Gladstone
Psychiatry and Wellness

Application for Adult 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 Email: dbt@gladstonepsych.com | Office: 443-708-5856 option #4 for the DBT Department.

Date of Application: _____

Legal name of Applicant: _____

Name you go by: _____

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

Applicant's Age: _____

Pronouns: _____

Address Line 1: _____

Address Line 2: _____

City, State, Zip Code: _____

Phone number: _____ - _____ - _____

Email address: _____

Clients 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: _____

Sex on file associated with your health plan: _____

Policy holder's full name: _____

Policy holder's date of birth: _____

Policy holder's address associated with insurance: _____

Policy holder's contact information (phone or email): _____

Applicant's relationship to policy holder: _____

Member ID or Policy #: _____

Group #: _____

Referring therapist or psychiatrist (if applicable): _____

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

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. *(Single Case Agreements only qualify for out of network insurances (EHP, Tricare, Kaiser) non- medicare or medicaid plans.)*

Please rank your availability to attend **group skills training** (1-6): ***Please note all groups are virtual at this time.***

___ Mondays 6:30pm - 8:30pm (Telehealth)

___ Mondays 6:30pm - 8:30pm (In person at Hunt Valley Office)

___ Tuesdays 4:00pm - 6:00pm (Telehealth; Transitional Age Youth ages 17-24 only)

___ Tuesdays 6:30pm - 8:30pm (Telehealth)

___ Wednesdays 10:00am - 12:00pm (Telehealth)

___ Wednesdays 6:30pm - 8:30pm (Telehealth)

Please describe your 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 12-5pm). 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: Your preference for an office location and/or telehealth services may impact the speed of your intake process, with flexibility likely leading to a sooner appointment. Please indicate your service preference below.***

____ Hunt Valley Office ____ Bethesda Office ____ Frederick Office ____ Telehealth

____ Columbia Office (limited availability) ____ Mt. Washington Office (limited availability)

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

To assist us in matching you with the most appropriate provider, please share any information about yourself that might be helpful, such as support needs or special circumstances:

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?

DBT Adult Application Acknowledgment and Agreement

I certify that I, the applicant, am completing this DBT Adult application on my own behalf.

Signature: _____

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.*