable to take on your case after review, we will notify you within 24 business hours with a call and a letter sent in the mail.

***** Our satellite offices share an office with Greenbrook TMS NeuroHealth our name is not on the directory downstairs nor on the door. *****

If you have questions regarding our locations, please call our main number 443-354-1200.

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Office Policies

The following list of practice policies will be enforced at all times to ensure the delivery of safe and effective care. No exceptions will be granted to the list of policies below.

Required for all appointments: At each visit you must bring your *most current insurance card, photo id, and a method of payment.* We accept cash, credit and checks at our Glen Burnie location. Credit and checks only at all other locations. Failure to provide your payment in full may result in your appointment being rescheduled and/or cancelled.

New Patients: Please note that the first evaluation appointment is to complete an assessment to determine appropriateness for our practice and is not a grantee of future care. If we are unable to take on your case after review we will notify you within 24 hours with a call and a letter sent in the mail.
Please arrive 5 minutes before your scheduled appointment, 15 mins if you are a new patient

Minors (anyone under 18 years of age) are not permitted in session with you or in our waiting room so that we may provide the best care possible to our patients.

Conduct/Compliance: We strive to work with patients to provide the most compliant care for their individual needs. However, occasionally we will decide as a group that we are not the right practice for a particular case. In this event, a patient will be notified in writing of a need to transfer care and if applicable a referral list may be provided. Active substance abuse or violent or inappropriate behavior will not be tolerated under any circumstances and will result in immediate termination of care. We reserve the right to randomly drug test all patients prescribed controlled substances by our office.

Office Fees

Cancellation/ No Show policy: Please notify our office 24 business hours in advance if an appointment will be missed to avoid being charged $75. *This fee cannot be paid by a flex spending or HRA card.* Should the patient **No Show/late cancel** this fee will need to be paid in full before the patient may reschedule. Failure to attend more than two consecutive or three total appointments may result in termination of care.

Prescription Refills: Please allow your provider at least 3 business days to refill your medication. Be advised that if you have not had a follow up medication visit in the past 3 months; your refill request may be denied. Patients are responsible for contacting MMH prior to running out of medications. There will be a **$25 fee for any refills** given between regularly scheduled appointments. Controlled substances will only be refilled during a scheduled visit.

We are not able to authorize phone sessions or changes to medications over the phone.

Confidentiality: Medical records are confidential and **WILL NOT** be released without written consent of the patient and/or legal guardian. The only instance where patient confidentiality may be compromised, is if the safety of the patient, provider, and/or others are in imminent danger. Please know that the provider is

obligated by law to report abuse, neglect, and or the endangerment of someone's safety. Except in the case of another physician's office making the request, a fee will apply to all records requested. This fee will be the patient's responsibility unless covered by the requesting party and will be collected in advance.

Documents/Letters/ Forms: Allow your provider at least **10 days** for any documentation/forms, etc. to be completed. If an address or fax number is provided, we will mail or fax on your behalf. Otherwise we will contact you once completed for pick up. There is a minimum fee of $25 that applies to all forms. This fee is the patient's responsibility and will be collected in advance. Providers have the right to decline completion of any form if they feel the request is not appropriate.

Patient Payment Obligations / Insurance Information

Payment for Services: Payment for services rendered must be paid in full at the time of your appointment. Our providers reserve the right to cancel an appointment at any time.

In Network Insurance: My Mental Health LLC has established arrangements with multiple healthcare carriers. If your provider is in network, we will bill your insurance directly. Please Note: All deductibles, co-insurance, and co-payments are the patient's responsibility.

Returned Checks: If your check is returned to My Mental Health LLC for insufficient funds there will be an additional charge of $35 billed which is patient responsibility.

Out of Network Insurance: If the patient's health plan and or Insurance provider declares a service by My Mental Health to be "Not Covered" and/or "Out of Network", the patient is responsible for the complete charge for that date of service. My Mental Health LLC will bill the patient for that date of service rendered and payment is due upon receipt. Late charges will be applied if not remitted within 45 days upon receipt of statement.

Self-Pay: If the patient is not currently insured or wishes to not use insurance My Mental Health LLC does provide self-pay services. If you have out of network benefits, please see the Out of Network check list (available at front desk) to help you submit claims to your insurance for reimbursement.

Collections: Accounts that are not paid within 30 days will begin our in house collection process. Any accounts 120 days old will be sent to Alacrity Collections Corporation and a **35% collections fee** will be applied to your outstanding balance.

Please sign that you have received this form and understand all policies. A copy can be provided to you upon request from the front desk.

Patient/Guardian signature: _____

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Patient Information

Patient Name: _____
Last First Middle Initial

Prior Last Names: _____ Race: African American Asian Caucasian Hispanic Native American Other

Social Security Number: _____ - _____ - _____ Date of Birth: _____/_____/_____
Sex: M or F Marital Status: Single Married Divorced Widow Separated

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell / Other: _____

Insurance Information

Name of Primary Insurance: _____ Policy ID Number: _____

Subscriber Name: _____ Subscriber DOB: _____ / _____ / _____

Subscriber Social Security #: _____- _____ - _____ Relation to patient: _____

Group Number: _____ Subscriber Employer / Group Name: _____

Subscriber work status: FT PT Retired

(Please fill out secondary insurance if applicable)

Name of Primary Insurance: _____ Policy ID Number: _____

Subscriber Name: _____ Subscriber DOB: _____ / _____ / _____

Subscriber Social Security #: _____- _____ - _____ Relation to patient: _____

Group Number: _____ Subscriber Employer / Group Name: _____

Subscriber work status: FT PT Retired

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Emergency Contact Information:

Person to notify / Next of Kin: _____
Last First MI

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Relationship to patient: _____

Protected Health Information:

For confidentiality reasons, family member phone calls about treatment will not be returned. I must request my family and or specified individual to join me as part of my appointment if I wish to include them in my care. I know and agree to the charges provided to me by My Mental Health LLC if they do join me during my appointment.

Therefore I, _____, give *My Mental Health LLC.* Permission to make and disclose the following with the person listed below:

□ Scheduling / Canceling appointments
□ Medication questions
□ Speak with the provider regarding patient (*Only in appointment*)

Name: _____ Phone: _____

Relation: _____

Current Medication and Allergies:

What daily / weekly medications are you currently taking?

_____

_____

Have you or are you currently taking any psych medication? *(if 'Yes' please list below)* □ YES □ NO

_____

_____

Do you have allergies to medication? *(if 'Yes' please list below)* □ YES □ NO

_____
_____

Current Concerns – Please **CIRCLE** one or more of the following items:

Anxiety/Worry/Nervousness	Thoughts of harming yourself
Sadness/Depression	Thoughts of harming others
Anger/Temper	Low self-esteem
Irritability	Paranoia/Suspiciousness
Sleep Difficulty	Hearing voices/noises
Change in appetite/weight	Seeing visions
Loss of pleasure in activities	Panic attacks
Concentration difficulties	Racing thoughts
Memory lapses	Recurring, unwanted thoughts
Low motivation	Alcohol or other substance use
Mood swings	Loneliness
Impulsivity	Risk-taking behavior
Nightmares	Flashbacks
Binge eating	Restrictive eating

Other: _____

Sources of stress – Please **CIRCLE** one or more of the following items:

Health	Family	Finances
Work	Relationships	Loss
School	Physical appearance/body image	Housing

Other: _____

Psychiatric History:

1. Have you ever been evaluated by a psychiatrist before? Yes No
2. Have you ever been in psychotherapy (talk therapy) before? Yes No
3. Have you ever been hospitalized on a psychiatric unit? Yes No
4. Have you ever attempted to end your life? Yes No
5. Have you ever been aggressive or violent towards others? Yes No
6. Have you ever been treated for an alcohol or drug abuse problem? Yes No
7. Have you ever been prescribed medication for a mental health condition? Yes No
8. Does any family member have a mental illness? Yes No
   (If yes, please specify relative in the space provided)

☐ Bipolar disorder:
☐ Major depression:
☐ Anxiety disorder:
☐ Panic disorder:
☐ Obsessive Compulsive Disorder (OCD):
☐ Post-traumatic Stress disorder:
☐ Schizophrenia:
☐ ADHD:
☐ Drug/Alcohol dependence:

Psychosocial History:

1. Place of birth: _____
2. Any history of birth complications or developmental delays? Yes No
   If yes, please specify: _____
   _____
3. My childhood was (please circle):
   Very Happy Happy Fair Unhappy Very unhappy
4. History of abuse (circle): None Verbal Emotional Physical Sexual
5. Marital Status (Please circle): Single Married Separated Divorced Widowed Partnered
6. With whom do you live? _____
7. Do you have any children? Yes No (If yes, list ages: _____)
8. Religion/Spiritual beliefs: _____
9. Military service: _____
10. Occupation: _____
11. Past employment: _____
12. Highest level of education? _____
13. History of arrests or other legal issues? Yes No

Substance Use History: Please **CIRCLE** one or more of the choices provided

Caffeine	Current	Past	Never
Alcohol	Current	Past	Never
Nicotine	Current	Past	Never
Marijuana	Current	Past	Never
Cocaine	Current	Past	Never
Amphetamines/Stimulants	Current	Past	Never
Hallucinogens (ex. PCP, LSD, mushrooms)	Current	Past	Never
Opiates (ex. Heroin, oxycodone)	Current	Past	Never
Sedatives (ex. Valium, Xanax)	Current	Past	Never

Alcohol History:

1. How many drinks can you hold without feeling drunk? _____
2. Have you ever felt that you should cut down on your drinking? Yes No
3. Have close friends or family members ever told you about things you said or did while you were drinking that you could not remember? Yes No
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes No
5. Have you ever had a DWI? Yes No

I verify that all information provided above is complete and accurate to my knowledge.

X_____ ____/____/_____
Patient signature Date

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PATIENT HEALTH QUESTIONAIRE (PHQ -9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been
Bothered by any of the following problems?
(use "X" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly Everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Felling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping to much	0	1	2	3
4. felling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself	0	1	2	3
Total				

Add Columns _____ + _____ + _____ + _____ = _____

Healthcare professional: For interpretation of TOATAL, please refer to accompanying scoring card)

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all Somewhat difficult Very difficult Extremely Difficult	_____ _____ _____ _____

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My Mental Health, LLC
Statement of Patient Financial Responsibility

Patient Name: _____ DOB:_____

My Mental Health, LLC appreciates the confidence you have shown in choosing us to provide for your mental health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to My Mental Health, LLC, for providing services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to My Mental Health, LLC the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-payment for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

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Consent for Treatment and Authorization to Release Information

I hereby authorize My Mental Health, LLC, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

I further authorize My Mental Health, LLC, to release to appropriate agencies, any information acquired during my or the above-named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment to avoid being charged $75.00 which must be paid by the patient before another appointment will be scheduled.

I understand if I fail to show for more than two appointments without notification will result in automatic discharged from care.

My Mental Health, LLC will notify you in writing, via USPS mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at My Mental Health, LLC. I agree to pay My Mental Health, LLC, the full and entire amount of treatment given to me or to the above-named patient at each visit.

Patient/Guarantor Signature _____ Date _____

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INSURANCE WAIVER

Please be advised that all services provided to you in our office will be billed to your insurance company if the provider participates with your plan. You may become the liable third party should your insurance company fail to pay us for the services.

Also, please be aware of what is covered and what is not covered under your specific insurance plan. We will try to verify coverage from the insurance information you provide, but it is NOT a guarantee of benefits. If insurance has changed, or there is a lapse in coverage; if Coordination of Benefits or PCP referral is required and not completed; or if for any other reason service is not covered by your insurance company, you will be the liable party.

I hereby acknowledge that I have read, accepted and understood the above insurance waiver for all the services provided to me at My Mental Health,

_____ _____

Patient / Guarantor Name Date

_____

Patient / Guarantor Signature

My Mental Health LLC
Ph: 443.898.9770 • Fax: 410.553.0019

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security: _____

I request and authorize My Mental Health LLC _____ to

□ Release healthcare information of the patient named above to

□ Receive Health care information of the patient named above.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates:
  _____
- All healthcare information
- Other: _____

Patient Signature: _____ Date Signed: _____

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? [ ] Yes [J No

If YES, please check and answer the following. If NO, please skip.

□ Do you currently feel that you do not want to live? [ ] Yes [ ]No

□ How often do you have these thoughts? _____

□ When was the last time you had thoughts of dying? _____

□ Has anything happened recently to make you feel this way? _____

□ On a scale of 1-10 (ten being the strongest) how strong is the desire to kill yourself currently? _____

□ Would anything make it better? _____

□ Have you ever thought about how you would kill yourself? _____

□ Is the method you would use readily available? _____

□ Have you planned a time for this? _____

□ Is there anything that would stop you from killing yourself? _____

□ Do you feel hopeless and/or worthless? _____

□ Have you ever tried to kill or harm yourself before? _____