PATIENT INFORMATION SHEET

Patient/client:
Last name:_________________________ First:____________________________ Middle:_____
Address:____
City:____ State:_______ Zip Code: ___________
Date of birth:__________________ Soc. Sec. #_______________________ Age: ____________
Sex: ☐Male ☐Female Marital status: ☐Single ☐Married ☐Sep ☐Div ☐Widowed ☐Other
Check the box next to number(s) where you give us permission to leave message(s) for you:
☐Home phone: __________________________ ☐Work phone: ___________________________
☐Cell phone: __________________________ ☐Other phone: ___________________________
Email address: __________________________ Pager: ___________________________
Employment status: ☐Full-time ☐Part-time ☐Unemployed ☐Disabled
Employer: ____
Student status: ☐Non-student ☐Full-time student ☐Part-time student
School:____ Grade: ______________________
Pharmacy: ___________________ Location:______________ Phone # ______________________
Referred by:____

Person responsible for payment (Guarantor):
Last name:_________________________ First:____________________________ Middle:_____
Address:____
City:____ State:_______ Zip Code: ___________
Date of birth:__________________ Soc. Sec. #_______________________ Age: ____________
Sex: ☐Male ☐Female Marital status: ☐Single ☐Married ☐Sep ☐Div ☐ Widowed ☐Other
Home phone: ____________________________ Work phone: ___________________________
Cell phone: ____________________________ Other phone: ___________________________
Email address: __________________________ Pager: ___________________________
Employment status: ☐Full-time ☐Part-time ☐Unemployed ☐Disabled
Employer: ____
Student status: ☐Non-student ☐Full-time student ☐Part-time student

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Next of kin:
Name:________________________________
Address:______________________________
____
Tel. # ________________________________
Relationship to patient: _________________

Person to notify in case of emergency:
Name:________________________________
Address:______________________________
____
Tel. # ________________________________
Relationship to patient: _________________

Primary Insurance:
Name of insurance: ____
Policy # ____________________________________ Group # ____________________________
Subscriber name: ________________________________ Subscriber ID # _______________
Plan type: ☐HMO ☐PPO ☐POS ☐Traditional

Secondary Insurance:
Name of insurance: ____
Policy # ____________________________________ Group # ____________________________
Subscriber name: ________________________________ Subscriber ID # _______________
Plan type: ☐HMO ☐PPO ☐POS ☐Traditional

I certify that the above information is complete and accurate.

____ ______________________
Patient or Parent/guardian Date

FINANCIAL LIABILITY AGREEMENT AND CONSENT

Patient name: ____

Guarantor (person responsible for payment): ______________________________

Relationship to patient:____

I understand that medically indicated services for psychiatric evaluation and treatment provided by Aroga Medical Associates, PC (Initial evaluation and subsequent treatment) may or may not be covered by my insurance plan. I understand that Health Insurance Plans and Benefits are between me and my insurance company and that the doctor or therapist can advocate for me but ultimately cannot influence what the insurer will or will not pay for.

I understand that if my insurance is an HMO, PPO, or other managed care plan for which my psychiatrist and/or therapist is an in-network provider, that it is my responsibility to contact the insurance plan prior to the first visit to obtain prior authorization for treatment and a prior authorization number. I understand that if I have HMO, PPO, or other managed care insurance for which my doctor and/or therapist is an in-network provider, that I am responsible for payment of all co-payments and/or co-insurance at the time of service.

Sometimes insurance plans give Aroga Medical Associates, PC, or the providers within our group, incorrect information about patients' co-payment or co-insurance structure and/or dollar amounts, and sometimes they change these without notice. I understand that if this occurs I will be responsible for any balance due as a result of incorrect co-payments and/or co-insurance.

Sometimes insurance plans mistakenly inform a patient that one or more of our providers are in-network provider(s) with their plan when actually we are not. I understand that I must confirm the in-network status of my provider with Aroga Medical Associates, PC before accepting as accurate any information obtained from an insurance plan over the telephone, internet, provider catalog, or other source.

Sometimes insurance companies will consider some psychiatric treatments not medically necessary even though the treatment is medically indicated and appropriate. I understand that payment will not be made by my insurance company for services if deemed by the insurance company not covered or not medically necessary, even if they have told me that my plan contains benefits for these services. Further, I understand that if a service is determined by my insurance company to be not covered or not medically necessary, then I am responsible for the payment. I understand that insurance companies generally do not pay for telephone sessions and I will be responsible for payment should I require these..

I consent to release of medical, mental health, and substance abuse information necessary to process claims and to bill my insurer and/or Medicare for services rendered. I consent to release of medical, mental health, and substance abuse information necessary for treatment, payment, and/or healthcare operations, including but not limited to billing and collections. I authorize Aroga Medical Associates, PC to submit insurance claims on my behalf and I authorize my insurance company and/or Medicare to make payments directly to Aroga Medical Associates, PC. And its providers.

Insurance companies do not pay for missed or improperly cancelled appointments. I understand that Aroga Medical Associates, PC maintains an office policy with regard to missed or improperly cancelled appointments (provided in a separate "Office Policies" brochure) and that I will be fully responsible for payment of applicable charges if I miss and/or do not properly cancel appointments accordingly.

In the event that my account is not paid, I understand that I shall be liable for any costs of collection, including, but not limited to, an additional 33.33% fee if my account is forwarded to a collection agency for collection, as well as any reasonable attorney's fees and court costs. I further understand and agree that there shall be 18% interest charged on any outstanding balance past 30 days.

I understand and agree to the above:

_______________________________ _______________________
Patient Date

_______________________________ _______________________
Guarantor Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND PROTECTED HEALTH INFORMATION

1. **Internal (within Aroga Behavioral Health)**

I, (print name) ______________________________________, understand that Aroga Behavioral Health is a group practice which operates on a team-based treatment model and that, upon entering into treatment with any healthcare provider within said group, information about my treatment may be shared/exchanged with any other healthcare provider employed by or contracted by said group during the course of my treatment. I understand that such sharing of information within the group is for the sole purpose of facilitating my treatment. Examples would include but not be limited to my psychiatrist communicating with my therapist and vice versa about my treatment, or a psychiatrist or therapist providing coverage during absence of my regular provider(s). I give full consent for my psychiatrist and/or therapist as members of Aroga's group practice to share information about my treatment with each other for the purpose of facilitating my treatment. I understand that under no circumstances shall any provider within the group share information about me or my treatment with any individual or organization outside of the group except where I have authorized below and/or in accordance with the HIPAA privacy policies I have been separately provided with.

2. **External (outside of Aroga Behavioral Health)**

In addition to the above, I hereby authorize Aroga Behavioral Health, and therefore my psychiatrist(s) and/or therapist(s) employed by or contracted by Aroga Behavioral Health, to release information about me and my treatment to the following individuals and/or organizations:

PRIMARY CARE PHYSICIAN:

Name:_______________________________

Address:_____________________________

____

Phone #:_____________________________

Fax #_______________________________

THERAPIST (outside of Aroga's group practice):

Name:_______________________________

Address______________________________

____

Phone #______________________________

Fax #_______________________________

OTHER:

Name:_______________________________

Rel. to patient:_________________________

Address:_____________________________

____

Phone #:_____________________________

Fax #_______________________________

OTHER:

Name:_______________________________

Rel. to patient:_________________________

Address______________________________

____

Phone #______________________________

Fax #_______________________________

With reference to all of the above, I understand that this information is not to be re-released to any person or facility except as provided by law. This release will continue in effect until termination of my treatment unless I specify another termination date here: _________________. I understand that I may revoke this release of information at any time. I understand, however, that any release which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. To the extent that my record includes information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I am also authorizing disclosure of such information.

X_____________________________________ ___________
Signature of Patient *or* Parent/Legal Guardian *or* Health Care Agent — Date

_____________________________________ ___________
Signature of Witness — Date

____
Print Name

____
Print Name

Aroga
Behavioral Health of Princeton
keeping good health in mind

Name:____ Date:_________________

HEALTH HISTORY QUESTIONNAIRE

Do you have or have you ever had:

- ☐ Hypertension
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Headaches
- ☐ Bleeding Disorder
- ☐ Sinus Problems
- ☐ Other __________
- ☐ Other __________

Surgeries:

- ☐ Appendix
- ☐ Gallbladder
- ☐ Tonsils
- ☐ Adenoids
- ☐ Thyroid
- ☐ Other __________
- ☐ Other __________

Hospitalizations:

Date:	Where:	For:

Please list all prescription medications, including birth control, over-the-counter medications, herbal or homeopathic remedies, or supplements you are taking:

____

____

Please list all mental health and alcohol or substance abuse treatment including therapy, counseling, psychologist, psychiatrist, outpatient group programs, inpatient programs, and ECT.

Date	Type of treatment	Name of provider or organization

Please list psychiatric medications that have been tried in the past:

Medication	Date From-To	Dose	Benefits	Side effects	Reason stopped

____
Patient signature

____/____/____
Date

____
Reviewed by M.D.

____/____/____
Date

RECEIPT FOR POLICY DOCUMENTS

Name: ____ Date: ______________

Please initial:

_____ I have received a copy of Aroga Medical Associates' Privacy Policies brochure, have reviewed it and am in agreement with the policies contained in it.

_____ I have received a copy of Aroga Medical Associates' Office Policies brochure, have reviewed it and am in agreement with the policies contained in it.

_____ I have received a copy of Aroga Medical Associates' Patients' Rights and Responsibilities brochure.

____ _______________
Patient Date

____ _______________
Parent or Guardian (Guarantor) Date

NOTICE OF PRIVACY PRACTICES

Effective August 21, 2006

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 speak to our Privacy Officer or call our Privacy Officer at (609) 279-1339.

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 required by law to do the following:

- Keep your protected health information private;
- Present to you this Notice of our legal duties and privacy practices related to the use and disclosure of your protected health information;
- Follow the terms of the Notice currently in effect;
- Communicate to you any changes we may make in the Notice.

We reserve the right to change this Notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

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 is 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.

For Treatment We may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, psychotherapist, or other person providing health services to you, will be recorded in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

We will use and disclose your protected health information to provide, 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 psychotherapist, pharmacist or laboratory) who, at the request of your physician, becomes involved in your care. This includes pharmacists who may be provided information on others drugs you have been prescribed to identify potential interactions.

In emergencies, we will use and disclose your protected health information to provide the treatment you require.

For Payment We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We will continue to request your authorization to share your protected health information with your health insurer or third-party payer.

For Health Care Operations We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical and/or clinical staff, risk or quality improvement personnel and others to evaluate the performance of our staff; assess the quality of care and outcomes in your case and similar cases; learn how to improve our facilities and services; and determine how to continually improve the quality and effectiveness of the health care services we provide.

We may also use or disclose, as needed, your protected health information to support our daily activities related to providing health care, including billing and collection. 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 Practice. These business associates of our Practice will also be required to protect your health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about our Practice and our services.

Appointments We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual. For example, we may contact you at your home telephone or cell phone number to remind you of your next appointment.

Required by law We may use and disclose information about you as required by law, for example, we may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their law enforcement duties.

Public Health Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

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 programs, other regulatory programs, or civil rights laws.

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, as required.

Legal Proceeding 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 responses to legal proceedings; information requests for identification and location; 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 cadaveric organ, eye or tissue donations.

Research We may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Threat to Health or Safety Under applicable Federal and State laws, we may disclose your protected health information to law enforcement or another 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 you, any other 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 other similar legally established 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.

Other uses Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent Aroga Medical Associates, PC has taken action in reliance on such.

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 With your permission, 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. 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 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 reasonable 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:

- what information you want restricted;
- whether you want to restrict our use or disclosure, or both;
- to whom you want the restriction to apply, for example, disclosures to your spouse; and
- 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 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 no more than six 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.

Right to Obtain a Copy of this Notice You may obtain a copy of this Notice from us by requesting one or view it or download it electronically at our Practice's website at www.arogaonline.com.

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. We will provide their address upon your request. No retaliation will occur against you for filing a complaint.

CONTACT INFORMATION

You may contact our Privacy Officer for further information about our complaint process or for further explanation of this Notice of Privacy Practices. Please contact: Edward Bilotti, MD, Aroga Medical Associates, PC, 188 Tamarack Circle, NJ 08558 ● Phone: (609) 279-1339

This Notice is effective in its entirety as of August 21, 2006.

Office Hours

Practice hours vary from clinician to clinician. Office staff is generally available Monday to Friday from 8:30 am to 5:00 pm. For non-urgent telephone calls after hours, you may follow the voice prompts to leave a message and every effort will be made to return your call as quickly as possible the next business day.

Initial Evaluation

Your first meeting with any clinician is an Initial Evaluation. During this initial session, the clinician will gather information and make an assessment. At this point you are not yet considered to have entered into a treatment relationship, and the clinician may determine or recommend that he or she is not able to treat you, and/or that it is in your best interests to receive treatment in a different setting, at a different level of care, or with a different provider. In the case of psychotherapy, this initial evaluation period may span the first one to three sessions.

Billing and Insurance

All payments are due at the time of service. The patient is responsible for payment in full unless the clinician is a participating provider in your insurance plan. If the clinician is a participating provider, your insurance requires this office to collect a co-payment and/or coinsurance at the time of service. For your convenience, the office accepts cash, checks and major credit cards. There will be a charge of $25.00 for each returned check.

It is the patient's responsibility to notify this office of any changes in address, telephone number(s), and/or insurance coverage. We cannot accept responsibility for any denial of payment due to lapse or change of coverage and you will then be responsible for full payment.

The patient is responsible for contacting their insurance company and/or the division that manages their mental health benefits prior to the first appointment. If pre-authorization is required by your plan and is not obtained, then you could be responsible for the full amount of the bill at the time of service.

Scheduling, Cancellations, & Missed Appointments

We encourage you to schedule your priorities carefully and remember that few things are more important than your mental and physical health. Therefore, it should be the rare exception that you are unable to keep a scheduled appointment.

When you must cancel an appointment, however, we require that you notify us as early as possible, but not less than 24 hours in advance. Because the appointment time is being reserved for you, less than 24 hours notice or simply not showing up at all for a scheduled appointment without notice will result in your being charged the full fee for the service you were scheduled to receive.

Three consecutive cancellations and/or no shows will be considered non-adherence with treatment. As a result, you will be discharged and your file will be closed.*

At the conclusion of a visit, your clinician will indicate when you should next follow up and it is your responsibility to schedule and keep this follow-up appointment. If you do not make it to an appointment, it can be difficult to schedule one quickly at the last minute. If more than three months have elapsed since your last appointment, this office cannot continue to be responsible for your care. Your file will be closed and you will be discharged.*

Prescription Refills

When calling in for a prescription refill, please have all information ready including the Patient's name, Medication name, Dosing, Pharmacy name and telephone number. Certain medications cannot be phoned into your pharmacy and will require a written prescription that you will have to pick up at the office or, in certain exceptional circumstances, may be able to be mailed to you. It is the patient's responsibility to allow ample time for prescriptions to be ordered and filled. Please do not wait until the last minute when you are out or about to run out of medication and expect us to be able to respond immediately. Generally we order enough medication to last at least until your next scheduled appointment, so if you are running out before that, it could be because you have missed appointments and have not followed through. Again, it is your responsibility to follow through with appointments and make sure that your medication supplies are adequate. Requests for refills may be left on the refills line of our office voice mail or may be done through our web site at www.arogaonline.com.

Emergencies

An emergency condition may include, but is not limited to, medication complications, side effects, allergic reactions, dangerousness to self, others, or property, thoughts of self-harm, or other medical or psychiatric crisis situation.**

Aroga Medical Associates, PC maintains an on-call schedule and someone will be available to respond to emergencies and/or crises 24 hours a day 7 days a week. Nonetheless, if you have a true emergency situation, you should always proceed to the emergency department of the nearest hospital and/or call 911 in addition to calling us.

In the event that such a situation arises outside of regular business hours, an emergency extension is available from the main number of our office voice mail. Messages left on this extension will activate the pager of the on-call clinician. This extension is to be used for emergencies only. There may be times when, due to vacations or other absences, another clinician from an outside practice may provide emergency coverage. In these cases, the name and telephone number or instructions on how to contact the covering clinician(s) will be made available on the recorded telephone announcement of our office.

Disability

Mental health disability, regardless of the term, can be a complicated issue and determination of disability is a process. Disability is not automatic simply because you have entered treatment. We do not make any promises to complete disability forms or excuse anyone from work unless it is the decision of your treatment team that you are truly unable to work and there is a real benefit to you being away from work. Making such a determination usually requires more than a single visit and may also depend on your adherence to treatment recommendations.

Telephone Contacts

With the exception of true emergencies, telephone contacts with your clinician are generally billable and may be charged at the clinician's regular fee. Telephone encounters other than emergency calls, whether scheduled or unscheduled, may be billed at 15-minute intervals according to the particular clinician's fee and are usually not covered by insurance.

Forms, Copies, Etc.

Because our practice is subject to the financial constraints of reduced fees imposed upon us by managed care and insurance plans, we are forced to charge a nominal administrative fee to cover our costs for copying, completing forms, composing or writing letters, or other similar administrative tasks that may become necessary during the course of your treatment.

Therapeutic Relationships

The relationships you develop with the various members of your treatment team will involve trust, sharing of personal and sensitive information, and, at times, a considerable degree of emotional vulnerability. Because of this level of psychological intimacy, it is common and natural for you to sometimes develop strong feelings, either positive or negative, towards your clinician. It is often therapeutic and helpful to discuss these feelings with your clinician if they arise. You must remember, however, that the relationships between you and your clinician(s) are strictly professional. You should not expect to interact socially with your clinician, invite them out or to your home, or to other social activities. You should not ask or expect them to relate to you in any way other than in the professional context of your treatment.

We treat our patients/clients with the greatest respect and dignity at all times and we expect that you will return this consideration. Any comments, requests, gestures, or overtures directed

at the therapist and/or staff that are considered inappropriate will result in immediate discharge from treatment.

E-mail and Internet Messaging

Secure, confidential e-mail messages can be sent through our web site at www.arogaonline.com.

E-mail must **NEVER** be used to communicate an emergency condition (see section entitled “Emergencies”). Your clinician and/or Aroga Medical Associates cannot be responsible for responding to an emergency in a timely and appropriate fashion if it is communicated in the form of an electronic message. Instead, the telephone and emergency system must be used for this kind of situation.

Lastly, our position on the use of e-mail in treatment is that it is appropriate only as an adjunctive communication tool between you and your clinician and cannot be a substitute for face-to-face sessions. E-mail communications may be billable and are generally not covered by insurance.

Public Encounters

There may be times when you encounter your clinician in a public place such as a supermarket, shopping mall, theater, etc. In order to respect your privacy, we will not greet you or make any public acknowledgement of your association with us. Please do not interpret this as coldness or indifference towards you, but rather as respect for your privacy. If you choose to initiate an interaction by saying hello, then your clinician may respond appropriately but will never discuss clinical material in a public place.

Notes & Letters

If you choose to write notes and/or letters to your clinician during the course of your treatment, they will become part of your clinical record. Your clinician has scheduled time for you during regular sessions and cannot promise that he or she will have additional time available to read lengthy notes and letters in between sessions. All important, clinically relevant material should be shared with your clinician orally during scheduled sessions.

Written notes and letters must NEVER be used to communicate an emergency situation (see section entitled “Emergencies”). Your clinician and/or Aroga Medical Associates cannot be responsible for responding to an emergency in a timely and appropriate fashion if it is communicated in the form of a written letter or note. Instead, the telephone and emergency system must be used for this kind of situation.

Gifts

Your relationship with your clinician is strictly a professional one and bringing gifts or personal greeting cards is generally not appropriate and is discouraged. Please do not be offended if your clinician cannot accept these items.

Confidentiality

Please refer to our separate Privacy Policies document for full details regarding use and disclosure of protected health information in accordance with HIPAA laws.

You should be aware that Aroga Medical Associates uses a collaborative treatment-team model and, internally within the group practice, information about you may be shared freely between members of the treatment team if it is felt that this is necessary for or will help your treatment.

In the event that a friend, family member, spouse, significant other, or anyone else contacts us, we cannot and will not identify you as a patient/client nor discuss anything about you unless you have given prior consent.

If you wish to have a family member or significant other informed of your treatment and/or progress, we ask that you designate one individual as the contact person rather than have us attempt to communicate with several different people, as this gets cumbersome and confusing for all involved.

In the event of an emergency such as dangerousness to self, others, or property, protecting you and/or others from harm always takes precedence and, by law, confidentiality may be broken (See separate Privacy Policies).

We reserve the right to change any of these Policies. They are effective in their entirety as of August 21, 2006.

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*We will usually make an effort to contact you by telephone and/or mail and provide you with resources to find a new provider if necessary. We will be available to you for emergencies and prescription refills for a limited time until you can obtain an appointment with a new provider.

**Please note that when you become a patient, you are making a contract with your therapist and/or psychiatrist to immediately report any thoughts, feelings or impulses you may have to harm yourself or someone else. We are available 24/7 to respond to a crisis or emergency and you are agreeing that you will do your part to contact us BEFORE acting on any such thought, feeling, or impulse. We are here to help, but we must rely on you to be honest and forthcoming about such issues at all times.

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Welcome To Our Practice

Office Policies

Edward J. Bilotti, MD
Arnaldo Negron, MD
Neeta Kher, MD
Lisa Bowman, LCSW
Jacqueline Oshiver, LCSW
Marion Pollack, MEd, LPC, SAC
Juliet Douglas, LCSW
Mitchell Douglas, LCSW
Marijayne Henry, LCSW
Benito I. Marty, MD
Robyn Klim, LCSW
Ellen Stem, LPC
Ann M. Dorocki, LCSW
www.arogaonline.com

Statement of Patients' Rights

Patients 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 information kept private. Only where permitted by law, may records be released without patient permission.
- Easily access timely care.
- Know about their treatment choices. This is regardless of cost or coverage by the patient's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about Aroga Medical Associates, 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 Patients' 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 provider decisions about their care made without regard to financial incentives.

Statement of Patients' Responsibilities

Patients 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 patient 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. Patients should call their provider 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 the quality of care they receive.

Welcome To Our Practice

Patients' Rights and Responsibilities

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Robyn Klim, LCSW
Ellen Stem, LPC
Ann M. Dorocki, LCSW

www.arogaonline.com
188 Tamarack Circle
Skillman, NJ 08558
(609) 279-1339
Fax (609) 279-1359