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info@itsnotover.email

Client Orientation Packet SUD 2.1- Adults

Revised 10/31/2023

Client Name:

DOB:

1

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Orientation Checklist

The following items have been reviewed with the client:

Orientation Checklist	2
Common Risks Associated with Psychotherapy	4
Client Signature Date	5
Client Rights and Responsibilities	6
Complaints and Grievance Procedure	7
Access to Emergency Services After Hours	8
No-Show/Missed Appointment Policy	10
Notice of Privacy Practices (HIPAA Laws)	13
Entitlements & Financial Information	19
Health and Safety	20
Restraint Policy	21
Tobacco, Drug and Weapon Policy	22
Person Responsible for Service Coordination	23
Assessment and Treatment Plan Development	24
Transition Planning	25
Discharge Planning	25
Release of Information: Mental Health Provider	26
Release of Information: PCP	27
Photograph/Media Consent and Release	29
SUD Liability Waiver	30
Consent for Services	31
Emergency Contact Form	32
SUD TRANSPORTATION FORM - ADULTS	33
Advance Directives	34

Client Signature _____ Date _____

Staff Signature _____ Date _____

Client Name:

DOB:

2

1626 E. Fort Ave.
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Common Risks Associated with Psychotherapy

There are potential risks to psychotherapy. People may initially feel worse as the therapy progresses. In rare cases, psychotherapy may even trigger some people to have thoughts about wanting to hurt themselves or end their lives. When this happens, your therapist will be able to help you understand and cope with these feelings safely, and can direct therapy to be more supportive until you are feeling stronger. It is always important that you tell your therapist if you are having any frightening or dangerous thoughts or feelings, or if you are considering harming yourself or someone else.

Some clients develop strong feelings about their therapists. This is especially true in longer therapies. Such feelings are normal, even if sometimes uncomfortable or confusing. Any feelings are possible, and the rule for them all is to talk them over with the therapist. They are experienced with this and will help you understand how this is part of your progress.

Therapy can complicate your life. Therapy is often about making changes or about looking at yourself differently. Therapy can change how you live, and it can change how you feel about your relationships. Your therapist will help you to anticipate these changes and will let you decide what changes are best for you, and when.

Psychotherapy is not free and for many there is a personal financial cost. Usually, if you have health insurance, it will pay some portion of the fee. Prior to beginning therapy we recommend you speak to your insurance representative and find out how much you are expected to pay and if there are limits to the number of sessions your insurance will provide.

Insurance companies have the right to ask about your counseling to determine if treatment is necessary and appropriate. Your therapist will be required to provide a diagnosis and may need to submit a report outlining what you are working on and how long it is likely to take to achieve your goals. If there is anything you wish to discuss in therapy that you do not want shared with anyone, including your insurance company, please discuss this with your therapist.

Insurance also requires that we provide a diagnosis, using the nationally approved DSM 5 or ICD 10 criteria. Your diagnosis, like all of your medical information, is protected by privacy and confidentiality rules and practices. However, some clients fear being labeled or “stigmatized” by their diagnosis, or fear that it could limit their career options or insurance rates. If you have any such fears, please speak about them to your therapist.

Some research suggests that when one spouse or partner meets alone with a therapist to discuss problems involving the other partner, there is a chance that this could increase tension for a couple. For this reason, many marital or relationship problems are best addressed with both individuals coming to therapy together.

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While your therapist could offer suggestions and advice when asked, research shows that a therapist's advice about life problems is often no more helpful than anyone else's. Helping you find your own solutions to your life's problems is a far more effective approach.

Finally, not all therapy is effective. If you have been in therapy for several weeks or months, and it does not feel like you are making progress, you should speak to your therapist. It may be that you would do better with a different approach to therapy, or even with a different therapist. As therapists, we know that we cannot be everything to everybody, and we are comfortable helping you make a change if needed.

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4

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Client Rights and Responsibilities

You are a partner in your mental health care and have the right to:

- Be in a safe environment and be treated with respect and dignity.
- Receive appropriate and humane treatment and services in the least restrictive setting that is consistent with your treatment needs and legal requirements.
- Know the names and titles of providers providing care and treatment.
- Refuse to participate in physically intrusive research conducted by a Provider or facility
- Ask questions and discuss your care and treatment with your doctor and provider(s) including potential risks and benefits of prescribed treatment.
- Privacy and confidentiality related to all aspects of care.
- Be protected from neglect and physical, emotional, sexual or verbal abuse.
- Participate in developing your individual treatment goals and/or service plan and all decisions made regarding your mental health care.
- Refuse treatment or medications unless ordered by the courts, or when there is an emergency, or if you are admitted to the hospital involuntarily and medication is approved by a clinical review panel.
- Refuse care and services from a Provider.
- Voice complaints and be told how to file grievances and appeals.
- See and read your medical/treatment record, unless the Provider determines it may be harmful, and then the Provider will explain this to you.
- Have the right to have your family and/or guardian participate in your care, treatment and service goals creation.

Because you are a partner in your mental health care you also have responsibilities to:

- Take charge of your recovery each day. Make Choices that help you stay healthy and meet your goals.
- Participate in activities that promote physical, emotional and spiritual health.
- Learn about your mental illness and treatment options.
- Understand benefits, risks and side effects of medication so you can make informed choices. Tell your healthcare provider and others if you are having side effects from medications.
- Ask for support when needed and accept support from people you trust.
- Give your therapist or doctor the information he/she needs to provide you with the best care.
- Actively participate in treatment decisions. Ask questions and offer suggestions to your therapist or doctor. Remember it is your recovery.
- Be on time for appointments. Call the office if you cannot keep an appointment.
- Eat well, exercise, and get enough rest.
- Plan ahead for psychiatric emergencies with people you trust to carry out your desires and give them a copy of your crisis plan.
- Apply for entitled benefits.
- Report suspected fraud or abuse.

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5

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6

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Complaints and Grievance Procedure

Clients have a right to address complaints about service provision with INO, and do so without fear of reprisal for doing so. INO process for addressing a complaint is as follows:

1. Clients are encouraged to address complaints/grievances with their counselors and attempt to work out the perceived problem in an informal manner.
2. If the informal attempt to address the complaint/grievance does not result in a satisfactory outcome for the client, a formal complaint/grievance may be initiated.
3. To file a formal complaint/grievance, a complaint/grievance form can be obtained from your counselor or in the clinic lobby.
4. Complete the complaint/grievance form and submit it to the clinic director.
5. Upon receipt of the complaint/grievance form, the clinic director will begin an investigation of the complaint, which may include interviews with the person submitting the complaint, and other persons noted on the form and/or within the clinic that may offer relevant information in resolving the complaint.
6. Within 5 working days of receiving the complaint, the clinic director will respond, in writing to the person who submitted the complaint, noting the result of the investigation. The written response will be provided during a meeting between the clinic director and the client, in which the outcome of the investigation will be discussed.
7. Should the client be dissatisfied with the result of the response to the complaint, an appeal can be made to the program sponsor by indicating to the clinic director that an appeal of the outcome is requested.
8. Within 5 working days, the program sponsor will respond in writing to the client as to the outcome of the appeal review
9. At any time in the process, from the initial informal attempt to resolve the complaint to the receipt of the written response from the program sponsor, the client has the right to seek assistance from an advocate outside of the organization. Available advocates for INO clients listed below:

Maryland Office of Administrative
Hearings
Department of Health and Mental
Health Hygiene
11101 Gilroy Road
Hunt Valley, MD 21031
(410) 229-4262

Civil Rights Compliance Office
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Office of Quality and Patient Safety
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181

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7

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8

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Access to Emergency Services After Hours

The crisis plan that you develop with your provider will make it easier for others to help you in the event that a crisis occurs. Sometimes, unexpected things can happen during a crisis. If you are having a mental health crisis after hours, It's Not Over's main number 443-835-4656 can be called. You will be asked to leave a voicemail message and it will be sent to the on-call staff. Someone will call you back immediately. Should a life-threatening medical emergency occur, please call 911 first.

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SUD Crisis Response Plan

Client Name:	Date:
Address:	Phone Number:
Parent/Guardian:	Phone Number:

You may never need to use a crisis hotline or a mobile crisis team. Preparing for a crisis does not mean that one will occur. However, it is wise to prepare for a crisis ahead of time so you have the support and plan if you even need them. You have access to a number of resources to help you prevent and prepare for a crisis.

Any of the names listed below can be contacted in a crisis:

Name	Person	Phone number
It's Not Over		443-835-4656
Mental Health Provider (Clinician)		
SUD Counselor		
Primary Care Physician		
Emergency Contact		
Suicide Prevention Hotline		800-273-8255
Maryland Suicide Hotline		410-752-2272
Maryland Youth Crisis Hotline		800-442-0009

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No-Show/Missed Appointment Policy

We, at INO, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the office number.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled client to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the client to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinician's at INO and whenever possible, we like to fill canceled spaces to shorten the waiting period for our patients.
2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.
3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.
4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. INO will assist you to reschedule this appointment if needed.
5. If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office.
6. If you have 3 "No-Show/Missed" appointments within a one-year time, dismissal from the practice will be considered. ***You will be notified by letter if the dismissal was approved.***

I have read and understand INO's No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify INO appropriately if I have difficulty keeping my scheduled appointments.

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12

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Confidentiality & Limits

The communication between you and It's Not Over is confidential. This means that we will not disclose or discuss information about you, with anyone without your express written consent. There are certain occasions in which confidentiality may be broken as governed either by legislation, government regulations and/or court orders. These include but are not limited to:

1. An emergency in which your life is in danger and which you are unable to provide information on your own.
2. If in our judgment you are a danger to yourself or others. In this case, we may be required to inform another healthcare provider, hospital, specific individual and/or a governmental/regulatory body.
3. When we are ordered to release information on your behalf by an appropriate legal authority.
4. When, in the case of an individual who has a guardian, such as a minor child, the guardian gives explicit written permission to do so.
5. When reporting is required by state-law, such as in the case of alleged child or adult abuse or neglect.

I have read the above disclosure and/or this disclosure has been explained to me. I understand and accept this arrangement of confidentiality.

Client Name and Signature

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Client Feedback

We welcome and encourage you to give us feedback on our services, including what we can do to improve the services we provide to you. To make it easy for you, there are multiple ways you can do this.

1. By letting your staff know your opinion
2. By completing the anonymous customer survey
3. By leaving a voicemail with your feedback

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Notice of Privacy Practices (HIPAA Laws)

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE FURTHER DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PHRASE “PROTECTED HEALTH INFORMATION” REFERS TO ANY MEDICAL OR BEHAVIORAL HEALTH INFORMATION, INCLUDING DEMOGRAPHIC INFORMATION THAT CAN BE USED TO IDENTIFY YOU.

Please Review This Notice Carefully

If you have any questions about this notice, please contact our Compliance Officer

It's Not Over understands that all protected health information (PHI) about you is personal and we are committed to protecting this information. We create a record of care and services you receive at this agency to provide you with quality care and to comply with certain legal requirements. This notice applies to all records about your care generated by It's Not Over whether made by It's Not Over staff or your own personal doctors and healthcare providers. Your personal doctor and other healthcare providers may have different policies or notices regarding their use and disclosure of your medical information that is created in their offices.

This notice will tell you about the ways in which we may use and disclose protected health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your protected health information.

We are required by law to:

- Make sure that protected health information that identifies you is private.
- Give you this notice of our legal duties and privacy practices with respect to the protected health information about you.
- Follow the terms of this notice that is currently in effect.

How We May Use Your Protected Health Information (PHI)

The following categories describe the different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of these categories.

For Treatment: We may use PHI about you to provide you with behavioral health services. We may disclose PHI about you to Case Managers, Nurses, Psychiatrists Advocates, or other It's Not Over staff members providing services within the agency. Different programs within the agency may also share PHI in order to coordinate the different services you need. For example, a case manager may share your address and telephone number with a client advocate who will assist you with filing papers to receive SSI payments. We may also disclose PHI about you to people

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outside of the agency such as family members, therapists or others we use to provide services that are part of your care.

For Payment: We may use and disclose PHI about you so that the services you receive from our agency may be billed to your insurance company or third party. For example, we may need to give your health plan information about the case management services we provide so that we may receive payment from them for providing you with those services.

For Health Care Operations: We may use or disclose your PHI for agency operations. These uses and disclosures are necessary to run the agency and make sure all of our clients receive quality care. For example, we may use PHI to receive the quality service provided and to evaluate the performance of our staff caring for you. We may also disclose PHI that we have about medical information that another organization has to compare how we are doing and to see where improvements can be made to the services that we offer. We may, however, remove information that identifies you so others outside of the agency cannot learn who our specific clients are.

Appointment Reminders: We may use or disclose PHI to contact you as a reminder that you have an appointment with It's Not Over staff to discuss services.

Health Related Benefits and Services: We may use or disclose PHI to tell you about health related benefits or services that may be of interest to you.

Individuals Who Are Involved in Your Care or Payment for Your Care: We may release PHI to a friend, family member or caregiver who is involved in your behavioral or medical care. We may also give information to someone who helps us to pay for your services. We may also tell your friend, family member or caregiver your condition.

Retirement Law: We may disclose PHI about you when we are required to do so by federal, state or local law. The disclosures will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified as required by law of any such disclosures.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose PHI about you to respond to a court order or administrative order. We may also disclose PHI about you to a subpoena, discovery request or other lawful processes by someone else involved in a dispute but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release PHI if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar person

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- About a victim of crime if under certain limited circumstances we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct of the agency and
- In emergency circumstances to report a crime, the location of the crime, or victim or the identity, description or location of the person who committed the crime.

Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose PHI if necessary for law enforcement authorities to identify or apprehend an individual.

Abuse and Neglect: We may disclose your PHI to a public health authority by law to receive reports of child/elderly abuse and neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity/agency authorized to receive such information. In this case the disclosure will be made consistent with the requirement of applicable federal and state laws.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to that correctional institution or law enforcement official. This release would be necessary for the institution to provide you with medical or behavioral healthcare to protect your health and safety, to protect the health and safety of others or for the safety of the correctional institution.

Coroners, Medical Examiners, Funeral Directors and Organ Donations: We may disclose PHI to a coroner or medical examiner for identification purposes, determining the causes of death or for the coroners and/or medical examiners to perform other duties authorized by law. We may disclose PHI to a funeral director in order for them to carry out their duties. PHI may also be used and disclosed for organ donation purposes.

Military and Veterans: When appropriate conditions apply, we may disclose the PHI of individuals who are in the Armed Forces personnel for:

- Activities deemed necessary by appropriate military command authorities
- The purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits
- To foreign military if you are a member of that foreign military service.

National Security and Intelligence Activities: We may use or disclose your PHI to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law. We may also use or disclose your PHI to authorized federal officials so that they may provide protection to the President of the United States, other authorized persons, or foreign heads of state.

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Emergencies: We may use or disclose PHI in an emergency situation. If this happens, a representative from It's Not Over will try to obtain your consent as soon as reasonably practical after the delivery of the emergency treatment.

Public Health Risk: We may disclose your PHI for public health services. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child/elderly abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls or products they may be using
- To identify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

Communicable Disease: We may disclose your PHI if authorized by law to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include for example, audits, investigations, inspections and licensing. These activities are necessary for the government to monitor the healthcare systems, government programs, and compliance with civil rights laws.

Food and Drug Administration: We may disclose PHI to a person or company required by the FDA to report adverse events, product defects or problems, biologic product deviations, track products, to enable recalls, to make repairs or replacements or to conduct post marketing surveillance as required.

Communication Barriers: We may use or disclose your PHI if a representative from It's Not Over attempts to obtain consent from you but is unable to do so due to significant communication barriers and the representative from It's Not Over determines using professional judgment that your intent to consent to use or disclose under the circumstances.

Worker's Compensation: Your PHI may be disclosed by It's Not Over as authorized to comply with worker's compensation laws and other similar legally established programs.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has received the research proposal and established protocols to ensure the privacy of your PHI.

Rights Regarding Your PHI: The following is a statement of your rights with respect to your protected health information (PHI) and a brief description of how you may exercise these rights.

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You Have a Right to Inspect and Copy Your PHI: This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. Usually these records include any medical, behavioral health or billing records that the agency uses for making decisions about your services. These records do not include psychotherapy notes.

To inspect and copy PHI, you must submit your request in writing to It's Not Over's Program Director. If you request a copy of the information, we will not charge for any cost of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in very limited circumstances. If you are denied access to your PHI, you may request that the denial be reviewed. Please contact the Administrator/Program Director if you have any questions about access to your record.

You Have the Right to Ask Us to Amend Your PHI: If you know that the PHI we have about you is incorrect or incomplete, you may ask to amend the information. You have the right to request an amendment for as long as the information is kept by It's Not Over .

To request an amendment, your request must be in writing and submitted to It's Not Over . Administrator/Program Director. In addition, you must provide a reason that supports your request. We may deny a request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by It's Not Over unless the person or entity that created the information is no longer available to make the amendment.
- Is not a part of the PHI kept by or for It's Not Over;
- Is not a part of the information which you should be permitted to inspect and copy;
- Is accurate and complete.

If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your amendment and will provide you with a copy of that rebuttal.

You Have a Right to Receive an Accounting of Certain Disclosures we have Made of Your PHI: This right applies to the disclosures for purposes other than treatment, payment or operations as described previously in the Notice of Privacy Practices. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

You Have a Right to Request a Restriction of Your PHI: This means that you may ask us not to use or disclose any of your PHI for the purpose of treatment, payment, or operations. You may also request that any part of your PHI not be disclosed to family members or friends who

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may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

It's Not Over is not required to agree to a restriction that you may request. If we believe it is in your interest to permit use and disclosure of your PHI, your PHI will not be restricted. If It's Not Over agrees to this restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting It's Not Over Program Administrator/Director. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both to whom you want the limits to apply (for example disclosures to your spouse).

You Have a Right to Obtain a Paper Copy of This Notice from us. You have the right to obtain a paper copy of this notice. You may ask us to give you a copy of this notice any time. We may deny a request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by It's Not Over unless the person or entity that created the information is no longer available to make the amendment.
- Is not a part of the PHI kept by or for It's Not Over ;
- Is not a part of the information which you should be permitted to inspect and copy
- Is accurate and complete.

If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your amendment and will provide you with a copy of that rebuttal.

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You Have a Right to Request a Restriction of Your PHI: This means that you may ask us not to use or disclose any of your PHI for the purpose of treatment, payment, or operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

It's Not Over is not required to agree to a restriction that you may request. If we believe it is in your interest to permit use and disclosure of your PHI, your PHI will not be restricted. If It's Not Over agrees to this restriction, we may not use or disclose your PHI in violation of that

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restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting It's Not Over Program Administrator/Director. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both to whom you want the limits to apply (for example disclosures to your spouse).

You Have a Right to Obtain a Paper Copy of This Notice from us. You have the right to obtain a paper copy of this notice. You may ask us to give you a copy of this notice any time. Even if you have agreed to this notice electronically, you are still entitled to a paper copy of this notice.

Changes to This Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the agency. This notice will contain the effective date of any changes or revisions, on the first page.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the secretary of the Department of Health and Human Services. Please contact the Program Administrator/Director for It's Not Over at the company office.

YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

Client Signature

Date

1626 E. Fort Ave.
 Baltimore, MD 21230
 443.835.4656 (Tel)
 410-646-8760 (Fax)
 info@itsnotover.email

Financial Policies

Client's Name:
DOB
Primary Care Physician's Name:
Address:
Phone #:
Fax #:

Insurance Policy Information:

Please provide your health insurance information. We require a copy of your health insurance card and a copy of your photo ID at the first appointment.

Medicaid #	Medicare #
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Entitlements & Financial Information

Number of Dependents:			
Income:		Expenses:	
Annual Gross Salary:	\$	Rent/Mortgage:	\$
Monthly salary:	\$	Food:	\$
Spouse Monthly Salary:	\$	Medical insurance:	\$
Unemployment Benefit:	\$	Child support:	\$
Disability:	\$	Utilities (BGE/Water):	\$
SSI Benefit:	\$	Education Expenses:	\$
SNAP Benefits:	\$	Childcare Expenses:	\$
TCA Benefits:	\$	Total Expenses:	\$
Total Gross Income:	\$		

Agreement:

I give INO permission to bill my insurance for services provided to me by INO. I agree to let INO know if my insurance coverage lapses so that I can be assisted with reapplying. I understand that my insurance will cover all treatment expenses, so I will not be responsible for any payment.

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Client Signature:

Date:

Witness Signature:

Date:

Client Name:

DOB:

24

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Health and Safety

All It's Not Over staff who provide direct care are trained in First Aid and CPR techniques. First Aid will be provided by It's Not Over staff for minor scrapes and cuts. In the event that a consumer is more seriously injured or becomes ill, the parent/legal guardian and/or caregiver will be notified and informed as to what action has been taken. In the event of a life-threatening emergency or sudden serious illness, It's Not Over staff will seek emergency care from the nearest hospital, medical facility, or physician. Any injuries occurring to a consumer must be reported immediately to a member of the It's Not Over management staff. We ask you to keep your case responsible person(s) updated if there are any changes to your emergency medical information because that sheet will be used by staff in the event of any emergency.

Whenever you are in an It's Not Over facility, we ask that you make a note of the emergency exit signs and the emergency/evacuation maps located in each room. Whenever you are being transported by an It's Not Over staff, they will have in their possession an emergency kit for fire or other first aid emergencies.

Client Signature

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Restraint Policy

Prohibited Restraint, Seclusion, or Restrictive Techniques. In no event may the following aversive, inappropriate techniques of managing behavior be used:

- Corporal punishment
- Punishment for a manifestation of a disability
- Prone restraints: those restraints in which a student is held face down on the floor
- Locked rooms, locked boxes, or other locked structures or spaces from which person cannot readily exit
- Noxious substances
- Deprivation of basic human rights, such as withholding meals, water, or fresh air
- Treatment of a demeaning nature
- Electric shock

Client Signature

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Tobacco, Drug and Weapon Policy

It is the policy of It's Not Over that no drugs (except those prescribed to you by a physician) or weapons should be brought or carried with you or any staff member while receiving services. If you bring prescription medication into the building, it **MUST** have your name on the container. Also, you and any staff member must only smoke in designated smoking areas or at least 20 feet from the inside of a building or car. Failure to follow these policies could result in your suspension or expulsion from services with It's Not Over.

Client Signature

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Person Responsible for Service Coordination

We will assign one person to work with you. That person will help you apply for entitlements, provide transportation to mental health appointments, schedule appointments at a time that works for you, and other program-related services.

The person assigned to work with you is _____
They will contact you within 48 hours to set up an initial appointment, and will provide you with their contact information.

Client Signature _____ Date _____

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Assessment and Treatment Plan Development

We will have you meet with one of our staff members to complete an assessment. This might be included in the intake, but may be a separate appointment. The purpose of this assessment is to gather information about your history, including medical and mental health-related items so that we can understand you holistically and understand your viewpoint. We will then use that information to help you create a treatment plan. The treatment plan is a roadmap for how we will work with you to help you reach the goals you have.

Client Signature

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Transition Planning

It's Not Over's ultimate goal is to ensure that you and your family are able to deal with your needs without the assistance of service providers. With this in mind, we start the planning for your success from the beginning of services. Our transition planning focuses on your needs in order to support ongoing recovery, treatment/service gains and/or increased community involvement. At least 60 days from your planned departure from services or 14 days if you are in substance abuse services, we will work with you to complete a transition plan that you can use after services have ended.

Discharge Planning

A consumer will be discharged for the following:

1. Consumer has achieved the goals of his/her treatment plan and is deemed ready to be discharged.
2. Individual and/or parent/legal guardian request discharge.
3. Individual behavior is such that it interferes significantly with the well-being or rights of others.
4. Constantly uncooperative behavior towards treatment from the consumer, parent/legal guardian, or placing agency.
5. Consumers have refused to make contact or participate in services for 30 consecutive days.
6. Individual has moved outside of It's Not Over's service area, so has been referred to a new provider in the consumer's new location.

Should a consumer be discharged because of difficulties, we will do our best to work with the parent and consumer until a suitable placement can be found.

Client Signature

Date

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Release of Information: Mental Health Provider

NOTE: This form is valid for one year from the date signed unless the client and/or client representative decides to void this release of information for any given reason prior to the one-year expiration date.

Client Name:	MA#:
Mental Health Provider:	Phone Number:

I, _____ voluntarily give my consent to authorize representatives of It's Not Over and the addressee to exchange information as indicated below. This information is to be kept confidential and may not be released to any other agency or individual(s) without my signed consent. The purpose of this information exchange is to provide continuity of care and to assist the addressee and It's Not Over in my treatment. In no way will information exchanged be used to discriminate against me or to deny me from receiving services at It's Not Over.

Addressee to Release Information to It's Not Over:

- Verbal Exchange between Addressee and It's Not Over
- Intake Assessment and Treatment Plan
- Medication List
- Quarterly Review
- Transfer/Discharge Summary
- Other

It's Not Over to Release to Addressee:

- Intake Assessment
- Entitlement Information
- Rehabilitation Assessment
- Treatment Plans (ITP, ITRP and Review)
- Psychiatric Assessment, Notes, Medication Log
- Transfer/Discharge Summary

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Client/Guardian Signature:

Date:

Staff Signature:

Date:

Date Release of Information Expires:

1 year from date signed

Release of Information: PCP

***NOTE:** This form is valid for one year from the date signed unless the client and/or client representative decides to void this release of information for any given reason prior to the one-year expiration date.*

Client Name:	MA#:
Primary Care Provider:	Phone Number:

I, _____ voluntarily give my consent to authorize representatives of It's Not Over and the addressee to exchange information as indicated below. This information is to be kept confidential and may not be released to any other agency or individual(s) without my signed consent. The purpose of this information exchange is to provide continuity of care and to assist the addressee and It's Not Over in my treatment. In no way will information exchanged be used to discriminate against me or to deny me from receiving services at It's Not Over.

Addressee to Release Information to It's Not Over:

- Verbal Exchange between Addressee and It's Not Over
- Intake Assessment and Treatment Plan
- Medication List
- Physical Examination Records (within one year of date signed)
- Transfer/Discharge Summary
- Physician Recommendation for Community Rehabilitation Services

It's Not Over to Release to Addressee:

- Intake Assessment
- Entitlement Information
- Biopsychosocial Assessment

Client Name:

DOB:

32

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- Treatment Plans (ITP, ITRP and Review)
- Psychiatric Assessment, Notes, Medication Log
- Transfer/Discharge Summary

Client/Guardian Signature:

Date:

Staff Signature:

Date Release of Information Expires:

Date:

1 year from date signed

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SUD EMAIL RELEASE OF INFORMATION

NOTE: This form is valid for one year from the date signed unless the client and/or client representative decides to void this release of information for any given reason prior to the one-year expiration date.

Client Name: _____ **MA#:** _____ **DOB:** _____

Phone Number: _____

I, _____ I authorize It's Not Over to contact me and/or other professionals involved in my or my child's care, via electronic mail (email). I am aware that It's Not Over does not have encrypted email software and cannot guarantee that information transmitted via email will not be intercepted by other parties. By signing this form, I agree to not hold It's Not Over or its employee responsible for any breach of confidentiality that may occur by someone else accessing the information contained in any emails sent to or from It's Not Over regarding my or my child's personal health information. I understand that reasonable means will be used to protect the security and confidentiality of the email. All concerns to and from me regarding my personal health information will be a part of my medical record and can be viewed by health care and insurance providers and the therapist's office support staff. My email will not be forwarded outside the office without my consent or as required by law.

Client/Guardian Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Date Release of Information Expires: _____ **1 year from date signed**

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Photograph/Media Consent and Release

- I hereby consent and authorize It's Not Over to take photographs or motion pictures of myself (and/or my child); or to produce videotapes, audiotapes, closed circuit television programs, webcasts, or other types of media productions that capture myself (and/or my child's), voice, and/or image (any of the foregoing types of media are called the "Materials" in this Consent and Release form).

- I authorize It's Not Over to copyright the materials, and I authorize It's Not Over to use, reuse, copy, publish, display, exhibit, reproduce, license to a third party, and distribute the materials in any educational or promotional materials or other forms of media, which may include, but are not limited to university publications, catalogs, articles, magazines, recruiting brochures, websites or publications, electronic or otherwise, without notifying me.

- I do not consent or authorize It's Not Over to take photographs or motion pictures of myself (and/or my child); or to produce videotapes, audiotapes, closed circuit television programs, webcasts, or other types of media productions that capture myself (and/or my child's), voice, and/or image (any of the foregoing types of media are called the "Materials" in this Consent and Release form).

I agree that I am participating on a voluntary basis and I will not receive any payment from It's Not Over for signing this release or as a result of any publication of the materials.

I represent that I am at least 18 years of age, or if not, that I have secured the signature of my parents or legal guardian.

Client Signature

Date

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SUD Liability Waiver

I, _____ hereby agree to release and hold harmless from any liability, It's Not Over including its paid and volunteer staff executors, administrators and other agents representing It's Not Over. This waiver specifically relates to personal injury which may occur while participating in any programs or activity of any kind conducted, approved, organized, or sponsored by It's Not Over or its representatives.

Further, that the consideration for this waiver, is the right, privilege and opportunity for _____ to participate in the programs and activities conducted, approved, organized or sponsored by It's Not Over.

Client Signature Date

Parent/Guardian Signature Date

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Consent for Services

Client Name:

Guardian Name (if applicable):

Check Applicable Services:

<input type="checkbox"/> Blended Services	<input type="checkbox"/> SUD Individual Sessions
<input type="checkbox"/> Tele- Health Services	<input type="checkbox"/> Non- HIPAA compliant for telehealth
<input type="checkbox"/> Group Services	<input type="checkbox"/> HIPAA compliant for telehealth
<input type="checkbox"/> On-site Services	<input type="checkbox"/> Services are private where no one can overhear.

I, _____, hereby voluntarily consent for myself/my child to receive consultative, diagnostic and therapeutic services and/or procedures from It's Not Over, as listed below:

I understand the benefits of each service as well as the alternatives to the recommended procedures and/or treatment. Unless specifically stated otherwise, this consent form expires upon completion of services from It's Not Over. I further understand that I am free to withdraw this consent for services at any time without prejudice to receiving alternative treatment available at It's Not Over SUD 2.1. I may also be discharged from It's Not Over SUD 2.1 if there is non-compliance with one or more of the agreed upon services.

Client Signature **Date**

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Parent/Guardian Signature

Date

Client Name:

DOB:

38

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Emergency Contact Form

Please complete this entire document

Client Name:

DOB:

MA#

I hereby authorize It's Not Over to release information to the following person in the event of a medical or mental health emergency:

Emergency Contact Name:
Relationship to client:
Address:
Phone number:

Emergency Contact Name:
Relationship to client:
Address:
Phone number:

Preferred hospital:

For the purpose of: Coordination/Care during a medical or mental health emergency

The information authorized to be released

- Any information related to a medical concern or emergency
- Any information needed to secure safety when suicidal or homicidal

Client Name:

DOB:

39

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I have been told that, in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be effective for one year after the date of my signature. A photocopy or facsimile of this form may be accepted in lieu of the original signed form. I also understand that this consent is revocable except to the extent that action has been taken on it already.

I further understand that It's Not Over, LLC will not condition my treatment on whether I give authorization for the requested disclosure.

Client Signature

Date

Client Name:

DOB:

40

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SUD TRANSPORTATION FORM - ADULTS

Clients Name:	MA#:
Parent/Guardian (if applicable):	Phone:
Address:	Other number#

I, _____, the client/guardian gave permission for It's Not Over to provide me transportation . I understand that staff of It's Not Over will take all reasonable precautions during transportation but cannot be held accountable for unavoidable accidents.

- I do not consent or authorize It's Not Over to provide me with transportation. I am clear that any events or activities I would like to participate in, I will be responsible for arriving/leaving the office. I do understand that in the event I would like to change my mind and would like to have transportation provided I will have to complete a new consent form.

Client Name

Date

Guardian Name

Signature

Signature of Witness

Client Name:

DOB:

41

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Note: *This authorization form (when signed and dated by the client or legal guardian) will remain valid until the client is discharged from It's Not Over or when the client or legal guardian requests that the authorization be voided.*

Advance Directives

- I currently have an advance directive (staff will need a copy of the advance directive from the client)
- I do not currently have an advance directive, and want assistance with creating one (staff will help the client complete an advance directive)
- I do not currently have an advance directive, and do not want assistance with creating one.

Signature

Date

Client Name:

DOB:

42