

Bartky HealthCare Center, LLC

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NOTICE OF PRIVACY PRACTICES

Effective Date: _____

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.

If you have any questions about this notice, please contact JOAN LAVENDER, PSY.D.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to maintaining the confidentiality of medical information about you. We create a record of the care and services you receive at this office. We need this record to treat you and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our office, whether made by your personal doctor or by the other personnel within our office.

This notice advises you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms described in this Notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other office personnel who are involved in your medical care and treatment. Different departments of the office also may share medical information about you in order to coordinate the different things you need, such as prescriptions and lab work. We may also disclose medical information about you to people outside the office who may be involved in your medical care after you leave the office, such as family members, therapists, clinicians or others we may rely upon to ask to assist us in caring for you.

Payment: We may use and disclose medical information about you so that the treatment and services which we provide to you at the office, hospital, or other site may be billed to and payment may be collected from you and/or insurance company or other responsible third party. For example, you may need to provide to your health insurance plan procedure and diagnostic codes so that your health plan will pay us or reimburse you for the services. We may also tell your health insurance plan about a treatment you are going to receive in order to obtain prior authorization or to determine whether your plan will cover the treatment.

Health Care Operations: We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students and other office personnel for review and learning purposes. We may remove information that identified you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders: We may use and disclose medical information in connection with our efforts to remind you that you have an appointment. This information will be limited in nature, such as leaving a message of the date and time of the appointment and the clinician it is with.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Individuals Involved In Your Care of Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care e.g. may also give information to someone who helps pay for your care. A babysitter responsible for the care of a child may be provided certain information about the treatment which we provided to the child.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will always ask for your specific permissions if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

As Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or conditions; and
- To notify the appropriate governmental authority if we believe a person has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if required by law or if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to JOAN LAVENDER, PSY.D. If you request a copy of the information, we may charge a fee as permitted by state law for the costs of copying, mailing or other supplies associated with your request.

Right to Inspect and Copy: (cont'd)

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the office.

To request an amendment your request must be made in writing and submitted to JOAN LAVENDER, PSY.D. In addition you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment,
- Is not part of the medical information kept by or for the office;
- Is not part of the information which you would be permitted to inspect and copy; or,
- Is accurate and complete.

Right to Accounting of Disclosures: You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to JOAN LAVENDER, PSY.D. your request must state a time period that may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, one paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request: If we do not agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to JOAN LAVENDER, PSY.D. In your request you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to JOAN LAVENDER, PSY.D. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of this current Notice in the office. The Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at or are seen at the office for treatment or health care services as an outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact JOAN LAVENDER, PSY.D. All complaints must be submitted in writing. ***YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.***

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will not longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (“PHI”) about you. You have the right to review our Notice and ask questions about our privacy practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by JOAN LAVENDER, PSY.D.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form you acknowledge that you have received our Notice of Privacy Practices.

Name of Patient

Signature of Patient

Date