GENPSYCH
Mental Health of the Future

## DEMOGRAPHIC AND INSURANCE INFORMATION

***** Please complete all questions on both sides of this form *****

| Date | Social Security Number |
|---|---|

**Demographic Information – Please Print**

| First Name | Middle | Last Name |
|---|---|---|
| Address | | |
| City | State/ZIP | Home Phone ( ) |
| Cell Phone ( ) | | Work Phone ( ) |
| OK to leave a voice mail at home? Yes ___ No ___<br>OK to leave a voice mail at work? Yes ___ No ___<br>OK to leave message on cell phone? Yes ___ No ___ | | OK to leave a message with a family member ?<br>Yes ___ No ___<br>Family member's name(s): _____ |
| Email | | |
| Date of Birth<br>_____/_____/_____ | Gender:<br>Male ____<br>Female ____ | Marital Status (ex. single, married, divorced, separated, etc.) |
| Age | Legal Guardian (if applicable) | |

**INSURANCE POLICY INFORMATION**

| Insurance Company/HMO | | Patient ID Number/Member ID |
|---|---|---|
| Group Number | | Policy Holder's Name |
| Policy Holder's DOB _____<br>Policy Holder's S.S. # _____ | | Relationship to Policy Holder (ex. spouse, child, guardian, etc) |
| Claims Mailing Address | | |
| City | State/Zip | Phone |

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**Secondary Policy Information (if applicable)**

| | | |
|---|---|---|
| Insurance Company/HMO | | Patient ID Number/Member ID |
| Group Number | | Policy Holder's Name |
| Policy Holder's DOB | | Relationship to Policy Holder (ex: spouse, child, guardian, etc) |
| Claims Mailing Address | | |
| City | State/ZIP | Phone |

**Pharmacy Information**

| |
|---|
| Pharmacy Name |
| Address |
| Phone Number |

**Signatures**

_____ _____
Client or Parent / Legal Guardian Signature Date

_____ _____
Responsible Party Signature Date

_____
Print Name

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## AUTHORIZATIONS AND AGREEMENTS with GENPSYCH

**Client Copy**

The paragraphs below contain several agreements.

Please read carefully and sign the ***Client Copy*** and the ***Office Copy.***

Client Name _____

### Medical Insurance

I authorize the medical insurance company to pay directly for GENPSYCH services. I, however, understand that the person who signs below is responsible for all my fees, including any fees not paid by the insurance company.

### Release of Information

I authorize GENPSYCH to release/receive verbal and written information about me to/from the medical insurance company and the referring physician. This authorization will end if I give written instructions to GENPSYCH to that effect, which I may do at any time.

### Financial Responsibility

We understand and agree that each of us is responsible for the client's fees to GENPSYCH, including any fees not paid by medical insurance; that if the account is not paid when due, reasonable collection and court costs will be paid by the undersigned; that we are responsible for the cancellation and "no-show" fees resulting from appointments not kept or canceled without a 24-hour notice; that fees for outpatient services must be paid at the time services are rendered.

### CANCELLATION AND MISSED APPOINTMENT POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment cancellation and "no-show" policy. This policy enables us to better utilize available appointments for our clients in need of medical care. Please be courteous and call the appropriate office in which you scheduled your appointment promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance, and calling early in the day is appreciated. If you do not reach the receptionist, you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave a phone number and let us know the best time to return your call.

A $100.00 fee will be applied to your account for cancellations not made in the 24-hour time frame or "no-shows."

For those clients who may be receiving GENPSYCH transportation services, as consideration for our lengthy van waiting list, a fee of twenty-five dollars ($25.00) will be charged for every cancellation of transportation without proper notice.

**CONTINUED ON NEXT PAGE**

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## NOTICE OF CLIENT FINANCIAL RESPONSIBILITY

**Billing and Insurance**
As a courtesy to our clients, GENPSYCH will verify your mental health benefits with your insurance carrier. In order to do so, we must obtain a copy of your insurance card and obtain the name, address and birth date of the subscriber. The information that we receive is not a guarantee of payment. We recommend that you reference your mental health benefit policy or consult your insurance carrier directly with questions regarding benefits and participation.

In addition, GENPSYCH will bill your insurance carrier for services provided. All co-payment amounts are due at the time of service. Co-insurance, deductible and any outstanding balances will be due upon receipt of our billing invoice.

**Payment Options**
GENPSYCH accepts cash, checks, money orders and major credit cards. Monthly payment plans may be arranged by calling the Billing Department at (908) 526-8370, extension 214.

**Returned Checks**
A fee of $35.00 will be added to your balance due for all returned checks.

**Missed Appointments**
We understand that there are rare exceptions when a client cannot make a scheduled appointment. However, we require 24 hour advance cancellation notice. If you give us less than 24 hours' notice or simply do not show for your scheduled appointment, you will be charged a missed appointment fee of $100.00

**Self-Pay**
To assist our self-pay clients, GENPSYCH has developed a Self-Pay Fee Schedule Discount Program. Designed to help defray the cost of medical care for the uninsured, the program offers a discount to uninsured clients only. For more information, please call the Billing Department at (908) 526-8370.

**Estimated Fees**
The fees associated with your care may include, but are not limited to the following services:

- $100.00 – Medical Management
- $300.00 – Psychiatric diagnostic evaluation exam
- $525.00 – Intensive Outpatient Program Per Diem
- $800.00 – Partial Hospitalization Program Per Diem

The self-pay fees may include, but are not limited to the following services:

- $100.00 – Medical Management
- $200.00 – Program per day
- $300.00 – Evaluation

**Collections**
GENPSYCH will make every effort to assist clients with meeting their financial obligations. However, in the event that the client does not respond to our billing invoices or neglects to make arrangements, we reserve the right to transfer the outstanding balance to a collection agency. We also reserve the right to report delinquent accounts to credit bureaus and charge applicable collection agency fees directly to the client.
By signing below, I have read, understand, and agree to all of the above.

_____ _____
Client or Parent / Legal Guardian Signature Date

_____ _____
Responsible Party Signature Date

_____
Responsible Party Printed Name

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_____ _____
Client or Parent / Legal Guardian Signature Date

_____ _____
Responsible Party Signature Date

_____
Responsible Party Printed Name

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## EMERGENCY CONTACT RELEASE

I authorize GenPsych to contact the following person(s) in the event of an emergency. Please provide ***at least one*** emergency contact.

**EMERGENCY CONTACT(S): (Please Print)**

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |

I understand that this request will remain in effect until I am discharged from GenPsych PC unless I submit a written request for a change.

**Client Name: (Please print)** _____

**Client Signature:** _____ **Date:** _____

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# INFORMED CONSENT FOR TREATMENT

I, _____ (print name of client), agree and consent to participate in behavioral health care services offered and provided by GENPSYCH, PC, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within: (1) the scope of the provider's license, certification and training; or (2) the scope of license, certification and training of the behavioral health care providers directly supervising the services received by the client. I understand that these services may include individual, group, and/or family therapy, medication management, and urine, blood, or other tests for substances. If the client is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Witness Signature: _____

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## Outpatient Acknowledgement of Documents

I, _____,

***PRINT NAME CLEARLY***

do affirm that I have read, understood, and received copies of the following documents:

- Clients' Rights
- Compliant and Grievance Procedure
- Notice of Privacy Practices
- Medications and the Heat Advisory

Signature: _____

Parent or Legal Guardian Signature: _____

Date: _____

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## GenPsych Clients' Rights

**All GenPsych clients have the right to:**

1. Be informed of their rights and responsibilities, and to be notified of any rules and policies the program has governing client conduct in the facility.
2. Be free from unnecessary or excessive medication.
3. Not be subjected to non-standard treatment or procedures, experimental procedures of research, psycho-surgery, sterilization, electro-convulsive therapy or provider demonstration programs, without written informed consent, after consultation with counsel or an interested party of the client's choice. If a client is adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of N.J.S.A. 30:4-24.2d(3). *Note: this information is provided to you as legally required. None of these procedures are performed at GenPsych.*
4. Be free from corporal punishment and treated with privacy and dignity.
5. Treatment in the least restrictive conditions necessary to achieve the goals of treatment/services.
6. To be free from physical or pharmacological restraints, isolation, interference, coercion, discrimination or reprisal.
7. Be treated with courtesy, consideration, respect, and individuality.
8. Refuse participation in any research studies without jeopardizing the right to receive services.
9. Be informed of the services provided at GenPsych and the names and professional status of all personnel providing those services, and whether the program has authorized other health care and educational institutions to participate in his or her treatment.
10. Be informed of all fees for service and their responsibility for payment.
11. Be provided with an explanation of their medical condition, treatment recommendations, risks, options and anticipated treatment results.
12. Be assessed for physical pain and provided with an appropriate referral to address the diagnosis, treatment and management of identified pain.
13. Participate in their treatment plan, and to refuse medication and treatment at any time.
14. Voice grievances or recommend changes in policies and procedures to GenPsych personnel, the governing authority and/or outside representatives of the client's choice.
15. Be free from any form of abuse, exploitation, punitive or aversive interventions.
16. Confidential treatment of all protected health information, unless that right is waived through the signed release of information permitting disclosure to the designated party. Additionally, all clients have the right to adequate notice of the uses and disclosures of their confidential medical information.
17. Exercise civil and religious liberties, including the right to make independent personal decisions.
18. Be treated fairly and not deprived of any constitutional, civil or legal rights, regardless of age, race, religion, gender, nationality, sexual orientation, marital status, disability, or payment source. Be free from any obligation to engage in the provision of any employment or services to the treatment provider.
19. The right to be transferred or discharged only for medical reasons, their own welfare, that of other clients or staff or upon the written order of a physician or other LIP.
20. The right to have access to and obtain a copy of their clinical record in accordance with applicable federal and state regulations.
21. The right to be notified in writing and to appeal an involuntary discharge *(applies to clients in the Division of Addiction licensed programs only).*

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# Consumer Grievance Procedure

It is the policy of GenPsych to ensure the rights of clients, family members, legal guardians, and/or significant others to submit a complaint to the organization or to an advocacy entity related to any aspect of their treatment experience. Clients, family members, legal guardians, and/or significant others are informed of this mechanism during the admission process and assured that a complaint does not compromise future access to care.

Anyone who has a grievance may present it to Gen Psych staff, Program Director and/or Medical Director. If the individual does not wish to present the grievance within the organization, he or she may present it directly to The County Mental Health Administrator or the Division of Mental Health Services, the Division of Protection and Advocacy, the Division of Youth and Family Services, as well as other entities listed at the end of this document.

## PROCEDURE

### Internal:

1. The individual may bring a grievance regarding any aspect of treatment or services to the attention of any staff member.
2. The staff member receiving the grievance will attempt to resolve it with the individual.
3. If the grievance is of serious concern, or if the staff member is unable to resolve it to the satisfaction of the individual, it will be immediately brought to the attention of the Program Director and/or Medical Director.
4. The Program Director and/or Medical Director will investigate all grievances within 24 hours of notification. This investigation will include meeting with any staff member involved in the grievance.
5. Results of such investigations are documented in an Incident Report. Any and all appropriate actions to resolve the grievance are taken.
6. The Program Director will meet with the individual to provide resolution. The results of this meeting are documented in the Incident Report.
7. If the individual disagrees with the method by which the Program Director addresses the grievance, the individual may bring the grievance to the Medical Director or to any of the external entities listed below. If the consumer brings the grievance to the Medical Director, he or she will meet with the individual to provide resolution. The results of this meeting are documented in the Incident Report as well as the consumer's clinical record.

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Mental Health of the Future

# Consumer Grievance Procedure

## External:

If the individual prefers to bypass the internal entities and bring the grievance to one of the external entities listed below, he or she is welcomed to do so without fear of any reprisal. The following advocacy agencies' contact information is provided to consumers at the time of admission and posted in a readily visible area in the facility:

Mercer County Mental Health Board
640 South Broad Street - PO Box 8068
Trenton, NJ 08650
609- 989-6574
Michele Madiou, Administrator
E-mail: mmadiou@mercercounty.org

Division of Addiction Services
877-712-1868 or 609-292-5760

Division of Mental Health Services
800-382-6717
Capital Center
P.O. Box 727
Trenton, NJ 08625-0727

Division of Mental Health Advocacy
Justice Hughes Complex
25 Market Street
Trenton, NJ 08625
Phone: 877-285-2844

Community Health Law Project
185 Valley Street
South Orange, NJ 07079
(973) 275-1175

Disability Rights of New Jersey
210 So. Broad St., 3rd Floor
Trenton, N.J. 08608
800-922-7233 or 609-292-9742

Division of Youth and Family Services
NJ Division of Children and Families
50 East State Street
P.O. Box 717
Trenton, NJ 08625-0717
**CHILD ABUSE/NEGLECT HOTLINE**
**1-877-NJ ABUSE (652-2873)**
**1-800-835-5510 (TTY)**
**24 hours a day - 7 days a week**

NJ Division of Children and Families
Office of Licensing
P.O. Box 717
Trenton, NJ 08625-0717
Phone: 877-677-9845

Division of Child Behavioral Health Services
P.O. Box 717
Trenton, N.J. 08625-0717
Phone: 609-888-7208

Division of Mental Health and Hospitals
Ombudsperson
Attention: Lisa Ciaston
Division of Mental Health Services
P.O. Box 727
Trenton, NJ 08625
Phone: 609-777-0694

Adult Protective Services
**Mercer County Board of Social Services Central Office**
200 Wolverton Street
Trenton, NJ 08611
Phone: (609) 989-4320

Department of Children and Families
20 West State Street, 4th Floor
PO Box 729
Trenton, NJ 08625-0729
DCF Office of Advocacy
Phone: 877-543-7864

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Mental Health of the Future

# NOTICE OF PRIVACY PRACTICES

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

## UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. Protected Health Information ("PHI") is the collective term referred to any information about you, or used to identify you and that relates to your past, present or future physical or mental health or condition, the provisions of health care services, or the past present or future payment for the provision of health care, including demographic information. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

## YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information (PHI)** for treatment, payment and health care operations. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit PHI that we are legally required or allowed to release, and we reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information (PHI) in confidence.** You have the right to request that we communicate with you in a certain way and in a certain location that ensures the utmost protection of your PHI.
4. **Inspect and obtain a copy of the protected health information (PHI).** You have the right to make a written request to inspect or obtain a copy of your medical and billing records used by us to make decisions about you. Such requests must be made in writing on an authorized release form. However, your right to view your record or obtain a copy may be restricted within the confines of NJAC 13:35-6.5(c)(3). In addition, a fee of $1.00 per page, not to exceed $100.00 for the entire record (inclusive of postage costs) may be charged for the reproduction of the record in accordance with NJAC 13:35-6.5.
5. **Request an amendment to your protected health information (PHI).** However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth in number (4) above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information (PHI)** made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;

- to correctional institutions or law enforcement officials as provided by law;
- for national security or intelligence purposes;
- that occurred prior to the date of compliance with privacy standards (April 14, 2003);
- incidental to other permissible uses or disclosures;
- that are part of a limited data set (does not contain protected health information that directly identifies individuals);
- made to patient or their personal representatives;
- for which a written authorization form from the patient has been received

7. **Revoke your authorization to use or disclose health information** except to the extent that we have already taken action in reliance on your authorization before revocation, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.

## HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

**Treatment:** We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

**Payment:** We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

**Regular Healthcare Operations:** We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

**Appointment Reminders:** We may use and disclose protected health information to contact you to provide appointment reminders.

**Treatment Alternatives**: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

**Health-Related Benefits and Services:** We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care:** Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

**Business Associates:** There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

**Organ and Tissue Donation:** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Worker's Compensation:** We may release protected health information about you for programs that provide benefits for work related injuries or illness.

**Communicable Diseases:** We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**Health Oversight Activities:** We may disclose protected health information to federal or state agencies that oversee our activities.

**Law Enforcement:** We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

**Military and Veterans:** If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

**Lawsuits and Disputes:** We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

**Abuse or Neglect:** We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Fund raising:** Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

**Coroners, Medical Examiners, and Funeral Directors:** We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

**Public Health Risks:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

**Serious Threats:** As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

**Food and Drug Administration (FDA):** As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

## OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site. Your health information will not be used or disclosed without your written authorization, except as described in this notice. Except as noted above, you may revoke your authorization in writing at any time.

## FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Kimberly L. Forino, Esq. at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Kimberly L. Forino, Esq. or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

**U.S. Department of Health and Human Services**
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

**GenPsych Privacy Officer**
Kimberly L. Forino, Esq.
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## NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request.

## PREVENTION OF HEAT RELATED ILLNESS

When in periods of high temperature and humidity, there are things everyone (and particularly, people at high risk) should do to lessen the chances of heat illness

### ❖ TRY TO KEEP COOL

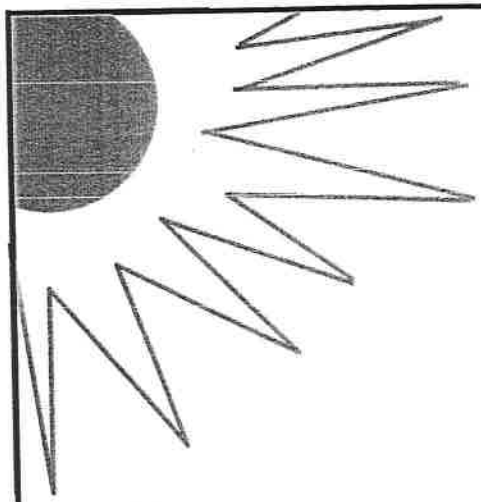
Keep windows shut, and draperies, shades, or blinds drawn during the heat of the day. Open windows in the evening or night hours when the air outside is cooler. Move to cooler rooms during the heat of the day

- Avoid overexertion, particularly during warmer periods of the day
- Apply sun screen lotion as needed.
- Drink plenty of fluids (Avoid coffee, tea & alcohol)
- Dress in loose fitting, light-colored clothing
- Lose weight if you are overweight
- Eat regular meals to insure that you have adequate salt and fluids

4/07

## MAJOR ANTIPSYCHOTIC MEDICATIONS

| Trade Name | Generic Name |
|---|---|
| Abilify | aripiprazole |
| Clozaril | clozapine |
| Geodon | ziprasidone |
| Invega | paliperidone |
| Risperdal | risperidone |
| Seroquel | quetiapine |
| Zyprexa | olanzapine |
| Haldol | haloperidol |
| Loxitane | loxapine |
| Mellaril | thloridazine |
| Moban | molindone |
| Navane | thiothixene |
| Prolixin | fluphenazine |
| Serentil | mesoridazine |
| Stelazine | trifluoperazine |
| Thorazine | chlorpromazine |
| Trilafon | perphenazine |



# Summer Heat and Sun Risks for Antipsychotic Medication Users

State of New Jersey
Division of
Mental Health Services

# ANTIPSYCHOTIC MEDICATIONS AFFECT BODY HEAT

Antipsychotic medications may impair the body's ability to regulate it's own temperature. During hot and humid weather individuals taking antipsychotic medications are at risk of developing excessive body temperature, or hyperthermia, which can be fatal. Individuals with chronic medical conditions are especially vulnerable e.g. heart and pulmonary disease, diabetes and alcoholism, etc.

Heat exhaustion is the most common heat-related condition, which is most likely to occur in people who are involved in physical activity outdoors during heat waves.

Heat stroke is a more serious condition of dehydration and salt depletion which can be life threatening.

## HEAT EXHAUSTION

This can occur in both active and sedentary individuals. It happens suddenly, and may be quite brief. **A doctor should be called**. Recovery may be spontaneous, or intravenous fluids may be needed to prevent unconsciousness.

### Symptoms of heat exhaustion:

- Irritability or change in behavior
- Low or normal temperature
- Slight low blood pressure
- Rapid, full pulse and heartbeat
- Rapid breathing
- Cold, pale skin (may be ashen-gray)
- Profuse perspiration
- Dizziness, headache, and weakness
- Nausea, vomiting
- Cramps in the abdominal area or in the extremities

### Treatment

If a person displays symptoms of heat exhaustion, he or she should be:

- Moved to a cooler place as soon as possible
- Given water or other liquids immediately (there is no need for salt)
- Encouraged to rest for a short time

## HEAT STROKE

This occurs mostly during heat waves. Persons with chronic illnesses are most vulnerable. Heat stroke, the most serious heat illness, **can lead to death if left untreated.**

### Symptoms of heat stroke:

- Agitation, confusion, seizures, lethargy, or coma (all may be first symptoms)
- High body temperature (102 degrees Fahrenheit or above)
- High blood pressure initially (shock may follow, resulting in low blood pressure)
- Rapid pulse and heartbeat
- Rapid, shallow breathing if person is moving about; slow and deep breathing if the person is still
- Hot, dry, flushed skin

### Treatment

As soon as you recognize the signs of heat stroke, take immediate action:

- **Call 911 immediately**
- Loosen or remove outer layers of individual's clothing
- Move to a cool place
- Use CPR if needed
- Replace fluids and sodium only under medical orders