The Western Maryland
Counseling Center, Inc.

Demographic Information

NAME: _____

AGE: _____

RACE: _____

GENDER: _____

CONTACT # _____

Client/Guardian & Clinician – please check all of the following that apply:

Other Characteristics of Persons Served	
Acquired Brain Injury	
Alcohol and/or Other Addictions	
Developmental Disabilities	
Dual Diagnosis - AOD/DD (Alcohol & Other Drug Use Disorder **AND** a Developmental Disability)	
Dual Diagnosis - AOD/MH (Alcohol & Other Drug Use Disorder **AND** a Mental Health Diagnosis)	
Hearing Impairments	
HIV positive/AIDS	
Homeless Individuals	
Mental Disorders	
New Immigrants	
Other Addictions	
Physical Disabilities	
Unemployed/Underemployed	
Visual Impairments	
Other Characteristic	
Dementia	
Unknown Characteristics	
Autism Spectrum Disorder	

X _____

Intake Clinicians Signature

My signature above indicates that I have validated the above information,

and that the information contained on the following pages has been

personally reviewed by me with the client whose signatures are contained herein.

The Western Maryland
Counseling Center, Inc.

Consent for Services

Confidentiality and Privacy: All records and information concerning your case are maintained in a secure, confidential location. All information is privileged and held in the highest regard. Should you require a copy of your file, you must provide a written request and appear in person with proper identification. Copying could take up to 7 days.

HIPAA: The Western Maryland Counseling Center requires all clients to sign our form acknowledging receipt of our Privacy Statement and understanding the terms of the Privacy Statement and of the terms of confidentiality.

Breaking Confidentiality:
There are several mandated regulations that allow the disclosure of case information. These include:

a) If you consent in writing.
b) If the therapist has evidence suggesting that you are in danger to yourself or others.
c) If there is suspicion of a child or elder abuse/neglect.
d) If the disclosure of information is allowed by a valid Court order.
e) If the disclosure is made to medical personnel in a medical emergency.

Phone Availability: We are available 24 hours a day to take and return phone calls. If it seems that the matter you need to discuss will take longer than 15 minutes then we will need to schedule additional session time to discuss the matter in more detail. If you are having an emergency after regular business hours you will be encouraged to call 911 for assistance.

Emergencies: In emergency situations, relevant information will be disclosed to Emergency Contact(s). In the event that your Emergency Contact is not available, WMCC will make the necessary arrangements to have the client transported to the nearest Emergency Room and continue to reach listed contacts to inform them of the situation. Therefore, by signing this consent, you authorize WMCC to speak with your emergency contacts about the reasons for your referral, any relevant history, or diagnosis and to share information that will assist with your treatment.

Professional Fees/Insurance: "I understand that I must make sure to request payment of benefits be made to Western Maryland Counseling Center for services rendered. I hereby authorize Western Maryland Counseling Center to release information necessary to process any claims, secure the payment of benefits, or to meet legal requirements required. I authorize the use of my signature on all insurance submissions. I permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until I revoke it in writing. I understand that it is my responsibility to notify WMCC of changes to my insurance coverage; failure to do so may result in my immediate discharge from the practice." WMCC does not charge Maryland Medicaid clients for missed appointments or any co-pays.

Cancellations: Clients need to give a 24-hour notice. 3 (semi)consecutive missed appointments could result in the closure of your case. Please schedule regular appointments during times that are most convenient for you, to ensure compliance. Clients arriving more than 15 minutes late for their appointments may have their appointments cancelled. Clients who are closed for non-complaince will not be allowed to return for at least 3 months.

Client Name: _____

The Western Maryland
Counseling Center, Inc.

Availability: Each therapist is available by appointment only. Walk-ins are handled on a case-by-case basis. All clients are expected to participate weekly in therapy in order for treatment to be effective. Clients must be active in therapy in order to qualify for medication management services.

Services Provided by The Western Maryland Counseling Center

- ***Individual, Family, and Couples Therapy:*** My signature on this document indicates my desire and willingness to engage in weekly (unless otherwise agreed upon) therapy with my assigned therapist. I understand that only by being completely honest and open with my therapist will I make progress on my goals. I agree to assist my therapist in formulating a treatment plan that will focus on the goals and objectives that I feel are important for my mental health. If I am a parent or guardian seeking treatment for my child I understand that my participation is imperative in helping my child reach their own goals, and promise to actively participate in their care.
- ***Group Work:*** Groups are run periodically. If we feel that you may benefit from a specific group experience I will make you aware of it and discuss your participation. If you feel you would like to participate in a certain group please advise your therapist.
- ***Psychiatric Care:*** Clients must meet regularly with their therapist in order to be eligible for medication management with the psychiatrist. Clients will not be allowed to see the psychiatrist only. Prescriptions will only be given during scheduled appointments. You will only receive one prescription a month. If you are on Methadone or Suboxone you must notify our psychiatrist or your case will be closed immediately. All documents that require completion by the psychiatrist should be dropped off with the office manager. The documents will be completed within 10 business days and ready for the client to pick-up. SSDI and SSI paperwork will be completed only after a minimum of 3 months of consistent compliance with treatment.
- Per **COMAR 10.42.03.03**, this consent serves to inform you of the risks, opportunities and obligations associated with the services available.
- While WMCC does not currently engage in research at this time, this consent serves to inform you that should that practice begin, you will be requested to sign a consent stating your voluntary and informed consent to participate in research, without direct or implied deprivation or penalty for refusal to participate.

In addition, I give consent to the Western Maryland Counseling Center:

- To arrange necessary diagnostic testing for me/my child.
- To administer first aid or authorize treatment to me/my child in case of an emergency that requires immediate or urgent attention.
- I grant permission for me/my child to be transported to and from authorized outings in vehicles owned or operated by staff of the Western Maryland Counseling Center and release them from any liability in the event of an accident.
- Finally, I release and hold harmless The Western Maryland Counseling Center, its employees, staff, agents or participants from any claim for injuries or unforeseen accidents while participating in any organized WMCC activity. The site of the program in no way implies that its employees, agents or students/interns are liable for any claim for injuries or unforeseen accidents.

Client Name: _____

The Western Maryland
Counseling Center, Inc.

ORIENTATION CHECKLIST

- ❑ Rights and grievance and appeal procedures
- ❑ Services provided, days and hours of operation, expected level of participation
- ❑ Access to emergency services, after hours
- ❑ Code of ethics/conduct
- ❑ Confidentiality policy, limits of confidentiality
- ❑ Explanation of health care coverage for services
- ❑ Fire, safety, and emergency precautions
- ❑ Policy on aggressive behavior, suicidal or homicidal ideation, and general safety
- ❑ Policy on tobacco products, illicit or licit drugs brought into the program
- ❑ Policy on weapons brought into the program
- ❑ Policy on Service Animals; absolutely no pets are permitted on WMCC property
- ❑ Identification of the person responsible for service coordination
- ❑ Program rules, including restrictions and the loss and regaining of rights
- ❑ Rules for involuntary discharge and mandatory waiting periods
- ❑ Information dissemination on preventable diseases
- ❑ Purpose and process of the Psychosocial assessment
- ❑ Individual treatment plan development and timeline
- ❑ Discharge/transition criteria and procedures

The information on the 3 preceding pages have been provided as part of the consumer orientation. A check of the item and the signature below indicate that each area has been fully explained and is understood by the consumer/guardian/guest.

Professional Agreement: *I hereby have read and understand the guidelines that have been specified in this Consent for Services. I have also had the opportunity for clarification regarding this document and about the services that are being provided. I understand that either party can terminate this agreement at any time.*

_X_____ _____

Parent/Guardian Signature Date

Parent/Guardian Printed Name: _____

The Western Maryland Counseling Center, Inc.

EMERGENCY & COMMUNICATION CONTACT FORM

Client Name: _____ DOB: _____

Parents Cell Phone: _____ Email Address: _____

Childs Cell Phone: _____ Email Address: _____

I give permission for WMCC to communicate with me/my child for the purpose of Coordination of Care via the following methods: ☐ Phone Calls ☐ Text Messages ☐ Emails ☐ Video Conferencing

WMCC can leave voicemails for me/my child at the phone numbers I provided: ☐ YES ☐ NO

Please list 3 Emergency Contacts below that you give the Western Maryland Counseling Center permission to contact on you/your child's behalf in case of a medical emergency while on WMCC premises only. Any other reason for communication will require a separate signed Release of Information.

Emergency Contact 1: Name: _____

Relationship: _____

Phone #: _____

Emergency Contact 2: Name: _____

Relationship: _____

Phone #: _____

Emergency Contact 3: Name: _____

Relationship: _____

Phone #: _____

Medical Assistance #: _____

Medical Conditions: _____

Physicians Name & Number: _____

Hospital Name & Number: Meritus Medical Center – 911__or: _____

X_____ _____

Parent/Guardian Signature Date

Parent/Guardians Printed Name: _____

The Western Maryland
Counseling Center, Inc.

PROGRAM PARTICIPANT'S RIGHTS AND RESPONSIBILITIES ACKNOWLEDGMENT

Every program participant at Western Maryland Counseling Center has human/civil/personal rights to be respected and honored. In addition, it is the responsibility of all program participants to act in a manner that respects the rights of others. Western Maryland Counseling Center is committed to the protection of individual rights and to providing services within an environment that is characterized by dignity and respect of all persons, and is responsive to the unique needs, abilities, and characteristics of each person served by the organization.

Program Participant Rights: As a participant in programming of Western Maryland Counseling Center, you and your guests have the right to:

- Be fully informed about the course of your care and decisions that may affect your treatment
- Revoke your consent for treatment at any time
- Timely and accurate information to assist you in making sound decisions about your treatment
- Be fully involved as an active participant in decisions pertaining to your treatment
- Have an individual identified in writing that will direct and coordinate your treatment
- Request a change in individual directing and coordinating our treatment, if you so desire
- Receive services in an environment that is free of all forms of abuse, including, but not limited to, (a) financial abuse, (b) physical abuse and punishment, (c) sexual abuse and exploitation, (d) psychological abuse including humiliation, neglect, retaliation, threats and exploitation, and (e) all forms of seclusion and restraint
- Have information about your treatment and your confidentiality protected to the greatest extent allowed by federal and state confidentiality laws and regulations
- File a grievance or complaint about the services you receive without fear of retaliation or reprisal of any sort
- Have family members, friends or others involved in your treatment with your consent and approval
- Receive services that comply with all applicable federal and state laws, rules and regulations
- File a grievance with an outside third party if you feel that the organization has not satisfactorily addressed any concerns you have or, does not adequately address any formal grievance you submit.
- To request a transfer to another program if you believe you are not receiving care that is meeting your needs and preferences.
- You may also have additional rights afforded to you based on federal, state, and local regulations. Your service coordinator will advise you of any additional rights that you may have.

Client Name: _____

The Western Maryland
Counseling Center, Inc.

PROGRAM PARTICIPANT'S RIGHTS AND RESPONSIBILITIES ACKNOWLEDGMENT

Program Participant Responsibilities: As a program participant of Western Maryland Counseling Center, you (and those joining you) have the responsibility to:

- Refrain from all forms of physical violence or abuse toward other program participants, staff, or visitors
- Refrain from abusive language, disruptive behavior or overt sexual conduct
- Refrain from loitering outside the organization's facilities
- Refrain from bringing any type of weapon into the organization's facilities or property
- Refrain from bringing any illicit (illegal) drug or alcohol onto the organization's property
- Refrain from using illicit drugs or alcohol while participating in services provided by the organization
- Refrain from using tobacco on clinic property
- Attend all services required by the organization to meet agreed upon goals.
- Notify any outside treatment provider (Physician, case worker, counselor, etc.) of participation in services, should your treatment impact, or compromise, the provision of those services
- Treat other program participants, staff, and visitors in a respectable manner.

Acknowledgement of Receipt of Notice of Information Practice

I acknowledge that I have been offered or have received a copy of the Notice of Information Practices of the Western Maryland Counseling Center, Inc. This notice can be received or reviewed at any time at 322 E. Antietam St., Suite 101 in Hagerstown, Maryland.

I understand that should I have questions or concerns regarding any policies or statements disclosed in this form, that I am free to contact the Western Maryland Counseling Center at any time to discuss. I have also been advised of my right to contact the Secretary of Health and Human Services should I have any concerns or questions that were not answered by the Western Maryland Counseling Center to my satisfaction.

By my signature below, I acknowledge that I have read and understand my rights and responsibilities as a participant in services at Western Maryland Counseling Center.

X_____ _____
Parent/Guardian Signature Date

Parent/Guardians Printed Name: _____

Client Name: _____

The Western Maryland
Counseling Center, Inc.

PARENTAL CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR

Child's Name: _____

Date of Birth: _____

As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor to seek counseling, psychotherapy, and/or psychiatric care from the professional staff associated with or employed by the Western Maryland Counseling Center, Inc.

The intake clinician I met with today has explained to me the process of treatment planning, the general nature and extent of the risks involved in engaging in treatment, and alternative treatment options, if any. This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification.

Any questions relating to this form or the proposed treatment of the minor identified above can be directed to The Western Maryland Counseling Center at 301-733-2431.

Specifications of the date, event or condition upon which this consent expires (if any):

_____

If not specified – this consent expires in 1 year from date of execution.

X_____ _____

Parent/Guardian Signature Date

Parent/Guardians Printed Name: _____

The Western Maryland
Counseling Center, Inc.

Consent to Receive Medication

My psychiatrist or nurse practitioner may recommend medication as an important part of my or my child's treatment. My provider and I talked about the possible benefits and possible risks of taking prescribed medication(s). We also discussed the risk of not using this/these medication(s).

In cases where antipsychotics were prescribed, the risk of Tardive Dyskinesia was discussed with me. Tardive Dyskinesia (a possible side effect of taking some medications) means involuntary movements in the face, tongue, arms, and or/legs and body. Tardive Dyskinesia may continue even after medication is no longer taken. In a small percentage of cases, some antipsychotics, as well as other medications, may cause liver problems or a rise in blood sugar which may lead to diabetes. There may also be an increase in fatty substances in the blood such as triglycerides ad cholesterol. Therefore, periodic blood tests are necessary. There have been reports of increased suicide risk among some patients taking certain antidepressant medications. Patients taking antidepressants may have to be seen frequently, particularly when first on the medication.

I understand that although we discussed the most common side effects of this/these medication(s), there may be other side effects. I understand that I should quickly tell the prescriber if I/my child experiences any other side effects or unexpected reactions.

I understand that, in deciding which medication to prescribe, my prescriber has used information which I gave him/her including: a complete medical history, a full report of all drugs, alcohol, and medications taken in the last 12 months, any past allergies, and a report of the medications that helped me in the past.

I understand that I/my child am/is not being forced to take this medication and can decide to stop taking it at any time. However, I also understand that if I/my child stops taking this medication, the illness could become worse, and there could be unexpected withdrawal effects. I understand that I should speak with my prescriber if the medication is not helping or if I/my child want to stop taking it.

I understand that the prescriber believes that this/these medication(s) will help. The prescriber also told me that he/she cannot promise the medication(s) will work exactly as expected.

I understand that taking some medications during pregnancy can hurt the baby. I agree to talk with my prescriber if it is possible that I/my child may become pregnant or if I think I/my child am/is pregnant.

I understand that laboratory or blood tests may be needed to check how safely the medication(s) is/are working. I agree to have the tests done to make sure treatment is safe.

I understand that not disclosing the use of methadone or suboxone to the psychiatrist/nurse practitioner will result in the immediate closure of my case as adverse reactions, possibly death, could occur if taken in conjunction with certain benzodiazepines.

I have been told about the medication(s), and agree to take/have my child take the medication(s) prescribed. I, therefore, give permission to the prescriber and to anyone authorized by him/her to administer it to me/my child as prescribed.

X_____ _____

Parent/Guardian Signature Date

Parent/Guardians Printed Name: _____

The Western Maryland
Counseling Center, Inc.

Consent to Participate in Telehealth Consultation

Client's Name: _____ DOB: _____

Purpose: This form is intended to obtain your permission to participate in Telehealth consultation.

Introduction: Telehealth is typically the use of video conferencing to enable healthcare providers and clients at different locations to engage in health care treatment and/or consult with you and/or your health care provider about your health care options and decisions. Telehealth consultations are not the same as direct patient/healthcare provider visits, as you will not be in the same location while engaging in services. Your participation in any Telehealth consultation is completely voluntary. Telehealth may involve phone sessions as long as permitted by the State of Maryland but only as a last resort and not for ongoing treatment. Details about the delivery of telehealth will be shared with you at the beginning of treatment including use of telehealth equipment (as applicable), emergency procedures and requirements for follow-up following the conclusion of the appointment.

Process: By signing this form, you are acknowledging that you understand the following:

- WMCC has explained to me how the video conferencing technology will be used to conduct a Telehealth consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same location as my provider.
- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my provider in order to operate the video equipment. The above-mentioned people will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the Telehealth room; and/or (3) terminate the consultation at any time.
- I have had the alternatives to a Telehealth consultation explained to me, and in choosing to participate in a Telehealth consultation, I understand that some actions that are typically conducted with my provider in-person, may be conducted by a different provider should the need arise (emergency intervention).
- That my provider will keep a record of the consultation.
- In the event that emergency assistance is needed during my appointment, (if I am at WMCC) I can ring the bell provided in the Telehealth room, ask my provider to notify the front desk, or open the door and ask for assistance if needed. If I am at home, confirmation obtained at the beginning of the session regarding my whereabouts, may be provided to emergency personnel by my provider.

The Western Maryland
Counseling Center, Inc.

Possible Risks: By signing this form, you are acknowledging that you understand the following:

- Despite our best efforts to protect the privacy of patient information, security protocol could fail causing a breach of privacy of personal medical information.
- Information provided over Telehealth to the provider may be insufficient to allow for treatment and general medical decisions to be made. In the event that this occurs, you will be promptly rescheduled with an on-site provider for continued treatment as able.
- I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my provider or myself can discontinue the Telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

Consent: I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the delivery of services explained and I hereby consent to participate in a Telehealth visit under the terms described herein.

I hereby consent to participation in a Telehealth consultation.

X_____ _____
Parent/Guardian Signature Date

Parent/Guardians Printed Name: _____

The Western Maryland
Counseling Center, Inc.

Release of Information

On behalf of my child, _____
Client's Full Name

I, _____, hereby consent to communication between
Parent/Guardian's Full Name

The Western Maryland Counseling Center

AND

Name and Address of Person/Organization with whom information may be mutually shared:

_____

_____

For the purpose of: Coordination of Care

The following Information:
☐ Attendance ☐ Diagnosis ☐ Treatment Planning ☐ Medication Mgmt. ☐Welfare Check

&/OR: _____

Communication with the above identified individual/agency, may be conducted via phone, text, email, video, fax or face to face.

I understand that my records are protected under Federal Confidential Regulations governing confidentiality of patient records, 42 CFR – Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in one year from the date below unless:

Specifications of the date, event or condition upon which this consent expires (if any):

_____

X_____ Date: _____
Parent/Guardian Signature

Release expires 1 yr from date above unless otherwise noted.

Note: Federal Regulations prohibit you from making any further disclosure of this information without the specific written consent of the patient.

The Western Maryland
Counseling Center, Inc.

Release of Information

Washington County Public Schools

On behalf of my child, _____
Client's Full Name

I, _____, hereby consent to communication between
Parent/Guardian's Full Name

The Western Maryland Counseling Center

AND

Washington County Public Schools
Address: 10435 Downsville Pike, Hagerstown, MD 21740

For the purpose of: Coordination of Care

The following Information:
☐ Evaluations ☐ Diagnosis ☐ Treatment Planning ☐ Medication Mgmt. ☐ Recommendations

&/OR: _____

Communication with the above identified individual/agency, may be conducted via phone, text, email, video, fax or face to face.

I understand that my records are protected under Federal Confidential Regulations governing confidentiality of patient records, 42 CFR – Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in one year from the date below unless:

Specifications of the date, event or condition upon which this consent expires (if any):

_____

X_____ Date: _____
Parent/Guardian Signature

Release expires 1 yr from date above unless otherwise noted.

Note: Federal Regulations prohibit you from making any further disclosure of this information without the specific written consent of the patient.

Parental Consent for Therapy from Approved MOU Providers
School Year 2022 - 2023

I, (parent/guardian) _____, hereby grant permission for my child, (name) _____ to be excused from class in order to meet with their therapist (or other mental health professional) from Western Maryland Counseling Center.

I understand that my child is responsible for completing all work that is missed during their absence from class. Failure to make up missed assignments will be reflected in their grade.

As the parent/guardian, I may terminate services at any time by notifying the therapist directly. I will not ask a Washington County Public Schools staff person to notify the therapist when services need to be terminated.

Also, by signing this consent form, I give permission for two-way communication between Western Maryland Counseling Center and appropriate school staff (administrator, teacher, counselor, etc.) to share pertinent information and to coordinate services.

Parent/Guardian Signature: _____ Date: _____

Western Maryland Counseling Center Witness: _____

Date: _____

This consent (unless expressly revoked earlier) expires one year from the date of parent/guardian signature.

The Western Maryland
Counseling Center, Inc.

Release of Information

The Mental Health Authority and/or Optum

On behalf of my child, _____
Client's Full Name

I, _____, hereby consent to communication between
Parent/Guardian's Full Name

The Western Maryland Counseling Center
AND
The Mental Health Authority and/or Optum

For the purpose of: Coordination of Care

The following Information: Diagnosis, evaluations, treatment planning, billing, authorizations, & recommendations

&/OR: _____

Communication with the above identified individuals/agencies, may be conducted via phone, text, email, video, fax or face to face.

I understand that my records are protected under Federal Confidential Regulations governing confidentiality of patient records, 42 CFR – Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in one year from the date below unless:

Specifications of the date, event or condition upon which this consent expires (if any):

_____

X_____ Date: _____
Parent/Guardian Signature

Release expires 1 yr from date above unless otherwise noted.

Note: Federal Regulations prohibit you from making any further disclosure of this information without the specific written consent of the patient.

The Western Maryland
Counseling Center, Inc.

Request for Records

Pediatrician, PCP &/Or Behavioral Health Care Provider

On behalf of my child, _____
Client's Full Name

I, _____, hereby consent to communication between
Parent/Guardian's Full Name

The Western Maryland Counseling Center

AND

Name and Address of Person/Organization from whom information is being requested:

_____

For the purpose of: Coordination of Care

The following Information:

Please send the above clients most recent Immunization record and last treatment note.

I understand that my records are protected under Federal Confidential Regulations governing confidentiality of patient records, 42 CFR – Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Specifications of the date, event or condition upon which this consent expires (if any):

_____

X_____ Date: _____
Parent/Guardian Signature

Release expires 1 yr from date above unless otherwise noted.

Note: Federal Regulations prohibit you from making any further disclosure of this information without the specific written consent of the patient.

The Western Maryland
Counseling Center, Inc.

Mental Health Advance Directive

(For individuals 16 and older)

What is an Advanced Directive?

A Mental Health Advance Directive is a legal document that describes what you want to happen if you become so incapacitated by mental illness that your judgment is impaired and/or you were unable to communicate effectively. It can inform others about what treatment you want or don't want, and it can identify a person to whom you have given the authority to make decisions on your behalf. For more information, please speak to your assigned therapist, the Clinical Director or the Office Manager.

How do I complete a Mental Health Directive?

Please obtain the forms from the office or from your therapist. These forms are optional. If you need assistance understanding the forms, please ask to speak to your assigned therapist, the Clinical Director or the Office Manager. If you decide to prepare an advance directive, be sure to discuss it with those close to you. If you have any legal questions, please consult a lawyer.

My signature below indicates that I have received information regarding the completion of a mental health advance directive.

X_____ _____

Parent/Guardian Signature Date

The Western Maryland
Counseling Center, Inc.

Authorization for Coordination of Behavioral Healthcare

You should complete this form if you wish to authorize your child's behavioral health provider to exchange information regarding their behavioral health condition to their primary care provider or other behavioral health providers who may be directly involved in making decisions regarding their health care. This authorization will remain in effect until the (a) date you specify; (b) one (1) year from date signed; or (c) the date you withdraw your permission.

The Behavioral Health Provider administering services is:

The Western Maryland Counseling Center, Inc., at 322 E. Antietam St., Suite 101, Hagerstown, MD 21740

Phone: 301-733-2431 ~ Fax: 301-733-2432 ~ email: westernmdcounseling@gmail.com

Client information (completed by the Behavioral Healthcare Provider)

Client Name: _____ DOB: _____

Behavioral Diagnosis_____

First Date of Service: _____

Significant Findings: _____

Treatment Plan: Individual Family Group Medication Mgmt

Treatment Frequency: Daily Weekly Monthly

Estimated Length of Treatment: _____

Notification of medication/changes: _____

Recommendations: _____

As the Client, you understand:

• You have the right to review the information that is being used or disclosed;

• You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits;

• The information used or disclosed by this authorization may be at risk for redisclosure by the recipient and no longer protected by federal privacy laws;

• It is your responsibility to notify your Behavioral Healthcare Provider if you choose to change your child's Primary Care Physician;

• You have a right to revoke this authorization at any time.

My child's Primary Care Physician is: _____

X_____ _____

Parent/Guardian Signature Date

Parent/Guardians Printed Name & Relationship to child: _____

** Attach a copy of the appropriate legal document granting authority if needed

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Client Name: _____

Date of Assessment: _____

Date of Birth: (For ages 8+ only) _____

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

The Western Maryland
Counseling Center, Inc.

Effectiveness of Therapy Scale

For ages 12+ Only

Instructions:

Below are 5 statements that you may agree or disagree with. Indicate your agreements with each item by putting an X over the number in the appropriate box, from strongly agree, to strongly disagree. Please be open and honest in your responding.

Client Name: _____ Date: _____

		Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree	N/A
1	I understand my mental health symptoms/diagnosis.	6	5	4	3	2	1	0
2	I have healthy ways of coping with my symptoms/behaviors.	6	5	4	3	2	1	0
3	I have the support I need to manage my mental health.	6	5	4	3	2	1	0
4	I feel that my sessions focus on my specific treatment needs.	6	5	4	3	2	1	0
5	I see an improvement in my mood and functioning due to the help I am receiving.	6	5	4	3	2	1	0

Total Score: _____

Scoring:

◊ **26-30** Extremely Satisfied | ◊ **21-25** Satisfied | ◊ **16-20** Slightly Satisfied |

◊ **15-11** Slightly Dissatisfied | ◊ **10-6** Dissatisfied | ◊ **5-0** Extremely Dissatisfied