



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)-247-3621.

Date of Application: _____

Legal name of Applicant: _____

Name applicant goes by: _____

Applicant's DOB: ____ / ____ / ____ (MM/DD/YYYY)

Applicant's Age: ____

Pronouns: _____

Address Line 1: _____

Address Line 2: _____

City, State, Zip Code: _____

Parent/Legal Guardian Name(s): _____

Phone number: ____ - ____ - ____

Email address: _____

Patients with locally billed (Maryland) CareFirst plans may be eligible to participate at no additional cost. Medical necessity requirements may apply. Some patients may qualify for Single Case Agreements.

The following insurances cover part of the program. A \$1,500 monthly fee applies to essential services not covered by insurance, such as phone coaching:

Aetna

United/Optum

Cigna/Evernorth

Non-local and third-party payer CareFirst plans (CareFirst Anthem, CareFirst Administrators, CareFirst Out-of-State billed plans)

Insurance carrier: _____

Policy holder: _____

Applicant's relationship to policy holder: _____

Member ID or Policy #: _____

Group #: _____

Referring therapist or psychiatrist: _____

CareFirst only: If this is an employer-based health plan, are the employer's headquarters located in any state outside of Maryland? Yes/no (if yes, please skip to the next question)

Aetna, United/Optum, Cigna/Evernorth, Non-local and third-party payer CareFirst plans only:

Please check here to indicate you understand there is an additional \$1,500 monthly fee that is not covered by insurance.

Please check here if you would like to self-pay rather than using insurance at a rate of \$2,200 monthly.

Please check here if you would like us to check your eligibility for a Single Case Agreement.

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** (1-2):

Monday 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**. **Please note: Offering flexibility in scheduling for individual therapy will likely result in a sooner intake. Those with limited scheduling availability will likely face a delay. Please list specific days and times** (ex. Any weekday after 3pm, Tuesdays and Thursdays from 12-2pm). Your specificity will help us place you with an available therapist.

Which office location do you prefer (please select a first and second location option): **Please note: offering flexibility in office location and/or telehealth services will likely result in a sooner intake.**

Hunt Valley Bethesda Frederick Columbia 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 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)- 901-3699) 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.*