NOTICE OF PRIVACY PRACTICES

Effective April 29, 2015

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how your provider may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), your provider is required to maintain the privacy of PHI and to provide you with notice of his or her legal duties and privacy practices with respect to PHI. Your provider is required to abide by the terms of this Notice of Privacy Practices. Your provider reserves the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that your provider maintains at that time. Your provider will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or by providing one to you at your next appointment.

HOW YOUR PROVIDER MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your healthcare treatment and related services. This includes consultation with clinical supervisors or other treatment team members. Your provider may disclose PHI to any other consultant only with your authorization.

For Payment: Your provider may use and disclose PHI so that he or she can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, only disclose the minimum amount of PHI necessary for purposes of collection will be disclosed.

For Health Care Operations: Your provider may use or disclose, as needed, your PHI in order to support his or business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging other business activities. For example, your PHI may be shared with third parties that perform various business activities provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. Your PHI may be used to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Required by Law: Under the law, your provider must make disclosures of your PHI to you upon your request. In addition, disclosures must be made to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit your provider to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations.
- Required by Court Order

- Necessary to prevent or lessen a serious an imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: Your provider may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI maintained about you. To exercise any of these rights, please submit your request in writing to your provider:

Right of Access to Inspect and Copy. In most cases, you have the right to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. Your provider may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI your provider has about you is incorrect or incomplete, you may ask for it to be amended, although your provider is not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures that your provider makes of your PHI. Your provider may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or healthcare operations. Your provider is not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that your provider communicate with you about medical matters in a certain way or at a certain location.

Right to a Copy of This Notice. You may ask your provider for a paper copy of this notice at any time.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a complaint with the Federal Government. Filing a complaint will not affect your right to further treatment or future treatment. To file a complaint with the Federal Government, contact:

Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and the limits on ways my provider may use or disclose personal health information to provide service.

Client Name: _____ Client Signature: _____

Date: _____

If signed by other than client, indicate relationship:

_____

S.S BEHAVIORAL HEALTH, INC

Demographic Form

Patient Name: _____

Patient Email (or family members): _____

Social Security # _____

Employment Status: _____

Highest Level of Education: _____

Marital Status: (Circle) Single Married Divorced Engaged Widowed Seperated

Ethnicity: _____

Religion: _____

Family Size: _____

Veteran: (Circle) Y/N

Preferred Language: _____

Disability: _____

Emergency Contact Name: _____ Phone# _____

Authorization to disclose information to Primary Care Physician

Name:_____ **DOB:**_____

I understand my records are protected under the applicable law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and drug abuse patient records 42 CRF part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I have the right to inspect and copy the information disclosed. I may revoke this authorization at any time by giving a written revocation to the facility to which I presented this authorization, however, my request for revocation will not be effective for uses or disclosures that have already been made or other actions that have already been taken, in reliance on this authorization or as required by law, this release will automatically expire 12 months from the signed date.

I,_____

(Print Patient Name) **(Address)** **(City, State, Zip code)**

Here by authorize M. Shafi Siddiqui, MD S S Behavioral Health, Inc. to disclose information relating to my psychiatric evaluation, progress notes, treatment plan, psychosocial history, psychological testing, lab results or any other information (Must list below) for the purpose of coordination of care (Verbal and/or written communication) to my primary care physician:

Other information to be released: _____

Primary Care Physician Information

PCP Name:_____ **Phone Number:**_____

Address: _____ **Fax Number:** _____

_____ Do not release information to my primary care physician, I understand the consequence of refusal to consent is non-disclosure of information.

_____ _____

(Patient signature) **(Date)**

_____ _____

(Signature of Guardian/if applicable) **(Date)**

S.S BEHAVIORAL HEALTH, INC

Patient's Legal Name: _____ Date Of Birth: _____ M/F

Street: _____ City: _____ Zip Code: _____

Home Phone: _____ SS# _____

Work Phone: _____ Referred By: _____

Cell phone: _____ Reason for visit: _____

Patient informed of our financial policy? Y/N

Guarantor Name: _____ DOB: _____ Relationship to Guarantor: _____

Guarantors address same as patient? Y/N _____

Primary Insurance _____ Phone: _____

Group# _____ ID# _____ Policy holder _____

Rel _____ SS# _____ DOB _____ Medicare effective date: _____

Secondary Insurance _____ Phone: _____

Group# _____ ID# _____ Policy holder _____

Rel _____ SS# _____ DOB _____ Medicare effective date: _____

Emergency Contact

Emergency Contact full legal name: _____

Emergency contact home phone: _____ Cell phone: _____

Emergency Contact address: _____

Relationship to patient: _____ POA: Y/N

S.S BEHAVIORAL HEALTH, INC

INFORMED CONSENT FOR ASSESMENT AND TREATMENT

Name:_____ Date of Birth:_____

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment). I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time, but agree to discuss this decision first with my provider.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my provider is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations, and discuss with your provider any questions or concerns you may have.

By my signature below, I voluntarily request and consent to behavioral health assessment, care, treatment, or services and authorize my provider to provide such care, treatment or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Signature: _____ Date:_____

Parent/Guardian signature: _____ Date:_____
(For minor)

S.S BEHAVIORAL HEALTH, INC

Patient Name:_____ DOB:_____

OFFICE POLICIES

Please INITIAL each section

Regarding insurance

_____As a service to our patients we will submit all claims on your behalf to your insurance carrier provided we are contracted with your insurance carrier. It is your responsibility to understand your insurance policy. Claims rejected by your plan (due to non-covered benefits, pre-existing conditions. etc- see your policy for details) will be billed to you. If you do not have insurance, choose not to utilize your insurance benefits, or if you do not have a plan that is contracted with S S Behavioral Health, Inc., payment in full will be required at the time of service.

Appointment Tardiness

_____As a service to our patients we will submit all claims on your behalf to your insurance carrier provided we are contracted with your insurance carrier. It is your responsibility to understand your insurance policy. Claims rejected by your plan (due to non-covered benefits, pre-existing conditions. etc- see your policy for details) will be billed to you. If you do not have insurance, choose not to utilize your insurance benefits, or if you do not have a plan that is contracted with S S Behavioral Health, Inc., payment in full will be required at the time of service.

Missed/Cancelled appointments

_____ If you are unable to keep your scheduled appointment, kindly notify us at least 24 hours in advance so we can accommodate our other patients and to avoid a cancellation charge of $50.00. If you simply do not show up for your appointment, a $50.00 charge will be applied to your account. This $50.00 charge is not covered by any insurance company or third party and will be the responsibility of the patient. On the third no-show, it will be the physician's discretion as to whether a discharge letter will be sent out disengaging you (from the practice end giving you 30 days to enroll with a new physician outside of this practice).

Past Due Amounts

_____ Statements are mailed monthly. If you are experiencing financial difficulty, we encourage you to contact us right away. In cases where an account is more than 60 days past due or the patient has shown an unwillingness to make reasonable efforts, the account may be tamed over to our collection agency, and your care may be terminated. If terminated, you will be allowed 30 days of emergency care and medication refills by your physician. We will make every effort to refer your care to another provider or to a community mental health center.

Payment Due at time of service

_____ Deductible, co-payment, or coinsurance is due at the time of service, if you fail to pay at the time of service, a $10 fee will be applied to your account

Medical Records

_____ Any notes, forms, letters or copy of your medical record that are requested to be sent to an individual/facility by you or someone on your behalf will require you to complete and sign our release of information document in the office. There is no charge for records to be sent to another physician; however, there is a charge to send to an individual/facility. The charge will depend on the number ofpages involved, and it is not a billable fee to your insurance.

Miscellaneous Charges

_____A $25-50 charge, which is not billable to your insurance, may be assessed for the completion of forms outside of an office visit. Forms or letters may not be completed same day as requested. The charge varies on the length of the form and the time taken to complete. Please allow at least one week for the physician to review and complete. A $10 charge may be assessed for rewritten prescription if lost or expired.

I, _____ have reviewed the policy above.
Please Print

Patient Signature: _____ Date:_____

S.S BEHAVIORAL HEALTH, INC

S S Behavioral Health Inc.

AGREEMENT AND AUTHORIZATION

CONSENT TO BEHAVIORAL HEALTHCARE SERVICES

I, (the Patient signing below, or person signing below who is responsible for consenting on Patient's behalf) request and consent to all care, treatment, and other services that may be ordered, requested, directed, or provided by physicians, or their associates, assistants, or designees, and carried out by physicians or personnel at S S Behavioral Health, Inc.

I understand that I have the right to refuse this care, treatment or other services, as long as refusal is allowed under the law.

I understand that the practice of medicine is not an exact science. I understand and agree that no guarantees have been made, or can be made, as to the result of diagnosis, treatments and medications, tests or examinations provided by S S Behavioral Health, Inc.

PAYMENT GUARANTEE

In consideration of the services provided by S S Behavioral Health, Inc. to Patient, agree to: i) Guarantee payment of all charges that are related to the services provided to the Patient: ii) For all time assigned and transfer to S S Behavioral Health, Inc. all of the Patient's right, title and interest to medical reimbursement benefits that are available to pay for those charges and iii) Authorize payment of these benefits directly to S S Behavioral Health, Inc. I agree that S S Behavioral Health, Inc. is not responsible for finding out if the Patient has any insurance or other benefits that may pay for care or services provided to the Patient, or what the extent of the Patient's benefits may be. I agree to be fully responsible for the payment of any/all charges if these charges are not covered by the assigned benefits.

S S Behavioral Health, Inc. provides many services to assist uninsured patients as well as patients who cannot afford the cost of care. I understand that if I have any questions about S S Behavioral Health, Inc. financial assistance policy I may ask the office supervisor during the registration process.

FOR MEDICARE PATIENTS

I certify that any information given by me as the Patient or Patient Representative in applying for payment by Medicare is correct.

I authorize any holder of medical or other information about Patient to release to Medicare or its agents any information needed for this or a related medical claim.

I authorize payment of benefits to S S Behavioral Health, Inc. on the Patient's behalf.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy S S Behavioral Health, Inc. of privacy practices. The Notice of Privacy Practices describes how the Patient's medical information may be used and disclosed by S S Behavioral Health, Inc. and describes the Patient's rights with respect to this medical information.

No revisions or changes to this form by you will be accepted by S S Behavioral Health, Inc.

This agreement and authorization Form covers services I receive from S S Behavioral Health, Inc. for a period of 365 days from the date of my signature below, unless revoked by me in writing sooner, or restricted to a shorter period by applicable law.

I have read this entire form and any questions I had about this form have been answered to my satisfaction. I understand and agree to its contents.

Patient signature:_____ Date:_____