Pascal Crisis Services, Inc.
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, Inc., 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.

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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.

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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

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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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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, Inc., 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 and 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 REQUESTING A COPY OF CLIENT RECORDS

Fulfilling any request for Medical 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 medical record copies, it has become necessary to ask for payment before each request can be processed.

An "abstract" of the medical records is often enough to meet the need of a request. An abstract consists of the patient'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 patient.**

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 medical records can be paid by cash, credit card, or check made payable to Pascal. 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 ACKOWLEDGING 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 Signature **Date**

_____ _____

Staff Signature **Date**

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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?** _____

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NOTICE OF PRIVACY PRACTICES FOR CRISP PARTICIAPTION

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: The front desk will schedule new client appointments and may only do so after the client has received an intake appointment and the intake note is documented in ICAN.

Follow Up Clients: The front desk will schedule follow up med appointments including refill appointments. An appointment note should be put into appointment to notify med team of reasoning for appointment with whoever is scheduling the appointment initials. Prior to receiving refills or a medication appointment for clients receiving psychiatric medications or suboxone, the client will need to have attended therapy at least twice within the last month. Medications will no longer be called in, but rather done via escribe during medication appointment or hand-written scripts. Pascal is a counseling center not a medication center and therefore counseling compliance must be documented in order to receive medication.
Prescribers request that any client on medication allow admin staff to put their photograph in ICAN chart for safe practice procedure.

Admin staff will call all no shows the following day after Med Clinic and see if the client would like to schedule the following week. There will be no bridge prescriptions if clients miss their appointments.

Prior Authorizations: Clients notified by their pharmacy that they need a prior authorization for a medication should request the pharmacy call their insurance and request a 30 day override. Clients should call front desk to notify the Med Team of the need for prior authorization. Prior authorizations may take three business days to complete.

Labs:
Precision Lab is in house on every medication clinic day. All clients who receive medications from Pascal are subject to random urinalysis. Those clients receiving suboxone, benzodiazepines or amphetamines are subject to monthly urinalysis.

Lab Policy: Clients over the age of 18 will be subject to random urinalysis on days attended during medication appointments. This is for safe prescribing practice only.

_____ _____
Client or Guardian Signature **Date**

_____ _____
Staff Signature **Date**

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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 breech 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_____