JACKSON JUBILEE

CLIENT INFORMATION & CONSENT

Secure website form - fields marked * are required

This packet explains behavioral health services, privacy, payment, telehealth, client rights, and website submission. Please read each section. Ask questions before signing. Signing does not waive any legal right.

1. Client Information

Client full legal name *

Date of birth *

Preferred name

Pronouns

Medicaid ID

Street address *

City *

State *

ZIP *

Phone *

Email

Parent/guardian name (if applicable)

Relationship

2. Services Requested

- ☐ Outpatient mental health clinic (OMHC)
- ☐ Psychiatric rehabilitation program (PRP)
- ☐ Substance use disorder services
- ☐ Telehealth when clinically appropriate

3. Emergency Contact

Name

Relationship

Phone

Alternate phone

4. Informed Consent to Evaluation and Treatment

I voluntarily request assessment and, if admitted, individualized behavioral health services. Services may include diagnostic evaluation, individual, family, or group therapy; care coordination; psychiatric evaluation and medication management; rehabilitation services; crisis planning; referrals; and discharge planning, as clinically indicated and permitted by the program's license.

My provider will discuss my diagnosis, proposed services, expected benefits, material risks, reasonable alternatives, estimated frequency and duration, and the likely results of declining care. No outcome is guaranteed. I may ask questions, participate in treatment planning, request a change of provider when reasonably available, and withdraw consent or end voluntary services at any time. Withdrawal does not cancel actions already taken and may be limited by a court order or other law.

Possible benefits include improved functioning, coping, relationships, safety, and symptom relief. Possible risks include temporary emotional discomfort, difficult memories, relationship changes, medication side effects, or lack of improvement. Alternatives may include another provider, another level of care, community support, medication, or no treatment.

I understand that services depend on clinical need, eligibility, authorization, attendance, participation, and continued medical necessity. The program may recommend transfer or discharge after notice and planning when goals are met, services are no longer appropriate or medically necessary, safety needs exceed the program's capacity, or program rules are repeatedly not followed. Emergency care will not be withheld because of a payment dispute.

5. Team-Based Care and Supervision

Care may be provided by independently licensed clinicians, licensed or certified professionals, interns, trainees, rehabilitation specialists, PRP staff, prescribers, peer support staff, and administrative or billing personnel acting within their roles. Qualified staff may consult with supervisors and treatment-team members for care, quality, compliance, payment, and operations. If my primary provider practices under supervision, I may ask for the supervisor's name and credentials.

- [ ] I consent to assessment and services described above.
- [ ] I had an opportunity to ask questions and received understandable answers.

Important: This document is not an authorization to release records to a school, employer, family member, attorney, or other outside person. A separate, specific authorization will be used when required.

6. Confidentiality and Permitted Disclosures

Behavioral health records are confidential under applicable federal and Maryland law. The program may use or disclose protected health information for treatment, payment, and health care operations and as otherwise permitted or required by law. Only the minimum necessary information will be used when that standard applies.

Information may be disclosed without my authorization when legally permitted or required, including: suspected child abuse or neglect; suspected abuse, neglect, self-neglect, or exploitation of a vulnerable adult; a serious and imminent safety threat or a qualifying threat against an identifiable person; medical or psychiatric emergencies; court orders and other lawful process; health oversight, licensing, accreditation, audits, program integrity, or fraud investigations; workers' compensation; public-health duties; and other disclosures authorized by law.

Substance use disorder records may receive additional protection under 42 C.F.R. Part 2. When Part 2 applies, information will not be used or disclosed except as permitted by Part 2 or with a valid authorization. A general consent to treatment does not authorize every outside disclosure.

7. Records, Maryland Medicaid, and Health Information Exchange

The program creates and maintains clinical and billing records, which may include assessments, diagnoses, plans, progress notes, medication information, service dates, attendance, claims, authorizations, and communications. Records are retained for the period required by law and payer contract. I may request access, amendment, restrictions, confidential communications, and an accounting of certain disclosures, subject to legal limits.

When Maryland Medicaid or another insurer pays for care, the program may send information needed to verify eligibility, request authorization, submit and correct claims, coordinate benefits, establish medical necessity, conduct utilization review, and respond to audits. Maryland Medicaid, its managed care organization or administrative service organization, and their authorized reviewers may inspect records as allowed by law.

The program may access or disclose information through Maryland's health information exchange (CRISP) for treatment, care coordination, payment, public health, and other legally permitted purposes. Any applicable patient choice or opt-out right is explained in the Notice of Privacy Practices or CRISP materials. Specially protected records will be handled under applicable law.

8. Notice of Privacy Practices Acknowledgment

☐ I received or was offered the Notice of Privacy Practices.

☐ I want a paper copy mailed to me.

☐ I want an electronic copy.

Questions or requested privacy restrictions (optional)

9. Insurance Authorization and Assignment

I authorize the program to verify coverage and submit claims for covered services. I assign directly to the program any insurance or Medicaid benefits payable for services provided, to the extent allowed by law. I authorize the payer to send payment and claim information to the program. I understand that eligibility or authorization is not a guarantee of payment and that I must promptly report changes in coverage, address, contact information, or other insurance.

10. Maryland Medicaid Protections

For services covered by Maryland Medicaid, the program will accept Medicaid payment as payment in full except for lawful cost-sharing, if any. The program will not balance bill me for a covered service solely because Medicaid pays less than the program's charge or denies a claim due to the program's billing error.

I will not be charged for missed appointments as a Medicaid-covered service, and a missed appointment will not be billed to Medicaid. The program may use a neutral attendance policy, outreach, or discharge process consistent with law and clinical need.

Before receiving a service that is not covered, exceeds a benefit limit, lacks required authorization, or is requested as a private-pay service, I will receive a separate written notice when required. That notice will identify the service, reason it may not be covered, estimated charge, and my choice. I will be personally responsible only when payment is legally permitted and I knowingly agree in writing before the service, except for lawful cost-sharing or another legal exception.

I am responsible for providing accurate insurance information and cooperating with eligibility and coordination-of-benefits requests. I may contact my health plan or the Maryland HealthChoice/Medicaid Help Line at 1-800-284-4510 about benefits, denials, appeals, or grievances.

11. Non-Covered Service Election (Complete only when applicable)

Specific service

Estimated charge

Reason not covered / authorization issue

☐ I decline this non-covered service.

☐ I request it and agree to the charge above.

Do not select both choices. Staff must complete this section before the client signs when a personal charge may apply.

12. Voluntary Telehealth Services

Telehealth uses live video, audio, secure messaging, or other approved technology when clinically appropriate. I may decline telehealth without losing access to other available services. I may stop a telehealth session and request another method, although availability and payer rules may affect scheduling.

Potential benefits include improved access, convenience, and continuity. Risks include technology failure, delay, miscommunication, reduced ability to observe nonverbal information, unauthorized access, and loss of privacy where I am located. The program uses reasonable safeguards, but no electronic system is risk-free. I will not record a session unless everyone agrees in advance and recording is permitted by law and policy.

At each visit I will confirm my identity, physical location, callback number, and privacy. My provider may verify identity and determine whether telehealth remains appropriate. If technology fails, we will attempt to reconnect, use the backup number, reschedule, or direct me to emergency care. Telehealth is not an emergency service.

13. Telehealth Safety Plan

Usual location/address during telehealth

Backup phone

Local emergency contact

Emergency contact phone

Nearest emergency department (optional)

14. Telehealth Choice

☐ I consent to telehealth when clinically appropriate.

☐ I decline telehealth at this time.

For an emergency, call 911 or go to the nearest emergency department. For a mental health or substance use crisis, call or text 988. Do not use a website form, email, portal message, or voicemail for an emergency.

15. Communication Preferences

Portal messages or secure methods are preferred for sensitive information. Standard email and text can be intercepted, misdirected, previewed on a locked screen, or seen by someone with access to my device or account. Choosing email or text is optional and may be withdrawn prospectively. Messages are not continuously monitored.

- ☐ Phone calls
- ☐ Voicemail with callback details only
- ☐ Secure portal
- ☐ Text for scheduling/reminders
- ☐ Email for scheduling/forms

Approved phone number

Approved email

- ☐ May identify the practice by name in voicemail/text/email.

16. Electronic Records, Signatures, and Website Use

I consent to receive, review, complete, sign, and return forms electronically. Typing my legal name and submitting this packet is intended as my electronic signature and has the same effect as a handwritten signature to the extent allowed by law. I may request a paper copy.

I understand that a public website inquiry form should not be used for clinical details or emergencies. This completed packet must be submitted only through the practice's designated secure, encrypted form or portal. The program will not place tracking or advertising technologies on authenticated clinical-form pages in a way that impermissibly discloses protected health information.

Electronic consent does not require me to accept optional marketing, unsecure communication, or telehealth. I may withdraw electronic-delivery consent prospectively by contacting the program, but records already created or submitted will be retained as required.

- ☐ I consent to electronic records, delivery, and signature.
- ☐ I request paper forms instead.

17. Accessibility and Language

- ☐ I need an interpreter.
- ☐ I need a disability accommodation.

Preferred language or requested accommodation

18. Your Rights

- Receive respectful, trauma-informed, culturally responsive care without discrimination or retaliation.
- Receive information in understandable language and reasonable auxiliary aids, interpreters, and accommodations.
- Participate in assessment, person-centered planning, treatment, transition, and discharge decisions; receive a copy of the plan when requested.
- Know provider names, roles, credentials, and supervision; ask questions and receive information about services, risks, benefits, alternatives, fees, and coverage.
- Privacy and confidentiality; access to records and privacy rights subject to law; freedom from abuse, neglect, exploitation, harassment, retaliation, and unnecessary restraint or seclusion.
- Refuse a service or medication and receive information about likely consequences, except where law or a valid court order provides otherwise.
- Choose among available qualified providers, request referral or a second opinion, and receive coordinated transition planning.
- Make an advance directive and have it addressed as required by law; name a representative when legally authorized.
- Complain, file a grievance, appeal a benefit decision, or contact an outside agency without punishment or loss of medically necessary care.

19. Your Responsibilities

- Provide accurate health, medication, insurance, contact, and safety information and report important changes.
- Participate in agreed services, ask questions, attend scheduled appointments, and notify the program as soon as possible when unable to attend.
- Treat clients, visitors, and staff respectfully; protect others' privacy; follow safety, conduct, and substance-free rules applicable to the service setting.
- Use emergency resources for urgent needs and tell staff promptly about safety concerns, adverse medication effects, hospitalization, or another provider's treatment.
- Pay only charges that are legally permitted and explained in advance, and raise billing questions promptly.

☐ I received or was offered a copy of client rights and responsibilities.

20. Internal Complaint and Grievance Process

You may raise a concern verbally or in writing with any staff member or the designated grievance contact. Staff will help you file if requested. Include what happened, dates, people involved, and the result you want. The program will acknowledge, review, and respond within the time required by its policy and applicable law. You may request review by a supervisor or program director. You will not be retaliated against for a good-faith complaint.

Program grievance contact/name

Phone

Email or mailing address

21. External Help

Maryland Medicaid / HealthChoice Help Line: 1-800-284-4510 (benefits, access, appeals, and grievances). You may also contact the member-services number on your insurance card.

Maryland Department of Health: 410-767-6500 or 1-877-463-3464. Maryland Relay: 7-1-1.

For a quality-of-care complaint, you may contact the appropriate licensing board, accreditor, payer, or Maryland oversight agency. Staff will provide the correct contact for the program's license and service type on request.

If you believe you were discriminated against, you may contact the Maryland Department of Health civil-rights office or the U.S. Department of Health and Human Services Office for Civil Rights.

22. Benefit Denials and Appeals

A complaint about staff or service quality is different from an appeal of a payer decision. If Medicaid, an MCO, or its behavioral health administrator denies, reduces, suspends, or terminates a requested service, you will receive notice explaining the reason and appeal rights. Follow the deadlines in that notice. You may ask the program for records or reasonable help with an appeal; the program cannot guarantee the outcome.

☐ I understand how to file a complaint or grievance and how to request help.

Urgent safety concern: call 911. Mental health or substance use crisis: call or text 988.

23. Client Acknowledgment

- [ ] 1I reviewed this packet, understand that I may ask questions, and received answers in a way I understand.
- [ ] 2I consent voluntarily to the services and disclosures described, subject to the choices I made in this packet.
- [ ] 3I understand my Maryland Medicaid protections, including limits on personal charges for covered services.
- [ ] 4I received or was offered client rights, grievance information, and the Notice of Privacy Practices.
- [ ] 5I understand that this consent remains effective during the episode of care unless a section states otherwise or I withdraw it prospectively. The program may request review or renewal when information, services, law, or policy changes.
- [ ] 6I certify that the information I provided is true and that I have authority to sign for myself or the client named on page 1.

24. Signature

- [ ] Adult client signing for self
- [ ] Parent/guardian/authorized representative

Electronic signature (type full legal name) *

Date *

Printed name of parent/guardian/authorized representative *

Relationship / authority *

Staff/witness name (if used)

Date

Staff/witness signature

If the client cannot or will not sign, staff should document the reason and the method used to provide the information below.

Staff documentation