New Patient Packet

FreeState
HEALTH & WELLNESS

FreeState
HEALTH & WELLNESS

Hello,

Welcome to Free State Health & Wellness. We are looking forward to providing you with mental health services. Please fill out the forms in this New Patient Packet. The packet must be returned prior to your scheduled appointment, or your appointment will be canceled.

IMPORTANT: In order to fill out this PDF, download it to your computer, fill it out, and save it using Adobe Acrobat Reader. You will not be able to save the document if filled out in a browser window. If you do not have Acrobat Reader here is a link to download it for free: **https://acrobat.adobe.com/us/en/products/pdf-reader.html**

Or if you prefer, you can print, fill out with pen, upload, and send back via email or fax.

We are happy you chose us to be your mental health provider.

Sincerely,
MELISSA WARD CRNP
Free State Health & Wellness

365 W. Patrick St., Suite 205
Frederick, MD 21701

P 240.647.9049
F 240.690.6095

info@freestatehw.com
www.freestatehw.com

FreeState HEALTH & WELLNESS

PATIENT REGISTRATION FORM

PATIENT INFORMATION

FIRST NAME | LAST NAME

DOB | SSN

ADDRESS | CITY | STATE | ZIP

PHONE

Home ☐ Cell ☐ Work ☐ Ok to leave a voicemail? Yes ☐ No ☐ Ok to text message? Yes ☐ No ☐

EMAIL

RELATIONSHIP STATUS Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed ☐

GENDER Female ☐ Male ☐ Other ☐

EMERGENCY CONTACT

NAME | RELATIONSHIP TO PATIENT | PHONE

INSURANCE INFORMATION

INSURANCE COMPANY | ID NUMBER | GROUP NUMBER

SECONDARY INSURANCE INFORMATION (IF ANY/APPLICABLE)

INSURANCE COMPANY | ID NUMBER | POLICY NUMBER

FreeState HEALTH & WELLNESS

PATIENT REGISTRATION FORM

POLICY HOLDER INFORMATION

FIRST NAME | LAST NAME

DOB | SSN

ADDRESS | PHONE

PARENT/GUARDIAN #1

NAME | DOB | GENDER Female ☐ Male ☐ Other ☐

RELATIONSHIP TO PATIENT | SSN

ADDRESS | PHONE

EMAIL

PARENT/GUARDIAN #2

NAME | DOB | GENDER Female ☐ Male ☐ Other ☐

RELATIONSHIP TO PATIENT | SSN

ADDRESS | PHONE

EMAIL

FreeState HEALTH & WELLNESS

INSURANCE POLICY

INSURANCE

- Insurance Cards are required at every visit. We will verify your insurance coverage at the time of your first visit if possible.
- Depending on your insurance, Free State Health and Wellness, LLC. will be reimbursed based on a percentage of the amount billed. We do not know the exact amount until we receive payment. All co-payments, deductibles, and payments for non-covered services are due at the time of the service or when balances become known. As the recipient of services, you are ultimately responsible for all services provided. Not all services may be covered by insurance, and you will be fully responsible for those uncovered charges. Free State Health and Wellness, LLC, is under no obligation to pursue reimbursement on the patient's behalf.
- If payment from your Insurance Provider is not received in full within thirty (30) days after submission of the request for payment, it is your responsibility to pay. If payment is not received in full within sixty (60) days, by providing your credit card and receiving provided services, you are authorizing Free State Health and Wellness, LLC. to charge your provided credit card for any unpaid bills or claims. Without a card on file, payment is due in full at the time services are rendered. Any claims paid after your credit card has been billed will be refunded to you.

If you are covered by accepted Insurance plans:

- It is your responsibility to contact your insurance carrier to discuss your plan's mental health benefits, including any deductibles, co-payments, annual and lifetime limits, and if pre-authorization is required. We will bill the carrier for you.
- Your co-pay is due at the time of service.
- You are responsible for all charges not paid by your insurance, including deductibles, co-payments, any uncovered charges, charges for missed appointments, etc.
- You are responsible for informing the front desk of any changes to your insurance coverage.

If you are covered by an Out of Network Provider Plan:

- The out of pocket payment is **due at the time of service.**
- After payment has been made and applied towards the billed services, we will provide you with an Insurance Invoice to submit to your insurance plan.

SIGNATURE

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above mentioned Health Insurance Providers, and hereby assign and convey directly to Free State Health and Wellness, LCC, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

PATIENT/GUARDIAN SIGNATURE DATE

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FINANCIAL AGREEMENT

PATIENT NAME DOB

1. PAYMENT RESPONSIBILITY

I understand that I am financially responsible for all charges incurred for services provided by Free State Health and Wellness, LLC, regardless of insurance coverage.

2. INSURANCE PATIENTS

If I have insurance coverage and choose to use it:

- I authorize Free State Health and Wellness, LLC, to bill my insurance company on my behalf. Free State Health and Wellness will only bill to our Contracted Provider Plans.
- I am responsible for verifying my mental health benefits, including copayments, coinsurance, deductibles, and session limits.
- I agree to pay:
  – copayment or coinsurance at the time of service.
  – Any deductible as determined by my insurance provider.
  – Any non-covered services or denied claims.
- I understand that insurance companies may not cover all services or may retroactively deny coverage.
- The fees discussed with Free State Health and Wellness, LLC, for all appointments are estimates and are not guaranteed, fees are subject to change upon submission to the insurance company according to provisions of your insurance policy.

PLEASE INITIAL

3. SELF-PAY (CASH PAY) PATIENTS

If I am not using insurance or choose to pay out-of-pocket:

- I agree to pay the full fee per appointment.
- Payment is due at the time of service by cash, credit/debit card, or other accepted payment methods.
- I may request a Superbill to submit to my insurance for possible reimbursement (if out-of-network benefits apply).

PLEASE INITIAL

4. CANCELLATIONS AND NO-SHOWS

- Appointments must be canceled or rescheduled at least 48 business hours in advance, not including weekends.
- I understand that I will be charged a late cancellation or no-show fee of $50.00.
- This fee is not covered by insurance and must be paid before the next session.
- I understand I will be discharged if I miss the initial appointment without 48 hours notice of cancellation.
- Dismissal from practice: if permitted by state law, you may be discharged as a patient from Free State Health and Wellness following 2 no-shows within a one year period (365 days).

PLEASE INITIAL

FreeState HEALTH & WELLNESS

FINANCIAL AGREEMENT

5. PAST DUE ACCOUNTS

- Unpaid balances over 90 days may be subject to collections.
- Free State Health and Wellness, LLC, reserves the right to suspend services for delinquent accounts until payment is made.

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have read, understand, and agree to the terms of this financial agreement. I authorize Free State Health and Wellness to charge my payment method on file for any balances due, if applicable.

PATIENT/GUARDIAN PRINTED NAME DATE

PATIENT/GUARDIAN SIGNATURE

NOTICE OF PRIVACY

FREE STATE HEALTH AND WELLNESS, LLC, NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 100 Middletown Pkwy., Unit 202, PMB 10, Middletown, MD 21769.

FreeState HEALTH & WELLNESS

NOTICE OF PRIVACY

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 100 Middletown Pkwy., Unit 202, PMB 10, Middletown, MD 21769 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

PATIENT/GUARDIAN SIGNATURE DATE

I hereby acknowledge that I have received and have been given and opportunity to read Free State Health and Wellness, LLC.'S Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Office Manager at 240-647-9049.

PATIENT SIGNATURE DATE

GUARDIAN SIGNATURE DATE

FreeState HEALTH & WELLNESS

AUTHORIZATION FOR RELEASE OF INFORMATION

NAME | DOB | SSN

ADDRESS | PHONE

I authorize Free State Health and Wellness, LLC, to:

☐ Release my health information to the below facility/clinician ☐ Receive my health information from the below facility/clinician

NAME OF PROVIDER/FACILITY | EMAIL

ADDRESS | PHONE | FAX

TYPE OF DISCLOSURE

☐ Verbal/Written/Electronic ☐ Copies of Record ☐ Letter

PURPOSE OF DISCLOSURE

☐ Ongoing treatment ☐ Academic ☐ Support ☐ Other

DESCRIPTION OF INFORMATION TO BE DISCLOSED

☐ Assessment ☐ Diagnosis ☐ Psychiatric Evaluation ☐ Medication Management Info ☐ Discharge ☐ 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-General4-301 et 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 Comments below.**

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

____ I understand that this information may be transmitted via written word, facsimile, or over the phone.

____ I understand authorization for this release of information can be revoked at any time. To revoke this authorization, I understand that I must provide a statement in writing with my request.

____ I understand that if I do not revoke this consent at any time, the consent will expire one year from the date of signing below.

____ **Comments regarding the release of information** (i.e. specific information you do not wish to be released):

REDISCLOSURE

I understand that there is the potential that the protected health information that is disclosed is pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

PATIENT NAME | DOB

PATIENT/GUARDIAN SIGNATURE | DATE

FreeState HEALTH & WELLNESS

TELEMEDICINE CONSENT

PATIENT NAME DOB

Telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different location than the healthcare provider. This may be for the purpose of diagnosis, treatment, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through the use of interactive video, audio or other telecommunications technology. Additionally, a physical examination of you may take place, and video, audio, and/or photo recordings may be taken.

All efforts will be made to utilize electronic systems with network and software security protocols to protect the privacy and security of health information and to safeguard the data against corruption. However, in order to ensure greater access to care while limiting the spread of COVID-19, the mode of communication used during your telehealth consultation may not be secure and may be subject to privacy risks.

ANTICIPATED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her location while the healthcare provider provides care from a distant site.
- Limiting the spread of COVID-19.
- More efficient medical evaluation and management.
- Ability to obtain consultation of a distant specialist.
- Conservation of personal protective equipment such as gloves and masks to reduce shortages for healthcare providers.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, it may be determined that the information transmitted is of poor quality, requiring a face to face visit or rescheduled telemedicine visit. This may cause a delay in medical evaluation/treatment.
- Security protocols could fail or not be available, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to all of your medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:

1. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
2. I understand that all efforts will be taken to protect the privacy and security of health information, and that no information obtained in the use of telemedicine which identifies me will be intentionally disclosed to researchers or other entities without my authorization.
3. I understand that during the COVID-19 pandemic, security measures may be lessened in accordance with U.S. Department of Health and Human Services (HHS) to ensure improved access to care.
4. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time without affecting my right to future care or treatment.

FreeState HEALTH & WELLNESS

TELEMEDICINE CONSENT

5. I understand there may be technological challenges that prevent recording the telemedicine interaction during the COVID-19 pandemic, but that I have the right to inspect all information obtained and successfully recorded and may receive copies of this information for a reasonable fee.
6. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My healthcare provider has explained the alternative to my satisfaction.
7. 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 healthcare provider and consulting healthcare provider in order to operate the video equipment. The above-mentioned people will all 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 telemedicine examination room; and/or (3) terminate the consultation at any time.
8. I understand that certain fees for service may be waived during the COVID-19 pandemic depending on my insurance carrier. While all efforts will be made to follow guidelines during this fluid situation, I may be responsible for any copayments or coinsurances that apply, and if my medical insurance coverage is not sufficient to satisfy any excess cost, I will be responsible for payment.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine during the COVID-19 pandemic. I have discussed and had an opportunity to ask my healthcare provider questions. All of these questions have been answered to my satisfaction.

SIGNATURE

I have read and understand the information provided above regarding telemedicine during the COVID-19 pandemic. I have discussed and had an opportunity to ask my healthcare provider questions. All of these questions have been answered to my satisfaction.

- ◯ I consent to telehealth services with Free State Health and Wellness
- ◯ I DO NOT consent to telehealth services with Free State Health and Wellness

PATIENT/GUARDIAN SIGNATURE DATE

FreeState HEALTH & WELLNESS

AI VIRTUAL SCRIBE CONSENT

PATIENT NAME DOB DATE

PURPOSE OF THIS CONSENT

At Free State Health and Wellness, we are committed to providing high-quality care while using technology to support your mental health treatment. This consent form explains the use of an AI-powered virtual scribe during your sessions. The purpose of this tool is to assist your provider with clinical documentation, allowing them to focus more on you during your visit.

WHAT IS AN AI VIRTUAL SCRIBE?

An AI virtual scribe is a secure, HIPAA-compliant software tool that helps generate clinical notes from sessions by:

- Transcribing or summarizing relevant information.
- Assisting providers in creating accurate medical records.
- Reducing time spent on documentation after your visit.

The scribe does not make medical decisions, and your provider reviews and approves all notes before they are finalized.

HOW YOUR INFORMATION IS PROTECTED

- The AI tool used by Free State Health and Wellness is HIPAA-compliant and meets industry security standards.
- No data is sold or used for advertising.
- Only authorized providers and staff may access the generated notes.
- You will not be recorded without explicit consent (if recordings are involved).

YOUR RIGHTS

- Participation is voluntary. You may choose to opt out of AI-assisted documentation at any time without affecting your care.
- You may ask your provider how your information is being used.
- You have the right to request a copy of your clinical notes.

CONSENT AND ACKNOWLEDGMENT

By signing below, I acknowledge and understand the following:

- I have been informed about the use of an AI virtual scribe.
- I understand how my protected health information (PHI) may be used to assist in documentation.
- I understand that the AI tool is not a substitute for professional medical care and does not make treatment decisions.
- I understand that I may revoke this consent in writing at any time.

FreeState HEALTH & WELLNESS

AI VIRTUAL SCRIBE CONSENT

SIGNATURE

- ◯ I consent to telehealth services with Free State Health and Wellness
- ◯ I DO NOT consent to telehealth services with Free State Health and Wellness

PATIENT SIGNATURE DATE

PROVIDER/WITNESS SIGNATURE DATE

FreeState HEALTH & WELLNESS

CONTROLLED SUBSTANCE AGREEMENT

PATIENT NAME | DOB

PROVIDER NAME | DATE

PURPOSE

The purpose of this agreement is to ensure safe, effective, and legally compliant treatment involving controlled substances (medications classified under DEA Schedules II–V). These medications can help with certain psychiatric conditions, but they also carry risks, including misuse, dependence, and diversion. This agreement outlines mutual responsibilities between the patient and provider.

MEDICATIONS COVERED BY THIS AGREEMENT

This agreement applies to medications such as:

- Stimulants (e.g., Adderall, Vyvanse, Ritalin)
- Benzodiazepines (e.g., Xanax, Ativan, Klonopin)
- Sleep Aids (e.g., Ambien)
- Other Schedule II–V medications prescribed for mental health conditions

PATIENT RESPONSIBILITIES

By signing this agreement, I agree to the following:

1. Use Medication Only as Prescribed

- I will take the medication exactly as directed by my provider.
- I will not increase the dose or take extra medication without approval.

2. One Pharmacy Policy

I will use only one pharmacy to fill my controlled substance prescriptions:

PHARMACY NAME | PHONE

3. One Prescriber Policy

- I will not obtain controlled substances from any other prescriber unless authorized by Free State Health and Wellness.
- I will notify Free State Health and Wellness of all medications prescribed by other providers.

4. PDMP Monitoring

- I understand my provider will regularly check the Maryland Prescription Drug Monitoring Program (PDMP) to monitor for overlapping or inappropriate prescriptions.

5. Urine Drug Screening

- I agree to periodic or random urine drug screens (UDS) to ensure appropriate use of medications.
- I understand a positive UDS for unapproved substances or negative for the prescribed medication may result in discontinuation.

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CONTROLLED SUBSTANCE AGREEMENT

6. No Early Refills or Replacements
- I understand early refills, replacements for lost/stolen medication, or missed appointments may result in denial of medication.
- I will keep medications in a secure location to prevent theft or loss.

7. Appointment Compliance
- I will attend all scheduled follow-up appointments as dictated by the provider (usually every 30–90 days).
- Failure to follow up may result in a pause or discontinuation of prescriptions.

8. No Sharing or Selling
- I will never share, sell, or trade my medication. Doing so is illegal and grounds for immediate discontinuation of care.

9. Tapering or Discontinuation
- I understand that if the risks outweigh the benefits, or if I violate this agreement, my provider may discontinue the medication gradually and off er alternative treatments.

10. I understand that controlled substances can not be sent to pharmacies outside of Maryland.

PROVIDER RESPONSIBILITIES

Your provider agrees to:
- Prescribe medications safely and appropriately.
- Monitor your progress and assess risks versus benefits at each visit.
- Provide alternatives if medication is not effective or appropriate.
- Explain the risks, side effects, and safe use of medications.
- NOT continue medications prescribed by others unless they are safe and the best option for my diagnosis. Medications during transfer of care are not guaranteed to be continued at the discretion of the provider.

ACKNOWLEDGMENT AND CONSENT

I have read and understand this agreement. I understand that violating this agreement may result in discontinuation of controlled substance prescriptions and possibly discharge from care at Free State Health and Wellness..

PATIENT SIGNATURE DATE

PROVIDER SIGNATURE DATE

FreeState HEALTH & WELLNESS

PATIENT MEDICAL INTAKE FORM

PATIENT INFORMATION

PATIENT NAME _____ DOB _____

DATE OF VISIT _____ PHONE _____

EMAIL _____

1. REASON FOR VISIT

_____

2. PAST MEDICAL HISTORY (PLEASE CHECK ANY CONDITIONS YOU HAVE BEEN DIAGNOSED WITH)

- ☐ Hypertension (High Blood Pressure)
- ☐ Diabetes (Type 1 or 2)
- ☐ High Cholesterol
- ☐ Heart Disease / Heart Attack
- ☐ Stroke / TIA
- ☐ Asthma
- ☐ COPD / Emphysema
- ☐ Cancer / Type: _____
- ☐ Kidney Disease
- ☐ Liver Disease / Hepatitis
- ☐ Thyroid Problems
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis / Autoimmune Disease
- ☐ Seizure Disorder
- ☐ Concussions / History of Head Injury
- ☐ Other: _____

3. SURGICAL HISTORY (LIST ANY SURGERIES YOU'VE HAD AND DATES, IF KNOWN.)

_____

_____

4. PREGNANCY HISTORY (IF APPLICABLE)

Are you currently pregnant? Yes ☐ No ☐ Not Sure ☐

Are you hoping to become pregnant? Yes ☐ No ☐ Not at this time ☐ Prefer not to answer ☐

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PATIENT MEDICAL INTAKE FORM

5. CURRENT MEDICATIONS (INCLUDE PRESCRIPTION MEDICATIONS, OVER-THE-COUNTER DRUGS, VITAMINS, AND SUPPLEMENTS.)

Medication Name	Dosage	Frequency	Reason

6. ALLERGIES (CHECK ALL THAT APPLY AND DESCRIBE THE REACTION.)

☐ No Known Drug Allergies

☐ Penicillin / Antibiotics—Reaction: _____

☐ Latex—Reaction: _____

☐ Food Allergies—Reaction: _____

☐ Other: _____

SIGNATURE

PATIENT SIGNATURE DATE

FreeState HEALTH & WELLNESS

CONSENT TO MEDICAL CARE

By my signature or electronic signature below, I voluntarily consent that I (or my child) will participate in a mental health evaluation and treatment by clinical staff at Free State Health & Wellness, LLC. I understand that the practice of psychiatry is not an exact science, and that there are risks and benefits associated with receiving psychiatric treatment. I acknowledge and agree that no guarantees are made to me concerning the results and outcomes of the mental health evaluation and treatment rendered to me (or my child) by the clinical staff at Free State Health & Wellness, LLC. I understand that Free State Health and Wellness does not offer crisis services, operate on a 24/7 basis, or maintain on-call providers. In the event of an emergency, I will proceed to the nearest emergency room or dial 9-1-1 immediately.

Free State Health and Wellness will only provide treatment to those who consent for this service.

1. I voluntarily consent to participate (or allow my child to participate) in a mental health evaluation and subsequent treatment (as deemed medically appropriate and necessary) conducted by clinical staff at Free State Health & Wellness, LLC. I understand that following the evaluation and/or treatment, information will be provided to me concerning each of the following areas:

a. The benefits of the proposed treatment;

b. Alternative treatment modes and services available;

c. The manner in which treatment will be administered;

d. Potential side effects from treatment and/or risks of side effects from medications (when applicable);

e. Probable consequences of not receiving treatment. The evaluation and treatment will be conducted by a licensed Nurse Practitioner. Treatment will be conducted within the boundaries of Maryland State Law.

2. Benefits of Psychiatric Evaluation and Treatment:

Evaluation and treatment may be conducted by psychiatric and psychological interviews, psychological assessment or testing, psychotherapeutic interventions and medication management. It may be beneficial to me, as well as any referring professional, to understand the nature and cause of any difficulties affecting daily functioning, so that appropriate recommendations and treatments may be offered. Uses of the evaluation include, but are not limited to, diagnosis, evaluation of recovery or treatment, estimating prognosis, education and rehabilitation planning. Possible benefits of treatment include: Improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. Charges:

Fees are based on the length or type of evaluation or treatment, which are determined by the nature of the service deemed appropriate and/or necessary by clinical staff at Free State Health & Wellness. I agree to be responsible for any charges not covered by insurance, including deductibles, co-insurance, copayments, late cancellation fees, no-show fees, and fees related to administrative services, such as the completion of disability evaluations, unemployment forms, and copying medical records. I agree that if I am a self pay patient, I will pay for the appointment prior to the scheduled appointment time. I understand if payment is not made, my appointment may be canceled.

*Please Note: The request for administrative services and the completion of clinical paperwork (copying medical records/documents, unemployment forms, disability evaluations, school forms, etc.) may take 7–10 business days to be completed depending on the nature of the request. A cost-based fee will be associated with these requests depending on the size and nature of the service. Refer to Form Completion Policy and Fees.

4. Confidentiality, Harm and Inquiry:

Information from my (or my child's) evaluation and treatment is contained in a confidential medical record at Free State Health & Wellness, LLC. I consent to disclosure and use of this information by Free State Health & Wellness, LLC for the purpose of continuity of care. In accordance with Free State Health & Wellness' Privacy Practices and Patient Rights, and Maryland State Law, all patient information will be kept confidential with certain exceptions, including, without limitation, the following:

FreeState HEALTH & WELLNESS

CONSENT TO MEDICAL CARE

a. The patient presents an imminent danger to self or others.

b. There are reasonable concerns of abuse or neglect of a child or vulnerable adult.

c. A court order or subpoena is issued.

5. Right to Withdraw Consent:

I have the right to withdraw my consent for evaluation and treatment (for myself or my child) at any time by providing a written request to Free State Health & Wellness, LLC.

- I voluntarily consent to participate in (or allow my child to participate in) evaluation and subsequent treatment as deemed medically appropriate and necessary by clinical staff at Free State Health & Wellness, LLC.
- I attest that I have the right to consent to evaluation and treatment (for myself or my child).
- I will complete the associated Parental Consent for Treatment if I am consenting to the evaluation and treatment of a minor under the age of 16.
- I have read this form in its entirety or had this form read/explained to me in its entirety.
- I fully understand its contents, including the potential risks and associated benefits of participating in psychiatric evaluation and treatment.
- I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand that I have the right to ask questions about the above information at any time.
- I understand that I have the right to withdraw my consent for evaluation and treatment (for myself or my child) at any time and I understand how to do so.

6. Mutual Respect:

At Free State Health and Wellness, we strive to maintain a professional and respectful relationship between our patients, their families, and staff. Respect is paramount in providing a safe and therapeutic environment for all. Any behavior deemed disrespectful or threatening towards our staff will not be tolerated. We kindly ask all patients to communicate through the appropriate channels provided by Free State Health and Wellness for any inquiries or concerns. Inappropriate behavior, including contacting providers at their homes or via social media platforms, is not acceptable and may result in immediate discharge from treatment. Your cooperation in adhering to these guidelines ensures a safe environment for all. We appreciate your support in fostering a respectful atmosphere for everyone's well-being.

SIGNATURE

I, the undersigned, herby certify that I have provided correct information about the patient during registration. I understand that any false statements or concealment of material fact may be prosecuted under applicable federal and state laws. I certify that I have read, fully understand, and accept the above information, terms, and conditions. I, the undersigned, further certify that I am legally authorized as the patient, or as the patient's parent or legal guardian, to execute the above and to accept its terms.

PATIENT/GUARDIAN PRINTED NAME DATE

PATIENT/GUARDIAN SIGNATURE

FreeState HEALTH & WELLNESS

CONSENT FOR TELEPHONE, EMAIL & SMS TEXT MESSAGING

I hereby authorize my clinician and other staff at Free State Health and Wellness to communicate with me via the following methods:

☐ Email

☐ Telephone (Including Voicemail)

☐ Standard SMS Text Messaging

I understand and consent to have my clinician and other staff at Free State Health and Wellness communicate with me by email, telephone (including voicemail), or standard SMS text messaging, as specifically indicated above, regarding various aspects of my medical care. This may include, but is not limited to, scheduling, appointments, billing, mental health treatment, and other private, protected, and confidential health information.

I acknowledge that while Free State Health and Wellness will make every effort to limit the amount of protected health information shared outside of the EHR, and to ensure my privacy and confidentiality as best as possible, email, telephone, and standard SMS text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email, telephone, and standard SMS text messaging regarding my medical care might be intercepted and read by a third party.

SIGNATURE

PATIENT SIGNATURE DATE

FreeState HEALTH & WELLNESS

REFILL POLICY

In compliance with the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) standards of care and applicable state regulations, Free State Health and Wellness is unable to authorize more than a one-week medication refill if you have not had an appointment within the past three months.

To ensure continuity of care, we kindly request that you contact our office to schedule an appointment. Once your appointment is confirmed, administrative staff will notify your provider, who will issue an additional medication refill to cover your needs until the date of your scheduled visit.

Thank you for your attention to this matter.

To contact our office, please call 240-647-9049.

SIGNATURE

PATIENT SIGNATURE DATE

FreeState HEALTH & WELLNESS

FORM COMPLETION POLICY & FEES

Free State Health and Wellness is devoted to providing comprehensive and well-coordinated care. The completion of medical forms can be a time- consuming process, often requiring careful review of medical records and detailed documentation. The form completion policy and associated fees help us cover the costs associated with completing various forms, ensure that forms are returned to patients in a timely manner, and allow us to maintain the quality of our services.

To help us better serve your needs, please be aware of the following:

GUIDELINES

- Payment is due at the time of request. Forms will not be completed or returned until payment is received.
- Most forms, including, but not limited to disability, FMLA, school, or employment accommodations, will require an appointment unless the patient has been seen by the treating provider within the 90 days.
- Patients may be asked to schedule a follow-up appointment to complete forms depending on the length and complexity of documentation needed.
- Ensure that any patient/parent portions of the form are completed before submitting it.
- Ensure that all pages of the form are included in your submission.
- Forms completed during a patient appointment and paperwork resulting from changes initiated by treatment plan adjustments will not be subject to completion fees.
- Most forms will be completed and returned within 7-10 business days (not including weekends and holidays). More complex forms may require additional processing time.
- An expedited form fee of $25.00 will be charged for any forms needed in less than 5 business days.

SUBMISSION

Forms can be submitted the following ways:

1. Bring forms to a scheduled follow-up patient appointment (if time allows) or schedule an appointment to complete forms.
- Please send the form to your provider via the “info@freestatehw.com” email address prior to your appointment.
- No fee will be charged if forms are completed during an appointment.

2. Drop off forms to Free State Health and Wellness 365 W. Patrick St., Fl 205, Frederick, MD 21701

3. Send forms via email or fax:
- Email: info@freestatehw.com
- Fax: 240-690-6095

FEES

- School/camp forms (1 page): $10.00
- Diagnosis verification letter (1 page): $10.00
- Accommodation letter (1 page): $10.00
- Disability/ accommodation form (school, work, government, etc.): $50.00
- FMLA form: $50.00

FreeState
HEALTH & WELLNESS

FORM COMPLETION POLICY & FEES

- Extensive diagnosis verification letter (>1 page): $50.00
- Expedited form fee: $25.00
- Other forms: Cost will be determined based on the complexity of the form and provided to you prior to completion.

PAYMENT

- Upon receiving the forms, our administrative team will review them and determine the associated fees.
- An invoice will be generated and sent in response.
- The invoice must be paid before forms are completed.
- Unfortunately, these fees are not covered by health insurance plans, as they are considered administrative in nature. We recommend contacting your insurance provider for more information.

SIGNATURE

PATIENT SIGNATURE DATE

MENTAL HEALTH CRISIS RESOURCES FOR MARYLAND RESIDENTS

Free State Health and Wellness does not offer crisis services, operate on a 24/7 basis, or maintain on-call providers. If you or someone you know is experiencing a mental health crisis that requires immediate attention, dial 9-1-1 for emergency assistance.

National Suicide Prevention Lifeline

- Call: 1-800-273-TALK (1-800-273-8255)
- Text: "HELLO" to 741741
- This hotline provides free, confidential support for people in distress and can connect you to local resources.

National Suicide & Crisis Lifeline

- Call: 988
- Website: 988lifeline.org
- Call, text, or chat. This lifeline provides 24/7, free and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals in the United States.

Maryland Crisis Hotline

- Call: 1-800-422-0009
- This statewide hotline offers crisis intervention and referral services 24 hours a day, 7 days a week.

Mobile Crisis Teams

- Maryland Crisis Response System (MCRS):
- MCRS provides rapid response to individuals experiencing a behavioral health crisis.
- Call: 1-800-422-0009
- Trained crisis counselors will come to your location to assess the situation and provide support.

Local Mental Health Authority (LMHA)

- Each county in Maryland has a designated LMHA that offers mental health services, including crisis intervention and counseling.
- Contact your local health department or visit the Maryland Department of Health website for information on your LMHA.

Community Mental Health Centers

- Many communities in Maryland have community mental health centers that provide a range of services, including crisis intervention, counseling, and support groups.
- Search online or contact your local health department for information on centers in your area.

Crisis Response Services by County

- Howard County: (410) 531-6677
- Anne Arundel County: (410) 768-5522
- Montgomery County: (240) 777-4000
- Baltimore County: (410) 931-2214
- Baltimore City: (410) 433-5175
- Frederick County:(301) 662-2255
- Prince George's County: (301) 429-2185
- Harford County: (410) 638-5248

Additional Resources

Maryland Behavioral Health Administration (BHA):

- Website: bha.health.maryland.gov
- BHA provides information and resources on mental health and substance use disorder services in Maryland.

211 Maryland

- Dial 2-1-1 or visit 211md.org
- 211 Maryland is a helpline that connects individuals to community resources, including mental health services, housing assistance, and more.

National Alliance on Mental Illness (NAMI) Maryland

- Website: namimd.org
- NAMI Maryland offers support, education, and advocacy for individuals and families affected by mental illness.