



Pascal Crisis Services

Robert A. Pascal Youth & Family Services, Inc.
741 Annapolis Rd, Gambrills, MD 21054
(410) 975-0067

ANNUAL INTAKE

Vision Statement

Robert A. Pascal Youth & Family Services, Inc., also doing business as Pascal Crisis Services, aspires to be a premier provider of crisis stabilization services and outpatient behavioral health services in the state of Maryland. Robert A. Pascal Youth & Family Services, Inc. develops and implements specialized treatment to meet the needs of various client profiles and provides these services in such a manner that social, economic and/or demographic factors do not limit an individual's access to appropriate services. Robert A. Pascal Youth & Family Services, Inc. utilizes a continuum of care so that there is 'no wrong door' for any individual seeking assistance.

We will achieve this by managing for the long term and by investing in our staff, volunteers and programs, not based only on immediate results, but also considering the evolving needs, in consistent accordance with our mission. We will constantly evaluate and improve the design of our services to uphold our stated values and beliefs in the attainment of our goals.

Mission Statement

Robert A. Pascal Youth & Family Services, Inc. helps persons experiencing behavioral health crises of every variety and through multiple treatment modalities, enhances the opportunity for those persons to achieve a better quality of life-allowing them to live as productive and stabilized individuals. This is accomplished through comprehensive treatment and prevention methods guided by an innovative service delivery model.

Robert A. Pascal Youth & Family Services, Inc. also conducts research and educates the community on the symptoms, treatment and prevention of behavioral health crises and other mental health conditions.

Core Values

We Believe Client Needs Come First

We Practice Radical Compassion

We Are Driven by Hope

We Embrace Innovation and Collaboration

We Continuously Strive for the Pursuit of Excellence

43 Community Place
Crownsville, MD 21032
(410) 571-4500

1226 Annapolis Road
Odenton, MD 21113
(410) 571-4500

1230 Annapolis Road
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(410) 874-1236

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CLIENT INFORMATION

First Name: _____ Last Name: _____ Email: _____
Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ Date of Birth: _____ Phone: _____
If minor: Father name, signature, phone _____
If minor: Mother name, signature, phone _____
Marital Status: _____, Sexual Orientation: _____, Ethnicity: _____
Religion: _____, Race: _____, Preferred Language: _____

INSURANCE INFORMATION

Insurance Company: _____ ID: _____ Group: _____

POLICY HOLDER'S INFORMATION (Leave blank if same as client information)

First Name: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ Date of Birth: _____ Phone: _____

ADVANCED BENEFICIARY NOTICE

This is to inform you about your decision to receive these services. There is always the possibility that your insurance company may not pay for these services. Insurance companies do not always cover mental health treatments. The fact that your insurance company may not pay for these services does not mean that you should not receive treatment. You must also be aware that by signing for us to bill your insurance company, you understand that auditors from that company have the right to inspect and read your file. All your diagnostic information is submitted to them after each session. Confidentiality is not preserved from the insurance company that is billed. 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 the time of service. ☐ **YES:** I have read the Advanced Beneficiary Notice and agree to let Pascal Crisis Services, Inc. bill my insurance company for services. ☐ **NO:** I have read the Advanced Beneficiary Notice and do not wish to have my insurance billed. I agree that I will be responsible for payments at time of service.

Client or Guardian Signature

Date

Staff Signature

Date

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Missed Appointment Fee Policy Client Notification and Acknowledgment

Enforcement Effective Date: October 19, 2026

Pascal Crisis Services maintains an established missed appointment fee policy requiring clients to provide at least 24 hours' advance notice when canceling or rescheduling an appointment.

Notice may be provided by contacting the front desk, including by leaving a voicemail.

Effective on the date indicated above, a \$25 missed appointment fee will be consistently enforced for clients utilizing private insurance and self-pay clients who fail to attend a scheduled appointment or do not provide the required 24 hours' advance notice. The fee is the client's financial responsibility and is subject to applicable insurance requirements and approved exceptions.

This notice serves to formally communicate the organization's existing missed appointment fee policy, including its expanded applicability to self-pay clients. Fees will only be assessed for qualifying appointments occurring on or after the enforcement date, provided the client has received advance notice of the policy.

Client / Parent / Guardian Acknowledgment

By signing below, I acknowledge that I have been informed of and understand Pascal Crisis Services' missed appointment fee policy, including the requirement to provide at least 24 hours' advance notice when canceling or rescheduling an appointment.

I understand that a \$25 fee will be assessed for qualifying missed appointments or late cancellations, effective on the enforcement date identified above. I agree to be financially responsible for applicable fees under this policy.

Client Name: _____

Name of Person Signing: _____

Relationship to Client (if applicable): _____

Signature: _____

Date: _____

Staff Signature: _____

Date: _____

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Parent/Guardian Consent for the Treatment of Minors

Prior to the treatment of a minor, Robert A. Pascal Youth & Family Services, Inc. d.b.a Pascal Crisis Services 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 Parents/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.

Staff Signature:_____ Date:_____



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STATEMENT OF UNDERSTANDING REGARDING CONFIDENTIALITY

Welcome to Robert A. Pascal Youth & Family Services, Inc. We are a 501(c)(3) non-profit organization that provides multiple mental health services to our community, such as comprehensive assessments, counseling, and referrals for a wide range of problems.

Any information shared during your sessions is kept confidential unless you have given us written permission to share it with another organization or individual. However, there are legal and ethical limitations to confidentiality in which information shared within a session would need to be reported to a third party.

Please review the following exceptions to confidentiality.

- Unreported physical abuse, sexual abuse, or neglect.
- Threats of harm toward yourself or others, including suicidal thoughts or behavior.
- Court ordered to reveal information obtained as part of an evaluation or therapy.
- The evaluation or therapy is paid for by a public or private agency, insurance company, a managed care company, or other third party.
- If you participate in group therapy as part of your treatment.
- If a report of your therapy or an evaluation of your level of functioning must be reviewed with a colleague for consultation.
- If Pascal is involved in legal action involving your evaluation or treatment.

If we are asked to reveal information about you, we make every effort to discuss this with you in advance and obtain written permission from you. If this is not possible, we will make reasonable efforts after the information has been disclosed to inform you of what information was revealed, to whom it was revealed, and for what purpose it was revealed.

Pascal, in some circumstances, may video and/or audiotape evaluation and therapy sessions. This may be done to protect the participants and Pascal from inaccurate statements and questions about activities associated with the treatment. In some situations, Pascal uses the taped material to seek consultation regarding the best possible treatment methods or it is purposed for training other mental health professionals; **however, this will never be done without written permission from you.** In every situation, the client's identity will be protected. If you have objections to the taping, you should discuss this with your counselor at the first session and taping will not be used.

BY SIGNING BELOW, I AM ACKNOWLEDGING THAT I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS REGARDING THEM.

Client or Guardian Signature

Date

Staff Signature

Date

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CLIENT BILL OF RIGHTS

The Board of Directors and Staff at Robert A. Pascal Youth & Family Services, Inc., also doing business as Pascal Crisis Services, endorse the civil and legal rights and liberties of clients with the expectation that observance of these rights will contribute to more effective care and greater satisfaction for clients and program staff. The following rights are affirmed:

1. The right to considerate care without regard to age, race, creed, sex, ethnicity, color, national origin, marital status, sexual orientation, disability, religion, political affiliation, or limited English proficiency.
2. The right to obtain current information concerning his/her diagnosis, treatment goals, and prognosis in terms that the client can be reasonably expected to understand.
3. The right to examine one's own record within the Federal guidelines and rebut any information in their record by inserting a counter statement of clarification or correction.
4. The right to receive information necessary to give informed consent prior to the start of any treatment.
5. When significant alternatives for treatment exist, or when the client requests information concerning alternatives, the client has the right to such information in a timely manner.
6. The right to refuse treatment to the extent permitted by law, to discharge oneself at any time, and to be informed of the consequences of his/her action.
7. The right to every consideration of his/her privacy concerning his/her treatment program. Client information shall be maintained as confidential unless disclosure is permitted by law and/or with documented, signed client consent.
8. The right to expect that within our capacity we will make a reasonable response to the request for a service and provide an evaluation, service, or referral as indicated by the nature of the case, including but not limited to legal entities, self-help support, and advocacy.
9. The right to be involved and receive complete information prior to a transfer.
10. The right to know about follow-up contact procedures post discharge.
11. The right to expect reasonable continuity of care, to know when and where appointment times and services are available, both in our program, in the community, and /or concurrently.
12. The right to know about any fees, payments, or surrendering of valuables, to examine and receive an explanation of his/her bill, and protection from exploitation regardless of funding status.
13. The right to expect to be informed by staff of the health, treatment, and other service requirements following discharge.
14. The right to be informed of written facility rules and regulations prior to admission.
15. The right to have one's religious beliefs respected.

16. The right to communicate by mail, phone, or other means of private communication, except when such is detrimental to the therapeutic process and reflected in the treatment course. At minimum mail will be distributed weekly, though generally daily. All mail must be opened in staff presence and screened for contraband.

17. The right to be treated with dignity and respect, and free from neglect, corporal punishment, abuse, physical restraint, seclusion, involuntary confinement, humiliation, and retaliation. All staff must adhere to a corporate code of ethics and professional licensure standards. Code of ethics details may be requested from staff.

18. The right to nutritious food, safe and adequate lodging, physical exercise, and provision for personal hygiene.

19. Clients have the right to register complaint and file a grievance related to their treatment experience and to expect investigation of said concerns or infringements.

_____ I have requested and was given an interpreter.

_____ I am unable to read and have had my rights read to me by _____ Staff Member and understand that my signature indicates I understand my client rights.

_____ Received a Copy

_____ Refused a Copy

Client Signature

Date

Staff Signature

Date



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NOTICE OF PRIVACY PRACTICES **RECEIPT OF ACKNOWLEDGEMENT OF NOTICE**

Client Full Name (Please Print)

Date of Birth

I hereby acknowledge that I have had the chance to review and understand Robert A. Pascal Youth & Family Services Inc. HIPAA policies and procedures. I understand that a reviewable copy is available at my request and I understand that I can request to take a copy with me. I also understand that if I have any questions regarding the notice or my privacy rights, I can contact the privacy officer.

Client or Guardian 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 surrogate, etc.).

Representative Name (Please Print)

Relationship

Representative Signature

Date

OFFICE USE ONLY BELOW THIS LINE

Only to be filled out if client refuses to acknowledge receipt.

BY SIGNING BELOW, I AM ACKNOWLEDGING THAT I AM A CURRENT STAFF MEMBER OF ROBERT A. PASCAL YOUTH & FAMILY SERVICES Inc., AND THAT I WAS PRESENT WHEN CLIENT WAS PRESENTED WITH THIS DOCUMENT AND REFUSED TO SIGN.

Staff Member Signature

Date

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RELEASE OF INFORMATION

Client Name: _____ D.O.B: ____ - ____ - ____

Phone: ____ - ____ - ____ SSN: ____ - ____ - ____

I hereby authorize Robert A. Pascal Youth & Family Services, Inc. to:

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

(Person/facility, address, phone, fax which has medical and/or mental health info)

Type of disclosure: ☐ Verbal/Written/Electronic ☐ Copies of record ☐ Letter

Purpose of disclosure: ☐ Ongoing treatment ☐ Academic ☐ Support ☐ Other _____

Type(s) of information: ☐ Initial Assessment ☐ Treatment Summary ☐ Attendance

☐ Psychiatric evaluation/medication history

☐ Other _____

By initialing below, you are authorizing the following information to be released:

____ **All counseling/mental health information** (subject to MD's Confidentiality of Medical Records Act, codified at Health-General 4-301et seq). Additionally, all information regarding Alcohol and/or Drug Abuse (42 C.F.R. and 2.35) or HIV/AIDS results (Health and Safety Codes 120980(g)) will be released **unless restricted in limitations below.**

____ **All medication management services information medical information** (This may include but is not limited to drug/alcohol and mental health information documented by psychiatrist).

Limitations, if any, upon disclosure: _____

Declining of Persons to be listed on Release of Information

____ I **do not** wish to list anyone on this release at this time.

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner.
- I understand 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 health 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 this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand that a photocopy or fax of this form is the same as the original.

Client or Guardian's Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

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EMERGENCY CONTACT INFORMATION FORM

This information will be extremely important in the event of an accident or medical emergency. Please be sure to sign and date this form.

Client Name (Print): _____
Last First Middle

Home Phone: _____ **Cell Phone:** _____

Home E-mail Address: _____

Home Address: _____
Street City State Zip

Primary Emergency Contact Name: _____
Last First

Relationship to Client: _____ **Home Phone:** _____

Cell Phone: _____ **Work Phone:** _____

Secondary Emergency Contact Name: _____
Last First

Relationship to Client: _____ **Home Phone:** _____

Cell Phone: _____ **Work Phone:** _____

Preferred Local Hospital: _____

Insurance Company: _____ **Policy #:** _____

Comments (Include any special medical or personal information you would want an emergency care provider to know – or special contact information):

Client or Guardian Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

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INFORMATION REGARDING MEDICAL RECORDS

Fulfilling requests for Medical Records is a time-consuming and costly process, involving coordinating and tracking each request, locating, copying and printing relevant documents and handling supplies like paper, toner, and postage. To offset these costs, payment is required prior to processing requests.

An "abstract" (containing client name, diagnosis, medications and appointment history) is often sufficient. Client-requested abstracts cost a flat rate of \$5. For requests beyond and abstract, the following fee schedule is based on HIPAA and Maryland law. You will always be sent an invoice prior to receiving records.

Client requested paper – Reasonable, cost-based fee in accordance with HIPAA. Not to exceed actual cost. **Client requested electronic** – Flat fee of \$6.50

Third-Party requested paper (e.g., attorney, insurer etc.) - \$0.76 per page + \$22.88 preparation fee + postage (if applicable). **Third-Party requested electronic (e.g., attorney, insurer etc.)** - \$22.88 preparation fee + postage (if applicable) + cost of media (e.g., CD/USB, if applicable).

Continuity of care (request from another provider) - no charge.

Payment can be made by cash, credit card or check to Robert A. Pascal Youth & Family Services, Inc. Processing begins upon payment, and records are released once payment is complete. Requests may take up to 21 days per Maryland law, though we strive to fulfill them in 3-6 business days. For questions, contact the Records Department at 410-975-0067.

The preceding information is in accordance with Federal and State laws: 42 CFR Part 2; 45 CFR ss160-164; Md. Code, Health-Gen. ss 4-301-310).

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 FEDERAL AND STATE LAW.

Client or Guardian Signature

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Staff Signature

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MEDICATION CONSULTATION FORM

Please record your current medication information.
If not on any medication, you may leave blank.

Client's Name: _____ Date of Birth: _____

Preferred Pharmacy: _____ Pharmacy Phone#: _____

Known Allergies: _____

Current Medications: _____

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

Previous Prescriber's name and phone: _____

Are you on Methadone? Y / N Are you on Suboxone/Zubsolv? Y / N

Which one? _____

Which clinic _____

How Long? _____ How many mg? _____

NOTICE OF PRIVACY PRACTICES FOR CRISP PARTICIPTION



CRISP

Connecting Physicians With Technology
to Improve Patient Care in Maryland

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in-order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Client or Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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Medication Management Policy

New Clients: Admin staff schedule new client appointments and may only do so after the client has completed an intake, and it is documented in ICAN.

Follow Up Clients: Admin staff schedule follow-up appointments including refill appointments. A note must be added to each appointment indicating the reasons/need for the appointment, evidenced with staff initials. Prior to receiving refills, the client will be required to attend therapy at least twice within the past month (30-day period). Medications are not called in by phone unless special circumstances require it; clients' prescriptions are done via "escribe" during the medication appointment. Medication management at Pascal requires documented counseling compliance.

Admin will contact all no-shows the day after Med Clinic to offer rescheduling for the following week. No bridge prescriptions will be given if appointments are missed.

Any client receiving medication management through Pascal must allow admin staff to obtain and put their photograph in their ICAN chart for safe practice procedure.

Prior Authorizations (PAs): If a pharmacy notifies a client that prior authorization is needed, the client should ask the pharmacy to request a 30-day override from insurance and notify the front desk of the need for a PA. Prior authorization may take up to three business days.

Labs: All clients receiving medications from Pascal are subject to random urinalysis. Clients prescribed Suboxone, benzodiazepines, or amphetamines will have monthly tests at a minimum (see exceptions below). Adults (18+) are also subject to random urinalysis during medication visits. This is for safe prescribing practice.

Medication Assisted Treatment (MAT): When clients are prescribed MAT through Pascal's OMHC, the following protocols are to be followed:

- Weeks 1-6: Weekly UAs required
- Weeks 7-12: Biweekly UAs required
- After 12 weeks: Monthly UAs required

If a UA is negative for prescribed MAT or positive for illicit substances, weekly testing resumes. Ongoing issues result in discharge from MAT services.

Controlled Medications: Clients on controlled substances (e.g., benzodiazepines, amphetamines) must provide monthly UAs. Negative results for prescribed meds trigger clinical review. Continued issues may lead to discharge from the program.

Client or Guardian's Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____



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Client Photo Authorization Form

Client Name: _____ **D.O.B:** ____ - ____ - ____

Name of Legal Guardian (if applicable): _____

I understand that Robert A. Pascal Youth & Family Services, Inc. D.B.A. Pascal Crisis Services (herein referred to as "Pascal") is requesting to take and store a photograph of me (or the above-named client, if signing as a legal guardian) for the following internal purposes:

- Identification and verification by clinical and administrative staff
- Accurate recordkeeping in the Electronic Health Record (EHR)
- Safety and continuity of care during treatment

I understand that this photo will NOT be used for any marketing purposes, social media, research, or external communication.

I understand that this photo is only stored in the EHR, and upon uploading it to the EHR, it is promptly deleted from the device on which it was taken. I understand that this photo will be treated as part of the medical record, stored securely in accordance with all federal and state privacy laws and regulations, and accessible only to authorized staff as required for treatment purposes.

I understand that any photos taken will not be released to anyone without signed consent, except when required by law. Copies of any photos are subject to procedure outlined in records requests.

I understand that if I, or above-named client of whom I am a legal guardian, is prescribed medication by Pascal, I am required to allow admin staff to obtain the photo for safe practice procedure in accordance with organization policies.

I hereby acknowledge the above statements and authorize Pascal to obtain the photograph described in this document.

Client or Guardian's Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

For Internal Use Only

Staff Member Obtaining Photo: _____

Date Photo Taken: _____

Confirmed Uploaded to ICAN: ☐



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INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name: _____ Date of Birth: _____

Location: _____

Clinician Name: _____ Location: _____

Introduction: Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Live two way audio
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure the integrity against international corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her remote location while the clinician consults from the practitioners site.
- More effective patient evaluation and management.
- Obtaining expertise of a distant specialist

Possible Risks:

- In rare cases, information transmitted may not be sufficient to allow appropriate medical decisions.
- Delays in medical evaluation and treatment can occur due to deficiencies or failure of the equipment.
- In very rare instances, security could fail, causing a breach of privacy of personal medical information.

I agree to participate in telemedicine for the procedure(s) described above

Signature _____ Date _____

Signature of parent or guardian _____ Date _____

I do not agree to participate in telemedicine for the procedure(s) described above

Signature _____ Date _____

Signature of parent or guardian _____ Date _____

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