



PJ Mercer & Associates, LLC
Priscilla Jones Mercer, LCSW-C, LCADAS, SAP
9199 Reisterstown Road Suite 201B
Owings Mills, MD 21117
(O) 667-303-3204 (F) 667-303-3560

New Client Packet

Client Name: _____

Date of Birth: _____

SSN: _____

Race African American Caucasian Hispanic Other Ethnic Preference _____

Address _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact Person: _____ Relationship _____

Phone Number: _____

Insurance Carrier: _____

Insurance Policy Number: _____

Client Signature: _____

_Date: _____



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Telemental Health Informed Consent

I _____, (**name of client**) hereby consent to participate in Telemental health with Priscilla Jones-Mercer, LCSW-C (**name of provider**) as part of my psychotherapy.

I understand that Telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. PJ Mercer & Associates is located in the state of Maryland, which is in the Eastern Standard Time (EST) zone, in the United States of America.

I understand the following with respect to Telemental health:

- 1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- 2) I understand that there are risk and consequences associated with Telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- 3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- 4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to Telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
- 5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Telemental health services are not appropriate, and a higher level of care is required.
- 6) I understand that during a Telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at (667) 303 - 3204 to discuss since we may have to reschedule.
- 7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.



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Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone:

FREE CONFIDENTIAL SUPPORT

**The National Suicide Prevention Hotline (24/7) 1-800-273-8255

**Baltimore Crisis Response Inc. (24/7) 410-576-5097

**Baltimore Crisis Response Inc. (Mobile Crisis Team) (24/7) 410-433-5175

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian

Date

Signature of therapist

Date



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Due to the Coronavirus (COVID-19) pandemic and national emergency, which constitutes a nationwide public health emergency Priscilla Jones-Mercer (LCSW-C) of PJ Mercer & Associates, LLC, will no longer conduct face to face mental health and/or group sessions, at this time. However, PJM, LLC is very concerned about your mental health and committed to servicing you via tele health through remote communications technologies; video conferencing, (G-Suites/Google Suites), telephonic by way of FaceTime and/or audio calls with smart phones, computers, laptop, iPad, notebooks or audio only by way of androids or home telephones. Also, use of email and/or text message is accessible to us.

In the past week, I have contacted most of you to identify the type of technology you have access to at this time, so we have made provisions and accommodations.

Please be advised that the session being conducted by telehealth/telephone may not be HIPPA compliant. However, I decided to utilize G-Suites because it is one of the telehealth services that is HIPPA compliant.

Please find attached a copy of PJM, LLC's telehealth consent form. Once you have read the consent form, please sign it and return it back to me ASAP. Note: at this time verbal consent can be given but written consent has to be in your client file.

Thanks so much for allowing me to continue to service your mental health needs. Please be safe, practice social distancing, and continue to practice all safety percussions provided by the CDC, local city, state and federal entities.

Stay well!!

Priscilla Jones-Mercer



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Consent for Treatment

I _____ agree to participate and consent to treatment with

(Client's Name)

PJ. Mercer & Associates, LLC's therapist _____

(Therapist's Name)

I consent to PJ Mercer & Associates, LLC, to provide clinical evaluation, intervention and mental health therapy services. This will include an intake and assessment of my demographic, clinical/psychiatric history and medical records. The information collected will be stored in a safe and secure location. The information collected may be used to evaluate if you are eligible for external programs and services. This information collected may also be used for staff meetings and/or clinical reviews. At any time, you may choose to withdraw your information by written request. This information will not be used for research.

I understand this service is being provided to me to treat my mental/behavioral health condition. I understand I have the right to ethical and fair treatment given without regard of my race, religion, ethnic origin, sexual orientation and/or color. I understand I have the right to refuse treatment or deny any recommendation and/or any decision made regarding my treatment. I understand if I refuse treatment, or rescind this consent for treatment, PJ Mercer & Associates, LLC and /or the treating therapist/ staff blameless, responsible and/or harmless for any pain/suffering I may incur as the result of treatment or failure to comply with treatment recommendations; however, P.J. Mercer & Associates, LLC has an obligation to explain what the consequences of voluntary termination might be, should I decide to end services before recommended.

I understand in conducting my mental health evaluation may require access to by Release of information and/or copies of my past treatment history and medical information, or the patient identify information, which contain mental health and may contain alcohol and/or drug use diagnosis, treatment, or refusal for treatment information, in addition to other forms of Protected Health Information (PHI).

I understand PJ. Mercer & Associates, LLC agree to use and disclose any patient identify mental health and/or alcohol and/or drug information only as allowed by Maryland Health-General Code Annotated ~4307 and the Federal Regulation pertaining to Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).



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Please be advised that documentation entered into your record will be based on the evidence provided by you, your diagnosis, treatment plan and medications. Although your information will be protected it could be subpoenaed by the court system.

I understand that I may be discharged from receiving treatment by PJ. Mercer & Associates, LLCs and/or treating therapist due to the following conditions, not including successful completion of treatment: {1) Failure to keep regular scheduled appointments; missing three {3) consecutive scheduled appointments, including no shows and/or no calls, (2) Disrespectful/rude/misconduct behavior towards therapist/staff or clients, (3) Violent, sexual inappropriate and/or criminal behaviors towards therapist/staff or clients.

I also understand that I have the right to request a transfer of therapist if I feel my needs are not being met, however I will discuss this decision to transfer with both treating therapist and President of PJ. Mercer, LLC, Mrs. Priscilla Jones-Mercer, LC5W-C.

I understand, as a commercial insured client, if my insurance carrier does not make payment for services rendered by PJ.M, UC/therapist, treatment may stop, and I will be responsible for payment of services.

It has been explained to me and I understand, as a Medicaid client, I will NOT be balanced billed or billed for any missed/no shows, cancellations or late fees.

Clinical Philosophy

therapist can deliver appropriate services for individuals we serve. Included in care management is the assessment and referral to clinical practitioners and programs, coordinating a continuum of services with behavioral health and medical disciplines, implementing health and wellness strategies, identifying natural supports in the community such as self-help groups, identifying resources to meet basic needs, and making available educational materials addressing mental health and substance disorders. Our overall agency goal is to meet our clients where they are and provide individualized support and services to help our clients achieve their highest potential. We are committed to supporting individuals in becoming responsible and active participants in their treatment.

The foundation of PJ. Mercer & Associates, LLC is based on:

- Clinical Excellence
- Ethical Care



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- Respect for cultural and linguistic preferences
- Professional integrity
- Compliance with State and Federal Regulations, as well as other external contracts
- Clinical/technical innovation to find new and improved ways to assist individuals
- Implementation of identification and assessment tools to identify the most vulnerable and at-risk /special need population

Risk Management

I understand that PJ. Mercer & Associates, LLC's staff are mandated to report suspected abuse or neglect of children and vulnerable adults. PJ. M, LLC staff will contact the appropriate agencies to report when there is a potential danger to one's self or others. Agency staff may warn an individual(s) of potential/threat and contact emergency and/or law enforcement personnel. These types of reporting do not require prior client consent and are an exception to any confidentiality that may be applicable to my medical records.

I consent to participate in treatment with PJ.M, LLC's therapist and I understand developing an (ITP) Individual Treatment Plan with my therapist, will involve regularly reviews on my progress/changes towards m treatment goals. I also understand these goals are in my best treatment and I agree to play an active role in my treatment process and progress. My obligation to therapy is to consistently participate in and comply with treatment recommendations to improve my quality of life. If I need a higher level of care that therapist is unable to provide, the agency will ensure effective transitions to the appropriate alternative levels of care. If further psychiatric evaluation and medication management is needed, I will be referred to the appropriate provider; a psychiatrist or Nurse Practitioner-Psych. Since this is outside of PJ. Mercer & Associates LLC's expertise a full informed consent will be required to co-managed proper use of the psychotropic and somatic medication. If therapist does not practice in an area of expertise that is/can be beneficial to my treatment, I will be referred to the appropriate provider for treatment.

I understand that PJ. Mercer & Associates, LLC will address the needs of high-risk special populations, such as children and adults with special healthcare needs, adults aged 65 or older, non-elderly adults who are disabled, chronically ill Individuals with developmental or complex physical needs, people with serious and recurrent mental illness, children in the child welfare system, women who are pregnant, individuals that are incarcerated and veteran's and their families. The agency will focus on building the ability to rebound from adversity, trauma, or other stressors and developing a sense of mastery and competence for children, adolescence and adults affected by mental illness and/or substance use disorders.



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I understand there are risks involved in participating in therapy and aware that discussing past traumatic experiences may trigger unresolved issues and may increase my symptoms; however, treatment will offer the opportunity to manage my symptoms associated with trauma. I am fully aware that therapy may not cure my symptoms but will allow me to process negative feelings and traumatic events in my life and may decrease my symptoms. I understand that therapy would allow me to build upon previous knowledge and strength to improve my quality of life, as well as learn and develop new skills not previously possessed. Other benefits to participating in therapy may decrease my symptoms and allow me the opportunity to heal and move forward with my life.

I understand my obligation in participating in therapy is to have a positive attitude, be motivated to change, be consistent with keeping my scheduled appointments and comply with my treatment recommendations and goals. Therapy will allow me the opportunity to learn how to manage my mental health and/or substance use disorders.

I understand in the event of an emergency, and I am unable to reach my therapist, I will dial 911 and go to the nearest emergency and/or call the **24/7 National Suicide Prevention lifeline at 1-800-273-8255**. I understand this information is on the agency answering machine.

Termination at Services- Voluntary and Involuntary Discharges

PJ. Mercer & Associates, LLC expects that active discharge planning begins at the point of admission and continues throughout the treatment course. The discharge criteria reflect the circumstances under which an individual can transition to a less intensive level of care or have been revised so that the individual can be discharged from care or be evaluated for a more intensive level of care, if required.

It is expected that the individual be a full participant in decision-making regarding their care and that significant others, as appropriate, are actively involved in both treatment and discharge planning. Discharge decisions and treatment alternatives are discussed with the individual throughout the course of treatment, and especially when discharge determinations are being considered. For some individuals whose condition has not stabilized but has intensified discharge will involve transition to a more intensive level of care. When a provider disenrolls from the network, a transition of service is provided for a specific period. Termination of services is based on the following criteria:

- The precipitating factors leading to admission have been resolved and individual no longer needs care
- Individual has demonstrated sufficient improvement and is able to function adequately without any evidence of risk to self or others



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- Evidence suggests that the individual is not making progress toward the goals
- Individual is competent and non-participatory in treatment
- Individual no longer meets admission criteria, or meets criteria for a less or more intensive level of care
- Consent for treatment is withdrawn and it is determined that the member has the capacity to make an informed decision and does not meet criteria

I understand if I choose to terminate services with PJ. Mercer & Associates, LLC I may request a copy of my medical records by contacting my therapist directly and putting my request in writing. I also understand that after my termination of services from the agency, my medical records will be discharged in Beacons Health Options' electronic system then transferred to and archived at Iron Mountain for the remaining (7) seven years.

This consent has been explained to me and I have voluntarily given my informed consent for services provided by PJ. Mercer & Associates, LLC. I understand that after I sign this consent, I have the right to revoke it (by writing a letter Informing I no longer consent) and the agency will comply with your wishes immediately. I understand, if I am a minor (under the age of 18) this consent must be signed by my Parent /Legal Guardian (Legal Guardian must have court documentation verifying guardianship)

_____	_____
Signature of client/Parent/Legal Guardian	Date

_____	_____
Printed name of client/Parent/Legal Guardian	Relationship to client

Description of Legal Guardian's authority



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Fee Agreement

There are four ways for services to be rendered at PJ. Mercer & Associates, LLC

1. Medicaid:

Medicaid is a state and federal program that provides health coverage for low-income individuals. Once you are authorized through EVS state Eligibility Verification System to verify active status of Medicaid. Your Medicaid policy will pay for Individual, family and or couples therapy, and individual evaluation. Medicaid clients do not pay late fees, missed appointment, no shows/ cancellation fees or, balanced billed or charged for, co-pays- **Medicaid will not be charged for any out-of-pocket expenses.**

2. Medicare:

Medicare is a federal Program that provides health coverage if you are 65 and older or have a severe disability and receive SSI, no matter your income you will automatically entitles you to Medicare. Medicare policy will pay for individual, family and or couples therapy and initial evaluation. Medicare clients do not pay for late fees, missed appointments, no-shows/cancellation fees or balanced billed or charged for co-pays

3. Commercial Health Insurance (I.e., Cigna, BC/BS, Care first)

Commercial Health Insurance is a benefit by an employer to provide health insurance for medical and health treatment. There is a co-pay with most commercial health insurances that need to be paid at the time of service. Commercial Insurance covers individual, family and couples therapy.

4 Self-pay:

Paying for individual, family, and/or couples mental health treatment and evaluation out of pocket with cash or credit card at the time of service.

Initial Evaluations: \$130.00

Follow-up sessions \$80.00

_____ Please initial if you have received a copy of this Fee Agreement