MAITRI
MENTAL HEALTH

Welcome to Maitri Mental Health (MMH)!

Our team provides mental healthcare and services for the body, mind, and spirit that are fundamental to an integrated healthcare system. We seek to make positive and profound impact upon those we serve and strive to contribute to the total health, security, and quality of life in our community. In doing so, we are dedicated to innovative services and best practices. We utilized research in realms of neuroscience, genetics, mind-body integration, and contemplative approaches. We are honored to have you with us!

Below, you will see a checklist, which serves two purposes: 1) it provides an overview of each form within this packet; and 2) it ensures that no paperwork is missed during the first step of this process. Please read and complete the enclosed forms and submit them to frondesk@mmh.hush.com prior to your first appointment.

Please take your time to read and ensure your understanding of all that is written within this packet. A therapeutic relationship works, in part, because of the clearly defined rights and responsibilities held by each person that are fully understood. This frame helps to create the safety to take risks and the support to become empowered to create change. Should you have any questions, you are welcome to discuss them with your therapist.

Intake Packet Checklist

These are the primary forms to be completed and submitted prior to your intake session:

Client Registration Form	Provides us with your basic demographic, contact, and payment information.
Informed Consent to Mental Health Services	Allows Maitri to provide services/treatment only with your consent, while detailing rights/responsibilities and benefits/risks of treatment
Financial Responsibility and Authorization to Disclosure of Protected Health Information (PHI)	Makes clear financial roles of you and your insurance company, while allowing us to share certain information with your insurance company (e.g. inquiring about benefits, filing claims on your behalf)
On File Credit Card Authorization Form	Authorizes Maitri to process payment at the time of your appointment using a card stored on file
Private Pay Agreement - Optional	To be completed only if you are electing to engage in services without the use of insurance coverage: serves as the payment agreement between you and your provider
Attendance and Engagement Policy	Provides information on engagement in mental health services, cancellation policies, inclement weather, and termination of services
Medication Management Policy	Details our approach to prescribing, information about specific types of medications/refills, and payment/attendance/termination with medication prescribers
Telementalhealth Agreement	An informed consent addendum due to COVID-19: clarifies risks/benefits of engaging in services using telehealth options (e.g. video therapy, phone calls)

These forms are enclosed, but are yours to keep:

HIPAA Notice of Privacy Policies	Provides information on your rights under the Health Insurance Portability and Accountability Act (HIPAA)
Release of Information	Enables your provider/Maitri to release or obtain protected health information, upon completion
Comment, Compliment, or Complaint	Allows your feedback to be heard and addressed as needed

Finally, please bring your ID and your insurance card with you to your first appointment. Thank you!

MAITRI
MENTAL HEALTH

CLIENT REGISTRATION FORM

Date: _____

Basic Information

Full Legal Name: _____ I identify my gender as: _____

I prefer to be called: _____ _ Pronouns: _____

Date of Birth: _____

Direct Contact Information

Address (Street, City, State, Zip): _____

Primary Phone Number: _____ May we leave you a voicemail? _____

Secondary Phone Number: _____ May we identify ourselves in a voicemail? _____

Email address: _____

Preferred Method of Contact / Time of Day to Be Contacted: _____

Emergency Contact Information

Name: _____

Phone Number: _____

Relationship with You: _____

Payment Information

Will you be paying for sessions out of pocket or using insurance? (Circle one)

Private Pay	Bill My Insurance	Another benefit plan (please specify)

MAITRI
MENTAL HEALTH

Informed Consent to Mental Health Services

MENTAL HEALTH SERVICES: At Maitri Mental Health, we offer individual, couple, family, and group therapy in a variety of approaches; peer support services, and medication management. These services are available for adults and in some cases offered to adolescents, all of which are voluntary for those who participate. Our service providers individually choose which insurances they accept, which may allow your insurance to cover your services. The general flow the first few sessions involve a comprehensive evaluation of your treatment needs/goals and the creation an initial and personalized treatment plan. From there, mental health services will follow this agreed upon plan (should you choose to continue). Mental health services require a very active effort on your part. In order to be most successful, you will have to work on things that we discuss outside of sessions.

RISKS AND BENEFITS: Mental health treatment has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Mental health treatment often requires discussing unpleasant aspects of your life. Benefits often include significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. There are no guarantees about what will happen, however.

RIGHTS AND RESPONSIBILITIES: As a client engaging in mental health services, you have certain rights and responsibilities that are important for you to know about. We, as therapists, have corresponding responsibilities to you. The most important of which is the quality of the therapeutic relationship. Mental health services involve a large commitment of time, money, and energy. As such, you should be very mindful about the provider you with whom choose to work. If you have questions or concerns about your provider's procedures, you have the right *and* responsibility ask to discuss them whenever they arise. You also have the right to speak with Maitri Mental Health's Clinical Supervisor, Jessica Boldt, about any concerns you may have.

Beyond this, your rights as a client at Maitri Mental Health include:

- To be treated with dignity and respect
- To have access to your treatment plan
- To choose from and receive available supports and services consistent with this plan
- To participate in the development of your treatment plan and receive a copy
- To have all services explained, including expected outcomes and possible risks
- To confidentiality and the right to consent to disclosure in accordance with state codes
- To give informed consent in writing prior to the start of services
- To access your medical records
- To receive medications specific to your diagnosed clinical needs
- To receive prior notice of service conclusion or transfer, unless it poses a threat to safety or health
- To be free from abuse/neglect and to report any incident of abuse/neglect without being subject to retaliation
- To receive services without discrimination based upon race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment.
- To be free from seclusion and restraint
- To be informed of the policies and procedures, service agreements, and fees applicable to the services provided
- To have family involvement in service planning and delivery
- To file a grievance in regards to any and all services received (please see attached Comment, Compliment, or Complaint Form)
- To choose a provider and make changes as necessary
- To receive notice if your appointment has been cancelled in a timely manner

As a client of Maitri Mental Health, you have the following responsibilities:

- To treat staff and others clients with dignity and respect
- To inform your provider of any changes in your behavior, physical health, or mental health that could affect your care, including adherence to your prescribed medication regimen
- To help your provider obtain past medical records
- To ask questions and get clarification regarding any diagnosis or treatment planning
- To follow your provider's recommendations, as appropriate
- To be prompt for scheduled appointments
- To cancel appointments if you are unable to keep them in a timely manner
- To pay at the time of services rendered or to inform staff of financial hardships
- To be as open and honest with your provider as you can
- To inform your provider if you feel you aren't making progress
- To adhere to the policies and procedures of Maitri Mental Health
- To be aware of any insurance changes that may have occurred for you

Above all, Maitri is a strives to create a safe place for all involved in the healing process – both provider and clients. All involved have the right to peaceful engagement in this process.

CONFIDENTIALITY: The guiding law of confidentiality for our services at Maitri Mental Health is the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. This Notice of Privacy Practices explains HIPAA and its application to your personal health information in greater detail and our practice is in general accordance with HIPAA policies. The law requires that we obtain your signature acknowledging that we have provided you with this information.

There are times in which we must break confidence (as required by law), times where we may need to break confidence to promote the greatest level of safety possible, and smaller disclosures to ensure quality and continuity of care. Please see the form titled HIPPA Notice of Privacy Practices for greater detail.

When disclosure is Required by Law: Disclosure is required by law when there is a reasonable suspicion of abuse or neglect of a child, dependent, or elderly person. It is also required when a client: presents a danger to themselves, to others, or to property; is gravely disabled; or when client's family members communicate to the therapist that the client presents a danger to others.

When Disclosure May be Required: Disclosure may be required in a legal proceeding by or against you. If you place your mental status at issue in litigation by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist. Additionally, in couple and family therapy, confidentiality and privilege do not apply between the couple or among family members unless otherwise agreed upon or if the revelation of confidential information would risk the safety of one or more individuals. Your therapist will not release records to any outside party unless authorized to do so by all adult family members who were part of the treatment. In all these situations your therapist will use their clinical judgment when revealing such information.

Emergencies: If there is an emergency during your work in therapy, where your therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychological care, they will do whatever they can, within limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose your therapist may also contact the person whose name you have provided on the patient information document.

E-mails, Cell Phones, Computers and Faxes: It is very important to be aware that computers, e-mail, cell phone and fax communication can be relatively easy to access by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. Your therapist's e-mails are not encrypted, their computers, however, are equipped with a firewall, virus protection and a password. Please notify your therapist if you decide to avoid or limit, in any way, the use of any or all communication devices, such as e-mail, cell phone or fax. Please do not use e-mail or faxes for emergencies.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in your or at any other proceeding. Additionally, therapy records will not be released without prior agreement between your therapist and you.

Records and Your Right to Review Them: Both the law and the standards of our practice require that appropriate treatment records be kept. All information disclosed in sessions and the written records pertaining to said sessions are confidential and may not be revealed to anyone without your consent. As a client, you have the right to review or receive a summary of your records. There are times, however, when your therapist may request to withhold these documents such as limited legal or emergency circumstances or when they believe that releasing such information might be harmful in any way. In such a case they may provide the records to an appropriate and legitimate professional of your choice. Taking the above-mentioned circumstances in consideration, if appropriate, upon your request your therapist will release information to any agency/person you specify.

Mediation & Arbitration: All disputes arising out of, or in relation to these services shall be referred to mediation, before, and as a pre-condition to the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of your therapist and you, the client. The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this a shall be submitted to and settled by binding arbitration in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Again, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, your therapist can us legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum and for attorney fees. In the case of arbitration, the arbitrator determines that sum.

Office Staff: On occasion, MMH utilizes volunteers or interns to assist in clerical and office work, including filing, scheduling and billing. These volunteers/interns maintain all information confidential and will never disclose information to any outside party without expressed written consent. Each volunteer/intern signs a confidentiality agreement on a yearly basis and is trained about confidentiality and HIPAA laws.

Your signature indicates you have read, agree to and understand the above information. You may revoke this agreement in writing at any time. That revocation will be binding on me unless we have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

Client Signature _____ Date ___/___/_____

Client Signature _____ Date ___/___/_____

MAITRI
MENTAL HEALTH

Financial Responsibility and Authorization to Disclosure of Protected Health Information (PHI)

Financial Responsibility: I accept financial responsibility for all services rendered on my behalf for which a charge is associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services as dictated by my insurance coverage (which may include, but are not limited to: telephone conversations, site visits, report writing, consultation with other professionals, reading records, longer sessions, travel time, and court appearances). Such non-covered services will charged at the same hourly rate, unless indicated and agreed upon otherwise. I am aware that payments are due at the time of service and that co-pays cannot be billed to me or anyone else. I am aware that there will be no refunds for payments made for services rendered.

Financial Hardship: I am aware that it is my responsibility to notify my therapist if any changes arise in my ability to make timely payments so that alternative payment plans may be created. I am aware that if my account is overdue (unpaid) and there is no written agreement on a payment plan, Maitri Mental Health can use legal or other means (courts, collection agencies, etc.) to obtain payment. Should you elect to pay by check, you are responsible to ensure that sufficient funds are available to cover the expense. Should a check be returned as un-payable due to insufficient funds, or any other reason, you are responsible for any fee charged to the account by the banking institution as well as the cost of the initial service. In addition, a $25.00 fee will be charged on all returned checks.

Consent to Internal Disclosure of PHI: I understand that Maitri Mental Health is a collaborative, integrative practice that uses a team-based approach to care. As such, I consent to my therapist/care provider consulting with other professionals regarding my care with the expectation that only the least amount of information is provided in this process. However, my health record may be shared.

Consent to External Disclosure of PHI: I consent to disclosure of confidential information that may be required by my health insurance carrier or HMO/PPO/MCO/ EAP in order for Sunrise Medical Billing – a billing company external to Maitri Mental Health, with whom MMH works - to process billing claims. I am aware that I may request that the least amount of information be released to my therapist / care provider. I am also aware that my therapist / care provider has no control or knowledge over what insurance companies do with the information submitted or who has access to this information. If I elect not to use insurance, a Private Pay Agreement must be signed. All other forms of external disclosure of PHI must be accompanied by a completed Release of Information (included in this packet).

Potential Risks of Insurance Reimbursement: I am be aware that submitting a mental invoice for reimbursement ("superbill") carries a certain amount of risk. Not all issues/conditions/problems dealt with in therapy are reimbursed by insurance companies. It is ultimately my responsibility to verify the specifics of my coverage.

By signing this document, I am consenting to all of the terms and policies indicated above.

Client Signature _____ Date ___/___/_____

Client Signature _____ Date ___/___/_____

MAITRI
MENTAL HEALTH

PRIVATE PAY AGREEMENT

Date: _____

By signing below, both the client and therapist acknowledge and agree to adhere to the private pay agreement for services as follows:

Amount per session: _____

Therapist name: _____

Client name and MR#: _____

Name of parent/guardian (if minor): _____

We also understand that insurance will not be billed for these services. Either party – therapist or client - may terminate this private agreement at any time. Notice must be made 24 hours before any scheduled appointments or the full cash-pay amount becomes due to the therapist by the client.

All payments must be made in cash, check, or credit card and provided to / processed at the front desk at the time of the appointment. We accept MasterCard and Visa. Checks should be payable to Maitri Mental Health, not the therapist's name.

If a payment is missed, the billing account must be brought current with either payment or another arrangement before the next session occurs.

Client or Parent/Guardian Signature:

_____

Client or Parent/Guardian Signature:

_____

Therapist Signature:

_____

MAITRI
MENTAL HEALTH

ON FILE CREDIT CARD AUTHORIZATION FORM

Provider Name:_____ Date: _____

Client Printed Name: _____

Maitri Mental Health (MMH) is authorized to maintain credit card payment information in our electronic health record, which is confidential. Please complete this form with the appropriate information for ease of payment and ability to charge for services rendered.

Your signature authorizes us to review this information and deduct fees from the credit card below for services received at MMH. You must sign to authorize use of this credit card.

Please note: We only accept MasterCard or Visa at this time.

Cardholder Name (as printed on credit card):

_____

Cardholder Signature:

_____

Cardholder Address & Zip Code:

_____

Credit Card Number:

_____

Expiration Date/CCV:

_____

List any Additional Authorized Users of this Card:

_____

MAITRI
MENTAL HEALTH

Release of Information (ROI)

Client Name: _____ Date of Birth: _____

With my signature below, I authorize _____ and Maitri Mental Health to:
(Provider's Name)

- ☐ **OBTAIN** information from
- ☐ **DISCLOSE** information to

Contact Person / Organization: _____
Physical Address: _____
_____
Telephone Number: _____
Fax Number: _____

Information to be used/disclosed is my protected health information, including:

- ☐ Assessment/Evaluation
- ☐ Treatment Plan
- ☐ Progress Notes
- ☐ Information to Support Coordination of Care
- ☐ Dates of Sessions – attended and not
- ☐ Other: _____

The purpose of the disclosure/communication is:

- ☐ Coordination of care
- ☐ Other: _____

I understand that additional laws about mental health, HIV/AIDS, genetic, and alcohol/drug treatment information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space.

Initial all types of information you would like to be released:

_____ Mental Health information
_____ Drug/alcohol diagnosis, treatment, or referral information
_____ HIV/AIDS information
_____ Genetic testing information

I understand that I am not required to sign this authorization. If I refuse to sign it, it will not prevent me from getting treatment at Maitri Mental Health. I understand that I may revoke this authorization at any time, in writing. If I do so, the information described may no longer be used or disclosed for the reasons described here. If Maitri has already received such information, it cannot be undone and will remain in your file. I understand that the information used or disclosed as a result of this authorization may be re-disclosed and no longer protected under federal law. However, state and federal laws may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

Unless revoked, this authorization expires 60 days after the completion of treatment or on this date:

_____

My signature below indicates that I have read and understood this authorization.

Client Signature/Date: _____

Parent/Guardian/Representative Signature/Date: _____

Signature of Witness/Date: _____

MAITRI
MENTAL HEALTH

Attendance and Engagement Policy

Attendance: Regular attendance is an essential element of successful, effective treatment. It assists clients in reaching goals and maintaining health gains. The frequency of your sessions will be agreed upon by you and your provider. The typically frequency when beginning treatment is weekly to every other week, becoming more spread out as time goes on.

Telephone & Emergency Procedures: If you need to contact your therapist between sessions, please leave a message with the front desk and your call will be returned as soon as possible. Messages are checked a few times during the daytime hours of weekdays only. If an emergency situation arises, indicate it clearly in your message, and if you are dealing with an emergency needing immediate assistance and cannot reach your therapist, call 911. Do not use e-mail or faxes for emergencies.

Cancellation/No Show Policy: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. If you arrive more than 10 minutes late for a 30 minute session or 15 minutes late for a 60 minute session, this will be considered as "no show," as providers no longer have adequate time to provide treatment. In both the instance of a late cancellation or a no show, the client will be responsible for 100% of the session fee.

Inclement Weather: In the event of inclement weather, where travel is not advised, the 24 hour cancellation notice policy will be waived and no late cancellation fees will be applied. However, in the event that you are not contacted by Maitri staff regarding your appointment and plan not to attend due to weather, we request that you contact the front desk via phone or email to express this.

Termination: Termination is an element in every therapeutic relationship, no matter the duration. It can happen in several ways. You have the right to terminate treatment at any time. You provider also has the right to terminate treatment. Ultimately, your Maitri provider has a responsibility to determine whether or not they can be helpful to you and this will be the deciding factor in termination for the provider. Maitri providers have the right to terminate the provider-client relationship under the following circumstances:

1) The client has achieved their therapeutic goals and wishes to conclude their care.
2) The client feels that it is time to "pause" their care and take a break from the healing process.
3) The client's presenting issue is outside of the provider's scope of practice
4) If - at any point during treatment - the provider assesses that they are not effective in helping the client reach their therapeutic goals
5) If - at any point during treatment - the client wants another professional opinion or wishes to work with another provider
6) If the client and provider cannot agree upon the treatment plan, or if the client refuses to engage in/adjust the established and ineffective treatment plan
7) If a client or client family member/significant other are hostile or aggressive, or if they create a sense of non-safety to others in the work space

In such instances, your Maitri provider will give you a number of referrals to other providers that may meet your needs. With your written and expressed consent, your Maitri provider can talk with your new provider to support the transition of care. My signature below indicates that I have read and understand this form.

Client Signature _____ Date ___/___/_____

Client Signature _____ Date ___/___/_____

MAITRI
MENTAL HEALTH

Comment, Compliment, or Complaint Form

This is a (please circle what is appropriate) :

Comment Compliment Complaint

Your Name: _____ Date: _____

Client's Name (if not the client): _____

Preferred Method of Contact for Follow Up (if necessary): _____

Please tell us what happened. When did it happen? Who was all involved? For complaints, provide any information you believe will help us resolve the situation. You can continue writing on the back of this form.

_____

_____

_____

_____

For Comments of Complaints: What resolution would you like to see come of this? What do you want done? What can help you feel a sense of closure or safety?

_____

_____

_____

_____

For Compliments: May we share this compliment with those involved? _____

You can file this form by:

1) Submitting this form to our front desk staff directly (in person or via email at frontdesk@mmh.hush.com)
2) Mailing this form to Jessica Boldt and Katie Ahrens – owners of Maitri Mental Health – at: 1711 Main Street, Vancouver WA 98660
3) Emailing this form Katie Ahrens – owner of Maitri Mental Health – at Katie@vic.hush.com

MAITRI
MENTAL HEALTH

ACKNOWLEDGEMENT OF THE RECEIPT AND UNDERSTANDING OF INTAKE PAPERWORK

Please initial next to each statement with which you agree.

_____ I acknowledge that I have received, understood, and completed the Client Registration Form.

_____ I acknowledge that I have received, understood, and completed the Adult Intake Form.

_____ I acknowledge that I have received, understood, and completed Maitri's Informed Consent document.

_____ I acknowledge that I have received and understood a HIPAA Notice of Privacy Practices.

_____ I acknowledge that I have received, understood, and completed Maitri's Attendance Policy.

_____ I acknowledge that I have received, understood, and completed Maitri's Financial Responsibility and Authorization to Disclose PHI document.

_____ I acknowledge that I have received, understood, and completed (as necessary) Maitri's Private Pay Agreement and On-File Credit Card Authorization forms

_____ I acknowledge that I have received, understood, and completed Maitri's Medication Management / Benzodiazepine Policy.

_____ I acknowledge that I have received, reviewed and understand how to complete (when necessary) Maitri's Release of Information and Maitri's Comment, Compliment, or Complaint Form.

Please sign below to indicate that you agree to engage in treatment at Maitri Mental Health with the aforementioned knowledge.

Printed Name _____

Signature _____

Date _____

Printed Name _____

Signature _____

Date _____