Compassionate Wellness Center, LLC Hagerstown, MD 21740
Office: (240) 513-6001 Fax: (240) 513-6122 https://compassionatewc.com

INTAKE REFERRAL

Date of Referral: _____ Staff staking referral: _____

Patient Demographics:

Full Name: _____DOB: _____ SSN#:_____
Address: _____ City: _____State: _____ Zip: _____
Contact Information:
May we leave messages?
Home: _____ **(Y/N)** Work: _____**(Y/N)**
Cell: _____**(Y/N)** Email: _____**Y/N**
Gender: (___ Male) (___ Female) (___ Transgender) (___Other)
Employed: (___Y) (___N) If yes list employer name: _____
Highest Level of Education Completed: _____ **School:** _____
Marital Status: (___Single) (___Engaged) (___Married) (___Separated) (___Divorced) (___Widowed)
Sexual Orientation: (___Straight/Heterosexual) (___Lesbian) (___Gay) (___Bisexual) (___Other)
Race: _____
Ethnicity: Hispanic or Latino (___Y) (___N)
Native American: (___Y) (___N) Tribe**:** _____
Veteran: (___Yes) (___No)
Religion: _____
Do you have a disability? (Y/N) If yes, please list:_____
Income: _____ **(**Social Security Disability $_____/monthly) (Supplemental Security Income $_____/monthly) Other; Explain _____

Emergency Contact:
Name: _____Relationship to Client: _____
Address: _____
Phone (C): _____ (H): _____ (W): _____

Preferred Pharmacy? _____

Reason for seeking services?
____Mental Health Therapy
____Medication Management
____Substance Abuse Therapy Drug Type: _____ Date of last drug use: _____
____Suboxone Drug Type: _____ Date of last drug use: _____
____Vivitrol Date of last alcohol use: _____
____Medical Marijuana
____Psychiatric Rehabilitation Program (PRP) Minor or Adult - Case Management

If Therapy/Substance Abuse therapy., please give a brief description of symptoms:
_____

For Substance Abuse (require evaluation only?) Please note the courts will typically want longer treatments if you can answer yes to:
1) Have you been in Substance Abuse treatment program before Y/N, How long? _____
***2*) Is this court ordered Y/N**
If this is a first offense, we may have to refer you to another agency.

Please list referral contact information (if applicable):

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REFERRAL SOURCE: How did you hear about CWC? Friend/Website/Agency/Other?

_____

Name of Agency/Referring Source: _____
Relationship to patient: _____ If a relative, are they being seen at CWC? **Y/N**
Best Number to call? _____ May **we leave messages Y/N Do we have a release? Y/N**
If this is a professional referral are you able to provide records of most recent visits? **Y/N**
If yes, please fax these along with the release of information to (240) 513-6122

Previous Behavioral Health Treatment (SUD/Therapy/MM. etc...)

In treatment Previously? Y/N If yes, where/who? _____For how long? _____
Type of Treatment: _____

Insurance/Source of Payment (if known, please complete or attach a card if possible)

No Insurance/Workman's Comp/Self Pay/Private Insurance/Medicaid/Medicare (Circle All that apply)
Primary Insurance: Who holds the insurance? (Self/Spouse/State Insurance)
Insurance Co.: _____
Policy/MA/MC#: _____ Group#: _____
Insurance. Co. Tel. (MENTAL HEALTH Claims on the back of the card) _____
Insured's Name: _____
Insured's Employer: _____
Insured DOB: _____

Secondary Insurance (If Applicable)
Insurance Co.: _____
Policy/MA/MC#: _____ Group#: _____
Insurance. Co. Tel. (MENTAL HEALTH Claims on the back of the card) _____
Insured's Name: _____
Insured's Employer: _____
Insured DOB: _____

For Medical Marijuana clients: Ask these preliminary questions:

1. Diagnosis for pain management, chronic illness? **Y/N** If yes, please list diagnoses?
   _____
2. Can client obtain records from diagnosing doctor? **Y/N**
3. Did you meet with this or any other doctor for prior treatments for the diagnoses? **Y/N**
4. If yes, for how long? _____Doctor(s)Name_____
5. If you never saw a Doctor/Specialist for your condition do you have other records to support DX? **Y/N** If yes, please note here: _____

Initial Medical Marijuana consult $75 nonrefundable. Medical Marijuana follow-up visit $50 nonrefundable. If you cancel an initial or follow up visit for medical marijuana less than 24 hours ahead of time, you will be charged the full fee of that service

Does the client have any records such as below and can they be obtained for appt?

Glaucoma records from ophthalmologist?	Y/N	Is there any additional information to be
ALS/MS records from neurologist?	Y/N	added in support of the reported
Records from infectious doctor?	Y/N	ailment/illness? Y/N
Cancer records from oncologist?	Y/N	Any other supporting information reported?
Nausea/vomiting records specialty?	Y/N	_____
Any significant changes in weight?	Y/N	

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Consent for Non-Face-to Face "Telehealth" Visits

Name: _____ DOB: _____ SSI: _____

I, _____ hereby voluntarily consent to receive "Telehealth" care.

Examples of the telehealth services offered at Compassionate Wellness Center are:

- **Virtual Check-ins** – You and your treating provider may have a brief phone call to determine whether or not an in-person visit or other appropriate treatment in needed.
- **E-visits** – You may communicate with your treating provider through our patient portal or secure email.
- **Telehealth visits:** You and your treating provider can use real-time communication – like FaceTime, Skype or WhatsApp – to conduct a visit while you are home.

I understand this consent form will be valid and remain in effect as long as I receive medical care at Compassionate Wellness Center LLC.

"Telehealth Visits" mean that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- Your treating provider will be at a different location from you. Additional medical or registration personnel may also be present in the room with the provider. _____(initials).
- I understand that my voice and image may be recorded in order to assist in my treatment and consent to any such audio and video recording. _____(initial)
- I understand there are potential risks to this technology, including, but not limited to, interruption, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my healthcare provider or I can discontinue the telehealth consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation. _____(initial)
- I understand that I may be disconnected before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangement for follow-up care. _____ (initial)
- I understand standard deductible and coinsurance amounts apply to "Telehealth Visits" and I consent to telehealth treatment. _____(initial)

This form has been explained to me. I fully understand and consent to the *Non-Face-to-Face "Telehealth" Visits.*

Patient signature: _____ Name: _____ Date: _____

Telepsychiatry Contract and Informed Consent

Introduction:

"Telemedicine" is one component of telehealth and technology is used to facilitate clinical care at a distance. The Center for Medicare and Medicaid Services (CMS) defines telemedicine as "… The use of medical information exchanged from one site to another via electronic communications to improve a client's health." Similarly, the American Telemedicine Associations to improve a client's health." Similarly, The American Telemedicine Association defines telemedicine as "the use of medical information exchanged from one site to another via electronic communications to improve a client's clinical health status.

"Telepsychiatry" is a subset of telemedicine. The practices of telepsychiatry encompasses tools used in telemedicine for the purpose of addressing a client's psychiatric needs. Both telehealth and telepsychiatry are accepted practices within the field, and are regulated by the appropriate authorities. Further, CWC uses network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Increased access to care by providing remote appointments.
- Access to a clinician for urgent needs that cannot wait until clinician returns to the office.
- In rare cases, information transmitted may not be sufficient "e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant (s).
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

Late Policy

Clients should arrive to their appointments at least 10 minutes before their scheduled visit. This gives staff time to complete any necessary paperwork or testing as needed. While we understand that issues arise, we need to assure that we are able to see all of our clients in a timely manner. As such, if you are more than 15 minutes late to your appointment, you will be rescheduled.

If an issue does arise and you know you will be late, please call the CWC office. We may have had a cancellation or need to make an exception on a case-by-case basis, to get you worked in for your appointment. While there are no guarantees we will be able to get you in if you are late, know that we are here to help you the best we can.

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Authorization to Release Records

Client Name: _____ Date of Birth: _____

I/we hereby authorize **Compassionate Wellness Center, LLC (CWC)** to send and receive from:

Name of the agency/Person: _____
Agency/Person Address: _____
Telephone number: _____
Fax number: _____

Please check all that you give consent to:

____Medical information, including immunization records

____Inpatient and/or outpatient psychological/psychiatric/substance treatment records

____Medication list and laboratory records

____Academic and educational records, including achievement testing

____Other (Please explain) **Verbal and written Exchanges**_____

The information requested is to initiate and continue treatment, payment, and associated costs of receiving quality care at CWC. Failure to sign this document will not result in the refusal of services.

I understand Federal, State, and HIPPA Regulations of privacy and confidentiality protect my medical records. I understand my information cannot be disclosed without my written consent unless overridden by law. I understand medical records may include information about sexually transmitted diseases and AIDS/HIV and or communicable diseases. I understand my records may also include history, diagnosis, and treatment of drug and or alcohol abuse, mental health disorders.

If the patient wishes to withdraw his/her permission, he or she may do so in writing. This authorization is valid for **12 months** from the date of the patient's signature.

Client/Guardian Signature: _____Date: _____

Expiration Date: _____

Signature of Witness: _____Date: _____

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Consent to Treat, Insurance Assignments, Financial Agreement, Authorization to Release Information and Privacy Notice Acknowledgement

1) **Consent to Therapy and Medication Management**. I consent to the therapeutic and medication management, as may be deemed necessary or advisable in the judgment of my physician, nurse practitioner or other provider. Which may include but, not limited to a laboratory procedure (including drug screenings), or other services rendered the patient under the general and special instruction of the patient's physician, nurse practitioner or therapist. _____(initials).

2) **Assignment of Insurance Benefits and Authorization to release Information**. In consideration of services rendered, I hereby transfer and assign to Compassionate Wellness Center (CWC) LLC all rights, title and interest in any payment due to me for services described here and as provided in the above-mentioned policy or policies of insurance. The center may disclose all or any part of the patient's record (Including psychiatric, alcohol and drug abuse) to a family member or employer of the patient for all or part of the centers charge, including but not limited to medical service companies, insurance companies, Workmen's Compensation carriers, welfare of funds or the patience employer. _____(initials).

3) **Financial Agreement**. The client agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the center in accordance with the regular rates and terms of the center. Should the account be referred to an attorney for collections, the client should pay a reasonable attorney fees and collection expenses. The client certifies that he/she has read the foregoing receiving a copy thereof and is the patient or duly authorized by the patient as patient's general agent to execute the above and accepts its terms. _____(initials).

4) **Medicare/Medicaid** patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security act is correct. I authorize that any holder of medical or other information about me to release to social security administration/ division of family services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid client I hereby certify all insurance pertaining to treatment shall be assigned to the center treating me. _____(initials).

5**) Use of Copies**. I permit a copy of these authorizations and assignments to be used in place of original, which is on file at the center. _____(initials).

6) **Payment Responsibility**. I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay any **CO-PAY, DEDUCTIBLE, COINSURANCE, OR ANY OTHER BALANCE NOT PAID BY MY INSURANCE OR THIRD-PARTY PAYNE WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS. _____**(initials).

Notice of Privacy Practices Acknowledgment

I have received on this, or a prior occasion, the notice of privacy practices and acknowledge that I have a copy of the notice or that I requested and was given a copy.
Received a copy: _____ Yes No_____

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____