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SHARE Wellness Center

Building Healthier Minds. Strengthening Communities

Full Client Enrollment & Admission Packet

OMHC Â· PRP Adult Â· PRP Minor Â· SUD Outpatient Â· IOP

605 Post Office Rd, Suite 305 Â· Waldorf, MD 20602

www.sharewellnesscenter.com Â· +1 (385) 375-0064

Joint Commission Accredited Â· BHA Licensed

Client Name placeholder=â?•As shown on government IDâ?•>

Date of Enrollment

Medical Record # placeholder=â?•Assigned by clinicâ?•>

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1. Client Information

Full Name

Date of Birth

Gender

Address

City

State

ZIP

Phone

Email

Emergency Contact

Relationship

Emergency Phone

2. Insurance / Payment Information

Insurance
○ Medicaid ○ Medicare ○ Commercial ○ Self-Pay ○ Other

Plan / MCO

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Member ID

3. Services Provided

Services are individualized and may change based on clinical need and provider recommendation.

☐ Individual Therapy ☐ Group Therapy ☐ Family Therapy (if applicable) ☐ Psychiatric Evaluation ☐ Medication Management ☐ Treatment Planning ☐ Care Coordination ☐ Crisis Support Services ☐ Behavioral Health Education ☐ Case Management Support

Client Initials
4. Mental Health & Functional History

Please indicate any history that applies:

☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Schizophrenia / Psychotic Disorders ☐ Trauma / Abuse History ☐ Substance Use ☐ Psychiatric Hospitalization ☐ Suicidal Thoughts or Attempts ☐ Sleep Disorders ☐ Stress / Anger Issues ☐ Relationship / Family Conflict ☐ Social Withdrawal / Isolation ☐ Difficulty with Daily Functioning ☐ Non-compliance with Treatment ☐ Legal or Behavioral Concerns

Additional Information

Client Initials

5. Primary Care Physician (PCP) Information

Primary Care Provider

Practice Name

Phone Number

Date of Last Physical Examination

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Address

PCP Status

○ I have a Primary Care Provider.○ I do not currently have a Primary Care Provider.

If no PCP, would you like assistance establishing care?

○ Yes○ No

May Share Wellness Center coordinate care with your PCP?

○ Yes○ No

6. Consent for Therapy & Medication Management

I voluntarily consent to receive outpatient mental health services, including therapy and medication management, at Share Wellness Center.I understand:â?? The nature of services providedâ?? My rights and responsibilitiesâ?? That participation is voluntaryâ?? That treatment requires active participation

Client Name

Signature

Date

7. Service Request / Referral

☐ OMHC ☐ PRP Adult ☐ PRP Minor ☐ SUD Outpatient ☐ IOP ☐ Psychiatric Evaluation ☐ Medication Management ☐ Therapy

Referral Source

Referral Phone/Email

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Reason for Seeking Services / Presenting Concern

☐ I consent to services ☐ I have questions and request additional explanation before a specific service

Client Signature

Date

Parent/Guardian/Authorized Rep

Guardian Signature / Date

Staff / Witness

Staff Signature / Date

8. Consent for Behavioral Health Services (Continued)

I voluntarily consent to evaluation, assessment, treatment, psychiatric rehabilitation, counseling/therapy, psychiatric services, substance use services, care coordination, and/or other

behavioral health services provided by Share Wellness Center, limited to the services for which I am admitted and that are clinically appropriate.I understand that the nature, purpose, expected benefits, material risks, alternatives, and possible consequences of refusing recommended services will be explained to me as appropriate. I may ask questions and may withdraw consent or refuse a service, subject to applicable law, emergency circumstances, payer requirements, and the clinical consequences explained to me.I understand that participation does not guarantee a specific outcome and that my treatment/recovery plan will be individualized and reviewed with me.

☐ I consent to services☐ I have questions and request additional explanation before a specific service

Client Signature

Date

Parent/Guardian/Authorized Rep

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Guardian Signature / Date

Staff / Witness

Staff Signature / Date

9. Informed Consent â?? Telehealth (When Used)

I understand that telehealth uses electronic communication for behavioral health services. Potential benefits include improved access and convenience. Potential limitations include technology failure, privacy/security risks, limits of remote assessment, and the possibility that in-person or emergency care may be recommended.I agree to provide my physical location and an emergency contact when requested for telehealth safety. I understand that I may ask to stop a telehealth session and discuss alternatives when clinically appropriate.

☐ I consent to telehealth when offered☐ I do not consent to telehealth at this time☐ Not applicable

Client Signature

Date

Parent/Guardian/Authorized Rep

Guardian Signature / Date

10. Privacy Practices / Confidentiality Acknowledgment

I acknowledge that I was offered/provided Share Wellness Centerâ??s Notice of Privacy Practices and information about confidentiality. I understand that my health information may be used or disclosed for treatment, payment, and health care operations as permitted by law, and that other uses/disclosures may require my written authorization unless otherwise permitted or required by law.I understand that certain behavioral health and substance use information may receive additional protections under federal or Maryland law. I may request restrictions or confidential communications as permitted by law and policy.

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☐ Notice provided in paper form ☐ Notice provided electronically ☐ Client declined copy ☐ Interpreter / assistance used

Client Signature

Date

Parent/Guardian/Authorized Rep

Guardian Signature / Date

11. Communication & Electronic Contact Preferences

I understand that ordinary email and text messaging can carry privacy risks. I choose the following communication preferences and understand that I may update them in writing.

☐ Phone calls permitted ☐ Voicemail permitted ☐ Text permitted ☐ Email permitted ☐ Portal permitted ☐ Mail permitted

Restrictions / safe contact times / words not to use in messages

Client Signature

Date

Parent/Guardian/Authorized Rep

Guardian Signature / Date

12. Client Rights & Responsibilities Acknowledgment

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My Rights Include:â?? Be treated with dignity, respect, consideration, and without unlawful discrimination.â?? Receive appropriate services in a safe setting and participate in decisions about my care.â?? Receive information in a way I can understand, including reasonable language and accessibility assistance.â?? Receive services according to my individualized plan of care or rehabilitation plan, as applicable.â?? Give informed consent and refuse treatment after possible consequences are explained, subject to applicable law.â?? Privacy and confidentiality of my information as provided by law.â?? Be free from abuse, neglect, exploitation, mistreatment, retaliation, and inappropriate coercion.â?? Make suggestions, complaints, or grievances without retaliation and receive information about the grievance process.â?? Know the names/roles of persons providing my care and ask questions about services.â?? Participate in discharge/transition planning and receive information needed for continuing care.â?? Have applicable mental health advance directive preferences respected in accordance with Maryland law.â?? Contact legal counsel, advocacy resources, and appropriate governmental oversight agencies as permitted by law.My Responsibilities Include:â?? Provide accurate and complete information to the best of my ability.â?? Participate in treatment/recovery planning and communicate concerns or changes in my condition.â?? Treat staff and others respectfully and follow safety rules.â?? Attend scheduled services or provide reasonable notice when unable to attend.â?? Ask questions when I do not understand information or instructions.â?? Provide current insurance/contact information and meet agreed financial responsibilities, when applicable.

☐ Rights/responsibilities reviewed ☐ Copy offered/provided ☐ Questions answered

Client Signature

Date

Parent/Guardian/Authorized Rep

Guardian Signature / Date

13. Grievance / Complaint Acknowledgment

I understand that I may raise a concern or grievance about services, discharge, changes in services/status, staff conduct, privacy, or other program decisions without fear of retaliation. I was informed how to submit a grievance and how to request assistance with the process.Share Wellness Center grievance contact/title: Amarachi Igwe(Director)Email: amarachi.i@sharewellnesscenter.comPhone: 2403551616I understand that I may also contact applicable external advocacy, local behavioral health authority, Maryland Behavioral Health Administration/Department of Health, or other oversight resources when appropriate. Current contact information should be maintained on the organizationâ??s grievance notice/posting.

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☐ Grievance procedure provided☐ External contact/resource information provided☐ Client declined paper copy

Client Signature

Date

Parent/Guardian/Authorized Rep

Guardian Signature / Date

14. Emergency / Crisis Information Acknowledgment

For an immediate life-threatening emergency, call 911 or go to the nearest emergency department. For behavioral health crisis support, call or text 988.

I understand that Share Wellness Center is not a substitute for emergency services. For an immediate life-threatening emergency, call 911 or go to the nearest emergency department. For behavioral health crisis support, call or text 988. I will use other local/mobile crisis resources provided by the program when appropriate.

Preferred Hospital / Emergency Department (optional)

Emergency Contact

Emergency Contact Phone

☐ Crisis information provided ☐ 988 reviewed ☐ Safety plan indicated / completed separately ☐ No current crisis identified

Date

Parent/Guardian/Authorized Rep

Guardian Signature / Date

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15. Advance Directive / Mental Health Advance Directive

An advance directive allows a person to state health care preferences and/or name someone to make health care decisions if the person later cannot make or communicate those decisions. Maryland law also permits an advance directive for mental health services. Share Wellness Center will document whether an advance directive exists and, when applicable, place a copy in the record or document how it can be obtained.I understand that this acknowledgment does not require me to create an advance directive and that services will not be denied solely because I do not have one.

☐ I have an advance directive ☐ I have a mental health advance directive ☐ I do not currently have an advance directive ☐ I am unsure ☐ Copy provided to Share Wellness Center ☐ Copy will be provided later ☐ I would like information on creating one ☐ I decline additional information at this time

Name of Health Care Agent / Mental Health Agent (if applicable)

Agent Phone

Location of original/copy if not provided

Stated preferences or important information for behavioral health emergencies (optional)

Preferred medications/treatments or approaches that have helped

Treatments/medications I prefer to avoid and why

Preferred hospital/provider and people I want contacted

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Triggers, de-escalation approaches, cultural/spiritual needs, or other preferences

Client Signature

Date

16. Financial / Insurance Acknowledgment

I authorize Share Wellness Center to submit claims and necessary supporting information to my insurer/payer as permitted by law. I understand that coverage and authorization do not guarantee payment and that any client financial responsibility will be explained according to applicable law, payer contract, and Company policy.

☐ Insurance/benefit information reviewed ☐ Financial policy provided if applicable ☐ Client sign payment expected at enrolment ☐ Other

Date _____

Parent/Guardian/Authorized Rep _____

Guardian Signature / Date _____

17. Attendance, Participation & Discharge Expectations

I understand that regular participation and timely communication support continuity of care. Share Wellness Center will explain program-specific attendance expectations, missed-appointment procedures, discharge/transition criteria, and how to request re-engagement or appeal/grieve a program decision when applicable.

☐ Attendance expectations reviewed ☐ Discharge/transition expectations reviewed ☐ Program signature/contact process reviewed

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Date _____

Parent/Guardian/Authorized Rep _____

Guardian Signature / Date _____

18. Final Enrollment Acknowledgment

By signing below, I acknowledge that I had the opportunity to review this enrollment packet, ask questions, and receive assistance in a language/format I understand. My signature confirms receipt/acknowledgment of the sections indicated above; it does not waive any legal rights or authorize optional disclosures or media use unless I separately selected and signed those sections.

Client Printed Name _____

Client Signature _____

Date / Time _____

Parent/Guardian/Authorized Rep

Guardian Signature / Date

Enrollment Staff Name / Credentials

Staff Signature / Date

SubmitEnrollment Packet

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By submitting you confirm the information above isaccurate to the best of your knowledge.

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Date Created
September 10, 2026
Author
wellnesscenter