HealthPort

HealthPort Outpatient Clinic
505 E Main St, Salisbury, MD 21804
P: 410-341-3420 F: 410-341-3397
referral@HealthPort.org

HealthPort Outpatient Clinic Intake Packet Instructions

1. Print and Complete all enclosed forms
2. Complete separate Releases of Information for agencies who hold your medical records, like:
    a. Current/Former Primary Care Provider
    b. Current/Former Psychiatric Provider
    c. Hospitals where you may have been admitted
    d. Other agencies with whom you are enrolled, like substance use disorder treatment or specialists, like a cardiologist
3. Submit copies of your insurance information, photo identification, and social security card with your packet
    a. If you don't have these documents, please contact the office for alternatives
4. Submit all paperwork, with signatures:
    a. In Person at HealthPort front desk at 505 E Main Street, Salisbury, MD 21804
    b. By Fax to 410-341-3397
    c. referral@HealthPort.org
5. Once all paperwork is in order and complete, HealthPort staff will contact you to schedule appointments

HealthPort

Client Registration Form

What are you here for today? ☐ Primary Care ☐ Behavioral Health Date: _____

Do you have a legal guardian? ☐ No ☐ Yes- MUST provide copy of guardianship paperwork

Name and Phone Number of Person Referring You Here: _____

Client Name: _____ Preferred Name: _____

Address: _____Apt #_____

City: _____ State: _____ Zip: _____ County: _____

Phone Number (Mobile): _____ (Home): _____

Email Address: _____

Appointment Reminders: Please select **One**: ☐ Text Reminder ____ Days Early

☐ Email _____ Days Early ☐ Text and Email _____ Days Early ☐ Phone Call Two Days Early

Social Security #: _____ Date of Birth: _____ Age: _____

Race: _____ Ethnicity: _____ Marital Status: _____Gender: ☐ Male ☐ Female ☐ Other

Primary spoken language: ☐ English ☐ Other: _____

Emergency Contact: _____ Phone Number _____

Insurance Information (provide cards): ☐ Uninsured ☐ Medicare ☐ Maryland Medical Assistance

☐ Maryland Medicaid MCO ☐ Private Insurance: **Insurance ID**:_____

Highest Level of Education: _____ Currently Enrolled in School: ☐ Yes ☐ No

Are you currently employed? ☐ Yes ☐ No *If Yes*: ☐ Full Time ☐ Part Time

Are you a Veteran? ☐ Yes ☐No Did you serve in Iraq and/or Afghanistan conflicts? ☐ Yes ☐ No

Military History: _____

Legal History: Have you been arrested in the last 30 days? ☐ Yes ☐ No 90 Days? ☐ Yes ☐ No

Do you have any friends/relatives in treatment at our facilities? ☐ Yes ☐ No

How can we help you today? _____

_____

HealthPort Consent For Services

Client Name: _____Client DOB: _____

We are excited to announce that Lower Shore Clinic, including the merged business of Go-Getters, has rebranded as HealthPort. We remain the same organization, retaining our taxpayer and other identification numbers. This new name aligns more closely with our mission.

Consent for Services:

I understand that HealthPort will provide the following services upon my enrollment:*

☐Assertive Community Treatment- ACT
☐Psychiatric Rehabilitation Program- PRP
☐Residential Rehabilitation Program- RRP
☐Supported Employment- SE
☐Residential Crisis Services
☐Outpatient Mental Health
☐Primary Care

Client Rights:

HealthPort adheres to the Department of Health and Mental Hygiene regulations, on which these rights are based.

HealthPort Clients have the right to:

1. Receive an explanation of their rights.
2. Be treated in a humane fashion with reasonable protection from harm and abuse, both physical and mental, and a reasonable right to privacy.
3. Receive treatment and care in the least restrictive setting regardless of race, religion, gender, gender identity, ethnic background, age, handicap, political affiliation, economic status, how you choose to pay for care, or sexual orientation.
4. Participate in making and understanding the person-centered plan, including the right to reject any portion of the plan.
5. Discuss your medications with your prescriber. This includes how the medication works, how it makes you feel, side effects, and any need for medication changes.
6. Have questions about your treatment answered.
7. Expect personal information to be kept confidential.
8. Review records with an advocate, counselor, therapist, or team leader.
9. Refuse to participate in physically intrusive research.
10. Speak with an advocate or other staff at reasonable times.
11. Initiate a complaint or grievance, following the grievance procedure.
12. Include family members and significant others in my treatment.
13. Have access to an On Call staff person for emergency needs at 410-341-3420
14. Have access to treatment in a timely manner, with consideration to routine, emergency, and urgent appointments.

Client Name: _____Client DOB: _____

15. These rights may be limited only by therapeutic considerations made known to the client in advance.
16. Know that motivational incentives will not be used to influence treatment.
17. Know that physical restraint or seclusion will not be used.

For those in residential rehabilitation services, these additional rights apply to you:

1. Send mail uncensored and receive mail unopened.
2. Use the public telephone.
3. Speak with an attorney, public defender, or clergyman privately.
4. Receive visitors at reasonable times.
5. Exercise all civil rights, including the right to vote and receive or dispose of property unless deemed legally incompetent.

Client Responsibilities:

All HealthPort clients are expected to carry out the following responsibilities to be clients in good standing:

1. Treat people with respect and do not hurt or threaten any other person or yourself.
2. Keep all agreements you make.
3. Participate in developing your Person-Centered Plan and follow its expectations.
4. Select a mental health provider and collaborate in treatment.
5. Learn about your illness and take charge of your health care.
6. Not use or have weapons, alcohol, or drugs on any program property.
7. Pay co-pays and other debts as required.
8. Engage in a manner that does not violate the civil rights of others, taking care not to knowingly expose others to communicable diseases.
9. Keep appointments as scheduled.
10. Notify your provider of any side effects from medications.
11. Not share prescriptions or over-the-counter medications or supplements with anyone else, as it is illegal and unsafe.
12. Be responsible for my prescription medications, on and off agency properties.
13. Not smoke or vape inside any agency building. There are designated smoking areas outside of the building with cigarette bins available.
14. If receiving Sliding Fee Scale billing, to supply verifiable proof of all income.
15. To supply accurate insurance information, including any changes in insurance information.

Policies and Handbook Information:

Complaint Procedure: If a client feels his or her rights have been violated, he or she is requested to present a Complaint in accordance with the Complaint Procedure. A Complaint form can be requested from any staff member on your treatment team or is available on our website. A member of the Consumer Advisory Board or a neutral staff person can assist you in filing your complaint.

Client Name: _____Client DOB: _____

Coordinated Care: If you participate in more than one of our programs (Outpatient Clinic, Psychiatric Rehabilitation, Residential Rehabilitation, Supported Employment/Vocational, and/or Assertive Community Treatment), agency staff will coordinate your care, which will include treatment planning, case coordination, and communication.

Mandated Reporters: I understand that as healthcare providers, staff are required by law to disclose my protected health information without my consent to report information about abuse and neglect, and to warn about other dangers. Reports of neglect or abuse made to healthcare providers, regardless of circumstances or when it happened, must be reported. Additionally, staff are required to provide information when asked by state agencies regarding cases of abuse or neglect, even when not initially reported by this office.

Discharge Policies: All services provided by HealthPort are on a voluntary basis. Our staff is committed to providing you with quality care. Our policies regarding the ending of treatment are listed below:

1. Discharge of services shall, wherever possible, be a joint effort between you and your providers. When this decision is made, you and your providers will develop a discharge plan including your service needs, progress in treatment, and medications. Staff will assist you with necessary referrals for treatment, rehabilitation, or community support.
2. You may be discharged from services when they are no longer necessary or required, or when the treatment team feels that treatment should not continue.
3. You may be discharged from services if you have not participated in services and staff has attempted to contact you with at least 30 days written notice.
4. A decision to discharge services may be recommended if you fail to comply with your person-centered plan that is mutually agreed upon between you and your treatment team.
5. You may discontinue services at any time. You should discuss this with your treatment team if you choose to do so.
6. Your treatment may end if you present a threat to the health or safety of staff or other clients.

Telehealth: Services rendered via telehealth technology, available at the Outpatient Clinic, will be subject to the same confidentiality standards as in-person services. Audio-Visual Telehealth Platforms used by the agency will be HIPAA Compliant and secure. Telephonic or Audio Only visits may not be secure due to technological limitations. It is your responsibility as the consumer to conduct telehealth visits in a secure, private location to minimize risk of unintentional information disclosure. Persons receiving telehealth services must be seen in person at the office at least three times annually or more frequently depending on recommendations of the provider and treatment plan.

Immunet: We participate with Maryland's Immunization Information System, a confidential and secure database that stores individual's vaccination records. Appropriate agency staff may check your immunization records for you to avoid under or over-vaccination and safe delivery of services.

MDPCP: Lower Shore Clinic Primary Care has chosen to participate in the Maryland Primary Care Program (MDPCP) as of January 1, 2020. Medicare beneficiaries who are eligible as determined by the MDPCP program will receive enhanced primary care coordination through the Care Wrap program. Medicare eligible beneficiaries may opt out of MDPCP reporting services at any time by contacting the MDPCP helpdesk at 1-844-711-2664 option 7.

Client Name: _____Client DOB: _____

Pharmacy Coordination: The agency utilizes CRISP resources and partner pharmacies to coordinate medication reconciliation, dispensing, and safe prescribing.

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. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Security: Your medical record is kept in a secure location and only those employees or clinicians who need access to your medical record for treatment, payment or health care operations, have access to your medical record unless you sign an authorization. It is our policy to reasonably limit disclosures of, and requests for, protected health information for payment and health care operations to the minimum necessary. We also limit which members of our workforce have access to protected health information for treatment, payment, and health care operations, based on those who need access to the information to do their jobs.

Consent for use of Protected Health Information: I understand that the Agency will maintain the confidentiality of my records in a manner that is consistent with company policy as stated in the HealthPort Privacy Notice and that I have the right to review this notice.

Your Rights to See Your Record: You have the right to see or to receive a summary of your record. You also have the right to ask us for an accounting of the persons or programs to whom we have disclosed your protected health information. (This does not include disclosures for treatment, payment or health care operations, or to persons authorized by you.) To receive this information, please contact: Custodian of Records, HealthPort, 505 E. Main Street, Salisbury, MD 21804; 410-341-3420.

How to File a Complaint: You have the right to file a complaint if you believe that your protected health information has been released in violation of the law. You have 180 days to file a complaint unless the Secretary of the Department of Health and Human Services waives or extends the time frame. You may file a complaint with our program by submitting a Complaint Form to the Chief Human Resources Officer

I understand that I have the right to request restrictions on the usage and disclosure of the contents of my records and that I can revoke my consent at any time through a written request to the Director of the program. _____ (Initial)

I release from liability and hold harmless the paid staff, volunteer staff, members and Board of Directors of HealthPort for any personal injury which may be suffered while participating in activities. _____ (Initial)

I give permission to film and utilize photos to promote community awareness. If not, I will remove myself from picture taking or filming. _____ (Initial)

Client Name: _____Client DOB: _____

Health Homes Services Consent:

For Participants of PRP, RRP, and/or ACT services (for all others, skip to Financial Policy Disclosure and Client Payment Agreement):

By signing this form I agree to receive Health Home Services from HealthPort:

This means that your mental health or substance use disorder provider will begin to give you additional services designed to help you better manage your health. This may include assisting with scheduling appointments with other providers, offering information about your physical health conditions, following up when you are seen in a hospital, or connecting you with other resources that can help improve your well-being.

While participating in a Health Home will help make sure you get the services you need, you will still be able to get health care and health insurance even if you do not sign this form or do not want to receive Health Home services from HealthPort.

Your health information is private and cannot be given to other people without following Maryland and U.S. laws and rules. Some special laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The partners that can get and see your health information must obey all these laws. They cannot share your information unless you agree, or the law says they can give the information to other people. This is true if your health information is on a computer or on paper. This form does not change the laws and regulations the partners must follow.

I Agree to receive Health Home services from HealthPort's Health Home. I understand that my consent lasts until I take back my consent, which can be done by signing a Withdrawal of Consent Form.
_____ (initial)

Financial Policy Disclosure and Client Payment Agreement

1. Authorization to Release Information: I hereby authorize HealthPort to release medical information pertaining to my medical treatment as requested by Third Parties in order to secure payment of services rendered by HealthPort.
2. Authorization to Pay Insurance Benefits: I hereby authorize any insurance or third-party benefits, related to this mental health and/or primary care treatment, to be paid directly to HealthPort.
3. Payment Guarantee: In consideration of the acceptance of the named client by HealthPort, and for the services rendered said client, the undersigned hereby guarantees payment of any and all charges made by HealthPort.
4. Sliding Fee Scale: If placed on a sliding fee scale, I will provide accurate and updated financial information no less than every 12 months. I am required to pay for any services provided to me by HealthPort based on the written financial agreement.
5. Good Faith Estimate: If I am uninsured, I understand that a Good Faith Estimate will be made available to me upon request. The Good Faith Estimate will provide cost information for any expected healthcare services or items. The Good Faith Estimate is not a contract and is subject

Client Name: _____Client DOB: _____

to change due to procedures not previously scheduled or recommended as part of the course of care.

6. Telehealth: Telehealth visits, visits conducted by two-way audio/video or audio only means, are subject to the same billing rules as in person services.
7. Medicare Assignment: I certify that the information given by me in applying for payment under TITLE IVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its' intermediary or carriers any information needed for this or a relation Medicare claim. I understand I am responsible for any deductible or co-insurance.
8. Authorizations: Some insurance payers require clients to participate in authorizations for services and medications, if your participation is needed, agency staff will complete paperwork and forms with you.
9. If more than one person signs this Disclosure/Agreement, their liability shall be joint and several.
10. By signing this document there is the understanding that all medical, diagnostic, and treatment information will only be released to the appropriate insurance carriers as designated by the signer.

My consent is given freely and fully for those services to be performed for my benefit.

I have received and read or had read to me the: Orientation Handbook and/or Consent Policies

Which Explains the Following:

☐My Rights and Responsibilities as a Client
☐How Fees are Established and Paid
☐The Complaint Procedure
☐The Discharge Procedure
☐Program Hours, Services, and After-Hours Procedures.
☐Other important information

I certify that I fully understand the information presented in the Handbook.

_____ _____
Client Signature Date

_____ _____
Guardian/Guarantor Date

_____ _____
Guardian/Guarantor Date

Lower Shore Clinic cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. (Spanish)

Lower Shore Clinic 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視任何人。注意：如果您使用繁體中文，您可以免費獲得語言援助服務(Chinese)

Lower Shore Clinic 은 (는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다. 주의: 한국어를사용하시는경우, 언어지원서비스를무료로이용하실수있습니다. (Korean)

Lower Shore Clinic tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đ ối xửdựa trên chủng tộc, màu da, nguồn gốc quốc gia, đ ộtuổi, khuyết tật, hoặc iới tính. CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụhỗtrợngôn ngữmiễn phí dành ho bạn. (Vietnamese)

Lower Shore Clinic respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap. Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. (French).

Sumusunod ang Lower Shore Clinic sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian. Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. (Tagalog)

Lower Shore Clinic соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола. Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. (Russian)

Lower Shore Clinic የፌደራልሲቪልመብቶችንመብትየሚያከብርሲሆንሰዎችንበዘር፡ በቆዳቀለም፣ በዘርሃረግ፣በእድሜ፣በአካልጉዳትወይምበጾታማንኛውንምሰውአያገልም ።
የሚናገሩትቋንቋአማርኛከሆነየትርጉምእርዳታድርጅቶች፣በነጻሊያግዝዎትተዘጋጀተዋል (Amharic)

Lower Shore Clinic tele ilana ofin ijoba apapo lori eto ara ilu atipe won ko gbodo sojusaju lori oro eya awo, ilu-abinibi, ojo-ori, abarapa tabi okunrin ati obinrin. tele ilana ofin ijoba apapo lori eto ara ilu atipe won ko gbodo sojusaju lori oro eya awo, ilu-abinibi, ojo-ori, abarapa tabi okunrin ati obinrin. (Yoruba)

Lower Shore Clinic na eso usoro iwu federal civil rights. Ha a nakwagi akpachapu onye o bula n'ihe e be o nye ahu si, a gburu ya, colo ahu ya, aha ole onye ahu di, ma o bu nwoke ma o bu nwanyi. O buru na asu Ibo asusu, enyemaka diri gi site na (Ibo)

Lower Shore Clinic cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo. Se fala português, encontram-se disponíveis serviços linguísticos, grátis. (Portuguese)

Lower Shore Clinic konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks. Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. (French Creole)

Lower Shore Clinic લાગુ પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અશક્તતા અથવા લિંગના આધારે ભેદભાવ રાખવામાં આવતો નથી. **સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. (Gujarati)**

Lower Shore Clinic ametimiza mahitaji ya sheria za serikali kuu na hana ubaguzi wa kikabila, rangi, asili, umri, ilemavu ama jinsia. Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. (Turkish)

nicLower Shore Cli قابلِ اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے اور یہ خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کہ نسل، رنگ ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا۔ (Urdu)

يلتزم Lower Shore Clinic بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس. ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم xxx-xxx-xxxx-1 (رقم هاتف الصم والبكم: xxx-xxx-xxxx-1). (Arabic)