Comprehensive Psychiatry Group

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date April 14, 2003

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.

WHO WILL FOLLOW THIS NOTICE:

This notice describes Comprehensive Psychiatry Group's practices and applies to:

- All employees, staff, volunteers, medical staff, contracted physicians, business associates, and any other workforce members who see patients at Comprehensive Psychiatry Group.

- All other entities, that are affiliated with Comprehensive Psychiatry Group, which shall be referred to collectively as "Comprehensive Psychiatry Group" for the purpose of this notice. These affiliated entities follow the terms of this notice and may share health information with each other for treatment, payment or regular health operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION:
We are required by law to maintain the privacy of our patients' protected health information (PHI) and to provide patients with notice of our legal duties and privacy practices with respect to your protected health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all protected health information maintained by us. If Comprehensive Psychiatry Group revises the terms of this Notice, it will post a revised notice at its office, and will make paper copies of this Notice of Privacy Practices for Protected Health Information available upon request. If you have any questions about this notice, please contact the Privacy Officer for Comprehensive Psychiatry Group at 330-726-9570, or in writing at 955 Windham Court Boardman, OH 44512.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Your Authorization Except as outlined below; we will not use or disclose your protected health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment We will make uses and disclosures of your protected health information as necessary for your **treatment**. For instance, doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and illness that may include procedures, medications, tests, etc. We may also release your protected health information to another health care facility or professional who is not affiliated with Comprehensive Psychiatry Group, but who is or will be providing treatment to you. For instance, if, after you complete your treatment at our office (or while you are currently involved in treatment at our office), you are going to a Primary Care Physician or Specialist, we may release your protected health information to that Primary Care Physician or Specialist so that a plan of care can be prepared for you.

Uses and Disclosures for Payment We will make uses and disclosures of your protected health information as necessary for the **payment** purposes of those health professionals who have treated you or provided services to you. For instance, we may forward information regarding your treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you, to the person responsible for your payment, or to a collection agency.

Uses and Disclosures for Health Care Operations We will use and disclose your protected health information as necessary, and as permitted by law, for our health care **operations**, which include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving the clinical treatment and care of our patients. We may also disclose your protected health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a patient relationship with you.

Family and Friends Involved In Your Care With your approval, we may from time to time disclose your protected health information to designated family, friends, and others who are involved in your care, or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide certain protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services We may contact you to provide appointment reminders or test results. You have the right to request, and we will accommodate reasonable requests by you, to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication in writing and may send your request to the Privacy Officer for Comprehensive Psychiatry Group at 330-726-9570, or in writing at 955 Windham Court Boardman, OH 44512.

Other Uses and Disclosures We are permitted or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization.

- We may release your protected health information for any purpose required by law
- We may release your protected health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations
- We may release your protected health information as required by law if we suspect child abuse or neglect; we may also release your protected health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence
- We may release your protected health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls
- We may release your protected health information to your employer when we have provided health care to you at the request of your employer to determine workplace-related illness or injury; in most cases you will receive notice that information is disclosed to your employer
- We may release your protected health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings
- We may release your protected health information if required to do so by subpoena or discovery request; in some cases you will have notice of such release
- We may release your protected health information to law enforcement officials as required by law to report wounds and injuries and crimes;
- We may release your protected health information to coroners and/or funeral directors consistent with law
- We may release your protected health information if necessary to arrange an organ or tissue donation from you or a transplant for you
- We may release your protected health information, if in limited instances, we suspect a serious threat to health or safety
- We may release your protected health information if you are a member of the military as required by armed forces services; we may also release your protected health information if necessary for national security or intelligence activities
- We may release your protected health information to workers' compensation agencies if necessary for your workers' compensation benefit determination

RIGHTS THAT YOU HAVE

Access to Your Protected Health Information You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. In following the State of Ohio guidelines, we will charge you $15.00 base fee, $1.00 per page for each page up to 10 pages. For pages 11-50 it is .50 per page, from page 51 on it is .20 per page if you request a copy of the information. We will also charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information if you request such summary. You may obtain a "Consent to Release and Request Information" form from our Medical Records Department staff at Comprehensive Psychiatry Group at 330-726-9570, or by requesting it in writing from 955 Windham Court Boardman, OH 44512.

Amendments to Your Protected Health Information You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an Amendment Request Form from the Medical Records Department staff at Comprehensive Psychiatry Group at 330-726-9570, or by requesting it in writing from 955 Windham Court Boardman, OH 44512.

Accounting for Disclosures of Your Protected Health Information You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your representative. Accounting Request Forms are available from the Medical Records Department our office. The first accounting in any 12-month period is free; you will be charged a fee of $25.00 for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your Protected Health Information You have the right to request restrictions on certain uses and disclosures of your protected health information for treatment, payment, or health care operations. A restriction request form can be obtained from the Medical Records Department. 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.

We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the address at the end of this Notice.

Right to Request Confidential Communications
You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we contact you at work or by mail. To request confidential communications, you must make your request in writing to the address at the end of this notice. 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.

OTHER USES OF MEDICAL INFORMATION
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us 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 no 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.

Complaints If you believe your privacy rights have been violated, you can file a written complaint with the Privacy Officer for Comprehensive Psychiatry Group at 955 Windham Court Boardman, OH 44512. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services 200 Independence Avenue SW, in Washington D.C.20201 in writing within 180 days of a violation of your rights. **There will be no retaliation for filing a complaint**.

Acknowledgment of Receipt of Notice You will be asked to sign an acknowledgment form that you received this Notice of Privacy Practices. We will keep the original acknowledgement page as part of your official patient medical record. You may request a copy of this form at any time during your treatment.

FOR FURTHER INFORMATION
If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer at Comprehensive Psychiatry Group at 330-726-9570, or you may ask to set up a meeting by putting your request for a meeting in writing and forwarding it to the Privacy Officer at 955 Windham Court Boardman, OH 44512.
As a patient you have the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

EFFECTIVE DATE This Notice of Privacy Practices is effective April 14, 2003.

I, the undersigned patient (or parent / guardian of a minor patient), do hereby attest that Comprehensive Psychiatry Group, Inc. provided me with a copy of its HIPAA NOTICE TO PRIVACY PRACTICES.

HIPAA, (the Health Insurance Portability and Accountability Act of 1996), requires that effective April 14, 2003 all health care providers present their patients with a copy of the health provider's Privacy Practices.

By signing below, I attest only that I was indeed provided with a copy of the Privacy Practices. The HIPAA Notice of Privacy Practices handout is mine to review and keep. This form will be kept as a permanent part of my medical record at Comprehensive Psychiatry Group, Inc.

_____ _____

Signature of patient / parent / guardian Date

Comprehensive Psychiatry Group

PATIENT RIGHTS & GRIEVANCES

POLICY

Ohio law provides specific safeguards of patient's rights while they are receiving psychiatric treatment.

PROCEDURE

Patients of Comprehensive Psychiatry Group have the following legal rights:

A. The right to be treated with consideration and respect for personal dignity, autonomy and privacy.

B. The right to treatment, including the right to:

1. A humane setting which is the least restrictive feasible as defined in the treatment plan.
2. Be informed of one's own condition, of proposed or current services, treatment or therapies and of the alternatives
3. Consent to or refuse any service, treatment or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment or therapy on behalf of a minor patient.
4. A current, written, individualized treatment plan that addresses one's own mental health, physical health, social and economic needs and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.
5. Active and informed participation in the establishment, periodic review, and reassessment of the treatment plan.
6. Be screened for pain.
7. Freedom from unnecessary or excessive medication.
8. Freedom from unnecessary restraint or seclusion.
9. Participate in any appropriate and available hospital service, regardless of refusal of one or more other services, treatments, or therapies or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the patient's participation in other services. This shall be explained to the patient and written in the patient's current treatment plan.
10. Be informed of and refuse any unusual or hazardous treatment procedures.
11. Be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, televisions, movies or photographs.
12. Have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense.
13. Confidentiality of communications and of all personally identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources,

state or federal statutes, unless release of information is specifically authorized by the patient or legal guardian of a minor patient or court-appointed guardian of the person of an adult patient.

14. The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual patient for clear treatment reasons in the patient's treatment plan. "Clear treatment reasons"' shall be understood to mean only severe emotional damage to the client such that dangerous or self-injurious behavior is an eminent risk. The person restricting the information shall explain to the patient and other persons authorized by the patient the factual information about the individual patient that necessitates the restriction. The restriction must be renewed at least annually to retain validity. Any person authorized by the patient has unrestricted access to all information. Patients shall be informed in writing of hospital policies and procedures for viewing or obtaining copies of personal records.
15. Be informed in advance of the reason(s) for discontinuance of service provisions, and to be involved in planning for the consequences of that event.
16. Receive an explanation of the reasons for denial of service.
17. Not be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay.
18. Know the cost of the services.
19. Be fully informed of all rights.
20. Exercise any and all rights without reprisal in any form including continued and uncompromised access to service.
21. File a grievance.
22. Have oral and written instructions for filing a grievance.

C. Law guarantees civil rights. Patients are considered legally competent to retain those rights, benefits and privileges unless there has been a court decision of incompetence for that purpose in a separate judicial proceeding. These rights include, but are not limited to.

1. Not to be deprived of public or private employment solely by reason of having received services, voluntary or involuntary, for a mental disability.
2. To retain all rights not specifically denied under the Ohio Revised Code.

D. Other rights include, but are not limited to the right to:

1. Social interaction with member of either sex, subject to adequate supervision, unless such interaction is specifically withheld under the patient's treatment plan.
2. Reasonable privacy including periods and places of privacy.
3. Confidentiality in accordance with state law.
4. Have personal possessions preserved and safeguarded.
5. Use personal funds for personal benefits.
6. Be informed of the reasons for admission, discharge procedures and to be involved in post-discharge plans.
7. Free exercise of religious worship including the right to services and sacred texts that are within the reasonable capacity of the institution to supply, provided that no person will be coerced into engaging in any religious activities.
8. Refuse to perform labor, which involved the operation, support or maintenance of the institution. (Additionally, privileges or release from the institution shall not be conditional upon such labor. Patients are, however, expected to perform therapeutic tasks if those

tasks are an integrated part of the treatment plan. Patients are also expected to perform tasks of a personal housekeeping nature).

9. Pursue a writ of habeas corpus.
10. The right to express your concern or grievance and to be heard in a non-judgmental, compassionate manner. The recommended process for doing so is as follows:
    a) Speak directly to your service provider at CPG about your concern or grievance
    b) If you have done so and are not satisfied, or you are not comfortable doing so, you may ask to speak to the CPG Grievance Officer, Jana Kanos MSW, LISW-s. You will also have the opportunity to document your concern or grievance on the Patient Concern / Complaint Form and submit this to Jana if you are not comfortable speaking directly to her. A written response from the Grievance Officer will be given to the patient within five business days.
    c) In case the patient / family are not satisfied with the outcome of a grievance, they can contact the county agency or the Joint Commission for further resolution. The local county agency is the Mahoning County Mental Health & Recovery Board and can be contacted at the following address: 222 West Federal Plaza, Suite 201, Youngstown, OH 44503. Their phone number is (330) 746-2959 and their fax number is (330) 746-1052. To address your concern or grievance with The Joint Commission, the preferred method for submitting a concern is through their online submission form as it allows for more direct, timely receipt and review of your concerns. You can access this online form at www.jointcommission.org. Alternately, you can mail your concern to the Office of Quality and Patient Safety, The Joint Commission One Renaissance Boulevard Oakbrook Terrace, Illinois 60181.

Comprehensive Psychiatry Group, Inc.

Failed Appointment Policy

Please Read this entire document

It is very important that you read this and understand this policy

If you fail to show for your appointment or do not call 24 hours in advance of your scheduled appointment, you will be billed:

- ❑ $75 for a therapist or psychologist 45 min – 1 hour session.
- ❑ $30 for a physician or nurse practitioner – 15 minute session

The CPG clinical staff need time to fill your time slot and when you cancel within at least a 24 hour notice, this is possible. If you do not show for your appointment or fail to cancel within 24 hours however, our clinicians do not receive ample notice to make that appointment available for another patient in need. For that reason, you will be billed at the above specified rates – *(insurance companies are NOT responsible for these charges).* The only exception is if an illness prevents you from attending the scheduled appointment and you present a medical excuse from your treating physician attesting to that fact. **Understand that the REMINDER CALL / EMAIL / TEXT you receive before your appointment is a COURTESY and because of the technology involved in this process, we cannot guarantee that these calls / emails will always be sent. *Failure to receive a reminder call or email does NOT excuse you of your responsibility to attend your appointment.***

At CPG we are serious about our treatment and realize that consistent attendance is key to your progress. We expect that patients who are serious about their care recognize the importance of consistent attendance at all scheduled appointments as well.

After the second missed appointment, you will be excused from the practice, and will be offered referrals to other area providers.

Please sign that you understand this policy.

Name_____ **Date**_____

Comprehensive Psychiatry Group, Inc.

TREATMENT CONSENT

A. Mental Health or Substance Use Counseling is a process by which people improve and change how they feel, act, or think by talking to someone. Sharing feelings about the past and about the present might be difficult. You or your child may even feel worse before things improve. In addition, you may be asked to change the things you do to improve the situation. For instance, if parents alter their responses to their child's problematic behaviors, the child may be helped greatly with his / her problems.

B. During your first session we will want to know your concerns, the history of your concerns, and how you have been dealing with them. We will ask about past events in your and your family's life. Additional information may be gained through more interviewing or testing, and this well be discussed with you at that time. After we understand your concerns we will develop a treatment plan to work with you and schedule sessions accordingly.

C. Issues discussed during the course of therapy with a therapist or physician is confidential; the information you reveal will not be discussed without a signed release from you. Nonetheless, there are unusual circumstances that are exceptions to confidentiality; in situations of potential harm to oneself (suicide), or others (homicide), or suspected child abuse or neglect, and in instances where the court may subpoena records (most commonly contested divorce actions). The release of confidential materials is, or may be, required by your counselor. You or your counselor may request that some information be discussed with another person by signing a release form.

I understand and agree to the following:

1. I will be actively involved in the counseling process, including the development of the treatment plan, and I will practice at home what is discussed in sessions.
2. I will pay for sessions that I do not cancel with a minimum of a 24-hour advance notice. (Insurance companies are not responsible for this charge). This applies to all situations unless emergency medical care is required. If I have a concern about this, I will discuss it further with my therapist / psychiatrist.
3. If more than ninety - (90) days lapse without payment to Comprehensive Psychiatry Group, CPG reserves the right to turn my account over to a collection agency or credit reporting service.
4. If I am unsatisfied with the services provided or if I have any complaints, I will be encouraged to discuss this with my Therapist / Nurse / Psychiatrist. If my concern is not addressed to my satisfaction, then I may contact the Grievance Officer.
5. If I have any questions about the nature of my counseling (i.e. goals, procedures, etc.) fees, or any other issue, I need to ask. I am encouraged to bring up such matters for discussion since they are an important part of my treatment.
6. I hereby commit to provide Comprehensive Psychiatry Group with current and timely insurance information. This includes any secondary or tertiary coverage as applicable. If I fail to provide Comprehensive Psychiatry Group with current & complete insurance information and it results in denial of payment, I understand that I will be held responsible for any unpaid balance. Failure to repay that balance in a timely manner or refusal to pay may result in termination of services at CPG.
7. According to Rule 5122:2-1-02 of the Ohio Revised Code, I have the right to refuse treatment or withdrawal from any or all of the specific modalities of treatment provided.

_____ _____

Patient Date Parent / Guardian (if applicable) Date

Comprehensive Psychiatry Group, Inc.

TREATMENT CONSENT

TREATMENT REVOCATION

In keeping with my rights, I refuse treatment or withdrawal from any part, or all of the treatment being provided (describe modality of treatment): _____
I also understand that in doing so, staff will work with me to develop alternative approaches to ensure that I receive the services I need.

SIGN BELOW ONLY TO REVOKE YOUR CONSENT

_____ _____
Patient Date Parent / Guardian (if applicable) Date

BILLING AUTHORIZATION

Comprehensive Psychiatry Group Benefit Verification staff makes every effort to obtain accurate information about my insurance benefits and the extent of my mental health / behavioral health coverage. While they attempt to follow my carrier's guidelines in obtaining this information, they cannot guarantee the accuracy of the coverage as stated to them by my insurance carrier. It is ultimately my responsibility to check on my benefits and to determine the extent of my coverage.

RELEASE OF INFORMATION

CONSENT TO RELEASE INFORMATION FOR BILLING PURPOSES: I hereby give Comprehensive Psychiatry Group permission to release information regarding my care to my insurance company, health benefit plan, employer (if work related), or other third party payer, including Medicare and Medicaid that is reasonably necessary to pay claims, determine eligibility and receive payment for the services I receive.
ASSIGNMENT OF BENEFITS: I hereby request that any payments under the terms of my insurance, health benefit plan, or from other third party payer, including Medicare and Medicaid be made directly to Comprehensive Psychiatry Group. This includes all monies payable on my behalf or payable to me under the terms of such plans or entitlements, but not to exceed customary or regular charges for the services I receive.
RESPONSIBILITY FOR PAYMENT: I understand that regardless of any insurance or other health benefits I may have, I am responsible for any applicable co-payments or deductibles and for any amounts not covered or reimbursed by such programs.

_____ _____
Signature Date Relationship to the Patient