Aroga Behavioral Health of Princeton

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:

Aroga Behavioral Health of Princeton

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

Aroga Behavioral Health of Princeton

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.

Aroga Behavioral Health of Princeton

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

Aroga Behavioral Health of Princeton

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 treatment to the following individuals and/or organizations:

PRIMARY CARE PHYSICIAN:

Name:_____

Address:_____

_____

Phone #:_____

Fax #_____

OTHER:

Name:_____

Rel. to patient:_____

Address:_____

_____

Phone #:_____

Fax #_____

THERAPIST (Outside of Aroga's Group):

Name:_____

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

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 Reviewed by M.D.

____/____/____ ____/____/____

Date Date

Aroga Behavioral Health of Princeton

RECEIPT FOR POLICY DOCUMENTS

Name: _____ Date: _____

Please initial:

_____ I have received a copy of Aroga Medical Associates' Privacy Policies brochure effective 9/23/2013. I 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 September 23, 2013

Aroga – Behavioral Health

Arnaldo E. Negrón, M.D. , Privacy Officer

11 Tamarack Circle, Skillman, New Jersey 08558

And

168 Franklin Corner Road, Lawrenceville, New Jersey 08648

Tel. (609) 279 - 1339

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it on a computer and in an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not

home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

6. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

7. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

8. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

16. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your

condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

17. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

18. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

19. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

20. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 5 (notification and communication with

family) and 15 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.]

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: **OCRMail@hhs.gov**

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

Aroga Behavioral Health of Princeton

Office Policies

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 $35.00 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 April, 25, 2012.

*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.

Aroga Behavioral Health of Princeton

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.


Aroga
Behavioral Health
of Princeton