

**Application for Adolescent DBT Program**

Thank you for your interest in our DBT program. Please complete and return the following application to be placed on the waiting list. Please be advised that completion of this application does not guarantee acceptance into the program. Individuals are accepted into the program based on the availability of both the applicant and therapists. Applications are valid for 6 months. Have questions? Feel free to contact us at dbt@gladstonepsych.com or 443-689-7740.

Date of Application: \_\_\_\_\_\_\_\_\_\_\_

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_ (MM/DD/YYYY)

Applicant’s Age: \_\_\_\_\_\_

Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

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

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

City, State, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s relationship to policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID or Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this is an employer-based health plan, are the employer’s headquarters located in any state outside of Maryland? Yes/no (please be advised that out-of-state insurance plans have generally denied DBT claims).

Referring therapist or psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a custody agreement in place? Yes/no

 If so, who is the medical decision maker? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please rank your availability to attend **group skills training** (1-4):

 \_\_\_\_ Monday 4:30pm-6:30pm – Transitional Age Youth (ages 17+ only)

\_\_\_\_ Tuesday 4-6pm (Teen Only – when clinically indicated)

\_\_\_\_ Thursday 6:30pm-8:30pm (Multifamily Skills Group – in-person Hunt Valley)

\_\_\_\_ Thursday 6:30pm-8:30pm (Multifamily Skills Group – telehealth only)

Please describe your child’s availability for **individual therapy**. None of our therapists work on the weekends. Some therapists offer early morning and/or evening appointments. **Please list specific times of day**. (ex. any weekday after 3pm, Tuesdays and Thursdays from 12-2pm). Your specificity will help us place your child with an available therapist.

When we return to the office, which office location do you prefer:

\_\_\_ Hunt Valley \_\_\_ Bethesda \_\_\_ Frederick \_\_\_ telehealth only

Do you have any preferences for your therapist (i.e. gender, race, etc.)? Please understand these requests will be considered pending provider availability.

Would you be willing to have your sessions recorded for the purposes of individual therapist and/or program certification? Your answer to this question will not impact your ability to receive services.

 Yes/No

What is the reason for treatment?

How did you learn about our program?

Please send your completed form to us by fax (443-353-5701) or mail\*

Attn: DBT Program

Gladstone Psychiatry and Wellness

11350 McCormick Rd

Executive Plaza 3, Suite 600

Hunt Valley, MD

*\*You may send the completed form by email to dbt@gladstonepsych.com; however, please know that email is not a HIPAA-compliant means of communication.*