

  
**Key Point**  
**HEALTH SERVICES INC.**  
OUTPATIENT MENTAL HEALTH PROGRAMS

Client Name: \_\_\_\_\_ Client DOB: \_\_\_\_\_

**ADULT HEALTH HISTORY - MEDICAL**

*Please explain any selected response(s) on the lines following the selection.*

**Eyes, Ears, Nose, Throat**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> None Reported            | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Ear/Hearing Problems |
| <input type="checkbox"/> Eye/Vision Problems      | <input type="checkbox"/> Throat Problems | <input type="checkbox"/> Other                |
| <input type="checkbox"/> Nose Problems/Nosebleeds |  |   |
- 
- 

**Musculoskeletal**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> None Reported | <input type="checkbox"/> Bone/Joint Difficulty | <input type="checkbox"/> Back Pain/Injuries |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Other                 |   |
| <input type="checkbox"/> Gout          |  |   |
- 
- 

**Blood/Lymphatic System**

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> None Reported          | <input type="checkbox"/> Bleed Easily | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Anemia (Low RBC Count) |                                       |  |
| <input type="checkbox"/> Other                  |                                       |  |
- 
- 

**Circulatory/Cardiac Systems**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> None Reported           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Chest Pain           |
| <input type="checkbox"/> Angina                  | <input type="checkbox"/> Abnormal EKG        | <input type="checkbox"/> Heart Attack         |
| <input type="checkbox"/> Rheumatic Fever         |  |   |
| <input type="checkbox"/> Other                   |  |   |
- 
- 

**Endocrine System**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> None Reported       | <input type="checkbox"/> Thyroid Disease    | <input type="checkbox"/> Excessive Thirst     |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Weight Gain        | <input type="checkbox"/> Weight Loss          |
| <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> Menopause Problems | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> Menopause           |   |   |
| <input type="checkbox"/> Other               |   |   |
- 
-

**Gastrointestinal System**

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> None Reported              | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Stomach Pain |
| <input type="checkbox"/> Difficulty Swallowing      | <input type="checkbox"/> Liver          | <input type="checkbox"/> Jaundice     |
| <input type="checkbox"/> Diverticulitis             | <input type="checkbox"/> Ulcer          | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Pancreatitis               | <input type="checkbox"/> Hepatitis B    | <input type="checkbox"/> Hepatitis C  |
| <input type="checkbox"/> Hepatitis A                | <input type="checkbox"/> Reflux         | <input type="checkbox"/> Nausea       |
| <input type="checkbox"/> Hemorrhoids/Rectal Disease | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Other        |
| <input type="checkbox"/> Vomiting                   |   |                                       |
- 
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**Genital/Urinary System**

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> None Reported          | <input type="checkbox"/> Prostate                   | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Urinary Tract Problems | <input type="checkbox"/> Sexual Transmitted Disease | <input type="checkbox"/> Other      |
| <input type="checkbox"/> Sexual Difficulties    |   |                                     |
- 
- 

**Nervous System**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> None Reported        | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Tremors                      |
| <input type="checkbox"/> Seizures/Epilepsy    | <input type="checkbox"/> Speech Problems    | <input type="checkbox"/> Loss of Feeling in Hand/Foot |
| <input type="checkbox"/> Loss of Coordination | <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Sleep Problems               |
| <input type="checkbox"/> Head Injury          | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Other                        |
| <input type="checkbox"/> Black-Outs           |   |   |
- 
- 

**Respiratory System**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> None Reported        | <input type="checkbox"/> Frequent Coughing | <input type="checkbox"/> Tuberculosis/Results |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Bronchitis           |
| <input type="checkbox"/> Pneumonia            |  |   |
| <input type="checkbox"/> Other                |  |   |
- 
- 

**Integumentary System**

- |  |                                  |                                 |
|--|----------------------------------|---------------------------------|
| <input type="checkbox"/> None Reported | <input type="checkbox"/> Itching | <input type="checkbox"/> Acne   |
| <input type="checkbox"/> Boils         | <input type="checkbox"/> Rashes  | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Psoriasis     |                                  |                                 |
| <input type="checkbox"/> Other         |                                  |                                 |
- 
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**Additional Questions**

Have you ever had any surgeries?  Yes  No

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Have you had cancer?  Yes  No

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Any abnormal lab tests/results?  Yes  No

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Have you ever had a head injury?  Yes  No  
If yes, did you lose consciousness/have a concussion?  Yes  No

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*\*Any questions that do not apply please leave blank:*

\*Any problems with menstruation?  Yes  No

\*Do you plan to become pregnant?  Yes  No

\*Do you use birth control?  Yes  No

\*Any history of pregnancy, miscarriage or terminations?  Yes  No

**ADULT HEALTH HISTORY - FAMILY**

*If yes, please explain on the lines following selection (family member, health/psychiatric problem)*

Has anyone in your family had health problems?  Yes  No

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Has anyone in your family had a psychiatric problem?  Yes  No

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Has anyone in your family had substance-abuse problems?  Yes  No

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**ADULT HEALTH HISTORY - PAIN**

*If yes to either, please explain (on a scale of 1 to 10, 1=lowest, 10=highest, what is your score?)*

Are you experiencing any pain right now?  Yes  No

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Do you experience any chronic untreated pain?  Yes  No

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Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

### SA-46 Questionnaire

#### Depression

	1-Not at all	2-A little bit	3-Moderately	4-Quite a bit	5-Extremely
Feeling low in energy or slowed down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor Appetite (or over eating)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling no interest in things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling everything is an effort	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoughts of death or dying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoughts of ending your life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of pleasure or sexual interest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble concentrating or remembering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crying easily	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worrying too much about things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Awakening in the early morning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep that is restless or disturbed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling hopeless about the future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feelings of guilt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feelings of worthlessness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Sub-Score Total</b>					
Comments	.....				

#### Anxiety-Panic

	1-Not at all	2-A little bit	3-Moderately	4-Quite a bit	5-Extremely
Nervousness or shakiness inside	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suddenly scared or fearful for no reason	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart pounding or racing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling tense or keyed up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spells of terror or panic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling so restless you couldn't sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Sub-Score Total</b>					
Comments	.....				

#### Phobia-Fear

	1-Not at all	2-A little bit	3-Moderately	4-Quite a bit	5-Extremely
Feeling afraid to go out of your house alone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling afraid in open spaces or on the streets	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having to avoid certain things, places, or activities because they frighten you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling uneasy in crowds, such as shopping or at a movie	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling afraid to travel on buses, subways, or trains	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Sub-Score Total</b>					
Comments	.....				

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Anger-Irritability**

	1-Not at all	2-A little bit	3-Moderately	4-Quite a bit	5-Extremely
Feeling easily annoyed or irritated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Temper outburst that you could not control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shouting or throwing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting into frequent arguments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having urges to beat, injure, or harm someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having urges to break or smash things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Sub-Score Total</b>					
Comments					

**Psychotic-Like**

	1-Not at all	2-A little bit	3-Moderately	4-Quite a bit	5-Extremely
Hearing voices that other people do not hear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The idea that someone else can control your thoughts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having thoughts that are not your own	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other people being aware of your private thoughts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The idea that something is wrong with your mind	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling that you are watched or talked about by others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Sub-Score Total</b>					
Comments					

**Obsessive-Compulsive**

	1-Not at all	2-A little bit	3-Moderately	4-Quite a bit	5-Extremely
Unwanted thoughts, words or ideas that won't leave your mind	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having to check and double-check what you do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having to repeat the same actions-touching, counting, washing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty making decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your mind goes blank	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling blocked in getting things done	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having to do things very slowly to ensure correctness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Sub-Score Total</b>					
Comments					



HEALTH SERVICES INC.  
OUTPATIENT MENTAL HEALTH PROGRAMS  
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

**DEMOGRAPHIC INFORMATION**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Preferred Name (if different): \_\_\_\_\_

Parent/Legal Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Cell #: \_\_\_\_\_ Other #: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Race: \_\_\_\_\_ Sex at Birth: \_\_\_\_\_

Gender Identity: \_\_\_\_\_ Pronouns: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Previous Mental Health Providers: \_\_\_\_\_

Referral Source: \_\_\_\_\_

**EMERGENCY CONTACT**

In the event of identified potential risk, Key Point Health Services staff members will make every effort to ensure that clients are transported to the closest emergency room for evaluation to determine if a more intensive level of services is appropriate. Please list an emergency contact below.

Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_

Cell #: \_\_\_\_\_ Other #: \_\_\_\_\_

**OPTUM DATA CAPTURE**

Client Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_

Client DOB \_\_\_\_\_ Diagnosis \_\_\_\_\_

**Individual – General and Guardian Information**

What does the Individual prefer to be called? \_\_\_\_\_

Please list any previous names (ex. Maiden name) \_\_\_\_\_

Mailing Address (If different from the one on file), Phone and E-Mail

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Phone Type \_\_\_\_\_

E-Mail \_\_\_\_\_

Does the consumer have a legal guardian? \_\_\_\_ Yes \_\_\_\_ No

**Parent/Guardian/Social Services/Juvenile Services Contact Information:**

Guardian First Name \_\_\_\_\_

Guardian Last Name \_\_\_\_\_

Guardian Address \_\_\_\_\_

Guardian City/State/ZipCode \_\_\_\_\_

Guardian Phone Number \_\_\_\_\_

**Ethnicity & Race**

Ethnicity – is the individual Hispanic, Latino or Spanish origin? \_\_\_\_ Yes \_\_\_\_ No

Race \_\_\_\_ White \_\_\_\_ American Indian/Alaskan Native \_\_\_\_ Black/African American

\_\_\_\_ Asian \_\_\_\_ Native Hawaiian/Other Pacific Islander

If the Individual is Multiracial, Select Other Race(s)

\_\_\_\_ White \_\_\_\_ American Indian/Alaskan Native \_\_\_\_ Asian \_\_\_\_ Native Hawaiian/Pacific Islander

**Language**

How well does the Individual speak English? (5 years or older)

Very Well  Well  Not Well  Not at all

Does the Individual need assistance with communicating in English?  Yes  No

Does the Individual speak a language other than English at home? (5 years old or older)

Yes  No  Not Available If yes, which language? \_\_\_\_\_

**Marital Status and Pregnancy**

Marital Status:  Single  Married  Separated  Divorced

Widow/Widower  Not Available

Pregnancy:  Yes  No  Not Available If yes, Due Date \_\_\_\_\_

**Education**

Educational Level (Highest level of school completed): \_\_\_\_\_

Did the Individual attend school any time in the past 3 months?

Yes  No If yes, Current Grade Level \_\_\_\_\_

**Military/Veteran Status**

Is this individual a Veteran?

Yes  No

If Yes, Which War is the Individual a Veteran of (if More than 1, Note Most Recent)

Afghanistan  Iraq  None  Other

Specify the Time Frame for Individual's Military Service

Never in Military  Veteran- in combat less than 6 months ago

Veteran- in combat 6-12 months ago  Veteran- in combat more than 12 months ago

On Active Duty  Veteran- Never in combat

Would the Individual Like to be Contacted by the Office of Maryland's Commitment to Veterans for the Purpose of Veteran Benefits?

Yes  No  Already in Contact  Unknown



**Disability Status**

Is the Individual deaf or hard of hearing?  Yes  No

Is the Individual blind or having serious difficulty seeing, even when wearing glasses?  
 Yes  No

Because of a physical, mental or emotional condition, is the individual having serious difficulty concentrating, remembering or making decisions? (5 years old or older)  
 Yes  No

Is the Individual having serious difficulty walking or climbing stairs? (5 years old or older)  
 Yes  No

Is the Individual having difficulty dressing or bathing? (5 years old or older)  
 Yes  No

Because of a physical, mental or emotional condition, is the Individual having serious difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)  
 Yes  No

**Other Information**

What is the Individual Living Arrangement?

Private Residence  Foster Home  Residential Care  Crisis Residence  
 Children's Residential  Treatment  Institutional Setting  
 Jail/Correctional Facility  Homeless/Shelter  Other

Was the Individual homeless in the last 6 months?  Yes  No

**Employment Status:**

Full-Time  Part-Time  Retired  Disabled  Homemaker  
 Student  Institutional/Incarcerated  Volunteer  
 Other unemployed/Not Seeking Work  Other unemployed/Seeking Work

Tobacco use in the past 30 days?  Yes  No

Does the Individual smoke cigarettes?  Yes  No

Was the Individual screened for gambling?  No  Yes – Gambling Problem Not Indicated

Yes-Gambling Problem Included in Treatment Here

Yes- Referred to Gambling Treatment elsewhere

**Type of Insurance:**

No Healthcare Coverage  Medicaid (Healthchoice)

Medicaid (Other than Healthchoice)

Number of times in Self-Help support group in the past 30 days: \_\_\_\_\_

Number of arrests within the past 30 days: \_\_\_\_\_

Number of dependent children: \_\_\_\_\_

Primary source of income

Wages/Salary  Public Assistance/TCA  Self-Employment

Retirement  Unemployment Comp  Disability

Other  Unknown

**Individual – Substance Use Information**

Please confirm individual's substance use history

No, individual does not have history of SUD

Yes, individual has history of SUD

If yes,

Primary Substance of Use \_\_\_\_\_ Age at First Use \_\_\_\_\_

Route of Administration:  Not Applicable  Oral  Smoking  Inhalation

Injection  Other

Frequency of Use \_\_\_\_\_ No Use Past Month  1-3 Times in the past Month

1-2 Time in the Past Week  3-6 Time in the Past Week  Daily  Not Applicable

Date last used \_\_\_\_\_

Expected source of payment:  BHA Grant/Uninsured  Medicaid  Non-Managed Private

Insurance  Out of Pocket Payment  Other Funds  Other  Drug Court  Unknown

Not collected

Psych problem in addition to alcohol or drug

Yes  No  Not Applicable

  
**Key Point**  
**HEALTH SERVICES INC.**  
 OUTPATIENT MENTAL HEALTH PROGRAMS  
 RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

**CONSENT FOR TREATMENT**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I am giving permission to Key Point Health Services, Inc., (KPHS) to provide outpatient mental health services to me/my child. I understand that an assessment will be completed by a licensed clinician to help identify my/my child's specific needs prior to treatment which may include individual, family and/or group psychotherapy. All clients will work with a therapist who will be responsible for service coordination and developing a person-centered treatment plan based on assessments and the needs of the client. Therapists will work collaboratively with the client and/or family to develop goals for treatment and track achievement of goals. Clients may be evaluated by a prescriber for the purpose of providing diagnostic confirmation and medication assessment. If medications are considered, I understand that I will be informed of the purpose of such and of any possible risks involved. In the case of an emergency, I authorize KPHS to provide any and all necessary emergency medical treatment. I am aware that all services are provided under clinical supervision.

My signature below indicates that I have been familiarized with the premises; given information about services provided and that I have received a copy of and understand the following policies and procedures:

- Client Rights & Responsibilities & Grievance Procedure
- Crisis Intervention Services
- Health and Safety Policy
- Maryland Advance Directive
- Notice of Privacy Practices
- Procedures for Discharge & Civility Policy

The following section is only to be completed if a Parent or Legal Guardian is providing consent for treatment in lieu of the above individual.

- I am legally authorized to consent for treatment as the client's (check one):
  - Parent(s)
  - Legal Guardian(s)
- I have provided photo identification and one of the following supporting legal documents (check one):
  - Birth Certificate
  - Court Order
  - Consent for Health Care Affidavit
  - Other: \_\_\_\_\_

\_\_\_\_\_  
Client/Parent/Legal Guardian Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client/Parent/Legal Guardian Signature

\_\_\_\_\_  
Date



OUTPATIENT MENTAL HEALTH PROGRAMS  
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

### FINANCIAL INFORMATION

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

#### Primary Insurance

Type of Insurance:  Medical Assistance  Medicare  Tricare  Uninsured Span  
 Other \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Member ID: \_\_\_\_\_

#### Secondary Insurance

Type of Insurance:  Medical Assistance  Medicare  Tricare  Uninsured Span  
 Other \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Member ID: \_\_\_\_\_

- I certify that the information given above is correct to the best of my knowledge.
- I understand that in some cases Key Point Health Services, Inc. (KPHS) may not be aware of fees until after my insurance company has been billed and KPHS receives payment.
- I understand that any insurance issues I may have are between me and my insurance company.
- I understand that if I acquire Medicare insurance at any time and fail to provide KPHS with my Medicare information as soon as possible I will be responsible for all fees not paid by Medicare during this time.
- I understand that the state of Maryland requires all individuals 65 years of age and older to apply for Medicare benefits.
- I hereby authorize payment directly to KPHS of the insurance benefits otherwise payable to me but not to exceed the charges for the services rendered.
- I understand that payment is due at the time of service unless prior arrangements have been made and that failure to remit payment may result in discontinuation of services.
- It is my responsibility to notify KPHS of any changes to my insurance.
- I understand that KPHS may bill my insurance company as a courtesy to me however if the insurance company denies claims or changes my co-pay amount, I am responsible for all fees not otherwise reimbursed.
- I understand that KPHS may contact my insurance company and/or employers for verification of eligibility and benefits and information regarding diagnosis and anticipated services may be provided for the purpose of reimbursement.
- I understand that I am required to provide financial information for a carrier to cover services provided to me and if I have not provided the appropriate information as of this date KPHS may charge me the normal and customary fee as determined at the time services are provided.

\_\_\_\_\_  
Client/Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (KPHS Staff) Signature

\_\_\_\_\_  
Date



# HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS  
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

## CIVILITY POLICY

In order to promote a safe and respectful environment at Key Point, this clinic has instituted a Civility Policy. If a client, client's guardian, or client's guest exhibits behavior found to be offensive to any staff person, clients, or visitors the following measures will be utilized:

- The individual will receive a verbal warning from Key Point personnel.
- Should the behavior continue, the individual will be asked to leave the premises
- If the individual refuses to leave, the police may be called.
- Rude and/or hostile behavior by clients or their parent(s)/guardian(s) will not be tolerated and may lead to discharge.

Behavior considered offensive is defined as including, but not limited to, verbal abuse, physically/verbally threatening others, refusal to wait patiently for the prescriber or therapist, showing disrespect to others i.e. cutting in line, speaking over someone, loud/obscene speech in waiting room or provider offices, creating confrontation or commotion unnecessarily. If you are unsatisfied with the service you receive, please request to speak to a supervisor. If you are still not satisfied, a grievance may be filed in writing with the Clinic Director.

## PROCEDURES FOR DISCHARGE

Termination of services shall, whenever possible, be a collaborative process between the client and therapist. A written discharge plan including referrals and conditions for readmission will be provided to clients. Key Point will provide clients with 30 days notice of discharge to help facilitate transition. The following are potential reasons for discharge:

- Missing more than one appointment with a prescriber
- Failure to adhere to treatment recommendations or attendance contracts

Clients will not receive 30 day notice and services will be terminated immediately for any of the following reasons:

- Failure to attend a psychosocial assessment or psychiatric evaluation
- Threatening behavior or harassment including, but not limited to, verbal, sexual, or physical actions, intimidating behavior, excessive phone calls, cyber stalking, gift giving, or suggestive comments
- Boundary violations including, but not limited to, stalking, inappropriate contact.
- Misuse of medications or prescriptions including, but not limited to, violation of any federal or state law.

\_\_\_\_\_  
Client/Parent/Legal Guardian Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client/Parent/Legal Guardian Signature

\_\_\_\_\_  
Date



## NOTICE OF PRIVACY PRACTICES

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

This notice describes how your medical information may be used and disclosed and how you can obtain access to this information. Please read this notice carefully. Key Point Health Services, Inc. (KPHS) may use and disclose your Protected Health Information (PHI) in accordance with applicable law as of May 2016. KPHS is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. KPHS reserves the right to change the terms of the Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. KPHS may disclose your PHI after you have given consent by completing a written authorization. You may revoke an authorization for disclosure of your PHI at any time, except to the extent that we have already made a disclosure based upon your authorization.

PHI may include, but is not limited to, the following:

- Demographic information including names, addresses, birth date, social security number, and phone/fax numbers
- Medical record information including account/record numbers and health insurance beneficiary numbers
- Full face photographic images and any comparable images
- Medical Records

Applicable law and ethical standards may permit the disclosure of information about you without your authorization regarding the following:

- Suspected Abuse or Neglect
- Judicial and Administrative Proceedings
- Deceased Clients
- Medical Emergencies
- Health Oversight
- Law Enforcement and Community Forensic Aftercare Program
- Specialized Government Functions
- Public Health and Safety
- Treatment Coordination between Key Point programs

You have the following rights regarding your PHI:

- To inspect and copy PHI that is maintained in a "designated record set." Your right to inspect and copy PHI may be restricted in situations where there is compelling evidence that access would cause serious harm to you. KPHS may charge a reasonable, cost-based fee for copies.
- To request that KPHS amend your PHI.



HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS  
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

- To request an accounting of disclosures that are made of your PHI. KPHS may charge you a reasonable fee.
  - To request a restriction on the use or disclosure of your PHI.
  - To request that KPHS communicate with you about health matters in a certain way or at a certain location.
  - If there is a breach of unsecured PHI concerning you, KPHS may be required to notify you of this breach, including what happened and what you can do to protect yourself.
  - You have the right to a copy of this notice.
- 
- To file a complaint, if you believe your privacy rights have been violated, in writing including your name and contact information to [info@keypoint.org](mailto:info@keypoint.org), Key Point Health Services, Attention: Chief of Operations, 135 N. Parke Street, Aberdeen, MD 21001, or The Secretary of Health and Human Services, 200 Independence Avenue, S.W. Washington, D.C. 20201.

\_\_\_\_\_  
Client/Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (KPHS Staff) Signature

\_\_\_\_\_  
Date

# Key Point HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS  
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

Jurisdiction	Mobile Crisis Team or Hotline	Contact Number
Statewide	Emergency Number	9-1-1
	Statewide Maryland Crisis Hotline	1-800-422-0009
	National Suicide Prevention Hotlines:	1-800-SUICIDE or 1-800-273-TALK (784-2433) (8255)
	Veteran's Crisis Line	1-800-273-8255, press 1
	Maryland Crisis Online Chat	<a href="http://www.Help4MDYouth.org">www.Help4MDYouth.org</a> (available Mon-Fri 4pm - 9pm)
Allegany	Family Crisis Resource Center	301-759-9244 2-1-1
	Frederick County Crisis Hotline - Mental Health Assoc. of Frederick County Western Maryland Regional Mental Center Hotline	301-662-2255 240-964-1399
	Anne Arundel County Crisis Response	410-768-5522
	YWCA Sexual Assault Crisis Center YWCA Domestic Violence Hotline	410-222-7273 410-222-6800
Baltimore City	Baltimore Crisis Information and Referral Line	410-433-5175
Baltimore County	Baltimore County Crisis Response System	410-931-2214
Calvert	Calvert County Health Department	410-535-1121 301-855-1075 Teen Line: 410-257-2216
	Walden Behavioral Health Hotline	301-863-6661
	Maryland Crisis Hotline	1-800-422-0009
Cecil	Cecil County Domestic Violence and Rape Hotline	410-996-0333
	Life Crisis Center Hotline	410-749-HELP (4357) 2-1-1
	Eastern Shore Operations Center	888-407-8018
Charles	Walden Behavioral Health Hotline	301-863-6661
	Center for Abused Persons	301-645-3336
Frederick	Frederick County Crisis Hotline	301-662-2255
	Mental Health Assoc. of Frederick County	2-1-1
Garrett	Frederick County Crisis Hotline	301-662-2255
	Mental Health Assoc. of Frederick County	2-1-1
Harford	Harford County Mobile Crisis	1-800-NEXT-STEP (639-8783)
	Sexual Assault/Spouse Abuse Resource Center	410-836-8430

Administration Offices  
135 N. Parke St · ABERDEEN, MARYLAND 21001  
Phone 443-625-1600 · Fax 443-625-1595  
[www.keypoint.org](http://www.keypoint.org)





# HEALTH SERVICES INC.

OUTPATIENT MENTAL HEALTH PROGRAMS  
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

Jurisdiction	Mobile Crisis Team or Hotline	Contact Number
Howard	Grassroots Crisis Intervention	410-531-6677
Mid-Shore	Eastern Shore Operations Center	888-407-8018
<ul style="list-style-type: none"> <li>• Caroline</li> <li>• Dorchester</li> </ul>	For All Seasons Inc. (Rape Crisis Center)	1-800-310-7273
	Life Crisis Center Hotline	410-749-HELP (4357)
		2-1-1
<ul style="list-style-type: none"> <li>• Kent</li> <li>• Queen Anne</li> <li>• Talbot</li> </ul>	Mid- Shore Council on Family Violence	1-800-927-HOPE (4673)
Montgomery	Montgomery County Crisis Center	240-777-4000
	EveryMind- Montgomery Country Hotline	301-738-CALL (2255)
Prince George's	Community Crisis Services, Inc.	301-864-7130
	Prince George's County Crisis Response System	301-429-2185
	Family Crisis Center of Prince George's County (Domestic Violence)	301-731-1203
Saint Mary's	Walden Behavioral Health Hotline	301-863-6661
Somerset	Life Crisis Center Hotline	410-749-HELP (4357)
	Eastern Shore Operations Center	1-888-407-8018
		2-1-1
Washington	Frederick County Crisis Hotline Services	301-662-2255
		2-1-1
Wicomico	Life Crisis Center Hotline	410-749-HELP (4357)
		2-1-1
	Eastern Shore Operations Center	1-888-407-8018
Worcester	Life Crisis Hotline	410-749-HELP (4357)
		2-1-1

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Key Point  
HEALTH SERVICES INC.  
OUTPATIENT MENTAL HEALTH PROGRAMS  
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

**CLIENT RIGHTS & RESPONSIBILITIES**

You have the right:

- To expect privacy and dignity in treatment consistent with providing you with good care
- To receive considerate, respectful care at all times and under all circumstances
- To expect prompt and reasonable responses to your questions
- To know the identity and professional status of your provider(s)
- To request and receive your medical record according to Clinic Policy
- To be informed of your condition, proposed treatment, and associated risks and benefits
- To discontinue treatment at any time
- To receive impartial access to treatment regardless of race, gender identity, creed, sexual orientation, national origin, religion, physical handicap or sources of payment.
- To participate in the decision-making process related to your treatment plan
- To exercise your cultural values and spiritual beliefs as long as they do not interfere with the well-being of others
- To participate in the discussion of ethical issues that arise
- To express concerns regarding any of these rights by following the grievance procedure
- To formulate an Advanced Directive

You are responsible for:

- Providing accurate and complete information about present and past medical conditions
- Reporting unexpected changes in your condition to your provider(s)
- Meeting with your provider to develop a treatment plan at least every six months
- Informing your provider(s) whether or not you understand your treatment plan
- Adhering to the objectives outlined in the treatment plan
- Scheduling and attending appointments, and if you cannot, notifying the proper person
- Being considerate of other clients and Key Point Staff

**GRIEVANCE PROCEDURE**

- If you have concerns about the care that you or your family member has received, we encourage you to speak directly with the staff member involved.
- If you have not found resolution, you may contact the staff member's supervisor.
- If efforts to resolve a complaint are still unsatisfactory, you may contact the Clinic Director in writing. You will receive a response within 3 days.



## HEALTH AND SAFETY POLICY

Key Point strictly prohibits the client recording the therapist and/or session in any form. This includes video and/or audio monitoring with or without the therapist's knowledge or consent. Recording of the session by the therapist may only be done with written consent of the client and only for purposes of training or development.

Each employee is expected to follow safety rules and to exercise caution and prudence in all work related activities. Specifically prohibited anywhere on KPHS property at any time are weapons of any kind, shape, or size, including but not limited to items such as firearms, knives, mace, pepper spray, etc. KPHS intends to maintain a healthful environment. This includes attempting to limit the exposure and spread of pests of significant public health importance including, but not limited to, bedbugs, lice, and various microorganisms. Accordingly, individuals may be asked to refrain from entering KPHS property until the risk of exposure and spread is minimized. The use of any tobacco product is prohibited anywhere on KPHS property, except for designated areas, at any time. The sale, use, possession or distribution of drugs (including prescription medications) or alcohol on KPHS property or while performing company business is prohibited at all times. Clients are encouraged to take unused and expired prescription medications to the local police station for disposal. Medications may also be given to prescribers for disposal. KPHS does not use restraint or seclusion when interacting with clients or the community.

- If a client or community member is found in violation of the policy the individual may receive a verbal warning from Key Point personnel or be asked to leave the premises. If the individual refuses to leave, the police may be called.
- Medications may be given to prescribers to add to Key Point's quarterly burn disposal of unused and expired medication or flushed down the toilet.
- All instances of client policy violation will be discussed by the treatment team and a decision will be made to determine if the client may remain in services.