THE COGNITIVE AND RESEARCH CENTER
OF NEW JERSEY, LLC
A Complete Memory And Dementia Center
Directed by Michelle Papka, Ph.D.

Dear New Patient:

The Cognitive and Research Center of New Jersey, LLC is a multidisciplinary center bringing together a specialized team in the fields of psychology, neurology, and psychiatry to offer the highest standard of care. Through our collaborative expertise, we can provide the most comprehensive diagnostic work-ups and treatment plans, resulting in a more successful outcome for you and your loved ones. We are pleased that you have selected us as your providers and we look forward to seeing you at your upcoming appointment.

Enclosed please find the following documents:

New Patient Information Sheet
Fees and Payment Policies
Self-Report Questionnaire
Authorization Form
Acknowledgement of Notice
New Jersey Notice Form

Please complete the packet and return it in the envelope provided at least a week before your first appointment. Please also include in this packet any relevant medical records or arrange to have them faxed to at 973-850-4621. Please arrive 15 minutes early to your appointment for registration purposes.

If you have any questions or need assistance completing this packet, please do not hesitate to contact us at 973-850-4622. Thank you for allowing us to participate in your care.

Sincerely,

Michelle Papka

Michelle Papka, Ph.D.

Clinical Trials for Alzheimer's Disease and Memory Impairment • Neuropsychology • Psychotherapy

Main Office/All Correspondence:
195 Mountain Ave
Springfield, NJ 07081

Phone: 973-850-4622
Fax: 973-850-4621
www.thecrcnj.com

575 Route 28
Bldg 2, Suite 2108
Raritan, NJ 08869

New Jersey Psychology License # SI 03813

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New Patient Information Sheet

Name: _____ Date of Birth: _____

SSN: _____

Home Address: _____

_____

Phone Number: _____

Is it OK for the doctor or a staff member to leave messages? _____Yes _____No

Email: _____

Contact Name (if Different than Patient): _____

Address: _____

_____

Phone Number: _____ Ok to leave messages?___Y ____N

Email Address: _____

Is the contact a legal guardian or holder of POA/Health Proxy? _____Y _____N

If yes, please provide documentation.

Office use only: documentation provided? Yes _____ No _____
POA _____ Health Proxy _____

How were you referred to the CRCNJ? (Physician's name and specialty, or other source);

_____

_____

Insurance Information

Primary Insurance Carrier: _____

Policy Number: _____

Secondary Insurance

Secondary Insurance Carrier: _____

Policy Number: _____

Please provide copies of your insurance cards (front and back) or bring them to the first scheduled appointment so that we may make copies.

Medicare Authorization and Release:

If Medicare is your primary insurance carrier, with the exception of services from Dr. Kurlan who currently does not participate in Medicare, we will bill Medicare on your behalf. In order for us to do so, you must sign the authorization below:

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to The Cognitive and Research Center of New Jersey, LLC ("CRCNJ") for services provided.

_____ _____
Signature of Patient Date

_____
Print Name Patient

_____ _____
Signature of Legal Guardian* Date

_____
Print Name Legal Guardian*

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**If the authorization is signed by a personal representative of the patient, a description and documentation of such representative's authority to act for the patient must be provided.*

Authorization to be contacted in the future for research or other opportunities:

CRCNJ conducts clinical trials, research, and offers workshops and other educational programs. Please check below to indicate whether we may enter your information into a database and contact you in the future to let you know of these opportunities.

☐Yes ☐No

_____ _____
Signature of Patient Date

_____
Print Name Patient

_____ _____
Signature of Legal Guardian* Date

_____
Print Name Legal Guardian*

**If the authorization is signed by a personal representative of the patient, a description and documentation of such representative's authority to act for the patient must be provided.*

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FEES AND PAYMENT POLICIES

Please refer to the attached table for current fees and co-pays for specific services.

Neuropsychological Evaluations: The Cognitive and Research Center of New Jersey, LLC ("CRCNJ") bills per hour and applies this fee to all time associated with the evaluation, including all face-to-face time as well as the time that the doctor devotes to the review of records, scoring of tests, report writing, and communicating with other healthcare professionals in the interest of providing integrated healthcare. The total amount of time spent on each case varies and can range between 8 and 15 hours or more, depending on the specifics of each case.

Psychotherapy Services: The CRCNJ bills per 45-60 minute session for individualized, group, and psychoeducational sessions.

Neurological Evaluations: The CRCNJ bills per 60 minute session for new patient visits and 30 minute sessions for follow-up visits.

Cancellation / Missed Appointment Policy: A 48 hour cancellation policy is strictly enforced. Without 48-hour notice, all patients are responsible for paying for reserved and pre-preparation time at the **out of pocket rate**.

The CRCNJ reserves the right to utilize a legal collections process for any unpaid balances. If balances remain unpaid, even after multiple attempts to receive payment owed, a legal collections process will be employed by CRCNJ to collect outstanding balances. In such cases, the following information about the patient will be disclosed to the third party represented by the CRCNJ: name, address, social security number, date of birth, dates of service for which payment is due, amount owed.

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Insurance Coverage: **CRCNJ PARTICIPATES ONLY WITH TRADITIONAL MEDICARE** with the exception of services performed by Roger Kurlan, MD.* If you are covered by a **PRIVATE** Medicare plan (i.e.Advantage plan), CRCNJ **DOES NOT** participate with your plan. As a courtesy to such patients, CRCNJ will bill you out-of-pocket at a reduced rate comparable to Medicare fees. Since many plans include benefits for neuropsychological, psychotherapy, and neurological services, the patient is responsible for learning about the relevant policies of his/her health insurance plan that may make reimbursement possible. In all cases, patients are responsible for any charges not covered by their insurance.

*If the patient **IS** insured by **Traditional Medicare as the PRIMARY carrier:*** CRCNJ will bill Medicare for the services rendered with the exception of the services performed by Roger Kurlan, MD.*. If Medicare accepts and agrees to payment, Medicare will pay 80% of the claim and often forward the claim to the secondary carrier. In some cases, secondary insurance will cover the remaining 20%. It is the patient's responsibility to be knowledgeable of his/her benefits. The patient is responsible for paying the 20% not covered by Medicare. If/when CRCNJ receives payment from secondary insurance companies to cover all or any part of the 20% co-pay, CRCNJ will promptly refund such payment to the patient. Therefore, a co-payment of 20%, payable by check or credit card, is required prior to any service rendered. The patient is fully responsible for any unpaid balances.

****Roger Kurlan, MD is currently an opt-out provider for Medicare. All Medicare patients must sign the opt-out agreement prior to the first appointment with Dr. Kurlan. Dr. Kurlan will be back on the Medicare panel as of January 1, 2019.***

*If the patient **IS NOT** insured by **Traditional Medicare as the PRIMARY carrier:*** **It is the patient's responsibility to pay The Cognitive and Research Center of New Jersey, LLC directly and seek reimbursement from their insurance carrier independently if s/he wishes to do so.** This also includes patients insured by **PRIVATE** Medicare plans. Patients being seen by Dr. Kurlan whose carriers are AmeriHealth, Horizon BCBS or Qualcare may not be able to receive reimbursement from their carrier for services rendered by Dr. Kurlan at the CRCNJ and must sign the Private Health Insurance Reimbursement Agreement before seeing Dr. Kurlan. Payment in full by cash, check or credit card is required prior to services rendered. For Neuropsychological Evaluations, payments will be collected in installments as outlined in the attached table. The CRCNJ will provide an invoice to each patient containing all necessary information for claim submission (i.e., procedure codes, and diagnosis codes, identifying information). Account balances must be paid in full prior to the Neuropsychological Feedback visit and release of reports. Reimbursements will be issued in a timely manner.

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I have read the above statements regarding fees and payment policies and agree to these terms.

_____
Print Name of Patient

_____ _____
Signature of Patient Date

_____
Print Name of Legal Guardian*

_____ _____
Signature of Legal Guardian* Date

**If the authorization is signed by a personal representative of the patient, a description and documentation of such representative's authority to act for the patient must be provided.*

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PAYMENT INFORMATION

Please read the Fees and Payment Policies agreement carefully and contact the office with any questions before signing.

____ If paying by check, please select the appropriate amount listed below and make the check payable to ***The Cognitive and Research Center of New Jersey, LLC***. Please note there will be a $35.00 service charge on all returned checks.

____ If paying by credit card, please complete page 4 authorizing the CRCNJ to bill the credit card company for any monies owed.

Services	Copay for **Medicare** Patients	Out-of–Pocket Payment for **Private Medicare p**atients only	Out-of-pocket Payment for Patients **without** Medicare
Psychotherapy			
First visit	$29.00	$145.03	$195.00
Subsequent visits	$28.16	$140.78	$195.00
Psychoeducational Series	$28.16	$140.78	$195.00
Group Therapy	$5.66	$28.31	$28.00
Consult only or Follow Up	$71.60	$357.99	$390.00
Neuropsychological Evaluation			
* 3 Sessions	$241.96	$1,209.83	$2145.00 **
* If additional sessions are needed, payment will be adjusted accordingly.			$700 session 1 $700 session 2 $745 session 3
Neurological Evaluation			
New Patient – 60 minutes	$230.12	$230.12	$275.00
Follow-up Patient – 30 minutes	$162.30	$162.30	$165.00

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CREDIT CARD AUTHORIZATION

I authorize The Cognitive and Research Center of New Jersey, LLC ("CRCNJ") to charge the credit card below for any unpaid balances for services rendered. Charges will correspond to amounts detailed in the Fees and Payment Policies Agreement. This authorization shall remain in effect until terminated by me in writing.

Cardholder Name:

_____

Billing address (please include city, state and zip code):

_____

_____

Card Type: _____Visa _____MasterCard _____American Express _____Discover

Card Number: _____

Expiration Date: _____

3-Digit Security Code: _____ (on back of card)

I understand that, in order for the CRCNJ to bill the credit card above, the following information will be released to the credit card company: the cardholder's name, date of service for which cardholder is being charged, and the amount owed.

_____ _____

Cardholder's Signature Date

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SELF-REPORT QUESTIONNAIRE

The information requested below will be used to help the doctor understand the presenting problem and the medical, psychological, and social context in which these symptoms have occurred. Please complete the following questionnaire as accurately and honestly as possible. The information that you provide is confidential and will be used to aid in the evaluation, diagnosis, and treatment plan.

Name_____ Date_____

Age: _____ Gender: _____ Height: _____ Weight: _____

Handedness: Right handed _____ Left Handed _____ Ambidextrous _____

Relevant History:

What are you experiencing in your daily life that has caused you to seek an evaluation?

_____

_____

_____

_____

When did these symptoms begin? _____ (approximate date)

Did the symptoms appear gradually or very suddenly?

_____

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Have the symptoms gotten worse, better, or stayed the same?

_____

Review of Symptoms: Have you had any of the following **symptoms in the past month?** Provide details below if necessary:

	Yes	No	Describe
Loss of Consciousness			
Daytime Lethargy/sleepiness			
Disturbed Sleep			
Abnormal Vision			
Loss of Hearing			
Ringing in the Ears			
Dizziness/Vertigo			
Weakness in one part of the body			
Tremor/Shaking			
Involuntary movements			
Problems with Walking			
Imbalance			
Frequent Falling			
Frequent Headaches			
Weight Loss			
Weight Gain			
Depression			
Anxiety			
Hallucinations			
Delusions			
Incontinence			
Persistent pain			

Reason for referral:

Who referred you for this evaluation? _____

What information is being sought by this evaluation**?** _____
_____

Neuropsychiatric Work-up:

Have you recently been evaluated by a neurologist or psychiatrist or had any related testing? _____

If so, please use the chart below to describe the purpose and status of these assessments.

Please also list any pending evaluations.

Type of Evaluation or Test	**Physician or Facility**	**Date**	**Results**	**Did You Provide Copies of the Report? Yes /No Will These Be Mailed, Faxed or Brought to the Appointment?**
Neurological Evaluation				
Psychiatric Evaluation				
Neuropsychological Evaluation				
MRI				
CT				
EEG				
Blood work				
Other				

Please mail copies of the above records with this packet, or arrange to have copies of those records sent to the CRCNJ prior to the scheduled date of the neuropsychological evaluation. Records can be faxed to 973-850-4621 or mailed to: The Cognitive and Research Center of New Jersey, LLC, 195 Mountain Avenue, Springfield, NJ 07081.

Past Medical History: Have you been **diagnosed** as having any of the following medical conditions? Please provide details as necessary.

	Yes	**No**
Visual Loss		
Glaucoma		
Loss of Hearing		
Recurrent Vertigo		
High Blood Pressure		
High Cholesterol		
Heart disease (angina, heart arrhythmia)		
Lung disease (emphysema, COPD, asthma)		
Gastrointestinal disease		
Liver disease		
Chronic skin condition		
Arthritis		
Chronic sleep disorders		
Stroke or TIA		
Alzheimer's or other cognitive disorders		
Parkinson's or other movement disorders		
Chronic tremor		
Fainting or blackouts		
Seizures/epilepsy		
Seizures with high fever as child or baby		
Head trauma w/loss of consciousness		
Back Trouble		
Hematological disorders (sickle cell, hemophilia)		
Bleeding tendency		
Diabetes		
Thyroid condition		
Immunologic disorders (rheumatoid arthritis, lupus)		
Chronic allergies/hay fever		
Depression		
Psychiatric illness other than depression		
Kidney disease or other urological disorders		
Tuberculosis		
HIV or AIDS		
Encephalitis or Meningitis		
Polio		
Infections (Lyme)		
Chronic gynecological disorders		
Cancer		

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Additional Medical History:
Please list any past or current medical conditions, along with dates: _____

_____

_____

_____

_____

_____

_____

Please list any past or current hospitalizations, along with dates: _____

_____

_____

_____

_____

Head Injury Assessment:

Date of Injury			
Age at injury			
Was there a loss of consciousness? How long?			
Event that caused the injury			
Post – injury symptoms/problems			
Treatment for injury			

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Current Medications:
(Please include a "B" for Brand Name and "G" for generic after stating medication name)

Please list any medications you are currently taking including over the counter medications, supplements and vitamins.

Medication Include form: ie tablet, liquid, capsule, etc.	**Start Date**	**Reason for Medication**	**Strength** (mg of each tablet/mg per ml)	**Dosing** How many tablets/ml per dose? (with times; ex: one tablet @8am & 8pm	**Medication side effects**

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Medication Allergies and type of reaction:

_____

_____

_____

_____

Past Medications:

Please list any medications prescribed in the past:

Medication	Start Date	End Date	Reason for Med	Dosing	Medication side effects

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Family History:

Does anyone in your family (i.e., blood relative) have a history of **neurological** or **psychiatric** illness? Please use the chart below to list these relatives and their history.

Family Member/Relation	Illnesses	Age of Onset of Illness

Additional Comments: _____

_____

_____

_____

Psychiatric History:

Do you have a history of psychiatric or psychological disorders? _____

If so, please describe: _____

_____

_____

_____

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Are you **currently** in treatment with a psychologist or therapist? _____

If so, for how long? _____ Is it helpful? _____

Name of Psychologist or Therapist: _____

Phone Number: _____ Fax Number: _____

Are you **currently** in treatment with a Psychiatrist? _____

If so, please provide name: _____Phone Number: _____

Please list any prescribed medication, including dose and duration of treatment:

_____

_____

_____

Please describe any **previous history** of psychological or psychiatric treatment:

_____

_____

_____

Have you ever been hospitalized for a psychiatric illness? _____

If so, please describe (and provide dates):

_____

_____

_____

_____

Social History:

How many years of education did you complete? _____

What is the highest degree you obtained? _____

From what school did you receive your degree? _____

Are you retired? _____ If so, for how many years? _____

What is your current occupation? _____

For how long have you been at your current job? _____

Please describe your previous employment history:

_____

_____

_____

_____

What is your marital status? _____

If married, for how many years? _____

Are you divorced or widowed? _____ If so, for how many years? _____

Do you have any children? _____ If so, how many? _____

Do you live alone or with others? _____

Do you need help with your daily routine (e.g., grooming, dressing, driving, eating)?

_____

_____

_____

_____

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If so, do you have adequate help and support? _____

_____

Do you have a driver's license? _____ If so, which state? _____

How do you like to spend your leisure time? _____

_____

Do you exercise regularly? _____ If so, please describe your exercise routine:

_____

_____

Alcohol/Drug Use:

Do you smoke cigarettes? _____ If so, how many per day? _____

For how long have you been smoking? _____

If you do not smoke currently, have you ever smoked cigarettes? _____

If so, for how long did you smoke? _____ How many per day? _____

Do you smoke any other substances? _____ If so, please describe:

_____

_____

Do you, or have you ever, used any illicit drugs? _____ If so, please describe:

_____

Do you consume alcohol? _____ If so, please describe daily or weekly use: _____

Did the patient fill out the questionnaire? _____Yes _____No

If not, please explain and list the name of the person who completed this:

_____

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Is there anything else you would like to add?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for completing this questionnaire.

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Authorization Form

This form when completed and signed by you, authorizes The Cognitive and Research Center of New Jersey, LLC (CRCNJ) to release protected health information from your clinical record to the person you designate, and to obtain protected health information from entities designated by you.

You have the right to revoke this authorization, in writing, at any time, by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I authorize The Cognitive and Research Center of New Jersey, LLC to release:
____ All CRCNJ records
____ These specific records only:
_____
_____
_____
(Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

This information should only be released to:
_____
_____
_____
_____
(Provide the name and address of person to whom the information is to be released, including relevant family members.)

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I understand that I am responsible for arranging for my medical records to be sent to the CRCNJ. However, if needed, I also give permission for the CRCNJ to obtain medical records and/or discuss my medical information with:
_____ Check here if list is the same as above
_____ or list each person or entity below:
_____
_____
_____

I am requesting the CRCNJ to release/obtain this information for the following reasons:
_____
_____
_____
("at the request of the individual" is all that is required if you are a patient of CRCNJ and you do not desire to state a specific purpose.)

This authorization shall remain in effect until _____ (fill in **expiration date**) or until _____(fill in an event that relates to the individual or the purpose of the use or disclosure, or you may write "until further notice").

I am aware of my right to confidential communications under psychologist/physician -patient privilege.

I understand that my psychologist/physician generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

If authorizing the use or disclosure of psychotherapy notes, I understand that such authorization cannot be required as a condition of treatment, payment, enrollment, or eligibility for benefits.

_____ _____
Signature of Patient Date

_____ _____
Print Name of Patient Date of Birth

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_____ _____

Signature of Legal Guardian * Date

_____

Print Name of Legal Guardian*

**If the authorization is signed by a personal representative of the patient, a description and documentation of such representative's authority to act for the patient must be provided*.

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Acknowledgment of Notice

1) I have reviewed and been offered written notice of psychologist/physician policies and practices with regard to the HIPAA Privacy Act. I understand and agree to the contents of this Notice.

2) I understand that the professionals at The Cognitive and Research Center of New Jersey, LLC share confidential patient information in an effort to work as a collaborative team in the delivering of patient care.

3) I also understand that I may contact The Cognitive and Research Center of New Jersey, LLC should I have questions regarding my rights as a patient of this provider.

Signature _____ Date _____

Print name _____

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NEW JERSEY NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

The Cognitive and Research Center of New Jersey, LLC (CRCNJ) refers to CRCNJ and all employees/delegates.

I. Uses and Disclosures for Treatment, Payment, Health Care Operations, and Research

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- *"Treatment, Payment, Healthcare Operations, Legal Collections, and Research"*
  – *Treatment* is when we provide, coordinate or manage your health care and other services related to your healthcare. An example of treatment would be when we consult with another healthcare provider, such as your family physician or another psychologist. The professionals at the Cognitive and Research Center of New Jersey, LLC share confidential patient information in an effort to work as a collaborative team in the delivering of patient care.
  - *Payment* is when we may assist you in obtaining reimbursement for your healthcare. Examples of payment are if we disclose your PHI to your health insurer to help you obtain reimbursement for your healthcare or to determine eligibility or coverage or when payment is made by credit card. In order for the CRCNJ to bill the credit card company, the following information will be released: the cardholder's name, date of service for which cardholder is being charged, and the amount owed.
  - *Healthcare Operations* are activities that relate to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

-*Legal Collections* is when the CRCNJ employs a legal collections process for unpaid balances. As outlined in the Fees and Payment Policies, in such cases, the following patient information may be disclosed to a third party - name, address, social security number, date of birth, dates of service for which payment is due, amount owed.
- *Research* is when you consent to participate in a research study conducted at CRCNJ. Monitors and auditors bound by HIPPA regulations may access your PHI in order to verify the work of our research team.

- "*Use*" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when we ask for information for purposes outside of treatment, payment, healthcare, and research operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have reasonable cause to believe that a child has been subject to abuse, we must report this immediately to the New Jersey Division of Youth and Family Services.

- **Adult and Domestic Abuse:** If we reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, we may report the information to the county adult protective services provider.

- **Health Oversight:** If the New Jersey State Board of Psychological or Medical Examiners issues a subpoena, we may be compelled to testify before the Board and produce your relevant records and papers.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. We must inform you in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate to us a threat of imminent serious physical violence against a readily identifiable victim or yourself or the public and we believe you intend to carry out that threat, we must take steps to warn and protect. We also must take such steps if we believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps we take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other healthcare facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.

- **Worker's Compensation**: If you file a worker's compensation claim, we may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation, or the Compensation Rating and Inspection Bureau.

There may be additional disclosures of PHI that we are required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common.

IV. Patient's Rights and Psychologist/Physician Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, we will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for

as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychologist/Physician Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will notify you at the time of your next visit.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact The Cognitive and Research Center of New Jersey, LLC at (973) 850-4622.

If you believe that your privacy rights have been violated and wish to file a complaint with the CRCNJ, you may send your written complaint to The Cognitive and Research Center of New Jersey, LLC, 195 Mountain Avenue, Springfield, NJ 07081.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date

This notice will go into effect on Jan 1, 2018.