Suburban Psychiatric Associates, L.L.P.

Child and Adolescent Psychiatry Intake Assessment

Please complete this form and bring it with you to the first appointment

Patient Name _____ DOB _____ Date_____

Referred by _____

Parent/Guardian Name _____ Age _____ Lives with child? _____

Marital status _____ Marital History _____

Employment _____

Parent/Guardian Name _____ Age _____ Lives with child? _____

Marital status _____ Marital History _____

Employment _____

Others in household	Age	Relation to patient

Please Note:

Children under 18 years of age ***must*** be accompanied by a parent or guardian to all sessions.

Reason seeking evaluation _____

Recent stressors _____

Duration of problem _____

How it affects child? _____

How it affects family? _____

How it affects school work _____

How it affects friendships _____

What makes it better? _____

What makes it worse? _____

Suburban Psychiatric Associates, L.L.P.

Is child in counseling? ____ With whom? _____ How often?_____How Long? _____

Previous counseling _____

Is child on psychotropic medication? Yes____ No____If yes, name/dosage/duration _____

_____

Previous medication name/dosage/duration _____

_____

Has child ever been hospitalized? _____ When/where/how long? _____

_____

Problems now or in the past with/describe:

Excessive worries _____

Sleep _____

Appetite _____

Hyperactivity _____

Compulsive behaviors _____

Drug/alcohol use _____

Excessive crying _____

Hallucinations (hearing / seeing things) _____

Unusual or strange thoughts _____

Temper tantrums _____

Fighting _____

Excessive lying or stealing _____

Extreme mood changes_____

Suicidal thoughts / actions _____

Child's pediatrician _____

Current medical problems _____

Allergies _____

Any history of seizures / head trauma / neurologic problems / lead exposure / heart problems / lung problems / endocrine problems? If yes, describe: _____

_____

_____

Suburban Psychiatric Associates, L.L.P.

Is there anyone in the child's biologic family that has had depression, attention deficit, anxiety disorder, obsessive compulsive disorder, bipolar disorder, learning disability, schizophrenia, or any other psychiatric disorder? If yes, describe: _____

Does anyone in the child's family have a substance abuse problem? If yes, describe: _____

Were there any complications in the pregnancy, delivery or early medical problems? If yes, describe: _____

Did the child have any early difficulties with feeding, sleeping, colic? If yes describe; _____

Child's primary caretaker _____

Did the child have any delays in motor or speech development? If yes, describe; _____

Child's age at toilet training _____ How long did it take? _____ Was it easy or difficult? _____

Did the child attend preschool? If yes, were there any problems with the separation from parents, aggression toward other children or any concerns at that time? _____

Was the child ever the victim of physical, sexual, or verbal abuse? If yes, describe: _____

Was the child ever involved with Child Protective Services? If yes, describe: _____

Suburban Psychiatric Associates, L.L.P.

Did the child ever witness domestic violence? If yes, describe: _____

School child attends _____ Grade _____

Is the child receiving special education services? If yes, describe: _____

Does the child have friends? _ How would you describe your child's ability to get along with other children? _____

Is the child invited to birthday parties, sleepovers, etc.? _____

Child's relationship with other adults: _____

Does the child have hobbies, participate in sports, school clubs, scouts, etc.? _____

Child's best qualities _____

What would you most like to be different for your child? _____

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Patient Information

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Home Phone# _____ Cell Phone# _____ Work Phone# _____

Date of Birth _____ SS# _____

Sex at Birth: Male Female Identifies as: Male Female Other_____

Preferred pronoun: He/Him/His She/Her/Hers Other _____

Student Status: Full-time _____ Part Time _____ Non-Student _____

Employer / School _____

Martial Status _____ Spouses Name _____

Emergency Contact_____ Phone # _____

Relationship to Patient _____

Pharmacy _____ Phone # _____ Fax # _____

Primary Doctor _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Referring Physician/ Source _____ Phone _____

Address _____ City _____ State _____ Zip _____

Responsible Party Information (if different from above)

Responsible Party Name_____

Address _____ City _____ State ____ Zip _____

Relationship to Patient _____ Home Phone # _____

Work # _____ Ext# _____ Date of Birth _____ Male _____ Female _____ Other _____

SS# _____ Employer _____

Responsible Party Information

Primary Insurance Name _____

Phone # _____ Plan Name _____ Group # _____

ID# _____ Effective Date _____ Employer _____

Insured Party Name _____ Date of Birth _____

Address _____ City _____ State ____ Zip _____

Relationship to Patient _____ SS# _____

Secondary Insurance Name _____

Phone # _____ Plan Name _____ Group # _____

ID# _____ Effective Date __ Employer _____

Insured Party Name _____ Date of Birth _____

Address _____ City _____ State ___ Zip _____

Relationship to Patient _____ SS# _____

Suburban Psychiatric Associates, L.L.P.

Thank you for choosing Suburban Psychiatric Associates, LLP as your mental health provider. Our practice is committed to providing you with the highest quality care, service and access. In order to help accomplish these goals, below is some introductory information.

General Information
Office Phone: 716.689.3333
Phone Hours: Monday - Friday 8:00 am - 5:00 pm
Patient Website: www.suburbanpsych.org
If you wish to contact a physician regarding a medical matter, please call the office or use the Patient Portal (see information on page 2). A medical provider is on call seven (7) days a week to take urgent calls outside normal business hours. Your call will be returned within one (2) hours.
For emergencies, call 911.

Appointments
Office visits are by appointment only and vary according to each practitioner's schedule. Please arrive 15 minutes prior to your appointment time to register. For your benefit and the benefit of all our patients, we try to stay on schedule (though emergencies sometimes occur) and aim for patients to be in the exam room at their appointment time. You will receive an automated pre-appointment reminder call two (2) to five (5) business days before your appointment. It is important for you to notify our office if your phone number has changed. Please specify if you prefer your home or mobile number as your primary contact.

Prescription Refills.
For routine refills, please contact your pharmacy to have the request sent electronically or call the office directly. Refills can be requested through our Patient Portal for those who are currently enrolled. Please allow five (5) business days to have all medications refilled. For refill requests needed in less than five (5) business days, contact the office directly.

Patient Record and Form Completion Fees
Your records, if copied, will cost $0.75 per copied page. Records requested by other health professionals rendering active treatment are free of charge.
Dictated reports and court appearances are charged based on the amount of time spent and may vary based on clinician.
There will be a $25 service charge for completion of forms not associated with an office visit. This fee is required to be paid at the time of request. More complex forms will be charged up to $45, depending on the length and time involved to complete the form. Please allow seven (**7**) business days for us to complete any forms.

Test Results
Please allow seven (7) business days for laboratory results or other diagnostic test results unless instructed by your physician. Your physician will review all test results and contact you if follow up is needed. Routine lab results may be relayed by postal mail, patient portal or telephone.

Address and/or Phone Number Change
Please advise our practice anytime there is a change in your address, phone number, insurance, or other contact information. Our staff is required to verify all demographic and insurance information at every visit.

Minors
The parent or guardian who holds the insurance for the child is considered the guarantor for the child and is responsible for full payment regardless of personal circumstances. A signed release to treat may be required for unaccompanied minors.

Patient Portal
The Suburban Psychiatric Patient Portal provides all participating patients the ability to communicate securely and manage their own healthcare with S.P.A. providers, 24 hours, seven (7) days a week. All messages received through the Patient Portal will be answered within one (1) business day excluding weekends. The ability to view portions of your medical records, verify or request appointments, request prescriptions, update personal information, receive reminders, and ask a question of your provider are some functions of the portal. All patients are encouraged to notify our staff by phone/at your next visit to request an invitation to create an account on Medent to become participants of the S.P.A. Patient Portal.

Insurance Verification and Copayments
Patients are expected to present valid photo identification and their insurance card at each visit. All co-payments and past due balances are due at the time of visit unless previous arrangements have been made with our billing office. We accept cash, check, credit card or flexible spending card. No post-dated checks are accepted. A $35 returned check fee is added to any insufficient funds amount owed by the patient. The patient will be placed on a cash-only basis following any returned check.

Insurance Claims
We process claims through your insurance as a courtesy. The practice will bill the patient's primary insurance company. In order to properly bill the insurance company, the practice requires that the patient disclose all insurance information including primary and secondary insurance, as well as any insurance changes. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although the practice may estimate the amount the insurance company may pay, it is the insurance company that makes the final determination of the patient's eligibility and/or benefits.

The patient is responsible and agrees to pay for any noncovered services provided. If the insurance company is not contracted with the practice, the patient agrees to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance.

Participating Insurances
The practice accepts most insurance plans including but not limited to: Aetna Blue Cross/Blue Shield, Independent Health, Nova, Optum, Univera, United Behavioral Health, and Medicare. Participation in insurance plans may change. It is your responsibility to verify if Suburban Psychiatric Associates, LLP participates in your plan. If your physician does not participate with your insurance, you have the right to request an estimate of cost. We ***do not*** participate with any Medicaid or Managed Medicaid plans. If there is a discrepancy with the insurance information on file with the practice, the patient is considered self-pay unless otherwise proven.

High Deductible Plans (Health Savings Accounts or Health Reimbursement Accounts)
If your insurance is a High Deductible Plan, you will be required to pay a minimum $50 deposit prior to your follow up visit and $100 for New patient visit. If the total cost of services rendered is more than collected you will be billed for the remaining amount. If the cost of your visit is less than amount collected, we will send you a refund for the difference. Refunds will be issued within 60 days if the overall patient account has a credit balance.

Referrals and Authorizations
It is the patient's or guarantor's responsibility to be aware of the details of his/her insurance coverage, including any requirements for referrals and/or authorizations. Not all of our providers participate with all insurance companies. Please verify whether your physician accepts your insurance coverage. If your insurance company requires a referral and/or authorization (for specialist visits/ testing), you are responsible for obtaining it. Failure to obtain the referral or preauthorization may result in a lower payment or no payment from the insurance company and the balance will be the patient's responsibility. To verify if we have received the appropriate referral or authorization, please contact our office.

Self-pay Accounts
Self-pay accounts are for patients without insurance coverage or patients without an insurance card on file with S.P.A. The practice does not accept attorney letters or contingency payments. Self-pay patients are expected to make payment at the time of service *($225-$300 for new patients* and *$115 - $185 for established patients*). If the down payment does not cover all treatment charges, the patient is billed for the remaining balance. Failure to make the payment at the time of service, may result in an additional fee.

Workers' Compensation and Automobile Accidents (No Fault) ARE NOT ACCEPTED AT OUR PRACTICE

No Show/Cancellation Fee
The practice requires 24-hour notice of appointment cancellation. If this procedure is not followed, a fee is assessed to the patient $75 for follow up visits and $150 for new patient visits. ***These charges are not covered by insurance and are due pay- able prior to any further appointments.*** In the event that you must cancel and cannot reach the office staff, please leave a message on the voicemail system. Our system will date and time your call. No fee will be charged if your call is within the above time frame.

Outstanding Balance Policy
A billing statement is sent to the patient/guarantor upon rendering of services. Statements are mailed every twenty- eight (28) days thereafter. If a patient's account is sixty (60) days past due, the patient is sent a Final Collection letter requesting payment within fifteen (15) days. Telephone calls may be made to the patient prior to sending an account to a collection agency in a final attempt to collect the outstanding balance. If no payment is received, the account is sent to a collection agency. Statements returned with an invalid address, will be sent to the collection agency. Any account sent to a collection agency will include collection, attorney and court fees and may be reported to credit bureaus. Patients with an outstanding balance of 120 days may be discharged from our practice unless a payment arrangement is made. If your account is unpaid, and no payment arrangement has been made, pursuant to this agreement, your account may be turned over to a collection agency.

Regardless of any personal arrangements that a patient might have with outside individuals or groups, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other individual.

Policy and Fee Changes
These policies and fees are subject to change. We will do our best to keep you informed of any modifications.

I have read and understand the above policies.

Patient Name: _____

Patient Signature: _____

Date: _____

D.O.B. _____

Suburban Psychiatric Associates, L.L.P.

Financial Policy

It is the policy of Suburban Psychiatric Associates to provide you with information related to our billing processes and your financial responsibilities as our patient. This policy helps us in our mission to provide you with exceptional medical care in the most cost-effective manner.

Things to bring with you to each visit:

1) Current insurance card(s)

2) Photo identification

3) Your preferred method of payment for any cost shares due at the time of service

Insurance Companies: Participation and Billing

1) While Suburban Psychiatric Associates participates with the majority of third-party insurance plans available in our area; it is **your** responsibility to verify that your physician is currently participating with your plan and that you have obtained all necessary referrals **PRIOR** to your scheduled appointment. Failure to do so may result in your responsibility for any incurred charges.

2) You will be asked to provide your insurance card(s) at every visit. This is to ensure that the information we have on file is correct, and that your plan is current.

3) The Practice will submit claims to your primary and secondary insurance companies we participate with, as a courtesy to you.

4) Except where my plan provides for automatic payment of benefits to the provider of services, I authorize payment of benefits, otherwise payable to me, for services rendered by Suburban Psychiatric Associates I understand that I am ultimately responsible to the provider for charges not covered by my benefit plan.

5) Due to the wide range of insurance plans, we are unable to quote specific plan benefits. To fully understand your individual insurance plan, please contact your insurance company directly to discuss your plan's benefits.

Time of Service Payments

1. Co-payments, deductibles, and coinsurance are part of the contractual agreement between you and your insurance company. Your insurance company requires us to collect your co-payment in full at the time of service. If your plan also has a deductible and/or coinsurance that has not been met, we may collect a deposit of $50.00 for any follow-up appointments and $100.00 for new patient appointments (since we can only estimate the future amount due) at the time of service.

2. Patients without medical insurance coverage (self-pay patients) are responsible for any and all charges that result from professional or medical services provided by our physicians. Payment is due when services are rendered, unless other payment arrangements have been approved.

Collections

The practice reserves the right to consider delinquent patient accounts for external collection efforts in accordance with state and federal regulations. Our office will allow a 30-day grace period for any outstanding charges after insurance payment have been made. If any charges are remaining after 30 days no appointments will be scheduled until balance is paid in full, unless other arrangements have been made.

Our practice will utilize an outside collections service for all accounts past due greater than 120 days. Patient will be responsible for any and all fees occurred by sending account to collections.

By signing below, I acknowledge that I have read, understand, and accept the policy.

Print Name:_____ Date of Birth:_____/_____/_____

Signature:_____ Date: _____/_____/_____

Phone 716.689.3333

85 Bryant Woods South • Amherst, New York 14228
4535 Southwestern Blvd • Bldg 700, Suite 704 • Hamburg, NY 14075

Fax 716.689.9695

Suburban Psychiatric Associates, L.L.P.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
For Suburban Psychiatric Associates, LLP

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

- ❒ *The patient refused to sign.*
- ❒ *Due to an emergency situation it was not possible to obtain an acknowledgement.*
- ❒ *We weren't able to communicate with the patient.*
- ❒ *Other (Please provide specific details)*

_____

_____

_____

_____

_____ _____

Employee Signature Date

Phone 716.689.3333
85 Bryant Woods South • Amherst, New York 14228
4535 Southwestern Blvd • Bldg 700, Suite 704 • Hamburg, NY 14075
Fax 716.689.9695

Suburban Psychiatric Associates, L.L.P.

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____

Patient's Date of Birth: _____ Patient's SS #: _____

Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent, we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

(*To Be Completed by Patient or Patient's Representative)*

I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations, as described in the notice of privacy practices.

_____ _____

Patient's Signature or Signature of Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Jennifer J. Hosmer
Practice Address: 85 Bryant Woods Amherst, New York 14228
4535 Southwestern Blvd. Suite 704 Hamburg, New York 14075
Phone: 716.689.3333 • Fax: 716.689.9695

Suburban Psychiatric Associates, L.L.P.

Limits of Confidentiality

In the event the practice or mental health professional must telephone the patient for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the practice or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the patient (or legal guardian) without identifying the name of the practice. If the person answering the phone asks for more identifying information, we will say that it is a personal call. We will not identify the practice (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

PLEASE CHECK PLACES WHERE YOU MAY BE REACHED BY PHONE. Include phone numbers and how you would like us to identify ourselves when phoning you.

_____ **HOME** _____ _____ _____ **YES** _____ **No**
Phone number How should we identify ourselves? May we say the practice name?

_____ **WORK** _____ _____ _____ **YES** _____ **No**
Phone number How should we identify ourselves? May we say the practice name?

_____ **OTHER** _____ _____ _____ **YES** _____ **No**
Phone number How should we identify ourselves? May we say the practice name?

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____ _____
Patient's Name (please Print) Patient (or Legal Guardian) Signature Date

Phone 716.689.3333
85 Bryant Woods South • Amherst, New York 14228
4535 Southwestern Blvd • Bldg 700, Suite 704 • Hamburg, NY 14075
Fax 716.689.9695

Suburban Psychiatric Associates, L.L.P.

Controlled Substance Agreement (Page 1 of 2)

My physician and I have a common treatment goal to improve my ability to function and/or work. In consideration of that goal, I am being treated with medications such as benzodiazepines or barbiturates. These medications may impair my alertness, reflexes, coordination, and judgment. The use of these types of medications is controlled and monitored by local, state, and federal agencies. These medications can be highly effective when taken as directed under medical supervision, but have the potential of abuse and misuse.

• I have been informed that psychological dependence and addiction to controlled substances can occur and are a risk of treatment. If this happens, I will follow my provider's guidance and participate in any treatment programs recommended, which may include medical detoxification, psychological counseling pertaining to substance misuse.

• I agree to inform my provider if I am diagnosed with or treated for a substance use problem.

• I have never been involved in the illegal sale, possession, or transportation of controlled substances.

• I understand that the giving or sale of my prescription medication to any other person is illegal and WILL result in my dismissal from Suburban Psychiatric Associates, LLP as well as being reported to law enforcement officers.

• I have been informed by my provider and I understand I should not consume alcohol with taking these types of medications.

• I am aware that my provider has access to, and will be reviewing my patterns of filling prescriptions through the New York State Prescription Monitoring Program.

• I take full responsibility for the consequences of driving a motor vehicle, operation of machinery or doing any other activity in which alertness, reflexes, coordination, and/or judgment are necessary.

• For women of childbearing age: I am not pregnant.

I AGREE TO ABIDE BY THE FOLLOWING CONDITIONS:

1. I will follow the treatment plan that my provider and I have agreed upon.

2. I agree to always be truthful with all my provider and my other physicians regarding my history, illness, and use of medication.

3. I will report any suspected side effects to my provider immediately.

4. I understand that my provider is not obligated, nor will he/she automatically refill prescriptions for controlled medications that I have been receiving from another physician.

5. I will not ask for, nor accept controlled substance medications or prescriptions from any other individuals or physicians while I am receiving such medications from any provider at Suburban Psychiatric Associates, LLP. This is not only ILLEGAL, but could endanger my health. The only exception to this would be if I were hospitalized.

6. I will take the medications as directed. If I use my medication up sooner than prescribed, lose my prescription or medication, or if my medication is stolen, I understand the providers at Suburban Psychiatric Associates, LLP will not refill my medication until it is time for the scheduled refill.

Controlled Substance Agreement (Page 2 of 2)

7. I will bring the unused portion of my medication to the office for a medication count if requested by my provider.

8. In the event that my prescription needs to be changed to another medication, I understand I may be asked to return the remaining portion of the prior prescription for disposal.

9. I understand my medication dosage may need to be increased or decreased depending upon my condition. I will not adjust my medication myself and understand if I need more medication due to a worsening of my condition, I must see my psychiatrist to be re-evaluated before my medication will be increased.

10. I understand that stopping my medications abruptly maybe dangerous and lead to withdrawal symptoms, including increased anxiety, sweats, tremors, nausea, vomiting and possible seizures, hallucinations, or confusion. If medications need to be discontinued, I will follow my psychiatrist's supervision.

11. I will submit to drug testing if requested, including urine, saliva, or hair testing.

12. I authorize Suburban Psychiatric Associates, LLP and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the board of pharmacy, in the investigation of any possible misuse, sale or other diversion of my controlled medications. I authorize Suburban Psychiatric Associates, LLP to provide a copy of this agreement to my pharmacy. I also authorize my pharmacy to provide records documenting prescriptions that I have received to Suburban Psychiatric Associates, LLP, if requested. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

13. I am responsible for keeping track of the amount of medication, and will plan ahead for refills in a timely manner, so I will not run out of my medication. I understand that these types of medications will only be refilled during regular business hours by Suburban Psychiatric Associates, LLP.

14. For women: am not pregnant and agree to utilize birth control at all times while taking these types of medications. Should I become pregnant, I agree to notify Suburban Psychiatric Associates, LLP. I will accept the risk to my baby and myself if I should use these medications while pregnant.

My signature below means I have read and understand the terms of this agreement and have had questions answered to my satisfaction. I understand if I violate this agreement, my controlled substance prescriptions and/or treatment will be terminated immediately and I will be dismissed from Suburban Psychiatric Associates, LLP.

Patient Name (Print):_____ MRN: _____

Patient (or legal Guardian) Signature:_____ Date: _____

NOTICE OF PRIVACY PRACTICES

Effective 7/1/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability & Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This Notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our Practice except when the release is required or authorized by law or regulation.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE You will be asked to provide a signed acknowledgment of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information in accordance with law.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION "Protected health information" is individually identifiable health information and includes demographic information (for example, age, address, etc.), and relates to your past, present or future physical or mental health or condition and related health care services. Our Practice is re- quired by law to do the following: (1) keep your protected health information private; (2) present to you this Notice of our legal duties and privacy practices related to the use and disclosure of your protected health information; (3) follow the terms of the Notice currently in effect; (4) post and make available to you any revised Notice; and (5) notify affected individuals following a breach of unsecured protected health information. We reserve the right to revise this Notice and to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. The Notice's effective date is at the top of the first page and at the bottom of the last page.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION - Following are examples of permitted uses and disclosures of your protected health information. These examples are not exhaustive.

Required Uses and Disclosures By law, we must disclose your health information to you unless it has been determined by a health care professional that it would be harmful to you. Even in such cases, we may disclose a summary of your health information to certain of your authorized representatives specified by you or by law. We must also disclose health information to the Secretary of the U.S. Department of Health and Human Services (HHS) for investigations or determinations of our compliance with laws on the protection of your health information.

Treatment We will use and disclose your protected health information to pro- vide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we may disclose your protected health information from time to time to another physician or health care provider (for example, a specialist, pharmacist, or laboratory) who, at the request of your physician, be- comes involved in your care. In emergencies, we will use and disclose your protected health information to provide the treatment you require

Payment Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities we may need to undertake before your health care insurer approves or pays for the health care services recommended for you, such as determining eligibility or coverage for benefits. For example, obtaining approval for a surgical procedure might require that your relevant protected health information be disclosed to obtain approval to perform the procedure at a particular facility. We will continue to request your authorization to share your protected health information with your health insurer or third-party payer.

Health Care Operations We may use or disclose, as needed, your protected health information to support our daily activities related to providing health care. These activities include billing, collection, quality assessment, licensing, and staff performance reviews. For example, we may disclose your protected health information to a billing agency in order to prepare claims for reimbursement for the services we provide to you. We may call you by name in the waiting room when your physician is ready to see you. We will share your protected health information with other persons or entities who perform various activities (for example, a transcription service) for our Practices. These business associates of our Practice are also required by law to protect your health information. We may use or disclose your protected health information as necessary to contact you in order to raise funds for our Practice. Any such communication will tell you how you may opt out of receiving future fundraising communications from us. We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, emails, phone calls, voicemail messages, text messages or letters.

Required by Law We may use or disclose your protected health information if law or regulations requires the use or disclosure.

Public Health We may disclose your protected health information to a public health authority who is permitted by law to collect or receive the information. For example, the disclosure may be necessary to prevent or control disease, injury, or disability; report births and deaths; or report reactions to medications or problems with medical products. We may provide proof of immunization without authorization, to your school if (i) the school is required by State or other law to have proof of immunization prior to admission and (ii) we obtain and document your permission or, for a minor, the permission of the parent, guardian or other person acting *in loco parentis* for the individual.

Communicable Diseases We may disclose your protected health information, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit pro- grams, or other regulatory programs.

Food and Drug Administration, We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events; track products, enable product recalls; make repairs or replacements; or conduct post marketing review.

Legal Proceedings We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement We may disclose protected health information for law enforcement purposes, including information requests for identification and lo- cation; and circumstances pertaining to victims of a crime.

Coroners, Funeral Directors, and Organ Donations We may disclose protected health information to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose protected health information to funeral directors as authorized by law. Protected health information may be used and disclosed for cadaver organ, eye or tissue donations.

Research We may disclose protected health information to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Threat to Health or Safety Under applicable Federal and State laws, we may disclose your protected health information to law enforcement or an- other health care professional if we believe in good faith that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to

identify or apprehend an individual.

Military Activity and National Security When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission, including determination of fitness for duty; or to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information, under specified conditions, to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

Workers' Compensation We may disclose your protected health information to comply with workers' compensation laws and similar government programs.

Inmates We may use or disclose your protected health information, under certain circumstances, if you are an inmate of a correctional facility.

Parental Access State laws concerning minors permit or require certain disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State (or, if you are treated by us in another state, the laws of that state) and will make disclosures following such laws.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSION - In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. Following are examples in which your agreement or objection is required.

Individuals Involved in Your Health Care Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. If you should become deceased, we may disclose your protected health information to a family member or other individual who was previously involved in your care, or in payment for your care, if the disclosure is relevant to that person's prior involvement, unless doing so is inconsistent with your prior expressed preference. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION - You may exercise the following rights by submitting a written request to our Privacy Officer. Our Privacy Officer can guide you in pursuing these options. Please be aware that our Practice may deny your request; however, in most cases you may seek a review of the denial.

Right to Inspect and Copy You may inspect and/or obtain a copy of your protected health information that is contained in a "designated record set" for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that our Practice uses for making decisions about you. This right does not include inspection and copying of the following records: psychotherapy notes; information compiled in reason- able anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. You will be charged a fee for a copy of your record and we will advise you of the exact fee at the time you make your request. We may offer to provide a summary of your information and, if you agree to receive a summary, we will advise you of the fee at the time of your request.

Right to Request Restrictions You may ask us not to use or disclose any part of your protected health information for treatment, payment, or health care operations. Your request must be made in writing to our Privacy Officer. In your request, you must tell us: (1) what information you want restricted; (2) whether you want to restrict our use or disclosure, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date. If we believe that the restriction is not in the best interests of either party, or that we cannot reasonably accommodate the request, we are not required to agree to your request. If the restriction is mutually agreed upon, we will not use or disclose your protected health information in violation of that restriction, unless it is needed to provide emergency treatment. You may ask us not to disclose certain information to your health plan. We must agree with that request only if the disclosure is not for the purpose of carrying out treatment (only for carrying out payment or health care operations) and is not otherwise prohibited by law and pertains solely to a health care item or service for which we have been paid out of pocket in full by you or by another person on your behalf other than your health plan. You may revoke a previously agreed upon restriction, at any time, in writing.

Right to Request Alternative Confidential Communications You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

Right to Request Amendment If you believe that the information, we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

Right to an Accounting of Disclosure You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment or health care operations as described in this Notice and excludes disclosures made directly to you, to others pursuant to an authorization from you, to family members or friends involved in your care, or for notification purposes. The accounting will only include disclosures made no more than 6 years prior to the date of your request. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this Notice.

Rights Related to an Electronic Health Record – If we maintain an electronic health record containing your protected health information, you have the right to obtain a copy of that information in an electronic format and you may choose to have us transmit such copy directly to a person or entity you designate,provided that your choice is clear, conspicuous, and specific. You may request that we provide you with an accounting of the disclosures we have made of your protected health information (including disclosures related to treatment, payment, and health care operations) contained in an electronic health record for no more than 3 years prior to the date of your request (and depending on when we acquired an electronic health record).

Right to Obtain a Copy of this Notice You may obtain a paper copy of this Notice from us, view or download it electronically at our Practice's website at www.suburbanpsych.org, or, if you agree, by email.

Special Protections This Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIV related information, family planning information, mental health information, psychotherapy notes, and substance abuse information. These laws have not been superseded and have been taken into consideration in developing our policies and this Notice. Psychotherapy notes, release of protected health information for marketing purposes or sale of protected health information, are all specifically subject to more strict privacy standards and most uses and disclosures require express authorization from you.

Complaints If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint.

CONTACT INFORMATION - Our Privacy Officer is Jennifer J. Hosmer, and can be contacted at this office or by calling our telephone number 716-689-3333. You may contact our Privacy Officer for further information about our complaint process or for further explanation of this Notice of Privacy Practices.