The Baltimore Therapy Center, LLC
103 Old Court Rd. Suite A
Baltimore, MD 21208
443-598-BTC1 (2821)

Montgomery County Abused Persons Program
New Beginnings Abuse Intervention Program

Full name: _____

Date of birth: _____

Please read through, fill in and sign this entire document. You must scroll down and fill in all fields before clicking the signature fields to e-sign the document.

After you sign the document you will be requested to upload a photo or scan of your ID (e.g., driver's license), your blue pre-trial card if you have been referred by pretrial services, and your proof of income if you are applying for a fee reduction.

You are not required to use this electronic signature medium to participate in the program and may request to come in person to sign hard copies.

A video is available at www.rockvilleapp.com/forms-video which explains all the pages of this document and how to fill it out.

ABUSED PERSONS PROGRAM
ABUSE INTERVENTION PROGRAM – NEW BEGINNINGS

STANDARD PROGRAM PARTICIPANT'S CONTRACT

The New Beginnings partner abuse counseling program is for individuals who want to not be abusive to their intimate partners and want to end all domestic violence in their relationships. The program offers an opportunity to share with others who have similar problems and learn how to recognize and avoid abusive behavior, how to communicate better, and how to build equal and satisfying relationships. Participants have chosen to attend the New Beginnings partner abuse counseling program voluntarily or to fulfill counseling requirements set by an agency such as the District or Circuit Court, Parole and Probation, MC Dept. of Corrections, or the State's Attorney's Office.

By signing this document, I agree to the following Program conditions:

I. The participant's partner/the complainant will be notified of the participant's referral to the Abuse Intervention Program, counseling attendance and completion of program requirements. Also, s/he will be informed if the participant fails to attend counseling or does not complete the program requirements. The information about you provided to the partner will be strictly limited to these specific areas (for example, s/he cannot be told what you say in counseling). Participants are expected to sign a consent for release of information to this effect. The partner will be contacted by program staff in order to present her/his account of violence in the relationship and to be informed of APP services available.

II. If a client is referred by a court or court-related agency, the referring agency will be notified in writing of the participant's compliance or noncompliance with the program and the reason for that determination.

III. Participants are expected to acknowledge that abuse is inappropriate and criminal behavior and to be committed to learning non-violent strategies for solving problems between people. Participants who are unwilling to make such a commitment will be dismissed from the program. New incidents of abuse will be treated seriously by the Program, requiring additional counseling. The criminal justice system also has in place penalties for such re-abuse.

IV. Fees: Fees for individual or group counseling are according to the Montgomery County Health and Human Services APP fee schedule and are based on cost of the service and a client's ability to pay. Clients who fail to pay fees on schedule or who do not accurately report family income may be dismissed from the program. Failure to pay fees (except in emergencies) will be considered non-compliance with the program. Fees are not charged for missed sessions.

V. Timeliness: Participants are expected to be on time for all sessions. Participants who arrive later than ten minutes after a session begins will be considered absent.

VI. Confidentiality: All counseling is confidential. While we encourage participants to practice communication exercises, the names and situations of other group members must not be shared with anyone outside the group. The leaders will break confidentiality only in cases of imminent harm to self or others, or in the case where abuse of a minor or vulnerable adult is reasonably suspected.

VII. Cooperation/Disruptions: The leaders have responsibility to remove from the group anyone they believe is not benefiting from group participation or who is interfering with the group's progress. Such removal will be addressed with each participant and may lead to dismissal from the group. All electronic devices must be turned off when entering group.

VIII. Session Attendance: If you are in individual counseling, the counselor will make an attendance plan with you. Group counseling participants will have an orientation session before beginning classes. You will be assigned to a Phase I Group which meets the same night each week for 6 weeks. After completing Phase I, you will be assigned to a Phase II group. Your attendance in Phase II will be a minimum of 16 weeks. Each meeting is 1 and 1/2 hours long. Participants may be excused for up to 6 absences at the discretion of the program director. However, all clients must attend 6 sessions in Phase I before moving to Phase II and 16 sessions in Phase II in order to be compliant with the program.

It is your responsibility to notify the program if you cannot attend groups for some reason. If you do not attend for 3 consecutive weeks and we do not hear from you, you will be dismissed from the program.

No one under the influence of alcohol or drugs will be admitted to a counseling session.

IX. The intake counselor has the responsibility to determine if any additional services (e.g., substance abuse, psychiatric medication, etc.) or evaluation is necessary in addition to the Abuse Intervention Program. Failure to comply with the counselor's recommendations will result in dismissal from the program.

Additional Rules for Online Groups

1. You must be online, on time, and awake for the entire group time, with your video on and face visible.
2. Do not engage in other activities during group time (e.g.: texting, social media, e-mail, games, etc.)
3. You must be in a private area, without other people present if at all possible. If you cannot be alone, we ask that you use earphones in order to protect the confidentiality of others.
4. You must be sitting down during group, not walking or lying down.
5. Do not have children or pets in the room with you.
6. Do not eat during group. You may drink non-alcoholic drinks.
7. You must be dressed as if you were attending group in person.
8. No audio or video recording of any of the online sessions by any party is permitted.
9. You must be physically located in Maryland while participating in group (even if you are participating virtually).

☐ **Acceptance**: I have read and agree to abide by the "New Beginnings" Abuser Intervention Program counseling program participant's contract.

☐ **Refusal:** Having read and discussed the participant's contract, I have decided not to enter the Abused Persons Program counseling program. I understand that any referring court/agency will be notified of my decision.

Participant's Name: _____

Signature: _____ Date: _____

DHHS
MONTGOMERY COUNTY
Department of Health and Human Services

ABUSED PERSONS PROGRAM
New Beginnings Abuse Intervention Program

CLIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Department's *Notice of Privacy Practices*:

By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____	_____	_____
Name of Client	**Signature of Client/Parent/Guardian**	**Date**

II. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the DHHS make all communications to me by the alternative means or locations that I have listed below.

You may request to communicate with the AIP Contractor via unencrypted methods such as e-mail and text messages. If you choose to use unencrypted communication options, please be aware that any computer, unencrypted e-mail or text communication can be accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication.

Unencrypted e-mails and texts are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails and texts that go through them. The following are some of the risks inherent in using these media:

- An unencrypted e-mail or text message might be sent erroneously to the wrong recipient, seen by someone in your house or workplace, or purposefully intercepted by a third party.
- Communication companies (e.g. Google) may be able to access e-mail accounts and text messages.
- Computers, tablets, and cell phones can be lost or stolen.

These risks exist both for unencrypted messages you send to your provider, and those your provider sends to you. (E-mails you receive from the AIP Contractor can be encrypted upon request.) In order to further address these possibilities from the side of the AIP Contractor, all e-mails bear a disclaimer in case of mistaken recipients, and all confidential data on computers, tablets, and cell phones is password-protected. AIP Contractor computers are equipped with virus protection and a password. Client information is stored in a HIPAA-secure cloud environment. Emails and text messages exchanged between you and your provider become a part of your record and subject to all the same laws and rights of access as any other part of your record.

You are not required to use any of these methods of communication to receive treatment. You have the right to request unencrypted communications and to revoke your request at any time. If you initiate communication with your provider via unencrypted methods, we will assume that you have made an informed decision to use such communication methods, will view it as your agreement to accept the risks associated with such methods, and will honor your desire to communicate using these methods. You may also choose to communicate electronically via iPlum, a secure and encrypted texting app (Apple/Android), and message us through the app at 240-906-0121.

Home Telephone Number: _____ ☐ OK to leave message with detailed information
☐ Leave message with callback numbers only

☐ Please use the following number to communicate with me by text.
☐ Please do not communicate with me by text.

Cell Number: _____ ☐ OK to leave message with detailed information
☐ Leave message with callback numbers only

☐ Please use the following address to communicate with me by email.
☐ Please do not communicate with me by email.

E-mail Address: _____

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Department.

2. These Authorizations may be revoked at any time by notifying the Department in writing at the Departments mailing address marked to the attention of "HIPAA Privacy Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.

6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____	_____	_____
Name of Client (Printed)	Signature of Client	Date

DHHS
MONTGOMERY COUNTY
Department of Health and Human Services

TELEHEALTH INFORMATION, AGREEMENT AND CONSENT

Abused Persons Program

New Beginnings Abuse Intervention Program

Telehealth sessions are designed to administer therapy as an alternative to in-person sessions. This allows your therapy to remain uninterrupted by illness, natural disasters, or the current requirements for social distancing. Therapy is most effective if it is consistent and participating in Telehealth sessions will help to ensure continued progress toward your goals.

Telehealth Requirements:

1. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated the use of telehealth services. All existing confidentiality protections under HIPAA apply to information disclosed during your telehealth service. Privacy laws that protect the confidentiality of your protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others).
2. No audio or video recording of any of the online sessions by either party is permitted.
3. Invites to telehealth sessions will be sent by email and one can use a tablet, desktop computer, or smartphone to connect.
4. Telehealth/video sessions are voluntary. You may choose to receive services in person when such services are being offered. If you do not have access to/are uncomfortable with the telehealth platform, please advise your therapist.
5. You must inform your counselor of the address where you are at the beginning of each session in case of emergency. The counselor will be unable to provide you services if you are outside of Maryland.
6. Please set up in a quiet room with no competing distractions such as TV, family, siblings, or pets if possible. You are required to tell the therapist if any additional people are in the room with you. Your therapist is required to tell you if any additional people are present in the room with them during the session. You must verbally approve the person being in the room before the counseling session can continue. If a person enters the room during the session, the therapist will briefly pause the session in order to protect confidentiality.
7. You must be dressed as if you are attending group in person.
8. Troubleshooting: Expect to take some time during the first video session to troubleshoot and get comfortable with the platform. If there are challenges, you and your therapist will work through them together.

RISKS OF RECEIVING TELEMENTAL HEALTH SERVICES

Telemental health services can be impacted by technical failures, may introduce risks to your privacy, and may reduce your service provider's ability to directly intervene in crises or emergencies. Here is a non-exhaustive list of examples:

- Internet connections and cloud services could cease working or become too unstable to use.
- Cloud-based service personnel, IT assistants, and malicious actors ("hackers") may have the ability to access your private information that is transmitted or stored in the process of telemental health-based service delivery.
- Computer or smartphone hardware can have sudden failures or run out of power, or local power services can go out.
- Interruptions may disrupt services at important moments, and your provider may be unable to reach you quickly or using the most effective tools.

There may be additional benefits and risks to telemental health services, which your provider will continue to assess, that arise from the lack of in-person contact or presence, the distance between you and your provider at the time of service, and the technological tools used to deliver services.

_____	_____	_____
Client Name	Signature	Date

H-1

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Montgomery County Department of Health and Human Services

Program/Service Area BHCS ABUSED PERSONS PROGRAM
Address 1301 PICCARD DRIVE, SUITE 1400 **Phone** 240.777.4000 or 240.777.4210
ROCKVILLE, MARYLAND 20850 *FAX* 240.777.4860
Please print all information. Use a separate form for each person or agency with which information may be shared.

Client Full Name	Date of Birth	Sex ☒M ☐F

1. The above-named program of the Montgomery County Department of Health and Human Services (DHHS) has my permission to:
☒ **send to** ☒ **receive from** ☒ **verbally discuss the information checked below with:**

Agency/Individual: ☐ Parole & Probation ☐ Pre-trial services ☐ State Attorney's Office ☐ Pre-Release Center
☐ Child Welfare Services ☐ District/Circuit/Juvenile Court
☐ Maryland Governor's Family Violence Council
☐ Petitioner/Victim (name:) _____
☐ Other: _____

2. ***Initial all items covered by this release.***
☒ **Acknowledgment of receipt of services**
☒ **Complete program record (includes all items below)**
_____ Intake Assessment _____ Treatment Plan _____ Progress Notes _____Diagnosis
_____ Psychiatric Evaluation _____ Service Summary _____ Psychological Evaluation
_____ Lab Results _____ Medication Record _____ History and Physical
☒ **Alcohol or other drug treatment records. Specify below and attach notice prohibiting redisclosure.**
____ Summary of assessment results and history
____ Summary of treatment and service plan progress and compliance
☒ **Other (specify)**: Records sent to DHHS from other providers and contained in the program record.
_____

3. Reason this information is being shared: Assessment and coordination of services

4. This authorization is valid (*Check only one-not to exceed one year*)
☐ until_____(date) ☐ for 90 days ☒ until these conditions are met: Final disposition of case(s) for which client was referred to program

5. I understand I can revoke this authorization at any time by submitting a request in writing to DHHS program staff. The revocation will become effective on the date it is received by DHHS and does not apply to information that has already been used or disclosed through this authorization. DHHS may not condition treatment, payment, enrollment or eligibility for services/ benefits based on whether I sign this authorization, unless authorization is required to determine eligibility for services/benefits. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to federal or State privacy laws, this information may no longer be protected and could be disclosed. I understand that if this authorization pertains to alcohol or other drug treatment records protected by federal regulations at 42 C.F.R. Part 2, I can orally revoke this authorization, and my records may not be redisclosed without my written consent or as permitted by the regulations.

_____ _____
Signature of client **Date**

_____ _____
Signature of parent, guardian, or other authorized person **Date**

If signed by other authorized person, please describe authority to act on behalf of the client (*Please Print)*
_____

_____ _____
Signature of DHHS staff member **Date**

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Signature of DHHS staff member **Date**