Mark's Place
COUNSELING

10816 Town Center Blvd #105
Dunkirk, MD, 20754

Our Mission Statement

At Mark's Place, our mission is to empower individuals to achieve optimal mental well-being through comprehensive, compassionate, and personalized care. We are dedicated to providing high-quality mental health therapy and medication management services in an environment characterized by honesty, openness, and flexibility.

We prioritize person-centered care, ensuring that each individual's unique needs and goals are at the forefront of their treatment plan. Our team of skilled professionals collaborates with clients to create tailored, flexible treatment plans that adapt to their evolving needs.

Committed to promoting mental health awareness, reducing stigma, and supporting our community's overall wellness, we strive to foster a supportive and inclusive environment where every person feels heard, valued, and understood.

Vision Statement

At Mark's Place, our vision is to be a leading beacon of mental health care, recognized for our unwavering commitment to honest, open, and flexible person-centered care. We aspire to transform lives by creating a world where mental health is prioritized, stigma is eradicated, and every individual has access to the compassionate support and innovative treatments they need to thrive.

We envision a future where our practice is a cornerstone of the community, empowering individuals to achieve their highest potential through personalized and adaptable mental health services. By fostering resilience and promoting holistic well-being, we aim to inspire a society where mental health is seen as integral to overall health, and every person is empowered to lead a fulfilling and balanced life.

Core Values

Honesty and Openness. We commit to transparent communication and fostering trust through honesty and integrity in all interactions.

Compassion. We provide empathetic and respectful care, ensuring that each person feels valued and understood.

Person-Centered Care. We prioritize the unique needs and goals of each individual, creating personalized and adaptable treatment plans.

Flexibility. We adapt our services and approaches to meet the evolving needs of our clients, promoting a responsive and dynamic care environment.

Inclusivity. We cultivate a supportive and welcoming environment where diversity is celebrated, and everyone feels accepted.

Collaboration. We work together with clients, their families, and other healthcare providers to ensure comprehensive and cohesive care.

Excellence. We strive for the highest standards of professional practice, continually improving and innovating our services.

Community Engagement. We are dedicated to promoting mental health awareness and reducing stigma within our community, advocating for accessible and equitable care for all.

Empowerment. We empower individuals to take an active role in their mental health journey, fostering resilience and self-efficacy.

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Client Information

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ SSN: _____ Natal Sex: _____

Address: _____

City: _____ State: _____ ZIP: _____

Preferred Phone: _____ Alternate Phone: _____

Email Address: _____

Protection of Privacy Regarding Communication

Are there any restrictions to leaving voice messages on the phone number(s) listed above regarding appointments or requesting a call back?

☐ No restrictions ☐ Yes: _____

Are there any restrictions to sending statements or other correspondence to your address listed above?

☐ No restrictions ☐ Yes: _____

Are there any restrictions to sending statements or other correspondence to your email address?

☐ No restrictions ☐ Yes: _____

Client Demographic Information

Marital Status: _____ Preferred Language: _____

Race: _____ Ethnicity: _____

Gender Identity: _____ Sexual Orientation: _____

Religion/Spirituality: _____ Occupation: _____

Emergency Contacts

Primary Emergency Contact (Full Name): _____

Primary Phone: _____ Alternate Phone: _____

Relationship to Client: _____

Secondary Emergency Contact (Full Name): _____

Primary Phone: _____ Alternative Phone: _____

Relationship to Client: _____

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Parent/Guardian Consent for the Treatment of Minors

Prior to the treatment of a minor, Mark's Place Counseling requires both/all parents or guardians to sign consent and/or may require court documents showing the legal custody of a parent/guardian to make legal decisions. If the parents/guardians share joint legal custody, that generally means that both share the right and the responsibility of making decisions regarding the health, education, and welfare of the minor, such as authorizing or consenting to treatment by a behavioral health practitioner. With respect to sole "legal custody," the person who has such custody is the one who must authorize or consent to the treatment of the minor. The sole legal custodian is generally viewed as the one who has the right and the responsibility to make the decisions related to the health, education, and welfare of the minor.

Full Name of Minor: _____ Date of Birth: _____

Parent/Guardian 1 Name: _____

Contact Information: _____

Signature: _____ Date: _____

Parent/Guardian 2 Name: _____

Contact Information: _____

Signature: _____ Date: _____

Additional Parent/Guardians Involved in the Care of the Minor:

_____

_____

Office Use Only

☐ No custody/guardianship concerns; no documentation required.

☐ Custody/guardianship legal documents obtained and on file.

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Consent to Behavioral Health Services

Your signature on this form confirms your consent to mental health services to be rendered to you or a person for whom you are a legal representative or are a legal guardian. The details of such mental health services have been explained to you as well as the risks and benefits of treatment, of alternative treatments, and of no treatment at all. You also understand there is NO GUARANTEE that any particular result will be achieved.

I understand and agree to behavioral health services that Mark's Place Counseling is qualified to provide within:

- The scope of the provider's license, certification, and training; or
- The scope of the license, certification, and training of those behavioral health providers directly supervising the services I receive.

Client or Guardian Name (Print): _____

Client Signature: _____ **Date:** _____

Insurance Information

Insurance Company: _____ ID #: _____ Group #: _____

Policy Holder Information *(if client is not policy holder)*

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ SSN: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Financial Agreement

I, the undersigned, hereby authorize Mark's Place Counseling release any medical information necessary to file a claim and secure the payment of insurance benefits. I authorize the use of this signature on all insurance submissions. I authorize payment of insurance benefits to Mark's Place Counseling for services rendered. I understand that I am responsible for any co-pays as determined by my insurance company. I understand that I may be financially responsible for any charges that are not paid by insurance. If you do not wish for us to bill your insurance company, you agree that you will be responsible for the full cost of each service. All payments are due at time of service.

Client or Guardian Name (Print): _____

Client Signature: _____ **Date:** _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Mark's Place Counseling is required by applicable federal and state law to maintain the privacy of your Protected Health Information (PHI). It is our duty to provide all clients with this Notice about our privacy practices that are in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time, as permitted by applicable law. Clients will be promptly notified if any such changes occur.

Uses and Disclosure of Health Information

Mark's Place Counseling uses and discloses health information about you for the purposes of treatment, payment, and healthcare operations. In addition to our use of your health information for these purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you have provided this authorization, you are free to revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you have provided written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. Below are some of examples of our possible uses and disclosures of your health information, this list is not exhaustive.

<u>Uses and Disclosures without Consent Relating to Treatment, Payment or Health Care Operations</u>:

- *For Treatment*: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- *To Obtain Payment*: We may use or disclose your health information in order to bill and collect payment for services rendered and to determine your eligibility to participate in services.
- *For Health Care Operations*: We may use and disclose your health information in connection with our healthcare operations. This includes quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, accreditation, certification, licensing, or credentialing activities.

<u>Other Uses and Disclosures of Health Information Required or Permitted by Law</u>:

- As required by law.
- *Information Purposes*: Unless you have provided us with alternative instructions, we may send appointment reminders and other materials to your home.
- *Health Oversight Activities*: We may disclose your health information to outside agencies as required by law. Examples include audits, inspections, investigations, and licensure.

- *Safety:* In order to avoid a serious and imminent threat to health or safety, we may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- *Abuse and Neglect*: As mandated reporters, we will disclose your health information to appropriate authorities if we reasonably believe that you, a child, or a vulnerable person may be a possible victim of abuse and/or neglect. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- *Your Family and Friends*: We must disclose your health information to you, as described in the Client Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you have given written authorization to do so.

Client Rights

In addition, a client, you have a right to:

- Request restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you. We will accommodate your request, if possible, but is not legally required to agree to the requested restriction. Except as otherwise required by law, we must accommodate your request if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.
- Request confidential communication. You have the right to ask that we send you information at an alternative address or by alternative means. We must agree to your request as long as it is reasonably easy for us to do so.
- Inspect and copy. With certain exceptions, you have a right to see your health information upon your written request. If you want copies of your health information, you may be charged a reasonable and cost-based fee for copying, postage, and preparing an explanation or summary of the PHI. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- Request amendment. You may request in writing that we correct or add to your health record. We will respond to your request within 60 days, with up to a 30-day extension, if needed. We may deny the request if we determine that the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; (3) not permitted to be disclosed. If we approve the request for amendment, we will change the health information and inform you, and we will tell others that need to know about the change in the health information.
- Require authorization. You have the right to require your authorization for most uses and disclosures of unless otherwise stated by law.
- Opt-out. You have the right to receive non-essential communication and the right to request to opt-out of such communication. You also have the right to opt-out of Maryland's Health Information Exchange (HIE), which is the Chesapeake Regional Information System (CRISP).
- Receive notice. You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request.

- Receive breach notification. You have the right to receive notification whenever a breach of your unsecured PHI occurs.

Our Responsibilities

Mark's Place Counseling is required to:

- Maintain the privacy of your health information required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Notice Acknowledgement

As a client of Mark's Place Counseling, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by Mark's Place Counseling. I understand I may request a copy of this Notice at any time.

Client or Guardian Name (Print): _____

Client Signature: _____ **Date:** _____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare agent, etc.).

Representative Name (Print): _____ **Relationship**: _____

Representative Signature: _____ **Date**: _____

Privacy Officer: Katherine Werner, MS, LCPC, NCC
Phone: (443) 440-5201

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Client Bill of Rights

Clients receiving services from Mark's Place Counseling are given all the rights and protection afforded to them under the law. No client will be denied access to treatment of services on the basis of age, race, sex, gender identity, creed, nationality, physical disability, marital status, sexual orientation, religion, spirituality, pollical affiliation, limited English proficiency, or the source of payment for services.

You have the right:

- To receive fair, humane, and respectful treatment at all times and under all circumstances.
- To be informed of the rules and regulations as they apply to your conduct.
- To expect privacy and dignity in treatment consistent with providing you with good behavioral health care.
- To expect prompt and reasonable responses to your questions.
- To know who is responsible for authorizing and performing your procedures or treatments.
- To know the identity and professional status of your providers.
- To have access to your record according to company policy and within Federal and State guidelines.
- To rebut any information in your record by inserting a counter statement of clarification or correction.
- To receive information necessary to give informed consent prior to the start of any treatment.
- To be free from mental, physical, and sexual abuse as defined by State law.
- To obtain current information regarding your diagnosis, treatment goals, and prognosis in understandable terms.
- To refuse treatment to the extent permitted by law, to discharge yourself at any time, and to be informed of the consequences of your actions.
- To know about any fees, payments, or surrendering of valuables, to examine and receive an explanation of your bill, and protection from exploitation regardless of funding status.
- To be treated with dignity and respect, and to be free from neglect, corporal punishment, abuse, physical restraint, seclusion, involuntary confinement, humiliation, and retaliation.
- To register a complaint and file a grievance related to your treatment experience and to expect investigation of your concerns or infringements.

By signing below, I acknowledge that I have reviewed the Client Bill of Rights above. I understand I may request a copy of this document at any time.

Client or Guardian Name (Print): _____

Client Signature: _____ **Date:** _____

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Telehealth Consent Form for Behavioral Health Services

Client's Full Name: _____ Date of Birth: _____

Provider(s) Name(s): _____

Mark's Place Counseling utilizes Doxy.me as the technology service for secure, HIPAA-compliant telehealth service delivery. Telehealth involves the use of electronic communications to enable healthcare providers to provide services to individuals who may not be in the same physical location. By signing this consent form, you agree to receive behavioral health services through telehealth technologies. The telehealth services provided are consistent with the provider's standard practices and professional standards.

Benefits of telehealth include increased access to care, convenience, and continuity of treatment. Potential risks include interruptions, unauthorized access, and technical difficulties.

All existing laws regarding your access to health information and copies of your records apply to telehealth services. Dissemination of any identifiable images or information from the telehealth interaction to anyone is strictly prohibited in order to protect confidentiality.

You may withhold or withdraw your consent to telehealth services at any time without affecting your right to future care or treatment.

You understand the need for a suitable device, internet connection, and appropriate software to participate in telehealth services.

You agree to ensure the privacy of your telehealth environment to maintain confidentiality.

You understand that telehealth is not suitable for all medical emergencies or urgent situations. In the event of an emergency, you should contact emergency services or go to the nearest hospital emergency room.

By signing below, you acknowledge that you have read and understand the information provided above and that you consent to participate in telehealth services.

Client or Guardian Name (Print): _____

Client Signature: _____ **Date:** _____

10816 Town Center Blvd #105
Dunkirk, MD, 20754

Authorization for Release of Information

Client Full Name: _____ **Date of Birth:** _____

I hereby authorize Mark's Place Counseling to:

☐ Release information to ☐ Receive information from ☐ Exchange information with

_____

_____

(please list persons/facilities, address, phone, and fax when applicable)

Type of Disclosure Authorized: ☐ Verbal ☐ Written ☐ Electronic ☐ Letter ☐ Copies of Record

Purpose of Disclosure: ☐ Ongoing treatment ☐ Support ☐ Other: _____

Type(s) of Information Authorized to Disclose: ☐ Initial Assessment ☐ Treatment Summary ☐ Attendance List ☐ Medication History ☐ Other: _____

Limitations, if any, upon disclosure: _____

_____

Acknowledgement of Understanding

- I understand that the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner.
- I understand that I may revoke this authorization at any time and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that if I have authorized the disclosure of information to someone who is not legally required to keep it confidential, it may no longer be protected by State or Federal confidentiality law.
- I understand that the release of information is subject to any applicable State and Federal laws that may, by law, supersede any authorizations or revocations I may have made. I understand that I will be informed of this if it becomes the case.
- I understand that a photocopy or fax of this form is the same as the original.
- I understand that leaving this form blank, or not signing this form, will be understood as no authorization to any other parties being given.

Client or Guardian Name (Print): _____

Client Signature: _____ **Date:** _____

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Medication Consultation Form

Client's Full Name: _____ Date of Birth: _____

Known Allergies: _____

_____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Current Medications

Name of Medication	Dosage	Prescriber

Any medication refills needed? Changes requested? Which meds? Why? Symptoms?

_____

_____

_____

_____

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Appointment Policies

When a client makes an appointment, the scheduled time is reserved for the client's exclusive use. If a client is unable to make the scheduled appointment, their clinician needs to know in advance so that they can contact those clients who may be waiting for an appointment. For these reasons, the client or responsible party must cancel the appointment forty-eight (48) business hours prior to the scheduled appointment time. For example, if the client's appointment is scheduled for Monday at 10 am, the client or responsible party must call or otherwise notify Mark's Place by Thursday at 10 am. If the appointment is scheduled for Wednesday at10 am, the client or responsible party must call prior to Monday at 10 am.

Late cancellations made within the 48-hour window will be offered a make-up appointment at a future date, however, there may be a fee charged (refer to the Fee Schedule). If required, the missed appointment fee must be paid in full prior to rescheduling another appointment.

Some providers offer virtual/telehealth services. An appointment scheduled for in-office may be changed to telehealth at the discretion of the provider if the provider is contacted before 9am on the day of the appointment. A telehealth accommodation cannot be guaranteed if the office or provider is notified after 9am on the day of the scheduled appointment, and the late cancellation/no-show fee may apply if the appointment is not attended.

If the client misses the appointment with no call/no show, a missed appointment fee may be charged (refer to the Fee Schedule). If required, the missed appointment fee must be paid in full prior to rescheduling the appointment.

Mark's Place Counseling providers and staff understand that true emergencies occur. Therefore, at the discretion of the provider, one (1) no-show fee may be waived per calendar year, to account for emergency situations. The client or responsible party is always responsible for calling 48 hours prior to the scheduled appointment time to reschedule and/or cancel. Failure to cancel and/or reschedule as specified prevents clients on a provider's waitlist from accessing treatment

Our office will confirm the client's appointment in advance electronically (by text message or email). Further communication is not available through the text message platform. To ensure timely rescheduling, it is advised to cancel an appointment by calling the office at 714-885-9903. If you cannot reach Mark's Place immediately, please leave a detailed message with the client's name, date of birth, date and time of the scheduled appointment, and the request to cancel and/or reschedule.

Please note that there is a 15-minute lateness window permitted for scheduled appointments. The client will have whatever time remains of their appointment with their provider. A client presenting more than 15 minutes past the scheduled appointment time may incur a missed appointment fee, and the appointment will have to be rescheduled (refer to the Fee Schedule). If required, the missed appointment fee must be paid in full prior to rescheduling another appointment. A client missing

more than three (3) appointments in any six (6) month period may be terminated from Mark's Place to not being an active participant in the treatment plan.

Due to confidentiality concerns and the importance of the ability of the provider to provide the best assessment and treatment for the client, please do not bring more than three (3) total persons (including the client) to the scheduled appointment.

By signing this form, you acknowledge and agree to the appointment policies.

Client or Guardian Name (Print): _____

Client Signature: _____ **Date:** _____

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Client Records Requests

Fulfilling any request for records is often a time consuming and costly process which involves the following: electronically logging, completing and tracking each request, retrieving and re-filling the paper chart, as well as locating, copying, and printing relevant documents. Supplies, such as paper, envelopes, toner, equipment usage, and postage are also applicable.

To off-set the rising costs associated with producing record copies, it has become necessary to ask for payment before each request can be processed.

An "abstract" of the records is often enough to meet the need of a request. An abstract consists of the client's name, diagnosis, medications, and appointment history. The typical cost of an abstract is $30.00; However, we have decided to waive that fee.

If more than an abstract is requested, the party requesting the record will be invoiced at the allowable Maryland rates as cited below. Please note that all requests require 72 hours' notice in writing with a signed release by the client.

Preparation Fee (applicable to hospitals, insurance companies, or other medical providers only): $22.88, plus a fee of $0.76 cents per page copied, plus the actual cost of shipping and handling if applicable.

Record Fee (applicable to clients): $0.50 cents per page copied, plus the actual cost of shipping and handling if not picked up in person.

The fee for records can be paid by cash, credit card, or money order. Money orders can be made out to Mark's Place Counseling. Your request will begin processing upon payment.

The preceding information is in accordance with Maryland law (Health General Sec. 4-304).

By signing below, I am acknowledging that I have read and understood the above stated policy for receiving copies of records. I understand that a reasonable fee may be charged for a records request in accordance with Maryland State law.

Client or Guardian Name (Print): _____

Client Signature: _____ **Date:** _____