CRCNJ
The Cognitive and Research Center
of New Jersey, LLC
Directed by Michelle Papka, Ph.D.

Dear New Patient:

Thank you for choosing The Cognitive and Research Center of New Jersey, LLC (The CRCNJ) as your provider. 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 provider, and we look forward to seeing you at your upcoming appointment.

Enclosed please find the following documents:
Fees and Payment Policies
New Patient Information & Acknowledgments
Authorization Form
Self-Report Questionnaire
Notice of Privacy Practice

Please:

- **Complete the packet and return it at least a week before your first appointment**
- Include any relevant medical records, or arrange to have them faxed to at 973-850-4621
- 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 The CRCNJ to participate in your care.

Sincerely,

Michelle Papka

Michelle Papka, PhD

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

TheCRCNJ.com
Phone: 973-850-4622
Fax: 973-850-4621
NJ Psychology License #35S100381300

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

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 ("The 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.

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

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 The 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.

Insurance Coverage: THE CRCNJ PARTICIPATES ONLY WITH TRADITIONAL MEDICARE. If you are covered by a **PRIVATE** Medicare plan (i.e. Advantage plan), The CRCNJ **DOES NOT** participate with your plan. As a courtesy to such patients, The CRCNJ will bill you out-of-pocket at a reduced rate comparable to Medicare fees. Since many plans include benefits for psychological 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:** The CRCNJ will bill Medicare for the services rendered. 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 The CRCNJ receives payment from secondary insurance companies to cover all, or any part of the 20% co-pay, The 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.

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. 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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PAYMENT INFORMATION

Services (if seen by a PhD)	Copay for **Medicare** Patients	Out-of–Pocket Payment for **Private Medicare** patients only	Out-of-pocket Payment for Patients **without** Medicare
Psychotherapy			
First visit	$31.28	$156.42	$210.00
Subsequent visits	$30.34	$151.70	$210.00
Psychoeducational Series	$30.34	$151.70	$210.00
Group Therapy	$6.05	$30.24	$30.00
Consult only	$60.92	$304.58	$420.00
Follow Up	$71.71	$358.56	$525.00
Neuropsychological Evaluation:			
-Memory Eval: 2 sessions*	$185.75	$928.75	$1,575.00
-Other Eval: 3 sessions*	$260.55	$1302.77	$1995.00
* If additional sessions are needed, payment will be adjusted accordingly per hour spent by provider			

Services (if seen by LCSW)	Copay for **Medicare** Patients	Out-of–Pocket Payment for **Private Medicare** patients only
Group Therapy	$4.54	$22.68
Psychotherapy	$22.76	$113.78
Psychoeducational Series	$22.76	$113.78

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

- If paying by check, please 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 the credit card authorization authorizing The CRCNJ to bill the credit card company for any monies owed.

Patient Signature: _____ **Date:** _____

Legally Authorized

Representative Signature: _____ **Date:** _____

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New Patient Information & Acknowledgments

Patient Name: _____ Date of Birth: _____

SSN: _____

Home Address: _____

_____

Phone Number: _____

Email: _____

Contact Name (if Different than Patient): _____

Address: _____

_____

Phone Number: _____

Email Address: _____

Is the contact a legal guardian or holder of POA/Health Proxy? ☐Yes ☐No *If yes, please provide documentation.**

The CRCNJ respects your right to confidential communication about your protected health information (PHI). As specified by you below, The CRCNJ will use the provided phone numbers and emails to leave messages about services and educational events.
☐ Yes ☐ No

Insurance Information - *Please bring your insurance card to the first scheduled appointment*

Primary Insurance Carrier: _____Policy Number: _____

Secondary Insurance Carrier: _____ Policy Number: _____

Medicare Authorization and Release:

Is Medicare is your primary insurance carrier? ☐ Yes ☐ No.

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 ("The CRCNJ") for services provided.

Patient Signature: _____ **Date:** _____

Legally Authorized

Representative Signature: _____ **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.*

Credit Card Authorization:

I authorize The Cognitive and Research Center of New Jersey, LLC ("The 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

Acknowledgment of Notice (See the Notice of Privacy Practice attached)

1) I have received and reviewed the Notice of Privacy Practices. 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.

Database Acknowledgment: The CRCNJ conducts clinical trials, research, and offers workshops and other educational programs within our disciplinary fields. Please check below to indicate whether we may enter your information into an internal database to be used for research or other purposes and contact you in the future to let you know of any relevant activities you may wish to consider.

☐ Yes ☐ No

Patient Signature: _____ **Date:** _____

Legally Authorized Representative Signature: _____ **Date:** _____

Office use only: documentation provided? Yes _____ No _____

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POA _____ Health Proxy _____

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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 of Birth _____

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

Handedness: Right handed _____ Left Handed _____ Ambidextrous _____

Reason for referral:

Who referred you for this evaluation? _____

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

Relevant History:

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

_____

_____

When did these symptoms begin? _____ (approximately) ☐ Gradual Onset ☐ Sudden Onset

Have the symptoms changed in the past month? ☐ worse ☐ better or ☐ same

Review of Symptoms: Have you had any of the following **symptoms in the past month?**

	Yes	No		Yes	No
Loss of consciousness			Weakness in one part of body		
Disturbed sleep			Tremor / shaking / involuntary movement		
Daytime lethargy / sleepiness			Frequent headaches		
Hearing trouble (i.e. loss, ringing or dizziness)			Weight gain or loss		
Abnormal vision			Persistent pain		
Frequent falling / imbalance			Incontinence		
Depression			Hallucinations		
Anxiety			Delusions		
Memory loss			Other cognitive symptoms		

Past Medical History: Have you been **diagnosed** as having any of the following medical conditions?

	YES	NO		YES	NO
Visual Loss or Glaucoma			Cancer		
Hearing Loss			Diabetes		
High Blood Pressure			Fainting or blackouts		
High Cholesterol			Seizures/epilepsy		
Heart disease (angina, heart arrhythmia)			Head trauma w/loss of consciousness		
Lung disease (emphysema, COPD, asthma)			Hematological disorders (sickle cell, hemophilia)		
Gastrointestinal disease			Thyroid condition		
Liver disease			Chronic skin condition		
Arthritis Immunologic disorders (rheumatoid arthritis, lupus)			Chronic allergies/hay fever		
Chronic sleep disorders			Kidney disease or other urological disorders		
Stroke or TIA			Infectious Diseases (Tuberculosis, HIV< Encephalitis)		
Alzheimer's or other cognitive disorders			Infections (Lyme)		
Parkinson's or other movement disorders			Recurrent Vertigo		

Additional Relevant History: Please explain above

_____

_____

_____

_____

Current Medications:

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

Medication	**Start Date**	**Reason for Medication**	**Strength** (mg/ml)	**Dosing** (frequency per day)

☐ Please check here if there are additional medications and a complete list was provided separately.

If not listed in above current medications, have you <u>ever taken</u> any of the following medications for cognitive symptoms?

Medication	**Yes**	**No**	**If so, when?**
Aricept® (donepezil)			
Exelon® (rivastigmine)			
Namenda® (memantine)			
Namzaric® (memantine and donepezil)			
Razadyne® (galantamine)			

Psychiatric History: Have you ever experienced or received treatment for?

	Yes	**No**		**Yes**	**No**	**Describe**
Depression			Other?			
Anxiety						
Hallucinations			Currently seeing a Psychologist or Therapist?			If yes, who?
Delusions			Currently seeing a Psychiatrist?			If yes, who?

Additional Relevant History: Please explain above including any psychiatric hospitalizations

_____

_____

_____

_____

Neuropsychiatric Work-up: Please use the chart below to describe any current or pending assessments by a neurologist or psychiatrist or any related testing:

Type of Evaluation or Test	**Physician or Facility**	**Date**	**Results**	**Provided to CRCNJ (Y/N)**
Neurological Evaluation				
Neuropsychological Evaluation				
MRI				
CT				
Blood Work				

PET (FDG or Amyloid)				
EEG				

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.

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

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? ☐ Yes ☐ No If Yes, for how many years? _____
If No, 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? ☐ Single ☐ Married ☐ Widow ☐ Divorced
If married, for how many years? _____
If divorced or widowed, for how many years? _____
Do you have any children? ☐ Yes ☐ No If yes, how many? _____
Who do you live with? _____

Do you need assistance with daily activities (e.g. grooming, dressing, driving, finances)? ☐ Yes ☐ No
If yes, please explain_____
Do you have adequate help and support? ☐ Yes. ☐ No

Do you have a driver's license? _____ If so, which state? _____
How do you like to spend your leisure time? _____
Do you exercise regularly? ☐ Yes. ☐ No If so, how _____

Alcohol/Drug Use:

Do you smoke cigarettes? ☐ Yes ☐ No ☐ In the past. If yes, how many per day? _____
If yes, for how long have you been smoking? _____
If in the past, how many per day? _____
If in the past, for how long? _____
Do you, or have you ever, used any illicit drugs? ☐ Yes ☐ No
If yes, please describe: _____
Do you consume alcohol? ☐ Yes ☐ No If yes, please describe daily or weekly use: _____

Did the patient fill out this questionnaire? ☐ Yes ☐ No
If No, who completed this form:_____

Authorization Form for Protected Health Information (PHI)

This form, when completed and signed by you, authorizes The Cognitive and Research Center of New Jersey, LLC ("The CRCNJ") to release Protected Health Information ("PHI") from your clinical record to the person you designate, and to obtain PHI from entities designated by you. **Please note, that, as per our standard practice, we will automatically send a copy of the neuropsychological reports to the referring physician.**

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.

Please complete the following:

I, _____authorize The Cognitive and Research Center of New Jersey, LLC to
☐ Release
☐ Obtain
☐ Discuss on an ongoing basis:

With the following individuals (please provide the name of the doctors or family members):
_____
_____
_____

☐ All Records
☐ Specific records only (provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.):_____

I am requesting The CRCNJ to release/obtain this information for the following reasons:
☐ At the request of the individual – (if you are a patient of The CRCNJ and you do not desire to state a specific purpose)
☐ Other purpose (please specify)
_____

This authorization shall remain in effect until:
☐ Expiration date _____
☐ Until further notice

The CRCNJ has collaborative, consultative relationships with Kurlan Specialized Neurology and Pelorus. Please check below if you wish to authorize The CRCNJ to release and/or obtain <u>all</u> records, including demographic paperwork that may be used across practices, to these entities. Please release all records, including forms, to:

____ Kurlan Specialized Neurology, LLC **____ Pelorus Elder & Behavioral Health**

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I am aware of my right to confidential communications under psychologist -patient privilege. **I understand that my psychologist 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 designated recipients and may no longer be 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

_____ _____
Signature of Legal Guardian* (Relationship) Date

_____
Print Name of Legal Guardian* (Relationship)

**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.*

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION (INCLUDING PSYCHOLOGICAL 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 (The CRCNJ) refers to The CRCNJ and all employees/delegates.

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

We may *use* and *disclose* your *health information* (*PHI*) for *treatment, payment, and health care operations* purposes *without* your written *authorization*. To help clarify these terms, here are some definitions:

"PHI" refers to information in your health record that could identify you.

"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 CRCNJ 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 certain PHI will be released to obtain payment. In addition, The CRCNJ employs a legal collections process for unpaid balances. As outlined in The CRCNJ's Fees and Payment Policies, in such cases, certain PHI may be disclosed to a third party in order to obtain payment.

"Healthcare Operations" are activities that relate to the performance and operation of our 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.

"Use" applies only to activities within The CRCNJ such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of The CRCNJ, such as releasing, transferring, or providing access to information about you to other parties.

II. Other Uses and Disclosures that Do Not Require Your Authorization

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

Child Abuse/Neglect: If we have reasonable cause to believe that a child has been subject to abuse/neglect, we must report this immediately to the New Jersey Department of Children and Families.

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: We may disclose your PHI for health oversight activities. For example, 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. Other examples include disclosure of your PHI for audits or governmental investigations.

Judicial or Administrative Proceedings and Law Enforcement Purposes: In certain circumstances, we may disclose your PHI without your authorization for judicial or administrative proceedings, for example, in response to certain subpoenas or court order, or to defend a lawsuit against our practice. In circumstances in which we are legally required to obtain your authorization prior to such disclosure, we will not disclose your PHI until your authorization is obtained or we are otherwise legally permitted or required to do so. We also may be required to disclose your PHI without your authorization for certain law

enforcement purposes, for example, disclosures for the reporting of certain types of wounds or physical injuries; disclosures to a law enforcement official's request for information for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or disclosures to a law enforcement official about an individual who is suspected to be a victim of a crime.

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.

Based on the new amendment, originating from bill A1181, signed into law by Governor Phil Murphy *(along with 5 other gun control bills)* on June 13, 2018, we are required to notify the chief law enforcement officer or the Superintendent of State Police (if you reside in a municipality that does not have a full time police department), in addition to taking other appropriate courses of action (such as arrange for a hospitalization, notifying the victim or their parents, notifying the parents of a minor), if we felt that there was a "duty to warn" (a threat of imminent, serious physical violence against a readily identifiable individual or against yourself). In such cases, we will provide your name and other nonclinical identifying information to law enforcement authorities.

Worker's Compensation: If you file a worker's compensation claim, we may be required to release relevant information from your 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.

Public Health Activities: We may be required to report PHI about deaths, adverse events, and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

To Coroners or Funeral Directors: We may provide coroners, medical examiners and funeral directors PHI relating to an individual's death, as permitted or required under state law.

For Specific Government Functions: We may disclose PHI of military personnel and veterans in certain situations. We also may disclose PHI for national security and intelligence activities.

Appointment Reminders and Health-Related Benefits or Services: We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather we contact you at a different telephone number or address.

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.

III. Incidental Uses and Disclosures and Business Associates

Certain other uses and disclosures of your PHI may be made without obtaining your authorization, including the following:

Incidental Uses and Disclosures: Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, discussions about a patient that are made by staff within our office that might be overheard by persons not involved in the person's care would be permitted, so long as we have applied reasonable safeguards intended to prevent others from overhearing such discussions.

Business Associates: We may engage certain persons or companies to perform certain of our functions on our behalf and we may disclose certain health information to these persons or companies. For example, we may share certain PHI with a billing company or computer consultant to facilitate our health care operations or payment for services provided in connection with your care, or we may disclose PHI to our accountants or attorneys for the services they provide to us. We will require our business associates to enter into an agreement to keep your PHI confidential and to abide by certain terms and conditions.

IV. Uses and Disclosures Requiring an Opportunity to Agree or Object

In certain circumstances, we may disclose your PHI to a family member, friend or other person you advise us is involved in your health care or payment for your health care, unless you object. In such instances, the PHI will be limited to PHI directly relevant to that individual's involvement in your health care or payment for your health care, unless you sign an authorization form permitting a broader disclosure.

V. SPECIAL RULE REGARDING PSYCHOTHERAPY NOTES

Notwithstanding any of the foregoing to the contrary, we will obtain your authorization ***for all uses and disclosures of psychotherapy notes***, except the following:

- Use by the originator of the psychotherapy notes for treatment;
- Use or disclosure by our practice for our own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family or individual counseling;
- Use or disclosure by our practice to defend itself in a legal action or other proceeding brought by you or on your behalf;

- A use or disclosure that is required by the Secretary of the Department of Health & Human Services to investigate or determine our compliance with HIPAA; a use or disclosure that is required by law; a use or disclosure required to be made to a health oversight agency with jurisdiction over the originator of the psychotherapy notes; a disclosure to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law; or disclosure if we believe, in good faith, the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and (i) is to the person or persons reasonably able to prevent or lessen the threat, including the target of the threat, or (ii) is necessary for law enforcement authorities to identify or apprehend an individual (a) because of a statement by an individual admitting to participation in a violent crime that we reasonably believe may have caused serious physical harm to the victim; or (b) where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody.

VI. Uses and Disclosures Requiring Authorization

Other than as stated herein, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon the authorization.

Marketing Communications: We will obtain your written authorization prior to using or disclosing your PHI for marketing purposes, such as communicating with you about a product or service in order to encourage you to purchase or use such product or service. However, your written authorization is not required for the following activities:

- We (or a business associate on our behalf) may send you refill reminders or otherwise communicate with you about a drug or biologic that is currently being prescribed for you. If any compensation we may receive from a third party for doing so is more than an amount reasonably related to the costs of making such communications, we will obtain your authorization prior to such reminders or communications.

- We may communicate with you regarding your treatment, including case management or care coordination for you, or to direct or recommend alternative treatments, therapies, health care providers or settings of care. However, if we receive compensation from any third party in exchange for such communications, we will obtain your written authorization prior to such communications.

- We may provide marketing materials to you in a face-to-face encounter, such as when you are in the office for an appointment.

- We may provide to you a promotional gift of nominal value.

Sale of PHI: We will disclose your PHI in a manner that constitutes a sale only upon receiving your prior authorization. Sale of PHI does not include a disclosure of PHI: for public health purposes; for research; for treatment and payment purposes; for the sale, transfer, merger or consolidation of all or part of our business and for related due diligence activities; to the individual; required by law; for any other purpose permitted by and in accordance with HIPAA.

VII. USES AND DISCLOSURES FOR RESEARCH PURPOSES

The CRCNJ may use and disclose PHI for research purposes with individual authorization, or without individual authorization under limited circumstances, as described below.

Research Use/Disclosure Without Individual Authorization: We may use or disclose a research participant's PHI without individual authorization only in one of the following circumstances:

- When we have obtained documentation that an alteration or waiver of the research participants' authorization for use or disclosure of information about them for research purposes has been approved by an Institutional Review Board (IRB) or Privacy Board.

- When we have obtained representations from the researcher, either in writing or orally, that the use or disclosure of the PHI is solely to prepare a research protocol or for similar purposes preparatory to research, that the researcher will not remove any PHI from The CRCNJ, and representation that PHI for which access is sought is necessary for the research purpose. This provision might be used, for example, to design a research study or to assess the feasibility of conducting a study.

- When we have obtained representations from the researcher, either in writing or orally, that the use or disclosure being sought is solely for research on the PHI of decedents, that the PHI being sought is necessary for the research, and, at the request of The CRCNJ, documents of the death of the individuals about whom information is being sought.

- When a data use agreement, which meets the requirements of applicable law, is entered into by both The CRCNJ and the researcher, pursuant to which The CRCNJ may disclose a limited data set to the researcher for research, public health, or health care operations. A limited data set excludes specified direct identifiers of the individual or of relatives, employers, or household members of the individual.

Research Use/Disclosure With Individual Authorization: We may also use or disclose a research participant's PHI for research purposes when a research participant authorizes the use of disclosure of information about him or herself. A research participant's authorization will typically be sought for most clinical trials and some records research. Unlike other authorizations, an authorization for a research purpose may state that the authorization does not expire, that there is no expiration date or event, or that the authorization continues until the "end of the research study". An authorization for the use or disclosure of PHI for research may be combined with a consent to participate in the research, or with any other legal permission related to the research study.

Accounting for Research Disclosures: As a research participant, you have the right to receive an accounting from The CRCNJ of certain disclosures of PHI made by The CRCNJ. This accounting must include disclosures of PHI that occurred during the six years prior to your request for an accounting, or since the applicable HIPAA

compliance date (whichever is sooner), and must include specified information regarding each disclosure. Certain types of disclosures that are exempt from this accounting requirement, as follows:

- Research disclosures made pursuant to an individual's authorization;
- Disclosures of the limited data set to researchers with a data use agreement.

VIII. Legal Representatives and Minors

We may disclose your PHI to your legal representative or your legal representative may authorize the use and disclosure of your PHI, with certain exceptions. Examples of legal representatives include the parents of a minor child (under the age of 18), the guardian of a minor child or incapacitated person, or the estate representative (administrator or executor) of a decedent's estate.

With respect to minors, there are exceptions to the above. In the following instances, the minor has the right to make decisions concerning the use and disclosure of the minor's PHI relating to a particular health care service in the same manner as an adult:

A minor has the authority to act on his/her own (as his/her own personal representative), with respect to a health care service, if:

- The minor consents to the health care service. There are certain circumstances under state law where a minor may consent to treatment, without obtaining parental or guardian consent. In such situations, and if the minor has not requested that the parent or guardian act as his/her personal representative, the minor has the right to control and authorize use and disclosure of such PHI in the same manner as an adult.
- The minor may lawfully obtain such health care service without the consent of a parent or guardian, and the minor, a court, or another person authorized by law consents to such health care service. In such situations, the minor has the right to control and authorize the use and disclosure of such PHI in the same manner as an adult.
- A parent or guardian assents to an agreement of confidentiality between our practice and the minor with respect to such health care service. In such situations, the minor has the right to control and authorize the use and disclosure of such PHI in the same manner as an adult.

Note that the parent or guardian of a minor child will act as the personal representative of the minor child with respect to PHI relating to other health care services.

IX. Patient's Rights Under HIPAA

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. Further, you may not limit the uses and disclosures we are legally required to make. Notwithstanding the foregoing, you have the right to ask us to restrict the disclosure of your PHI to your health plan for a service we provide to you where you have directly paid us (out of pocket, in full) for that service, in which case we are required to honor your request. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction.

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 us. 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 health and billing records used to make decisions about you for as long as the PHI is maintained in the record, except for psychotherapy notes or information compiled for legal proceedings. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. In most circumstances, we must act on your request within thirty (30) days. 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, but we will tell you why within sixty (60) days of 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). We must act on your request for an accounting within sixty (60) days of your request. 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 this Notice of Privacy Practices from us upon request, even if you have agreed to receive the notice electronically.

Right to Receive Notice of a Breach of Unsecured PHI – You have the right to receive notification of a breach of your unsecured PHI by us, or by our business associates, which we discover.

X. Duty to Safeguard your PHI:

We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of our Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of this Notice of Privacy Practices and our privacy policies at any time. Any changes will apply to the PHI we already have. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice in public areas of our offices. You can also request a copy of this notice from our office at any time and can view a copy of this notice on our Web site at https://thecrcnj.com/resourcesfor-patients/

XI. 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 CRCNJ 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.

XII. Effective Date

This notice will go into effect on October 3, 2019.