PRACTICE INFORMATION CONSENT

PSYCHIATRIC ARTS OF NEW JERSEY LLC

Your signature below affirms that you understand and agree to the following:

Conditions Not Appropriate for Telepsychiatry Treatment – There are a number of conditions that are not appropriate for treatment via telemedicine either due to federal/state regulations, safety issues, or because they are conditions that clinically require face-to-face meetings and/or an integrated team approach.

I Do Not Fall Into Any of the Following Categories –

- Active substance/drug or alcohol abuse or dependence within the last two years
- Receiving prescriptions or taking any of the following: medical cannabis/marijuana, buprenorphine, methadone or significant opioid and other pain medications on a daily basis
- Seeking prescription maintenance for long-term use of benzodiazepines or sedative hypnotic medications
- Seeking psychiatric evaluation for legal, civil or forensic issues (including but not limited to child custody or divorce issues, disability/workman's comp applications, therapy animal letters, civil/criminal cases).
- Women who are pregnant or plan to be imminently pregnant
- Having an eating disorder, personality disorder or dissociative disorder
- Suicidal, self-injurious or extreme risk taking behavior or attempts within the last three years OR persistent and/or recurring thoughts of suicide or self-harm within the last three years
- Impulse control problems resulting in violence or destruction of property within the last five years

Emergencies – In case of a serious or life-threatening emergency during off-hours or when practitioners of Psychiatric Arts of New Jersey are not available, I will call 911 or go to the nearest emergency room. For non-emergent issues, I will wait to be contacted by office staff or a practitioner of Psychiatric Arts of New Jersey.

Internet Issues – In the case of disrupted internet service that does not allow video calls, scheduled sessions will still occur but be conducted by phone.

Session Privacy – Every attempt will be made to conduct the session in a quiet, private location and to use headphones to avoid interruptions and background noise, and to ensure others cannot overhear the conversation.

Medical Chart – I give my consent to practitioners of Psychiatric Arts of New Jersey to:

- Take a photo screenshot during the first session to have a photo of me in my medical chart
- Conduct searches in SureScripts and Prescription Drug Monitoring Programs to obtain my history of prescription and controlled medications.
- Send email reminders, text / SMS reminders, voice reminders and messaging

Billing

- Other than cases of true emergencies, appointments canceled in less than 24 hours of the scheduled meeting time, or no-shows, will be charged a fee of $75.
- Requested completion of paperwork incurs a fee of $50.
- Credit card information will be kept securely on file.
- Email and phone communications between appointments are not charged. It is assumed that the number of communications between sessions is kept at a reasonable frequency, otherwise, an appointment will be required.
- I do not have Medicaid.

Termination of Treatment – Treatment can be terminated by patient or by practitioners of Psychiatric Arts of New Jersey at any time and for any reason. In this case, a referral to alternate providers will be given and prescriptions for on-going medications will be supplied for an additional month.

Signature: _____ Print Name: _____

Date: _____

When asked to provide a signature, you have the option of: [1] typing your name, [2] uploading an image of your signature, or [3] signing with your computer mouse.

NOTICE OF PRIVACY PRACTICES
PSYCHIATRIC ARTS OF NEW JERSEY LLC

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY**.

We are committed to protecting the confidentiality of your health information, and are required by law to do so. This notice describes how we may use your health information within Psychiatric Arts of New Jersey LLC ("**Practice**") and how we may disclose it to others outside Practice. This notice also describes the rights you have concerning your own health information. We must follow the obligations described in this notice and give you a copy of it. Please review this notice carefully and let us know if you have questions.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We are allowed or required to use or disclose health information about you for certain purposes without your authorization. Certain uses and disclosures of your health information, however, require your authorization. The following are ways in which we may use or share your health information:

Treatment:
We may use your health information to provide you with medical treatment or services. We may also disclose your health information to others who need that information to treat you, such as doctors, physician assistants, nurses, medical and nursing students, technicians, therapists, emergency service and medical transportation providers, medical equipment providers, and other facilities involved in your care. For example, we will allow your physician to have access to your medical record to determine what treatment you should receive.

We may use and disclose your health information to contact you to provide treatment-related services, such as treatment options or alternatives or to tell you about other health-related benefits and services that may be of interest to you.

Payment:
We may use and disclose your health information to insurers, health plans, HSAs and FSAs to facilitate reimbursements to you. For example, your health plan or health insurance company may ask to see parts of your health information before they will send you a reimbursement.

Health Care Operations:
We may use and share your personal health information (PHI) to run our organization, improve your care, and contact you when necessary. For example, we may use and disclose PHI about you to assess the use or effectiveness of certain drugs, develop and monitor medical protocols, manage your treatment and to provide information regarding helpful health-management services.

Family Members and Others Involved in Your Care:
With your explicit signed consent and authorization, we may disclose your health information to another treating clinician, family member or close friend who is involved in your healthcare, or to someone who helps to pay for your care. We also may disclose your health information to disaster relief organizations so that your family can be notified about your condition, status, and location.

Business Associates:
We may disclose your health information to our third-party service providers ("**Business Associates**") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our Business Associate are obligated, under contract with us, to appropriately safeguard health information about you and are not allowed to use or disclose any information other than as specified in our contract.

OTHER USES AND DISCLOSURES

Required by Law:
Federal, state, or local laws sometimes require us to disclose patients' health information. For instance, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively, "**HIPAA**"). We also are required to give information to Workers' Compensation Programs for work-related injuries.

Public Health Activities:
We may report certain health information for public health purposes. For instance, we may need to report adverse reactions to medications or medical products to the U.S. Food and Drug Administration (the "**FDA**"), or may notify patients of recalls of medications or products they are using.

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Public Safety:
We may disclose health information for public safety purposes in limited circumstances. We may disclose health information to law enforcement Officers in response to a search warrant or a grand jury subpoena. We also may disclose health information to assist law enforcement officers in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal conduct within Practice. We also may disclose your health information to law enforcement officers and others to prevent a serious threat of health or safety.

Health Oversight Activities:
We may disclose health information to a government agency that oversees Practice or its personnel for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Coroners, Medical Examiners, and Funeral Directors:
We may disclose information concerning deceased patients to coroners, medical examiners, and funeral directors to assist them in carrying out their duties.

Military, Veterans, National Security and Other Government Purposes:
If you are a member of the armed forces, we may release your health information as required by military command authorities or to the Department of Veterans Affairs. Practice may also disclose health information to Federal officers for intelligence and national security purposes or for presidential protective services.

Organ and Tissue Donation:
We may use or disclose health information to organ procurement organizations or others that obtain, bank or transplant organ, eye or tissue donation or transplantation.

Judicial Proceedings:
Practice may disclose health information if ordered to do so by a court or if a subpoena or search warrant is served. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your health information.

Information Not Personally Identifiable:
We may use or disclose health information about you in ways that do not personally identify you or reveal who you are.

Marketing/Sale of Information:
We will never sell your information or share your information for marketing purposes unless you give us written permission. If we contact you for any fundraising efforts, you can ask that we not contact you again.

State Laws and Information with Additional Protection:
Certain types of health information have additional protection under state and federal law. We will comply with your state's laws or other federal laws if they provide you with stricter rights over your health information or provide for more restrictions on the use or disclosure of your health information than HIPAA. For instance, under state law, health information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and evaluation and treatment for a serious mental illness is often given more protection than other types of health information. For those types of information, Practice may be required to get your permission before disclosing that information.

Psychotherapy Notes:
Practice is required by law to obtain your authorization for most uses and disclosures of psychotherapy notes, unless the use or disclosure is: (i) for treatment; (ii) for Practice's own training programs for students, trainees, or practitioners in mental health; (iii) to defend Practice in a legal action or other proceeding brought by you; (iv) required to determine Practice's compliance with HIPAA; (v) required by law; (vi) to a health oversight agency for oversight activities authorized by law; (vii) to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or other duties authorized by law; or (viii) believed by Practice, in good faith, to be necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Psychotherapy notes means notes of a mental health professional from a counselling session that are maintained separate from the rest of your medical record.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information:
If Practice wishes to use or disclose your health information for a purpose that is not discussed in this notice, Practice will seek your authorization. If you give your authorization to Practice, you may take back that authorization any time, unless we have already relied on your authorization to use or disclose information. If you would ever like to revoke your authorization, please notify the Privacy Officer in writing.

NOTICE OF PRIVACY PRACTICES
PSYCHIATRIC ARTS OF NEW JERSEY LLC

Restrictions on Disclosure of PHI to Health Plan:
Practice must abide by a request to restrict disclosure of PHI to a health plan if the disclosure is for payment or health care operations and is not otherwise required by law, and pertains to a health care item or service for which the individual has paid out of pocket in full.

WHAT ARE YOUR RIGHTS?

Right to Request Your Health Information:
You have the right to look at your own health information and to get a copy of that information. Please note that exceptions may apply as provided by law. (The law requires us to keep the original record.) This includes your health record, your billing record, and other records we use to make decisions about your care. To request your health information, call or write to the Privacy Officer at the address below A fee may be charged for the expense of fulfilling your request. We will tell you in advance what this copying will cost. You can look at your record at no cost. We may deny your request in certain limited circumstances but we will respond to your request with an explanation within thirty (30) days. If you are denied access to your health information, you may request that the denial be reviewed.

Right to Request Amendment of Health Information You Believe is Erroneous or Incomplete:
If you examine your health information and believe that some of the information is wrong or incomplete, you may ask us to amend your record. To ask us to amend your health information, submit a written request to the address below. We may deny your request under certain circumstances but we will respond to your request with an explanation within sixty (60) days.

Right to Get a List of Certain Disclosures of Your Health Information:
You have the right to request a list of many of the disclosures we made of your health information. Your request must state a time period which may not go back further than six (6) years. If you would like to receive such a list, submit a written request to the address below. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost and you may choose to modify or withdraw your request at that time.

Right to Request Restrictions on How Practice Will Use or Disclose Your Health Information for Treatment, Payment, or Health Care Operations:
You have the right to ask us NOT to make uses or disclosures of your health information to treat you, to seek payment for care, or to operate the system. We are not required to agree to your request, but if we do agree, we will comply with that agreement. If you want to request a restriction, write to the Privacy Officer at the address below and describe your request in detail.

Right to Request Confidential Communications:
You have the right to ask us to communicate with you in a way that you feel is more confidential. For example, you can ask us not to call your home, but to communicate only by mail. To do this, please discuss this with your caregiver, or submit a written request to the Privacy Officer at the address below. You can also ask to speak with your health care providers in private outside the presence of other patients – just ask them.

Right to be Notified Following a Breach of Unsecured PHI:
You have the right and will be notified if your health information has been breached as soon as possible, but in any event, no later than sixty (60) days following our discovery of the breach.

Right to Choose a Representative:
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure this person has the authority and can act for you before we take any action.

CHANGES TO THIS NOTICE:

From time to time, we may change our practices concerning how we use or disclose patient health information, or how we will implement patient rights concerning their information. We reserve the right to change this notice and to make the provisions in our new Notice effective for all health information we maintain. If we change these practices, we will post a revised Notice of Privacy Practices. You can get a copy of our current Notice of Privacy Practices at any time by requesting one from the Privacy Officer at the address below.

NOTICE OF PRIVACY PRACTICES
PSYCHIATRIC ARTS OF NEW JERSEY LLC

DO YOU HAVE CONCERNS OR COMPLAINTS?

Please tell us about any problems or concerns you have with your privacy rights or how Practice uses or discloses your health information. If you have a concern, please contact Practice's Privacy Officer with any questions or concerns.

If for some reason Practice cannot resolve your concern, you may also file a complaint with the federal government by sending a letter to the U.S. Department of Health and Human Services, Office for Civil rights. www.hhs.gov/ocr/privacy/hipaa/complaints/

We will not penalize you or retaliate against you in any way for filing a complaint with the federal government.

DO YOU HAVE QUESTIONS?

Practice is required by law to give you this notice and to follow the terms of the notice that is currently in effect. If you have any questions about this notice, or have further questions about how Practice may use and disclose your health information, please contact the Privacy Officer.

Privacy Officer:
Sylvana Garcia, MSN, APN, PMHNP-BC
Michael Lozovatsky, MD

Contact form at: https://www.psychiatricartsofnj.com/

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
PSYCHIATRIC ARTS OF NEW JERSEY LLC

Psychiatric Arts of New Jersey LLC (the "**Practice**"), and its staff and providers, may use and disclose my Protected health Information ("**PHI**") to carry out treatment, payment and healthcare operations ("**TPO**"). I understand and acknowledge that the Practice's Notice of Privacy Practices (the "**Notice**") has a more complete description of such uses and disclosures.

I permit the Practice to send me messages via e-mail, text and/or the Patient Portal, contact me by telephone and leave voice messages regarding my appointments, prescription renewals, lab results, and all other PHI, or to provide such information to person(s) I authorize by signing a separate consent form.

- I understand that I can change or revoke any of the foregoing agreements, at any time, by giving written notice to the Practice to the attention of the Privacy Officer. I understand and acknowledge that the Practice may decline to provide me with any services should I decline to sign this agreement, or should I later revoke this agreement.

- I agree that my PHI may be shared with my credit card vendor(s) if I contest any credit card charges, so that the practice can submit records to support its charges.

- I agree that the Practice may contact me at any phone numbers or email addresses provided by me regarding both PHI and non-PHI.

My signature below acknowledges that I agree with the above statements and have received the Practice's Notice and/or have been provided with an opportunity to review it.

PRINT NAME :

SIGNATURE:

DATE:

When asked to provide a signature, you have the option of: [1] typing your name, [2] uploading an image of your signature, or [3] signing with your computer mouse.

PATIENT AUTHORIZATION AND CONSENT FOR CARE AND TELEMEDICINE SERVICES
PSYCHIATRIC ARTS OF NEW JERSEY LLC

I. CONSENT FOR CARE:

I, with my signature below, authorize Psychiatric Arts of New Jersey LLC (the "**Practice**"), the physicians, physician assistants and nurse practitioners employed by or working on behalf of Practice (each, a "**Practitioner**"), and any individual working under the direction of Practice physicians (any such individual or any individual Practitioner, a "**Provider**"), to provide medical care for me, including consultations, evaluations, treatments, monitoring of overall health status, advanced care planning, and/or related services within the scope of each Provider's professional scope of practice (collectively, "**Medical Care**"). The scope of this consent includes contact and discussion of my Medical Care and health conditions and status between Provider(s) and other health care professionals for purposes of care and treatment. I understand that I may withdraw this consent at any time by making a request in writing.

II. GENERAL CONSENT FOR CARE ACKNOWLEDGMENT:

I acknowledge that I have been informed about, understand and have been given the opportunity to ask whatever questions I may have regarding the following information:

- In providing Medical Care, the Provider(s) will provide comprehensive Medical Care, evaluation and treatment within each Provider's professional scope of practice.
- The goal of each Provider is to monitor, manage and improve my acute and/or chronic medical conditions and health status.
- Any risks associated with Medical Care depend upon my specific diagnoses and health status. The Provider(s) will provide me with additional information about any risks associated with my individual treatment and care.
- Benefits include convenient access to providers who can assist in monitoring and managing my medical conditions and overall health status.
- I understand that my Provider will recommend Medical Care when my Provider(s) believe(s) that the benefits exceed the risks of such Medical Care.
- I acknowledge that Medical Care is not an exact science and that there are NO GUARANTEES as to the results of any consultations, evaluations, treatments, and/or services that may be provided to me.

III. CONSENT FOR TELEMEDICINE:

Telemedicine Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations (the "**Telemedicine Providers**") to share individual patient medical information for the purpose of improving patient care ("**Telemedicine**"). The information may be used for diagnosis, consultation, treatment and/or follow-up and may include any of the following:

- Patient medical records and/or medical images (i.e., store and forward);
- Live two-way audio and visual communications; and
- Output data from medical devices and sound and video files (i.e., remote patient monitoring).

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

PATIENT AUTHORIZATION AND CONSENT FOR CARE AND TELEMEDICINE SERVICES
PSYCHIATRIC ARTS OF NEW JERSEY LLC

Expected Benefits

- Improved access to Medical Care by enabling a patient to remain at a remote site while the Provider obtains test results and consults with Telemedicine Providers at distant/other sites.
- More efficient medical evaluation and management.
- Expertise of a distant specialist Telemedicine Provider.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of Telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the Telemedicine Provider;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment, which could result in the Telemedicine Provider's inability to complete the evaluation and/or prescription process;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information; or
- In very rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

IV. CONSENT FOR TELEMEDICINE ACKNOWLEDGMENT:

I acknowledge that I have been informed about, understand and have been given the opportunity to ask whatever questions I may have regarding the following information:

- I understand that I have the option to withhold or withdraw my consent for the use of the Telemedicine services in the course of my care at any time, without affecting my right to future care or treatment with other provider(s).
- I understand that the laws that protect privacy and the confidentiality of medical information also apply to the Telemedicine services.
- I understand that all existing laws regarding patient access to health records and copies of health records apply to the Telemedicine services. I have the right to inspect all information obtained and recorded in the course of the Telemedicine services, and may receive copies of this information for a reasonable fee. I also understand that other individuals may be present to operate the Telemedicine equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.
- I understand that Telemedicine may involve electronic communication of my personal medical information to other medical practitioners and ancillary service providers.

PATIENT AUTHORIZATION AND CONSENT FOR CARE AND TELEMEDICINE SERVICES
PSYCHIATRIC ARTS OF NEW JERSEY LLC

V. INFORMATION PRACTICES:

I authorize Practice and its agents and its representatives to furnish and/or release any information acquired in the course of my Medical Care to insurance carriers concerning my diagnosed condition(s) and treatment (including information about substance abuse, mental health services, or HIV, if applicable) necessary to process my insurance claim(s), and to allow a photocopy of my signature to be used to process my insurance claim(s) for the lifetime of the claims. I authorize any holder of my medical information to release to Practice and its agents and representatives any information needed to determine my insurance benefits and/or coverage. This authorization will remain in effect until revoked by me in writing.

Photocopies/scans/faxes of this consent and photocopies/electronic transmissions/faxes of any and all signatures on this consent are to be considered as valid originals.

MY SIGNATURE BELOW INDICATES THAT I VOLUNTARILY AGREE TO ALL OF THE ABOVE AND THAT THE NATURE OF THIS CONSENT WAS EXPLAINED TO ME AND THAT I HAD THE OPPORTUNITY TO ASK ANY AND ALL QUESTIONS REGARDING THE ABOVE.

PRINT NAME :

SIGNATURE:

DATE:

When asked to provide a signature, you have the option of: [1] typing your name, [2] uploading an image of your signature, or [3] signing with your computer mouse.

CREDIT CARD ON FILE BILLING AUTHORIZATION FORM

PSYCHIATRIC ARTS OF NEW JERSEY LLC

Psychiatric Arts of New Jersey LLC is offering a secure and convenient method of payment for medical services. Your credit card information is kept confidential and secure. For appointments, your credit card will be charged on the day of the appointment. Your credit card will also be charged for: 1) cancellation in less than 24 hours of the appointment with the exception of true emergencies, 2) "no-show" appointments, or 3) paperwork requested to be filled out.

- I authorize Psychiatric Arts of New Jersey LLC to capture my credit card information and securely store my credit card on file.
- I authorize Psychiatric Arts of New Jersey LLC to charge my credit card on file the appropriate service fees, late cancellation fees, and "no-show" fees.
- I understand that Psychiatric Arts of New Jersey LLC has multiple providers. Certain providers may or may not participate with health insurance companies. It is my responsibility to make certain whether a particular provider is in-network or entirely self-pay.
- I understand that this form is valid until termination of treatment OR until I give a 30-day written notice to cancel the authorization to Psychiatric Arts of New Jersey LLC. Written notice must be submitted through email (PsychiatricArts@MDofficemail.com).
- I certify that I am an authorized user of this credit card or have obtained permission from credit card holder to use this card for payments to Psychiatric Arts of New Jersey LLC.

Cards Accepted: Visa, Mastercard, American Express, Discover

Patient Name:

Card Holder's Name (as it appears on card):

Billing Address for Credit Card:

Street:
City:
State:
Zip Code:

Credit Card Number:

Expiration Date (mm/yy):

Security Code (3-digit on back or 4-digit on front for AMEX):

Signature: **Date:**

When asked to provide a signature, you have the option of: [1] typing your name, [2] uploading an image of your signature, or [3] signing with your computer mouse.