



BRAVO PSYCHOLOGICAL GROUP

**Eric W. Bravo, Psy.D.
Clinical Psychologist
656 Quince Orchard Road
Suite 600
Gaithersburg, MD 20878
(301) 233-5020**

POLICIES OF THE PRACTICE

Welcome to our practice. This document contains important information about our professional services and business policies. Please read this information carefully and ask about anything you do not fully understand.

Benefits and Emotional Risks

The majority of people who obtain mental health services benefit from the process. The therapeutic process is generally quite useful, but some risks do exist. Risks sometimes include experiencing uncomfortable feelings such as sadness, anger, guilt, or frustration. Also, psychotherapy often involves discussing unpleasant aspects of your life. However, many people have found that therapy ultimately leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. Still, there are no guarantees about what will happen in any one therapeutic process. We encourage you to raise any questions you may have about treatment goals, procedures, or your impression of the services you receive.

Confidentiality

Our patients' confidentiality is of primary importance and is legally protected. There are, however, circumstances that impose limitation on a patient's right or ability to maintain confidential communications. State and Federal laws protect your confidentiality and require that we inform you of our privacy practices. We have a separate privacy policy that we will ask you to read and sign.

Cancellations

If you must cancel an appointment please give a minimum of 48-hour advanced notice. If you cancel an appointment without giving at least 48-hour notice, you will be charged at the usual rate. In

cases of inclement weather, we will attempt to contact patients who have scheduled appointments and we will decide jointly if the appointment will stand. The 48-hour notice policy does not apply to cancellations due to inclement weather.

Payment for Services

Payment is expected at the time services are rendered unless other billing arrangements have been made. There is a \$35.00 fee assessed for checks returned for insufficient funds. In the unusual circumstances that your account is more than 60 days in arrears, we have the option of using legal means to secure payment, including collection agencies or small claims court. The State of Maryland allows us to charge you for any fees incurred via collection services. Our collection agency charges fees of 30 to 50% of the debt. In most instances, you will have been contacted by our representatives several times before legal action would be taken.

Insurance Coverage

CareFirst, BlueCross BlueShield

We are preferred providers with all BlueCross BlueShield (BCBS) plans, including CareFirst and Magellan Behavioral Health. We strictly adhere to BCBS policies in terms of payments and fees.

Other Insurance

We accept most insurance plans provided that the patient has “out of network” benefits. In most cases, we will collect the patient’s co-payment and bill the insurance carrier for the balance of the fee. In some instances, we may request that the patient pay the full fee at the time of service and apply insurance benefits after the claim is paid.

Emergency Situations

On the rare occasion that a clinician cannot be reached, please call 911 or go to the nearest hospital emergency room.

Authorization/Agreement

By signing this document, you agree that you have reviewed this information and agree to these conditions.

Signature of Patient / Legal Guardian

Date



BRAVO PSYCHOLOGICAL GROUP

**Eric W. Bravo, Psy.D.
Clinical Psychologist
656 Quince Orchard Road
Suite 600
Gaithersburg, MD 20878
(301) 233-5020**

Policies and Practices to Protect the Privacy of Health Information

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you
- “Treatment” is providing, coordinating, or managing your health care and other services related to your health care. Examples of this disclosure include consulting with another health care provider, an attorney, or a probation officer.
- “Payment” is obtaining reimbursement for your healthcare. We must disclose your PHI to your health insurer in order to obtain reimbursement for your health care or to determine eligibility or coverage.
- “Health Care Operations” are activities that relate to the performance and operations of my practice. Examples of health care operations are business-related matters such as audits and administrative services.
- “Use” applies only to activities within the practice such as sharing, utilizing, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of the practice such as releasing, transferring, or providing access about you to other parties.
- “Authorization” is your written permission to disclose protected health information. All authorizations to disclose must be on a specific, legally-required form.

II. Other Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances, when we are asked for such information, we will obtain your written authorization before releasing the information.

You may revoke an authorization at any time, provided that the revocation is in writing. You may not revoke an authorization to the extent that: (1) We have relied on that authorization and action has already been taken, or (2) the authorization was obtained as a condition of obtaining insurance coverage. The law allows the insurer to contest claims under their policy.

III. Uses and Disclosures Without Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse or Elder Abuse** – If we have reason to believe that a child or a senior has been subjected to abuse or neglect, we are legally and ethically bound to inform the appropriate authorities.
- **Health Oversight Activities** – If we receive a subpoena from the Department of Health and Mental Hygiene and/or the Department of Social Services, we must disclose any PHI requested by them.

- **Judicial and Administrative Proceedings** – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, you may invoke your right of privilege, in which case, we would not release the information. Privilege no longer applies once you introduce mental health issues as part of the legal proceeding or if the court orders a psychological evaluation.
- **Serious Threat to Health or Safety** – If you communicate a specific threat of imminent harm against another individual or if we believe there is a clear, imminent risk of physical or mental injury to another individual, we may make disclosures that we believe are necessary to protect the health and safety of that individual. If we believe that you present an imminent, serious risk of injury or death to yourself, we may make disclosures that we consider necessary to protect you from harm.

IV. Patients’ Rights and Clinician’s Duties

Patients’ Rights:

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of your protected health information. However, we are not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are in therapy. On your request, we would forward bills to another address).
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We can deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- **Right to a Paper Copy** – You have the right to obtain a paper copy of this notice upon request.

Clinicians’ Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide you with written notification of the revision and will provide notice of revised policies and procedures.

V. Complaints

If you are concerned that we have violated your privacy rights, you may contact Dr. Eric W. Bravo to discuss your concerns. If you disagree with a decision we have made about access to your records, you may send written complaint to the Secretary of the U.S. Department of Health and Human Services.

I, the undersigned, acknowledge that I have reviewed the Policies and Practices in regard to Protected Health Information (PHI). I understand that I may also request a copy of this document at any time and that I will be notified in writing if any changes are made to the policy.

Signature of Patient / Legal Guardian

Date

Intake Form

First Name: _____ Last Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone _____ Work/Cell Phone _____

Date of Birth: _____ Email Address: _____

Insurance Carrier: _____

Membership ID # _____

Group # _____

Claims Address: _____

Provider Phone Number: _____

EMERGENCY CONTACT INFORMATION

In case of emergency, whom should we contact? _____

Contact person's phone numbers: Home: _____

Work: _____

Cell: _____

Contact person's relationship to patient: _____

Relationship Status (circle): Single Married Partnered Separated Divorced Widowed

Occupation: _____

Employer: _____ Work Hours: _____

Have you been in therapy before?: _____ If so, when? _____

Have you ever been evaluated by a psychiatrist for medication? _____

Please list any medications you are currently taking (including over-the-counter meds):

_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been hospitalized for mental health issues? _____

If so, when? _____ Where? _____ How long? _____

PRIMARY COMPLAINTS AT THIS TIME

Please check **all** that apply:

- | | |
|-------------------------------------|-------------------------------------|
| _____ Depression | _____ Substance Abuse |
| _____ Anxiety | _____ Sexual Abuse |
| _____ Post-traumatic Stress | _____ Panic Attacks |
| _____ Relationship Issues | _____ Obsessive thoughts/behaviors |
| _____ Grief/Loss | _____ Medical Issues |
| _____ Sexual dysfunction | _____ Adjustment to a new situation |
| _____ Suicidal/Homicidal thoughts | _____ Job dissatisfaction |
| _____ Other (please explain): _____ | |

DEBIT/CREDIT CARD AUTHORIZATION FORM

I, _____, understand and agree to the following:

My card may be charged every time that I do not bring cash/check to pay for my appointment, or I miss an appointment without giving more notification than 48-hours.

CREDIT CARD INFORMATION

Patient Name:

Name on Card:

Billing Address:

Card Number:

Expiration Date:

CVV Code:

I authorize Bravo Psychological Group, LLC to charge my credit/debit card provided herein. It is my responsibility to update this card if it no longer becomes valid. Please print name, date and sign below:

Signed:

Date:

Printed Name:
