The Retreat
Outpatient Services
Patient Information

Name:_____

Social Security Number: _____

Date of Birth: _____ Gender: _____

Race: _____ Ethnicity: _____

Marital Status: _____ Religion: _____

Address: _____

_____

Phone: _____ Cell: _____

Does patient have legal guardian: (Y or N) _____

Guardian (Name and phone number):_____

_____

Advance Directives, Medical (Living Will): (Y or N) _____

Smoker: (Y or N) _____

Co-occurring? (Y or N) _____

Veteran? (Y or N) _____

Patient Portal? (Y or N) _____

The Retreat
Sheppard Pratt Health System

Adult Consent to Contact and Emergency Information

Name (print last, first) **MR#**

I agree to the involvement in my treatment of the following members of my family and other important persons in my life, as appropriate –

Emergency Contact

The following person(s) may be contact in the event of an emergency, thus disclosing my treatment in Sheppard Pratt Health System Outpatient Programs. I understand that in an emergency requiring immediate medical attention, I will be transported to the nearest hospital emergency department.

Name:	Telephone:
Address:	

Name:	Telephone:
Address:	

Primary Care Physician to be contacted:

Name:	Telephone:
Address:	

Signature **Date**

Sheppard Pratt
HEALTH SYSTEM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH AND/OR ACADEMIC INFORMATION

PATIENT / STUDENT INFORMATION

PATIENT / STUDENT NAME	NAME AT TIME OF TREATMENT	BIRTH DATE

ADDRESS	TELEPHONE NO. *(With Area Code)*

RELEASE OF INFORMATION

I hereby authorize: ☐ Sheppard Pratt Health System ☒ Other Facility Name: THE RETREAT

to release health information from: ☐ medical record ☐ school record ☐ verbal health and/or academic information by service provider

of the above named patient / student for the following purpose: ☒ provision of services ☒ continuum of care ☐ legal

☐ other _____

To: _____

Name / Address of person / organization to which disclosure is to be made

_____

Fax information to: _____ Fax #: _____

Send electronically to: _____ Email Address: _____

For treatment dates: _____

☐ Inpatient ☐ Residential *(specify)* _____ ☐ School *(specify)* _____

☐ Partial Hospitalization *(specify)* _____ ☒ Outpatient Program *(specify)* THE RETREAT - OUTPATIENT SERVICES

Substance use treatment programs: ☐ TE Co-Occurring Unit ☐ Ellicott City Co-Occurring Unit

☐ Outpatient dual diagnosis day hospital ☐ BOS (Behavioral observation services)

TYPE OF ACCESS AUTHORIZED:	*SELECT PORTIONS OF THE RECORD:*
☐ Copies of the record ☐ Inspection of the record	☐ Discharge Summary ☐ Admission Note ☐ History & Physical ☐ Labs / Medical Tests ☐ Discharge Information Sheet ☐ Psychosocial History ☐ Medication List ☐ Educational Records ☒ Other, specify FINANCIAL STATEMENTS AND INVOICES
☐ Verbal communication	☐ Information regarding service provided, specify _____

This authorization will expire one year from the date signed for records below unless specific expiration event or condition is named here: FINANCIAL STATEMENTS - NO EXPIRATION DATE. *For verbal communication, this authorization will expire upon discharge. The authorization covers only treatment for the dates specified above. I understand that I have the right to refuse to sign this Authorization for Release of Protected Health and/or Academic Information. I understand that authorizing the disclosure of this information is voluntary. I need not sign this form in order to assure treatment. I understand that I may inspect the information to be used or disclosed, as provided in 45 CFR 164.524.*

- **I, the undersigned**, have read the above and authorize the staff of the disclosing facility named to disclose such information as described within this document.
- **I understand** that this authorization may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I may withdraw this authorization by notifying, in writing, Health Information Mangement or above specified program.
- **I acknowledge** that the material authorized for release may contain alcohol, chemical dependency, psychiatric, HIV testing or results, or AIDS information.
- **I understand** that health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2.
- I understand that, once information is released, this facility cannot prevent the recipient from further disclosing the information.

This facility is released and discharged of any liability and the undersigned will hold the facility harmless for complying with this "Authorization for Release of Protected Health and/or Academic Information".

Signature of Patient / Student _____ Date _____

Signature of Parent, Guardian / Authorized Representative _____ Date _____

Relationship to Patient / Student _____

Fees / charges will comply with all laws and regulations applicable to release of information

PROHIBITION ON REDISCLOSURE: **This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

0101140 (R 8/28/2017) (INDD)

The Retreat

Retreat Outpatient Services and Rates

Patient Name: _____

Date Service Begins: _____

Individual Therapy with Doctor, 30 minutes: $300

Individual Therapy with Doctor, 45 – 50 minutes: $410

Individual Therapy with Doctor, 65 – 75 minutes: $590

Medication Management, 20 – 25 minutes: $275

Intake Evaluation: $600

Consultation: $650

Report Preparation/Phone Calls: $500

Psychoanalysis: 45-50 min: $410

Psychoanalysis: 65-75 min: $590

Master's Level Individual Therapy, 45 - 50 minutes: $190

- Includes Family Therapy, Recreation Therapy, Occupational Therapy, Art Therapy, Co-occurring Therapy

Yoga, Individual/Group: $75

Traditional Chinese Medicine, Acupuncture, Individual/Group: $75

Social Work/Supportive Counseling Services: $190

Outpatient DBT Group: $450

Outpatient Psychodynamic Group : $1800-$2100 per month

Outpatient Co-Occurring Group: $190

Fees are subject to change. Patients who miss a scheduled appointment or group will be charged the full fee for the appointment or group unless a cancellation has been requested greater than 24 hours prior to the scheduled appointment or group time. May include synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system per HIPAA guidelines.

Guarantor Signature_____ Date_____

Print Name_____

The Retreat

MEDICARE OPT-OUT

This agreement is between Retreat at Sheppard Pratt Clinician , _____ (the "Clinician"), and _____ who is a Medicare Part B beneficiary (the "Beneficiary"). The Clinician has informed Beneficiary that Clinician has opted out of the Medicare program effective on _____ (the "effective date").

Beneficiary or his/her authorized representative understands, agrees, and acknowledges the following:
Initial:SEP
_____Neither the Clinician nor the Beneficiary can receive payment from Medicare for the services that are performed by the Clinician on and after the effective date.

_____Beneficiary or his/her authorized representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from other clinicians and practitioners who have not opted out of Medicare.

_____Beneficiary or his/her authorized representative accepts full responsibility for payment of the Clinician's charge for all services furnished by the Clinician to the Beneficiary on or after the effective date, and agrees to personally pay out of pocket for those charges.

_____Beneficiary or his/her authorized representative understands that Medicare limits do not apply to what the clinician may charge for items or services furnished by the Clinician.

_____Beneficiary or his/her authorized representative agrees not to submit a claim to Medicare or to ask the Clinician to submit a claim to Medicare.

_____Beneficiary or his/her authorized representative understands that, on and after the effective date, Medicare payment will **NOT** be made for any items or services furnished by the Clinician that would have otherwise been covered by Medicare.

_____Beneficiary or his/her authorized representative acknowledges that a copy of this contract has been provided to him/her.

The Retreat

In applying to the Retreat outpatient services, I accept these financial arrangements and do not expect care to be paid for or reimbursed by Medicare. I acknowledge that claims will not be submitted to Medicare and agree not to file claims with Medicare.

Patient Signature_____ Date_____

Print Name_____

Witness Signature_____ Date_____

Print Name_____

The Retreat • 6501 North Charles Street • Towson, MD 21204 • retreatatsp.org • 410-938-3891

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED (shared) AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review it carefully

Sheppard Pratt

Purpose of the Notice:

This Notice of Privacy Practices describes how we may share your "protected health information" (PHI) to carry out treatment, payment, health care operations, and for other purposes that are permitted or required by law. It also describes your rights to see and control your PHI.

Sheppard Pratt is required by law to:

- Make sure PHI is kept private,
- Give you this Notice of our legal duties and privacy practices that affect your PHI,
- Follow the terms of the notice that is currently in effect,
- Notify affected individuals following a breach of unsecured protected health information.

Uses and disclosures not described in this Notice will be made only with your written authorization, which may be revoked as provided below.

Definitions:

Protected Health Information (PHI) is medical information that identifies you or may provide a basis for identifying you, including demographic information. Your PHI relates to your past, present, or future physical or mental health condition and related health care services. Sheppard Pratt is required by law to keep records of the care which is provided to you.

You/Your/Patient/Client is defined as any person receiving a health-related service through Sheppard Pratt. If the subject of the PHI is a minor, "patient/client" means the parent (unless subject to a limiting court decree or custody agreement) or authorized legal representative(s). If the subject of the PHI is incapable of making an informed decision, "patient /client" means the authorized legal representative(s).

Sheppard Pratt in this Notice is defined as: Sheppard and Enoch Pratt Foundation which includes Sheppard Pratt. Sheppard Pratt operates hospital programs, partial hospitalization programs, The Retreat at Sheppard Pratt, Sheppard Pratt School & RTC - Towson, Sheppard Pratt Community Services, and the Sheppard Pratt Physicians' P.A. These groups may share PHI with each other for treatment, payment, or health care operation purposes described in this Notice.

Treating Clinician is defined as the individual primarily responsible for providing the patient's/client's mental health services at Sheppard Pratt.

Medical Record is defined as a record of clinical services provided. This may be in electronic or paper form. Billing records are separate from the medical record. In addition, psychotherapy notes are separated from the rest of the patient's medical record. Psychotherapy notes are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Who Will Follow this Notice:

- Any Sheppard Pratt health care professional authorized to enter information into your medical record
- All Sheppard Pratt employees, physicians, departments, and units that have access to PHI
- Any Sheppard Pratt volunteer who is permitted to provide you services or assistance and volunteers providing Sheppard Pratt operational services assistance
- All these entities, sites, and locations defined as Sheppard Pratt

How We May Use and Share PHI About You:

These categories describe different ways that Sheppard Pratt uses and shares your PHI. For each category we will explain what we mean and try to give some examples. Not every use in a category will be listed. However, all of the ways Sheppard Pratt is permitted to use and disclose information will fall within one of the categories.

For Treatment: Sheppard Pratt will use and share your PHI to provide, coordinate, or manage your health care and related services. We may use and disclose your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you. We may share PHI about you with:

- Health care practitioners such as doctors, nurses, technicians, student trainees, or other personnel who are involved in taking care of you at Sheppard Pratt.
- Different departments of or contract personnel with Sheppard Pratt in order to coordinate the different things you need such as prescriptions, lab work, and x-rays.
- People outside of Sheppard Pratt who may be involved in your medical care, such as referrals to aftercare placement or providers outside of Sheppard Pratt who are treating you.

For Payment: Your PHI will be used to obtain payment for health care services provided by Sheppard Pratt. This will include contacting your insurance company to get approval for payment of recommended psychiatric services, to determine eligibility for benefits, to review services for medical necessity, and to undertake utilization review activities. This also may include sharing information with others, such as Medicare or Medicaid, for the purposes of obtaining payment.

Healthcare Operations: We may use and share your PHI to support healthcare operations of Sheppard Pratt. For example, we may use PHI to review our treatment and to evaluate the performance of our staff in caring for you. This helps to make sure all of our patients/clients receive quality care and services. We may also combine PHI about many patients/clients to decide what additional services Sheppard Pratt should offer, what services are not needed, and whether certain treatments are effective. We may also share information with health care practitioners such as doctors, nurses, technicians, student trainees, and other personnel for review and learning purposes. We may also share your PHI with state, federal, or accrediting agencies for activities such as audits, inspections, and licensure.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services: We may use PHI to remind you that you have an appointment for treatment or services at Sheppard Pratt. We may also tell you about possible treatment options that may be of interest to you, such as drug treatment services, clinical research studies, or services to address domestic violence.

Fundraising Activities: We may use PHI about you to contact you in an effort to raise money for Sheppard Pratt. We only would use contact information, such as your name, address, and phone number, treating physician, and the dates you received treatment or services at Sheppard Pratt. If you do not want Sheppard Pratt to contact you for fundraising efforts, you must notify the Office of Philanthropy at Sheppard Pratt in writing or by emailing the Office of Philanthropy at give@sheppardpratt.org. If you opt out, we will take reasonable measures to ensure you don't receive further fundraising communication.

Individuals Involved in Your Care or Payment for Your Care: With your agreement, we may share your PHI with a family member, relative, close friend, or any other person you identify. Only information that directly relates to that person's involvement in your healthcare will be shared. If you are unable to agree or object, we may share information, if based on professional judgment we determine that it is in your best interest. In addition, in the event of a disaster, we may share PHI related to your status and location with your family and/or organization assisting in disaster relief effort.

Research: In special cases, we may use and share your PHI for current or future research purposes. For example, a research project may compare the health and recovery of all patients /clients who received one medication to those who received a different medication for the same condition. However, all research projects must be approved through an Institutional Review Board. This process evaluates a proposed research project and its use of medical information. The patients'/ clients' need for privacy is balanced with the researcher's need for medical information. The Institutional Review Board will review and set up rules for using PHI before any information is released. If you volunteer to participate in a research study, the consent form you sign to participate in the research study will inform you of any special uses to be made of your PHI.

As Required By Law and Public Health Activities: We may use or share your PHI to comply with local, state, or federal law. Only information that is required will be released. Examples of this would include reporting for public health activities; notification of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceeding; and law enforcement activities.

To Avert a Serious Threat to Health or Safety: We may use and share PHI about you when, in our judgment, it is necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military Activity and National Security and Intelligence Activities: Under certain circumstances we may share your PHI with authorized federal officials involved in national security and intelligence activities. This may include activities such as providing protective services to the President or foreign heads of state. Information may also be given to federal officials to conduct special investigations. When appropriate conditions apply, we may use or share PHI of Armed Forces personnel (l) for activities deemed necessary by military command authorities, (2) to determine your eligibility for benefits by the Department of Veterans Affairs, or (3) to foreign military authority if you are a member of that foreign military services.

Workers' Compensation: Your PHI may be disclosed to comply with workers' compensation laws and other similar legally established programs. These programs provide benefits for work related injuries or illness.

Your Rights Regarding PHI About You:

You have the following rights regarding the PHI we maintain about you:

Facility Directory: At admission for inpatient services, you will be asked if you want your name listed in the Facility Directory. The Facility Directory is used to reveal your location in the Sheppard Pratt hospitals to outside callers not otherwise legally entitled to the information. If you desire to be listed in our Facility Directory, your name and location will be given to those calling to speak to you or visit you. If you do not want to be listed, you must inform the Admissions Office or your treatment team.

Right to See and Copy Your PHI: For as long as we keep your PHI, you have the right to see and get a copy of your PHI that is contained in your medical and/or billing records. In most cases, the use or disclosure of psychotherapy notes requires your specific written permission.

To read and copy PHI: You must contact the Department of Health Information Management or medical records designee at the Sheppard Pratt location where you received treatment.

- If you request a copy of the information, we may charge a reasonable fee for the associated costs of copying and mailing your request.
- In certain limited situations, we may deny your request to read and copy your PHI. In some circumstances, you may have a right to have this decision reviewed, and the decision to deny access may be reversed. Please contact our Department of Health Information Management or the medical records designee if you have questions about access to your PHI.
- You have the right to an electronic copy of the electronic medical record in a form that is readily producible by Sheppard Pratt.

Right to Amend Your PHI: You have a right to amend by adding to your PHI in your medical record for as long as we keep this information. To request to add information, your request must be in writing to the Department of Health Information Management or medical records designee where you received treatment. You must include a reason for your request. If your request is not in writing or does not include a satisfactory reason, we may deny your request to amend the record. In addition, we cannot permit you to amend information that:

- Was not created by us,
- Is not part of the PHI kept by or for Sheppard Pratt,
- Is not part of the information which you would be permitted to inspect and copy,
- Is accurate and complete.

If we should deny your amendment request, you have the right to insert in the record a concise statement of the reason you disagree with the record.

Right to a List of Disclosures: You have a right to receive a list describing specifically who has received PHI about you during the last six (6) years. There are certain restrictions and limitations. This list will not include those who have received PHI for treatment, payment, or healthcare operations, as described in this Notice of Privacy Practices. It also will not include those who have made inquiry of a Facility Directory, family members or friends involved in your care, or to whom notification was given.

- To request this list or accounting of disclosures, you must write to the Department of Health Information Management or medical records designee at the Sheppard Pratt location in which you received services.
- Your request must state a time period that may not be greater than six years.
- The first list you request within a 12-month period will be free.
- For additional lists, we may charge you for the costs of providing the list.

Right to Request Restrictions: You have the right to request that we limit how we use and disclose your PHI. You may restrict giving your PHI to your health insurance plan if you pay out-of-pocket in full for services. In other circumstances, if you request limiting how we use or disclose your PHI, we will consider your request but, we are not legally required to agree to your request.

- To request restrictions, you must make your request in writing at the time of your admission or to your treating clinician for each admission and/or registration for services. Your request must list (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) who may not receive information.

If we do agree, we will limit the information unless it is needed to provide you emergency treatment.

Right to Choose Confidential Communications: You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

- To request confidential communications, you must make your request in writing to your treating clinician.
- Your request must list how or where you wish to be contacted.
- You do not have to give a reason for your request.
- We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. It may be obtained at our website sheppardpratt.org or you may contact the Privacy Officer.

Changes to This Notice: We have the right to change this Notice. We have the right to make the revised or changed Notice effective for PHI we already have about you, as well as any PHI we receive in the future. The effective date of the notice will be posted in the Notice. In addition, we will offer you a copy of the current Notice in effect each time you register or are readmitted to a Sheppard Pratt program. Copy of the current Notice will be posted on the Sheppard Pratt web page and at the facility.

Other Uses of PHI: Other uses of PHI not covered by this notice or the laws that apply to us will be made only with your written permission.

Right to Revoke Authorization: If you give us permission or authorization to use or share PHI about you, you may take back that permission or authorization in writing at any time. If you take back your permission, we will no longer use PHI about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission. Also, you are unable to take back permission to share PHI if it was to permit the sharing of your PHI to an insurance company as a condition of obtaining coverage to the extent that other laws allow the insurer to contest claims or coverage. We are required to keep records of the care that we provided to you.

- To take back your permission or authorization, you must make your request in writing. Send your request to the Department of Health Information Management or medical records designee at the Sheppard Pratt location in which you gave your permission to share your PHI.
- Written permission to use or share PHI about you is not a condition of receiving treatment at Sheppard Pratt except:
    - If the treatment is research-related, provision of treatment may be conditional on receipt of written permission to use or share PHI related to the treatment as necessary for the research or:
    - If the purpose of the treatment services is to create PHI for disclosure to a third party, provision of the services may be conditioned on receipt of written permission from you to share PHI to that third party.

Chesapeake Regional Information System for our Patients, Inc. (CRISP): Sheppard Pratt has chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. 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. Sheppard Pratt Health System, Inc. will not be sharing your health information but may obtain information provided by other providers. You may "opt-out" and disable all 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. Please note that public health reporting, in accordance with the law, as well as Controlled Dangerous Substances Information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers. If you have previously opted out and your demographic information has changed, for example your address or phone number has changed, CRISP suggests that you contact them again to ensure that your status as opted out remains unchanged.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with Sheppard Pratt by contacting the Privacy Officer at Sheppard Pratt.

- All complaints must be made in writing
- You will not be penalized for filing a complaint

You may also file a complaint directly with the secretary of the U.S. Department of Health and Human Services. If you have questions about this Notice, or would like to exercise your Privacy Rights, please contact the Privacy Officer for Sheppard Pratt at 410-938-3407.

This Notice is effective March 1, 2021 and replaces earlier versions.

Sheppard Pratt

sheppardpratt.org

The Retreat
Sheppard Pratt Health System

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Sheppard Pratt Notice of Privacy Practices

PRINTED NAME	
DATE OF BIRTH	
SIGNATURE OF : ☐Patient/Resident ☐ Parent ☐ Guardian ☐ Authorized Representative	DATE

Sheppard Pratt Staff Only

Complete this section if patient/resident/representative does not sign this form	
Explanation:	☐ Patient/resident or patient's/resident's representative received the Notice of Privacy Practices, refused to sign the acknowledgement.
	☐ Patient/resident or patient's/resident's representative refused to sign the acknowledgement.
	☐ Other, Explain:
Sheppard Pratt Representative Name and Title:	
Sheppard Pratt Representative Signature:	
Date:	

SELF-PAY FINANCIAL AGREEMENT
The Retreat Outpatient Services

In consideration of services rendered to _____ (the "Patient") by The Retreat Outpatient Services (the "Program"), a non-contracted service program of Sheppard Pratt Health System, Inc. (the "Provider"), the undersigned jointly and severally agree to the terms and conditions of this Self-Pay Financial Agreement. This Agreement covers all services rendered to the Patient, beginning on _____ and continuing until the Patient is discharged from the Program.

All of the Program services are self- pay (private pay) and none of these services can be reimbursed by a policy of health insurance. Provider will not request or obtain pre-certification for these services from any health insurer and Provider is, accordingly, prohibited from billing any health insurer for these services.

NOTICE: In signing this Agreement, the undersigned understand and agree that: Provider will not bill the Patient's health insurance for the services rendered; the undersigned will personally pay for the services that are rendered to the Patient; and the undersigned have accepted full financial responsibility for paying the cost of these services. The undersigned have also disclaimed any and all rights to the payment for these services by any provider of public or private health insurance.

The Patient has received from the Program a Rate Sheet on the current rate(s) for the services that may be provided to Patient. The undersigned have been informed that services and rate(s) may change and increase. The Program will provide the Patient with a new Rate Sheet of rates and services prior to the initiation of any change.

Responsibility for Payment: I agree to pay the Provider for services rendered to the Patient from the Patient's date of admission to the Program to the date of discharge, in accordance with the rate that is in effect at the time of service. I disclaim any and all rights to reimbursement by any health insurance that might be available to pay for these services.

Refund: If the Patient is discharged from the Program before exhausting any prior payments, any remaining funds shall be returned within thirty (30) days after discharge.

Responsibility for Valuables: I accept responsibility for any valuables in the possession of the Patient and agree that Provider is not responsible for any loss of or damage to these valuables.

The Retreat

SIGN THIS AGREEMENT ONLY IF YOU HAVE HAD SUFFICIENT TIME TO UNDERSTAND IT AND YOU ARE SURE THAT YOU AGREE TO ITS TERMS.
THIS IS A BINDING CONTRACT UNDER SEAL AND SHALL BE INTERPRETED ACCORDING TO THE LAWS OF THE STATE OF MARYLAND. PLEASE READ CAREFULLY BEFORE SIGNING.

In signing below, I certify that I have read, understood and agree to the above terms and conditions:

Patient Name: _____

Full name(s) of person(s) responsible for payment:

_____

_____

Signature(s) of person(s) responsible for payment:

_____

_____

Signature of witness:

_____

_____
Date