HUDSON PSYCHIATRIC
ASSOCIATES, LLC
www.hudsonpsych.com

Patient Registration Form

last name	first name	birth date
street address	apartment	
city	state	zip code
○ preferred contact home telephone	○ preferred contact mobile telephone	age
○ preferred contact office telephone	e-mail	gender
occupation	social security number	
employer	How did you hear about us? Please identify:	
primary care physician	○ friend or family ○ website ○ other physician ○ directory listing ○ other therapist ○ article or publication ○ presentation or workshop ○ other	
primary care physician phone number		

Emergency Contact

last name		first name		relationship
home telephone		mobile telephone		release of information

Legal Guardian (if patient is a minor)

last name	first name	birth date
○ preferred contact home telephone	○ preferred contact mobile telephone	age
○ preferred contact office telephone	e-mail	gender
occupation	social security number	
employer	relationship to patient	

Insurance Information

○ same as above insured's last name		insured's first name	○ same as above	birth date
insurance company			phone	
address			state	zip code
subscriber ID number		group number		co-pay amount

I, as the insured individual named above, give Hudson Psychiatric Associates permission to file my information and request payment. I understand that I am responsible for all charges not paid by the insurance or managed care company.

signature	date

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Office Policy

Insurance

1. Patients are responsible for being aware of their current insurance coverage. This includes:
   - Out of network benefits
   - Deductible and/or "out-of-pocket"
   - Need, if any, for pre-certification
   - Current coverage and co-payment
   - Limits and current usage on annual visits
   - Any changes in coverage
2. If you have exceeded your benefits covered you are responsible for the **full payment** for any uncovered sessions.
3. Your mental health coverage may be "carved out" to other managed care companies. We are considered **out-of-network** with those companies.
4. Please note that your insurance may place limits on the number of visits allowed per year. This may not be sufficient to cover the clinically appropriate level of care determined by your doctor.

Medications

1. To ensure quality of care, regular follow-up with routine office visits is necessary for prescriptions to be provided.
2. If one or more scheduled office visits have been missed, the physician **must be seen** before any prescriptions are written or renewed.
3. Please inform your physician about needed refills at least three business days before your medication runs out. Set aside an emergency reserve of three to five days of each prescription.

Cancellations

1. Because your appointment time has been reserved for you, **you will be charged for missed appointments and cancellations with less than 48 hours (two full business days) notice.** For example, if your appointment is scheduled on a Monday or following a long weekend, please call on the preceding Thursday.
2. Charges for missed appointments are **not covered** by your insurance and are due and payable prior to any further appointments. Please note that such charges include the amount normally covered by the insurance company in addition to any copay amount.

Telephone Calls and Email

1. Please leave your full name and phone number with your message. Return calls are made within 24 to 48 hours. If you are experiencing an emergency (such as a medication reaction or crisis situation), you should call your individual provider and then either proceed to the nearest Emergency Room or dial 911.
2. Phone calls cannot substitute for office visits. For complex concerns and medication adjustments, an appointment with your physician is necessary.
3. E-mail is limited to the exchange of **non-clinical** information. Please allow 24 to 72 hours for response to email inquiries.

Payment

1. Payment is expected at the time of appointment. We accept cash, checks, Visa or Mastercard.
2. Fees for written reports or records may incur additional charges.
3. There is a $50 charge for returned checks.

Office Policy Patient Acknowledgement

patient name | birth date

I have received a copy of the Office Policy of Hudson Psychiatric Associates, LLC and agree to the terms within.

signature | date

☐ parent ☐ legal guardian ☐ other:
relationship to patient (if signed by authorized representative)

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Notice of HIPAA 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.

I. Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care. It also includes bills, insurance claims, or other payment information that we maintain related to your care.

This Notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to maintain the privacy of your health information as required by law; provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain; and follow the terms of our Notice currently in effect.

II. Contact Information

After reviewing this Notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to the privacy officer at 201-222-8808.

III. Uses and Disclosures of Information

Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. Participants in this organized health care arrangement also share health information with each other, as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement. We may share the minimum amount of personal health information necessary for business associates performing services on our behalf.

IV. Other Uses and Disclosures

- As required by the Food & Drug Administration.
- As required during an investigation by law enforcement agencies
- Health oversight activities
- In response to legal proceedings
- Other covered entities' payment activities
- Other covered entities' healthcare operations activities to the extent permitted under HIPAA
- Other healthcare providers' treatment activities
- Other public health activities
- To prevent a serious threat to public health or safety
- To workers' compensation or similar programs for processing of claims
- Uses and disclosures required by law
- Uses and disclosures required by law for unempancipated minors
- Uses and disclosures in domestic violence or neglect situations

V. Any Other Use or Disclosure

Before using or disclosing your personal health information for any other purpose not identified above, we will obtain your written authorization. Unless action has already been taken in compliance with the authorization, you have a right to revoke such authorization by submitting your written request to us.

VI. Your Health Information Rights

Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.

Request that we communicate with you by alternative means, such as making records available for pick-up, or mailing them to you at an alternative address, such as a P.O. Box. We will accommodate reasonable requests for such confidential communications.

Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates. We reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with

your request. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.

Request that we amend the health information about you that is maintained in our files and the files of our business associates. Your request must explain why you believe our records require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement disagreeing with the decision. This statement will be added to your records.

Request a list of our disclosures of your health information. This list, known as an "accounting" of disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting free of charge, however if you request more than one accounting in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested. We will be unable to provide you an accounting for any disclosures made before

Request a paper copy of this Notice.

In order to exercise any of your rights described above, you must submit a written request to our office. If you have questions about your rights, please speak with our contact person, available by phone during normal office hours.

VII. To Request Information or File a Complaint

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to our contact person. You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-(800) 368-1019; or by sending an email to *OCRprivacy@hhs.gov*. We cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from us, or penalize you for filing a complaint

VIII. Revisions to this Notice

We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, post it in the waiting area of our offices, make copies available to our patients and others, and post it on our website.

Privacy Practice Patient Acknowledgement

patient name	birth date

I acknowledge that I have received a copy of the Notice of Privacy Practices of Hudson Psychiatric Associates, LLC. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

signature	date

relationship to patient (if signed by authorized representative)