Garden State Behavioral Health Services, South

2 Eves Drive, Suite 104

Executive Court

Marlton, New Jersey 08053

(856) 797-8777

Welcome to Our Practice

Please take some time to read this introductory letter to acquaint you with our practice and its policies. Garden State Behavioral Health Services South, L.L.C. is an independent practice located in Marlton, NJ. We provide outpatient behavioral health and substance abuse services and evaluations. We intend to provide the highest quality care possible. Your familiarity with us will assist us in doing so.

Please let us know what we can do to provide you with quality care. Your input and participation in your care is essential. We view the providing of care as a partnership between you and us.

We accept fee-for-service clientele as well as many insurance plans. Feel free to ask us about you plan. Should your insurance fail to pay your bill, you agree to make payment based on the rates billed to your insurance.

It is essential that you keep all scheduled appointments. Please call at least 24 hours in advance of any cancellations or changes. You will be responsible for payment is proper notice is not provided. If we are able to book the appointment with another person you will not be charged. We will charge the full value of the appointment as billed to your insurance provider.

Psychotherapy and psychiatry are not practiced via the telephone. It is not the normal course of treatment to provide phone sessions or to talk to your clinician in-between sessions. It is not food practice to prescribe medications over the telephone. If you experience and emergency and need to talk to your clinical, you may be billed a fee.

Your signature below indicated your understanding and agreement with the terms above. If you are representing a minor child you agree that you have the legal right to act on this child's behalf. Signing below also serves as a Consent For Treatment and agreement to receive services from Garden State Behavioral Health Services South, L.L.C.

______________________________ ______________________________

Client or Parent Signature Date

______________________________ ______________________________

Client Printed Name Witness

Magellan Behavioral Health

Members rights and Responsibilities Statement

Statement of Members Rights

Members have the right to:

Be treated with dignity and respect.

Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment

Have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.

Easily access timely care

Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan,

Share in developing their plan of care.

Information in a language they can understand.

A cleat explanation of their condition and treatment options.

Information about Magellan, its practitioners, services and role in the treatment process

Information about clinical guidelines used in providing and managing their care.

Ask their provider about their work history and training

Give input on the Members'' Rights and Responsibilities policy.

Know about advocacy and community groups and prevention services

Freely file a complaint or appeal and to learn how to do so.

Know of their rights and responsibilities in the treatment process.

Receive services that will not jeopardize their employment.

Request certain preferences in a provider.

Have a provider decisions about their care made without regard to financial incentives.

Statement of Members' Responsibilities

Members have the responsibility to:

Treat those giving them care with dignity and respect.

Give providers information they need. This is so providers can deliver the best possible care.

Ask questions about their care. This is to help them understand their care.

Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.

Follow the agreed upon medication plan.

Tell their provider and primary care physician about medication changes, including medications given to them by others.

Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.

Let their provider know when the treatment plan isn't working for them.

Let their provider know about problems with paying fees.

Report abuse and fraud.

Openly report concerns about quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

Provider Signature Date

Garden State Behavioral Health Services, South

2 Eves Drive, Suite 104

Executive Court

Marlton, New Jersey 08053

(856) 797-8777

Authorization to Disclose Information

To Primary Cary Physician

I understand that my records are protected under the applicable state 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 can not be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, ________________________________ hereby authorize ___________________________________

(Please print patient's name) *(Please print Treating Clinician's Name)*

Please check one:

_____ To release any applicable information to my Primary Care Physician

_____ To release medication information only to my Primary Care Physician

____ ________________

(Patient or Patient's Guardian, please sign)

____

(Please print the name signed above)

Primary Care Physician's Name, Address & Phone

____

____

____

____

____

Note to Behavioral Health Care Provider: Please maintain original copy in patient's file.

Garden State Behavioral Health Services, South

Informed Consent for Treatment

I _____________________ (name of patient), agree and consent to participate in behavioral health care services offered and provided by _____________________ (name of provider), a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within the scope of the provider's license, certification, and training. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature _________________________________ Date __________________

Relationship to Patient (if applicable): ____

Garden State Behavioral Health Services, South

2 Eves Drive, Suite 104

Executive Court

Marlton, New Jersey 08053

Notice of Privacy Practices

Receipt and Acknowledgement of Notice

Patient/Client Name: ____

Date of Birth: ____

Social Security Number(SSN): _______________________________

I hereby acknowledge that I have received and have given an opportunity to read a copy of Garden State Behavioral Health Services, South's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Michael Adornetto, LCSW at Garden State Behavioral Health Services, South at 2 Eves Drive, Suite 104 Marlton, NJ 08057 or by calling (856)-797-8777.

____

Signature of Patient/Client **Date**

____

Signature or Parent, Guardian or Person Representative **Date**

____

If you are signing as a personal representative of an individual, please describe your Legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

____

Signature of Staff Member **Date**

Garden State Behavioral Health Services, LLC

2 Eves Drive Suite 104

Marlton, NJ 08053

(856) 797-8777

Patient Information

Name:______________________________________ Age: ______Sex:_____

Last First

Address: ____________________________________ Date of Birth: ______________________

City: ______________________ State: __________ Zip Code: ____________________________

Home Telephone Number: ______________ Work Telephone Number: ____________________

Cell Number: ___________________

Marital Status: M S D W Other

Social Security Number: _________________________

Employer's Company Name: __________________________________

Emergency Contact: ____________________________

Emergency Contact Telephone Number (Day) ________________ (Night) _______________

Primary Physician: __________________________________ Telephone: ___________________

****REQUIRED****

Primary Insurance Company: __________________ ID#: __________________________

Policy Holder's Name: _______________________ Group #: _______________________

Policy Holder's Address: _____________________ Holder's DOB: __________________

Policy Holder's Address: _____________________ Telephone: _____________________

Copay: _____________

Authorization to Release Information and Assignment of Benefit

I authorize the release of any medical information necessary to my Insurance Carrier to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize the physician(s) to apply for benefits on my behalf for services rendered. I request that payments be made directly to, Garden State Behavioral Services, LLC or its designee. I certify that the information I have reported with regard to my insurance coverage is correct and accurate. I understand that I am financially responsible for the charges uncured for services received at the date the service is rendered. I authorize the physician(s) to treat me and/or my child.

Signature: (Patient/Guardian): ____________________________ Date: _________________________

Garden State Behavioral Health Services, South

2 Eves Drive, Suite 104

Executive Court

Marlton, New Jersey 08053

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATON.

PLEASE REVIEW THIS NOTICE CARFULLY.

Your health records 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 we may use and disclose your PHI in accordance with applicable laws, including the Health Insurance Portability and Accountability Act ("HIPAA"), Regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW MAY WE 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 health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for treatment services provided to you. This will only be done with your authorization. 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 processed due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

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

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports or child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Decreased Patients. We may disclose PHI regarding deceased patients as mandated by state law or to a family member or friend that was involved in your care or payment for care prior to death. , based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identifies as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose our PHI in a medical emergency situation medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member if the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI is necessary to prevent or lessen a serious and 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.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation your receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures will be made of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of those rights, please submit your request in writing to our Privacy Officer at Garden State Behavioral Health Services, South:

- **Rights of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designed record set". A designated record set contains mental health/medical and billing records and any other records that are 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 or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request and electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We 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 health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI pertains to a health care item or service that you paid out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy right, you have the right to file a complaint in writing with our Privacy Officer at Garden Behavioral Health Services, South or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of the Notice is September 2013