CENTURY MENTAL HEALTH, INC.
5570 Sterrett Place, Suite 101, Columbia, Maryland 21044
Tel: 410.730.0552 Fax: 410.715.4720

POLICIES, PROCEDURES AND TREATMENT AGREEMENT

Welcome to Century Mental Health. We have compiled this information sheet in an effort to answer the many questions people ask about therapy. If you have any questions regarding our policies, please don't hesitate to ask your therapist for clarification. Our goal is to provide you with high quality, attentive care.

Appointments:

In person: when you arrive for your appointment, please have a seat in the waiting room and your therapist will come out to greet you. Therapy sessions will run 45-50 minutes. Arrangements can be made for longer or shorter sessions with advance notice.

Virtual: please join your virtual meeting at the designated hour. Please make arrangements regarding how to communicate with your therapist if you are having technical trouble.

Please note, therapists will wait 20 minutes for you to arrive at either in person or virtual session and then will consider it a late cancellation and you will be charged.

Cancellation Policy: If you must cancel an appointment, at least **24 hours** advance notice is requested. *Unless notice of cancellation is received **24 hours** in advance, you will be billed for any missed appointments.*

Payment Policy: Payment is expected at the time of your scheduled appointment, unless otherwise arranged with your therapist. Please discuss preferred method of payment with your therapist. Forms of payment may include cash, checks, Zelle, Venmo or Paypal.

There will be a $25.00 processing fee for any returned checks.

Fees and Insurance Information: At each visit (or monthly), we will provide you with a statement with all the information necessary for submission to your insurer for reimbursement directly to you. Your insurance policy is a contract between you, the employer and the insurance company. For that reason, you are expected to communicate with your insurance company for any pre-authorization of treatment (if required by your insurance) and to initiate/maintain reimbursement. We will gladly provide you with a treatment plan if necessary for reimbursement, but it is your responsibility to inform your therapist, in a timely manner. At this time, we are not in-network providers for any insurance plans and we do not accept payment directly from any insurance companies.

Communication Policy: Please discuss preferred method of communication with your therapist. Please be aware that therapists check their voicemail Monday through Friday from 9:00-5:00, but not after 5:00 on Fridays, over the weekend, or on holidays. If your therapist is not available during regular office hours, please leave a message on your therapist's voicemail including your name, phone number and the best time to be reached. Phone calls requiring longer than 15 minutes involving conversations of a clinical nature will be charged at half hour intervals. You may leave a message in your therapist's voicemail over the weekend, but these messages will not be picked up until Monday morning at 9:00 am.

It is impossible to guarantee the confidentiality of email or text messaging content. By signing this agreement, you grant the staff of Century Mental Health, Inc. permission to email and text you. You acknowledge the risks and release CMH, Inc. from liability for the risk to your confidentiality. Email and texts should be limited to administrative issues such as scheduling and not be of a clinical nature. The staff of Century Mental Health, Inc. does not accept friend requests from clients on any social media sites.

EMERGENCY CONTACT POLICY: We try our best to respond to individual crises in a timely fashion. However, due to the nature of our practice, we are not able to respond to life threatening emergencies. If you are having a life threatening emergency, dial 911 or go to the nearest hospital emergency room. Please leave a message for your therapist so they are aware of your situation.

You may also contact the following agencies for help, in the case of an emergency:

1. Grassroots Crisis Hotline (Howard County): (410) 531-6677
2. Sheppard Pratt Walk-In Clinic: (410) 938-5302
3. National Suicide Prevention Hotline: 1 (800) 273-8255
4. Baltimore County Crisis Response System: (410) 931-2214

Inclement Weather: If it is necessary to cancel office hours due to inclement weather, individual therapists will have a message on their specific voicemail. Therefore, if you have any question about your appointment, please call before coming to the office.

Termination: If the client wishes to stop therapy, termination should be discussed in a session so that proper closure can be attained.

Separation/Divorce Policy: In separated or divorced families, the person who initiates treatment is held financially responsible. We will not bill another person or estranged spouse for services rendered. Specific arrangements can be made with your individual therapist, based on particular provisions in the divorce settlement. However, payment remains due at the time of each therapy session. If a child is brought for treatment and both parents share legal custody, then both parents must consent to treatment.

Confidentiality: Confidentiality between patient and therapist is an important part of treatment. Information you share with your therapist will not be disclosed to a third party without your consent. There are, however, certain exceptions to this rule and include the following:

1. If you are in imminent danger of harming yourself or others.
2. If there is suspected abuse or neglect of a child, elder or other vulnerable adult, as required by law of the state of Maryland.
3. If required by a law enforcement official or by a court order or other legal proceeding.

As your treatment providers we are committed to your privacy. Please discuss with your therapist any questions or concerns you may have regarding these policies.

Jan Carlson, LCSW-C

Tamara Lubliner, LCSW-C, BCD

Tammy Goldberg, LCSW-C

Suzanne Matty, LCSW-C

Suzanne Ricklin, LCSW-C, BCD, CEDS-S

Kelly Thompson, LCPC

Consent for Treatment and Statement of Financial Responsibility

I have read and understand the policies and procedures agreement as outlined in this information sheet for Century Mental Health, Inc. and agree to abide by its terms during our professional relationship.

I understand that by signing this document I am consenting to treatment with

_____(Name of therapist)

If the client is a minor:

I, _____, give my consent to have my child,

_____, to be seen for treatment by

_____(Name of therapist).

I understand that I am financially responsible for all charges incurred during treatment, including payment for missed visits.

Signature of Responsible Party _____

Printed Name of Responsible Party_____

Relationship to Patient_____

Date_____