



A F F I L I A T E D   S A N T É   G R O U P

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# **Seniors Program**

# **Consumer Handbook**

**The Affiliated Santé Group  
12200 Tech Road, Suite 330  
Silver Spring, Maryland 20904  
(Office) 301-572-6585  
[www.thesantegroup.org](http://www.thesantegroup.org)**

# Welcome to The Affiliated Santé Group

## Mission Statement

Santé facilitates the wellbeing and safety of individuals at risk for emotional distress, as well as their communities. We developed and deliver tailored, recovery-based health services and innovative crisis intervention and response systems.

## OUR VALUES

- ✓ **Recovery** - We provide services knowing that recovery is possible and hope is always present.
- ✓ **Accountability** - We are responsible for our actions and committed to fostering autonomous functioning and accountability among our staff as well as our consumers.
- ✓ **Innovation** - We strive to foster a spirit of learning and creativity that supports innovation for the ultimate benefit of individual consumers as well as the public agencies and others that are involved in their care.
- ✓ **Diversity** - We embrace diversity as it brings strength and fresh perspectives to the development and delivery of our services, as well as the growth and durability of our organization.
- ✓ **Safety** - The physical and emotional safety of our consumers, staff and the communities we serve are an utmost priority.
- ✓ **Resiliency** - We are not discouraged by setbacks, but instead see them as opportunities to learn.

## Hours of Operation

Monday	8:30am-4:30pm
Tuesday	8:30am-4:30pm
Wednesday	8:30am-4:30pm
Thursday	8:30am-4:30pm
Friday	8:30am-4:30pm
Saturday	Office Closed
Sunday	Office Closed



**\*\* Please note Mobile Crisis Teams are available 24/7 for emergencies before, during, and after normal business hours at 240-777-4000.**

## Staff Directory

Corporate Office  
Silver Spring, Maryland



Seniors Services, Director (301) 572-6585 ext. 2104

Seniors Services, Referrals (301) 572-6585 ext. 2190

Administrative Services Coordinator (301) 572-6585 ext. 2100

# Welcome to the Seniors Program

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The following services and programs are free to homebound seniors, 60 years of age and older, who reside in Montgomery County, Maryland. Services are offered in English and Spanish.

- Therapy for Homebound Seniors: (In-home or telehealth) Assessments, brief psychotherapy and practical support helps homebound individuals cope with issues like stress, anxiety, depression, adjustment, and chronic disease management.
- Spanish Speaking Outreach Program: (In-home or telehealth) This program provides culturally sensitive, bilingual short-term therapy and psychiatric care to homebound seniors in our community who speak Spanish.
- Psychiatric Consultation and Treatment: (In-home or telehealth) Assessment, treatment and follow-up visits with a psychiatric nurse. Seniors must be in counseling with a Seniors Services therapist to receive psychiatric visits. Following discharge, appropriate referrals and recommendations are shared with the primary care physician or other specialist if ongoing care is needed.
- Educational Seminars for Seniors: Psychoeducational talks on mental health and wellness issues for seniors. The primary goal of these seminars is mental illness prevention and early intervention for seniors.
- Professional Consultations & Staff Training: Free case consultation, staff training and collaborative activities are offered to service professionals and community organizations that provide services to seniors in Montgomery County.
- Drop-in Support Groups for Seniors: Community outreach and drop-in support groups are offered throughout Montgomery County. Drop-in groups offered at Senior Centers are designed to decrease social isolation, develop coping skills, and encourage learning about self-care and wellness.
- Mental Health Support for Caregivers: Professionals that understand the unique mental health needs of seniors and caregivers offer ongoing education and support services to caregivers in our community.

## Other Treatment Options available at The Affiliated Santé Group

**Additional services through Santé include the Outpatient Mental Health Clinic and Psychiatric Rehabilitation Program (PRP). Please let us know if you are interested in more information about these programs.**

## Types of Discharge

### Discharged Completed

- Consumer has fulfilled all goals in the treatment plan or agrees to continue working on goals post discharge.
- A discharge form will be completed including copy given to the consumer.
- The counselor will assist the consumer when making necessary referrals.

### Consumer Terminated Services

- The consumer terminates treatment.
- The consumer no-shows three consecutive appointments and attempts to contact consumer go unanswered (unless the team decides to extend the limit).
- Whenever possible, consumer will be given a discharge form that includes referral.
- The counselor will assist consumer when making necessary referrals

### At Staff request

- Consumer is asked to leave treatment by their counselor for rule violations.
- Discharge form will be completed with referral and a copy will be given to the consumer.
- The counselor will assist consumer when making necessary referrals.

### Increased Level of Care

- Consumer is discharged by the staff to enter an increased level of care.

### Readmission Requirements

If you have been discharged from the program and want to return for treatment, you must call Seniors' Services or submit a referral online. Based on the amount of time that has passed since your last contact with Seniors' Services, you may have to do one of the following things:

- 1) Participate in new intake assessment, treatment plan and associated paperwork.
- 2) Update any information including medical changes that have occurred since your last treatment.
- 3) Meet eligibility requirements for Seniors' Services.

## Things You Need to Know



### Tobacco

Please refrain from smoking while in session with your counselor for the safety and health of ASG employees.

### Weapons are prohibited

Seniors' Services team members will not provide services in the home of any consumer where weapons are present, regardless of whether the person is licensed to carry the weapon.



### Advance Directives



In Maryland, **Advance Directives for Mental Health Treatment** is a legal document that tells doctors and health care providers what mental health services or treatment you would want and what services or treatment you would not want if you later became unable to decide for yourself. You can name a person to make health care decisions for you if you are not able to make them yourself. You may contact the Maryland Disability Law Center at 1-800-233-7201 or TTY 410-727-6387 if you would like more information.

### Fees and Financial Obligations

Seniors' Services is sponsored and funded through The Montgomery County Department of Health and Human Services. **All services are free of charge to residents of Montgomery County.**





## Positive Environment

ASG works hard to promote a positive healthy environment. We believe in an open and welcoming facility and program. Awards and incentives are used to encourage and promote personal growth. We celebrate success and use encouragement during setbacks. Please feel free to approach any staff member with any questions, concerns, or requests.

## Feedback

During your course of treatment, you will be asked to participate in a survey possibly more than once. This is to allow ASG a chance to get feedback about the quality of services and you a chance to make suggestions. The administrative team uses this information to improve services and the quality of care that is provided. Your input is vital in helping us with that process. There may be a suggestion box in the front lobby that you may utilize at any time. The staff is open to all of your suggestions, and you are free to approach any staff member with your suggestions or concerns as well.



## Code of Ethical Conduct

The Affiliated Santé Group has developed its own Code of Ethical conduct for its employees. ASG also follows the ACA Code of Ethics.

(<https://www.counseling.org/resources/aca-code-of-ethics.pdf>). Both are available upon request.

## Use of Restraints

ASG will not use restraint or seclusion on any of the participants enrolled in any ASG program. ASG staff will address conflict situations primarily with positive interventions such as by separating individuals and talking out problems.





## Rescheduling and Cancellations



If you need to cancel or change your appointment, you must contact your therapist directly. **If you cannot reach them, you must leave a voicemail.** Calls without accompanying voicemails do not suffice as notice. If you attempt to cancel your appointment within 24 hours of its scheduled time, you may or may not be able to reschedule your visit in that same business week.

## Use of email and text messages

ASG employees will not communicate with consumers through email or text messages regarding the specifics of the consumer's treatment. ASG, in certain circumstances, may communicate with consumers with email and/or text messages regarding non-clinical issues. ASG cannot ensure the level of protection with these forms of communication.



## Returning Calls



ASG is not able to return calls to numbers that are blocked, numbers marked restricted, or are private based on federal confidentiality laws. If your phone has a block, please know that ASG will not be able to return your call. You may leave an alternative number, call ASG back, or remove the block.

## Severe Weather and Natural Disasters

Severe weather is any weather condition or natural event that could cause physical harm or property destruction, such as extreme thunderstorms, snowstorms, tornados, and flash floods. In the event of severe weather in the area, your Seniors' Services counselor will contact you regarding your appointment.







## The Assessment, Treatment Plan and Transition Plan

The purpose of the assessment is to identify strengths, weaknesses, abilities, and preferences of a client through an interview process with a qualified counselor. Based on information identified in the assessment, together, client and counselor will develop an individualized treatment plan to identify goals, objectives, and specific treatment interventions to be used. Any transition from the ASG program or to another level of care will be based on an on-going assessment process throughout treatment. If ASG is not able to meet the specific needs of a client at any point in the treatment experience, ASG will make an appropriate referral. If the client successfully completes the program, the counselor and client will develop a transition plan to include referrals that will support and enhance on-going recovery.

## Forms and Consents

A copy of all the forms and consents you are asked to sign are included in this handbook for your review. If you should have any questions, please feel free to ask questions.



## Gifts

It is the policy of ASG employees not to accept gifts from consumers or their family members for any reason.

## After Hours

While Seniors' Services therapists are available during regular business hours, for emergencies 365 days a year, a crisis center counselor is always available. Simply call the Mobile Crisis Team at:

Montgomery County Crisis: **240-777-4000**



## What is talk therapy or counseling?

In simplest terms, it is an ongoing conversation between you and mental health counselor to help you make the changes you want. Therapists take different approaches. Some will be more directive, providing feedback on your progress, and/or giving you homework exercises to practice some of the techniques learned in therapy. Others will give you more space to draw your own conclusions. In all cases, Seniors' Services therapists are there to help you make progress towards your goals.

Your counselor will help you learn new ways to think through and approach daily situations so that you have healthier beliefs and behaviors. While different counselors use different approaches, it all begins with the relationship with your therapist and your willingness to talk about what is troubling you.

Therapy is a team effort. While counselors are trained to ask the right questions, they're not mind readers. Therapy will be most effective when you share your thoughts and feelings openly and honestly. While engaging in counseling, it is normal to disagree with your therapist from time to time. When this happens, it is important to honestly share your feelings or concerns. This will help you and your therapist agree on how to handle this.

**Remember: Counseling is not a quick fix for your problem, rather it is a process.** However, with some effort on your part and a strong relationship with your therapist, counseling can be a successful tool towards recovery.



The following are copies of the forms you may have signed in the admission process.



**GENERAL INFORMATION**

I, \_\_\_\_\_, voluntarily give my permission and consent to The Affiliated Santé Group (ASG) for providing behavioral health services including evaluation, treatment and/or services provided by ASG. I have been informed and understand that the services rendered by ASG may include an intake, diagnostic process, evaluation of treatment and/or rehabilitation needs and any additional evaluations, therapies, and/or medication that may be recommended or provided by the ASG and its programs. I understand that the information gathered through the above interventions will be used to help me develop a crisis plan when necessary. I have had these services explained to me and have had the opportunity to ask questions. Any questions I asked were answered fully to my satisfaction.

I understand and acknowledge the results of evaluations will be made available to me as appropriate according to law. I understand all evaluation, treatment, and services are voluntary and I may request, refuse, and/or terminate any or all of them at any time which request ASG will honor. I understand the consequences, if any, will be explained to me if I refuse or terminate evaluation, treatment, or services.

**CONFIDENTIALITY**

I understand and acknowledge that strict confidentiality of my information is practiced and ensured by ASG with the following exceptions:

1. If I have signed a consent form to release designated information to named parties.
2. If there is a court order signed by a judge directing the release of designated information to named parties.
3. If ASG finds that there is a perceived threat of injury to myself or others, ASG is legally bound to disclose certain information to designated parties.
4. If ASG believes that there is a suspicion of abuse involving children or other vulnerable individuals (e.g. intellectually disabled or elderly adults) ASG is legally bound to disclose certain information to designated parties.
5. If ASG is required to defend against a claim or investigation it may use certain designated information in its defense.
6. If ASG is part of a legitimate audit certain information may be disclosed.
7. If ASG is required to disclose certain information in order to obtain payment from a third party payer.

I understand and acknowledge that demographic and utilization information regarding my treatment and/or services may be reported in statistical form to the State of Maryland and/or the contracted managed care organization. This information will be kept confidential and may not be released to any other agency or person without my consent except as identified previously. I understand that information obtained by law enforcement during my involvement with ASG may not be covered by ASG's confidentiality policy. All substance abuse information will be confidential



## INFORMED CONSENT FOR TREATMENT Continued

according to 42 CFR Part 2.

I understand that although email and text message correspondence may not be considered as a preferred form of communication between consumer and staff, there may be times when these forms of communication may be useful and necessary. I understand any information relayed in email or text message will be limited and will not be used to provide any form of treatment. You are advised that ASG cannot guarantee complete privacy with regards to text messages and emails that you send. I also understand that ASG will apply reasonable safeguards to protect confidentiality with regards to these forms of communication.

### FEES

I acknowledge that any fees for evaluations, treatment, and/or services provided by ASG are charged to the contracted managed care organization or to my insurance plan. I understand services provided by agencies, programs, or companies working with ASG are billed and paid for in accordance with that agency's programs, or company's procedures. I also understand ASG is not responsible for explaining the provisions contained in another agency's programs or company's billing structure or procedures.

### NOTIFICATIONS

I acknowledge I have been provided a copy of ASG' Human Rights Notification, HIPAA Privacy Practices, Grievance Procedures and general orientation information. I acknowledge this information was explained satisfactorily to me and I was given the opportunity to ask questions and am satisfied with the responses given to me.

### STATEMENT OF UNDERSTANDING

By my signature, I indicate that I have reviewed and understand the above information. I acknowledge that my rights as a consumer have been satisfactorily explained to me and I had the opportunity to ask questions and am satisfied with the responses given to me. I understand that I may withdrawal this consent at any time. I voluntarily give my informed consent for evaluation, treatment, and/or services.

Consumer or Consumer Representation Signature	Date
Print Name of Consumer Representative	Relationship of Representative to Consumer
Staff Signature	Date





## **GRIEVANCE PROCEDURES**

The following is an outline of the Grievance Procedures for consumers who receive services from The Affiliated Santé Group (ASG).

1. Consumers will be advised of the grievance policy at the time of admission.
2. Consumers may initiate a complaint or grievance by informing their counselor, the Clinical Supervisor, or any staff member of their concern.
3. Consumers will then be asked to submit the grievance initially to the direct care staff in writing or verbally. The direct care staff will inform the Clinical Supervisor of such concern.
4. If direct care staff is unable to resolve the grievance to the consumer's satisfaction, then the consumer will be asked to speak with the Clinical Supervisor to review the grievance and determine a resolution or plan of action within 5 working days of the initial complaint/grievance.
5. If the consumer is still not satisfied with the resolution or plan of action, the consumer will be asked to speak with the Program Director. Once the consumer has met with the Program Director, the Program Director will resolve the issue or take the issue to the Director of Corporate Compliance and Quality Assurance for a final decision. The Program Director will provide a written response to the consumer within 5 days of the meeting that includes:
  - a. A summary of the complaint/grievance as presented by consumer;
  - b. The decision of the Program Director with respect to the grievance;
  - c. An explanation that the consumer has the right to ask the Program Director to present the complaint/grievance to the Director of Corporate Compliance and Quality Assurance for review.
6. Grievance/Complaint forms will be available for consumers to use if desired.

Every consumer has the additional right of addressing a grievance to the Maryland Disability Law Center or the appropriate Core Service Agency. Contact information will be made available upon request and will be included in the form signed by the consumer at orientation.

The Program Director will retain all consumer grievance files and will review all complaints with the Director of Corporate Compliance and Quality Assurance and, if appropriate, the Operations Committee.





## **GRIEVANCE PROCEDURES Continued**

All consumers must be informed that, at any time, they may seek outside assistance with their complaint/grievance, such as from the referral source or from other agencies.

ASG will comply with the Core Service Agencies (CSA) and/or Department of Health & Mental Health (DHMH) policy regarding any complaint lodged against ASG to the CSA or DHMH.

Consumers will be free from any form of retaliation or barriers to services as a result of any action they take to regarding the filing of a grievance.

This is notice that you may submit any concerns and/or grievances in writing to: The Affiliated Santé Group, 12200 Tech Road, Suite 330, Silver Spring, MD 20904, ATTN: Director of Corporate Compliance. You may also file a complaint with the Maryland Department of Health and Mental Hygiene at (410) 402-8060.



## HUMAN RIGHTS NOTIFICATION

Individuals receiving services from any ASG program are entitled to the following human rights:

**Non-Discrimination:** You are entitled to receive treatment regardless of your race, color, religion, creed, ancestry, national origin, physical or mental disability, veteran status, gender, gender identity, age, social-economic status, intellectual ability, sexual orientation, political opinion, personal appearance, physical characteristics, marital or familial status or any other characteristic protected by law. You will be treated with courtesy, respect, and full recognition of your individuality. You have the right to dignity, privacy, and humane care. You have the right to live as normally as possible while receiving care and treatment.

**General Information:** You are entitled to be informed about all rules of the program and services and the nature of the services provided. Before your admission to the program, you will be informed of admission, attendance, and discharge policies. You have a right to know why you are being discharged and the plan for your mental health and physical health requirements after you are discharged. You have a right to be informed of all the programs and services of the company. You have the right to access a private physician of your choice at your own expense.

**Fees:** In clear language that you can understand and before you are admitted to the program, you are entitled to know how much your treatment costs, who will pay for it, any limit to the amount they will pay, and any amount for which you are responsible for payment. You have a right to be free from exploitation for financial gain. This includes misuse of any funds for your use or care.

**Treatment Services:** All services will be provided consistent with applicable federal, state, and local laws and regulations. You have the right to treatment. You have a right to have your care explained to you and to be informed what we will do if you refuse any treatment.

**Medication:** You may refuse medication as part of your treatment. If you choose to take medication, you will be informed of the reasons for it, what it is intended to do, of any common side effects, and of any risks associated with the medication.

**Research:** You have the right to refuse to participate in any research trial. You will be informed if you will be participating in any medication (or other treatment) trial prior to being placed in a research trial. If you do choose to participate in such a trial, you will be given all relevant information required by law so that you can make an informed decision about your participation.

**Media use:** You have a right to know if any audio or visual recording devices, television, movies, or photographs will be used in your treatment. You have the right to refuse the use of any such devices and to understand what will happen, if any, if you refuse to have them used.

**Restraints:** **You have the right to be free of all chemical and physical restraints; ASG will not use restraint, restrictive interventions or seclusion on any of the participants enrolled in the ASG program. ASG staff will address conflict situations with positive interventions such as by separating individuals and talking out problems.**



## HUMAN RIGHTS NOTIFICATION Continued

**Confidentiality:** All of the information recorded in your record, in accordance with medical record policy is confidential *except for legal or regulatory exceptions including the following:*

- You have signed and completed an *Authorization to Release Private Health Information* form that is valid for no more than one year from the date it is signed or until it's intended purposes are completed. You may cancel in writing your authorization at any time.
- There is a court order signed by a duly appointed or elected judge
- There is a perceived threat of injury to yourself or others or there is the likelihood that you will commit a felony or violent misdemeanor
- There is a suspicion of abuse involving children or other vulnerable individuals
- Representatives of a funding source for your treatment or services require that your records be made available to them
- You are an inmate in the Department of Correction and are determined to need treatment for mental illness, developmental disabilities, or substance abuse
- You are receiving emergency medical treatment (only the information necessary to meet the emergency will be released)

**Record review:** You (or your legally-responsible person) have a right to review your record consistent with company procedures and legal requirements. You can contact the Program Director to request a copy of your record.

**Freedom from abuse:** You have the right to be free from mental or physical abuse, harassment, physical punishment, or humiliating, threatening or exploiting actions. You have the right to have any allegations of abuse reported to local law enforcement agencies.

**Legal:** You have the right to representation by a lawyer in matters relating to your care. You may consult with a lawyer and have your lawyer interview staff members who work with or previously worked with you under reasonable circumstances. You may have access to your medical records in accordance with company procedures and legal regulations. You have a right to have your lawyer provide information before a hearing or other judicial proceeding.

**Advance Instruction for Mental Health Treatment:** Maryland individuals have the fundamental right to control the decisions about their mental health care. The State of Maryland has established an additional, nonexclusive way for an individual to exercise the right to consent to or to refuse mental health treatment when the person does not have sufficient understanding or ability to make or communicate mental health treatment decisions. You have the right to complete a mental health advanced directive to make your choices known. If you are interested, please contact the Maryland Disability Law Center at 1-800-233-7201 or TTY 410-727-6387

**Grievances:** You have a right to present a grievance you have and to understand how we handle your complaint. Maryland consumers also have the right to contact the Office of Health Care Quality with Maryland's Department of Health and Mental Hygiene, the statewide agency designated under federal and state law to protect and advocate for the rights of persons with disabilities. You **will not be penalized** for filing a grievance or complaint about your care or treatment.



## AUTHORIZATION FOR THE RELEASE/EXCHANGE OF PROTECTED HEALTH INFORMATION

Name of agency/person that information can be released to or exchanged with. (“Receiving Party”)	Name of agency/person that information can be released from or exchanged with. (“Releasing/Exchanging Party”)
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I, \_\_\_\_\_, hereby authorize that the above-name Releasing/Exchanging Party shall release/exchange the following health information to the above-named Receiving Party:

<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Information obtained from other agencies	<input type="checkbox"/> Discharge/Transition Plan
<input type="checkbox"/> Lab results	<input type="checkbox"/> Results and recommendations of assessment	<input type="checkbox"/> Medication information
<input type="checkbox"/> Participation and attendance	<input type="checkbox"/> Medical Information	<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> Other:	

For the specific purpose of:

<input type="checkbox"/> Aiding in and coordinating services	<input type="checkbox"/> Legal purposes
<input type="checkbox"/> Insurance/Managed Care purposes	<input type="checkbox"/> Other:

This Authorization is *valid until one year after the signature date*, for the period of time needed to fulfill its purpose, or until the date expressed by the client (please indicate date if less than one year) \_\_\_\_\_.

The exception to this time period is in the case of disclosures for financial transactions, or as otherwise authorized by law, where the Authorization is valid indefinitely. I also understand that I have the right to revoke this Authorization at any time and that in order to do so I must sign the *Revocation Section* on this form. I further understand that any actions taken pursuant to this Authorization prior to the revocation date and time is legal and binding. I understand information may be released verbally, in writing, by mail, via secured electronic means or secured fax.



## **AUTHORIZATION FOR THE RELEASE/EXCHANGE OF PROTECTED HEALTH INFORMATION Continued**

I understand that my information should not be re-disclosed by the requester of the information without my further written authorization and that the Federal Substance Abuse Confidentiality Regulations may protect this information. In any event the recipient should not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to chronic illnesses, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information unless I specifically exclude such information from disclosure.

I also understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), that service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed Authorization.

\_\_\_\_\_  
Client Signature or legally appointed representative

\_\_\_\_\_  
Client Date of Birth

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

### Revocation Section

I do hereby request that this Authorization to disclose health information of \_\_\_\_\_ (*Client's Name*) on \_\_\_\_\_ (*Date of Original Signature*) be revoked, effective \_\_\_\_\_ (*Today's Date*) at \_\_\_\_\_ (*Time*).

I understand that any action taken on this Authorization prior to this revocation date and time is legal and binding.

\_\_\_\_\_  
*Client Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Time*

\_\_\_\_\_  
*Witness Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Time*

### Verbal Revocation Section

I do hereby attest to the verbal request for revocation of this Authorization by

\_\_\_\_\_ (*Client's Name*) on \_\_\_\_\_ (*Date*)

at \_\_\_\_\_ (*Time*).

The client has been informed that any action taken on this Authorization prior to the revocation date is legal and binding.

\_\_\_\_\_  
*Staff Signature*

\_\_\_\_\_  
*Date & Time*

\_\_\_\_\_  
*Witness Signature*

\_\_\_\_\_  
*Date & Time*



## EMERGENCY MEDICAL TREATMENT FORM

In the event of an emergency, Employees and Representatives of The Affiliated Santé Group, have my permission to seek emergency care for me while in their care. I also give my permission to release medical information concerning me to any pertinent medical providers and to my emergency contact. The medical information to be released includes, but is not limited to, information outlines below.

### EMERGENCY CONTACT (FAMILY MEMBER OR FRIEND)

First Name:		Last Name:	
Address:			
Home Phone:	Work Phone:	Other Phone:	
Relationship to the client:			

### CURRENT MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER)

If none, indicate so here.

Current Medications:

### ALLERGIES

If none, indicate so here.

All known allergies (medication, food, bee stings, etc.)

### PERTINENT MEDICAL HISTORY

If none, indicate so here.

List any current pertinent history:

### CURRENT PHYSICIAN

Current Physician:

Physician's Address:

Physician's Phone Number:





## EMERGENCY MEDICAL TREATMENT FORM Continued

This consent has been explained to me and I understand that the contents to be released, the need for the information, and that there are statues and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is voluntary and is valid based on any need for medical treatment while in treatment at The Affiliated Santé Group. This consent will no longer be valid once I am discharged from the program.

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Client Signature

---

Date

---

Witness Signature

---

Date

## **CONSUMER'S RESPONSIBILITIES**

The following are the responsibilities of each consumer:

1. A consumer has the responsibility to provide to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to unexpected changes in his condition to the responsible practitioner. A consumer is responsible for making it known whether he/she clearly comprehends a contemplated course of action and what is expected of him/her.
2. A consumer is responsible for following the treatment plan developed in congress with his/her therapist.
3. The consumer is responsible for keeping appointments and when he/she is unable to do so for any reason, for notifying their counselor.
4. The consumer is responsible for inviting people who will be helpful and supportive to be included in your treatment planning.
5. The consumer is responsible, if applicable, for taking medications as they are prescribed for you.
6. The consumer is responsible for telling your doctor or therapist if you do not agree with their recommendations.
7. The consumer is responsible for telling your doctor or therapist if or when you want to end treatment.
8. The consumer is responsible for cooperating with those trying to care for you.

# The Affiliated Santé Group

Notice of Privacy Practices

**Your Information. Your Rights.  
Our Responsibilities.**



**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

## **YOUR RIGHTS**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

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### **Get an electronic or paper copy of your medical record.**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### **Ask us to correct your medical record.**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### **Request confidential communications.**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say, “yes” to all reasonable requests.

### **Ask us to limit what we use or share.**

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say “yes” unless a law requires us to share that information.

### **Get a list of those with whom we’ve shared information.**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

## Get a copy of this privacy notice.

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

## Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

## File a complaint if you feel your rights have been violated

- You can complain if you feel we have violated your rights by contacting us using the information on the back page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## YOUR CHOICES

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

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### **In these cases, you have both the right and the choice to tell us to:**

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
  - *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

### **In these cases we never share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

### **In the case of fundraising:**

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## OUR USES AND DISCLOSURES

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

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### **Treat you:**

- We can use your health information and share it with other professionals who are treating you.
  - *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

### **Run our Organization:**

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  - *Example: We use health information about you to manage your treatment and services.*

### **Bill for your service:**

- We can use and share your health information to bill and get payment from health plans or other entities.
  - *Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may “opt-out” and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at [www.crisphealth.org](http://www.crisphealth.org). Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

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### **Help with public health and safety issues:**

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

**Do research**

- We can use or share your information for health research.

**Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

**Respond to organ and tissue donation requests**

- We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address worker’s compensation, law enforcement, and other government requests**

- We can use or share health information about you:
  - For workers’ compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**The Affiliated Santé Group follows the requirements outlined in 42CFR Part 2.**

**OUR RESPONSIBILITIES**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see:  
[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).



## Changes to the Terms of This Notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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## This Notice of Privacy Practices applies to the following organizations.

- All of the Affiliated Santé Group's programs

The Affiliated Santé Group  
12200 Tech Road  
Silver Spring, Maryland 20904  
301-572-6585

Compliance Officer  
Melissa Quick, D.Min, CCS, LCAS, LPC  
Director of Quality Assurance and Corporate Compliance

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*Effective Date: 03/15*

## **CHESAPEAKE REGIONAL INFORMATION SYSTEM for our PATIENTS (CRISP)**

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at [www.crisphealth.org](http://www.crisphealth.org). Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.



## Receipt of Client Handbook

I \_\_\_\_\_ have received a copy of the ASG Consumer Handbook and have been given an opportunity to ask questions. I understand this handbook is not all-inclusive and will merely serve as a reference to general guidelines. If I should have any questions, I will consult my counselor or appropriate ASG staff member.

\_\_\_\_\_  
Consumer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## *Mental Health Crisis Resources*

### **Montgomery County Crisis System:**

- 240-777-4000 (available 24/7)
- Mobile Crisis services: available 7 days a week from 8am to midnight; provides emergency evaluations in the community

### National Help Lines:

#### **National Suicide Prevention Lifeline**

- 988
- Available 24/7; phone calls transferred to trained counselors in more than 130 sites worldwide

#### **American Psychiatric Association Center**

- 1-888-35-PSYCH (77924)
- Operators available 8:30am-6pm, referrals to local board-certified psychiatrists

#### **Maryland 211**

- 2-1-1 is a free referral and information helpline that connects people to a wide range of health and human services, 24/7.