AFFILIATES IN CLINICAL SERVICES, PC
305 Roseberry Street, Suite 8
Phillipsburg, NJ 08865-1600
(908) 454-7244 – Fax (908) 859-2109

COUPLES PATIENT FORMS CHECK LIST

ONE SET OF FORMS FOR EACH PARTNER

Print Patient's full name: _____

- ☐ Cover Letter (sent separately)
- ☐ Provider-Patient Services Agreement Informed Consent-Couples (keep)
- ☐ Biographical Form (complete and return)
- ☐ Patient Contact Information (complete and return)
- ☐ Patient Acknowledgements and Authorization (complete and return)
- ☐ Coodination of Care - PCP (complete and return)
- ☐ Payment Contract for Services (keep)
- ☐ HIPAA Notice (keep)
- ☐ Directions to our Office (keep)

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PROVIDER-PATIENT SERVICES AGREEMENT
INFORMED CONSENT-COUPLES

Welcome to our practice. This document (the Agreement) contains important information about our professional services and business policies. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about them. When you sign the acknowledgement of receipt of this document, it will also represent an agreement between patient and Affiliates in Clinical Services (ACS). You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PROFESSIONAL CREDENTIALS

Dr. Gerald Groves is a Licensed Psychiatrist. Dr. Gerard Machado is a Licensed Clinical Psychologist and Board Certified as an Advanced Practice Nurse With Prescriptive Authority (APN). Linda Beal and Dr. Linda Esposito are Board Certified as Advanced Practice Nurses With Prescriptive Authority (APN). Dr. Carolyn Regan is a Licensed Clinical Psychologist. Michael Ware is a Licensed Professional Counselor. Kevin Kassick and Lori Vargo Heffner are Licensed Professional Counselors as well as Licensed Clinical Alcohol and Drug Counselors. John Shalhoub is a Licensed Clinical Social Worker.

INITIAL EVALUATION

We normally conduct an evaluation that will last from one (1) to two (2) sessions. We may order some tests as part of our initial diagnostic assessment. These will include laboratory tests to determine your level of health and safety in taking medications. Sometimes an electrocardiogram is included as part of those tests. In addition, we may recommend some psychological tests that can help us understand your problem better and faster, and serve as guides to evaluate progress. Feedback regarding this evaluation is usually verbal.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the provider and patient, and the particular problems you bring forward. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychopharmacology provides treatment via prescription psychiatric medication and requires close follow up by the prescriber to ensure the agent or combinations of agents prescribed are beneficial. Side effect management and patient education is an important part of psychopharmacology.

Psychological Services can have benefits and risks. Since treatment often involves discussing unpleasant aspects of life, the patient may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, treatment has also been shown to have benefits for people who go through it. Your provider will recommend the type(s) of Psychological Services that will best address your treatment and may consist of stand alone Psychopharmacology, Individual Psychotherapy or Counseling, or a combination of treatments. Treatment often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what the patient will experience.

Our first few sessions will involve an evaluation of needs. By the end of the evaluation, we will be able to verbally offer some first impressions of what our work will include and we will establish goals, if you decide to continue with treatment. You should evaluate this information along with your own opinions of whether you feel comfortable working with us. Treatment involves a large commitment of time, money, and energy, so you should be very careful about the provider you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a referral.

APPOINTMENTS

We will usually schedule regular fifteen (15) to thirty (30) minute visits for Medication Management. If we see you for psychotherapy or psychotherapy with medication management, we will usually schedule regular forty-five (45) to sixty (60) minute sessions. **After an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours (1 business day) advance notice of cancellation.** If charged for a missed appointment (currently the fee is $50.00), your insurance company does not cover this expense and you (or your responsible party) will be personally responsible for the charge. This fee must be paid prior to the next appointment.

PROFESSIONAL FEES

Our fees are from $175.00 to $300.00 for Pharmacological (Medication) Management; $300.00 to $500.00 for the initial intake session; and $300.00 per hour for other professional services you may need, though we will break down the hourly cost of other professional services if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals that have been authorized, preparation of records or treatment summaries, and the time spent performing any other professional service. Our general policy is to not become involved in legal proceedings while we are acting as your provider, however, if the patient becomes involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge $500.00 per hour for preparation and attendance at any legal proceeding.

CONTACTING US

If the patient has an adverse reaction to any medication that we have prescribed and is unable to reach us, have someone take the patient to the nearest hospital emergency room.

Due to our work schedules, we are often not immediately available by telephone. We probably will not answer the phone when in session with a patient. When unavailable, telephones are answered by office staff or by voice mail. We monitor messages frequently and will make an effort to return your call on the same day if we are in the office. If not that day, then we will make an effort to return your call on the next business day in the office. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

Voice mail is available at all times so messages may be left even if the office is closed. **If psychiartric emergency, go to the nearest hospital emergency room or call 911.**

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a mental health professional. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by Health Insurance Portability and Accountability Act (HIPAA). See the *HIPAA Privacy Notice* for details. We are legally obligated to bring any concern regarding health and safety to the attention of relevant authorities.

PROFESSIONAL RECORDS

All should be aware that, pursuant to HIPAA, we keep two sets of professional records. They includes information about reasons for seeking therapy, a description of the ways in which problems impact life, the diagnosis, the goals that we set for treatment, any progress towards those goals, medical and social history, treatment history, any past treatment records received from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone, including reports to the insurance carrier.

Except in unusual circumstances that involve danger to the patient and others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm, you may examine and/or receive a summary copy of your Clinical Record, if requested it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend they initially be reviewed in our presence, or have them forwarded to another mental health professional so the contents may be discussed. We are sometimes willing to conduct this review meeting. In most situations, we are allowed to charge a copying fee of $1.00 per page (and for certain other expenses). If we refuse your request for access to your summary Clinical Record, you have a right of review, which we will discuss with you upon request.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for treatment. If there is a health insurance policy, it will usually provide some coverage for behavioral health treatment. Our administrative staff will provide assistance in helping receive the benefits; however, the patient/responsible party (not the insurance company) is responsible for full payment of our fees. There are cases where the insurance company, by contract, has arranged to pay your expenses subject to certain terms and restrictions. In cases where the contract is not enforceable, the financial responsibility reverts back to the patient/responsible party. It is very important to determine in advance the exact benefits for behavorial health services covered by the insurance policy.

Carefully read the section in the insurance coverage booklet that describes behavioral health services. If questions about the coverage, call the plan administrator. Of course our administrative staff will provide whatever information they can based on our experience and will be happy to help in understanding the information from the insurance company. If it is necessary to clear confusion, we may be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much behavorial health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for behavioral health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While progress is possible in short-term therapy, some patients feel that they need more services after insurance benefits end. If the choice is to continue therapy without insurance approval, the patient/responsible party will be expected to pay for services directly, and we can discuss this further should the need arise. Some managed care plans will not allow us to provide services to you once the benefits end. If this is the case, the insurance company bay provede another specialist that will help continue the treatment.

Be aware that if the health benefits are provided by a self-insured employee benefit plan or other arrangement regulated by the federal ERISA statute, such plan will have considerably more access to information in the Clinical Record. They will not have access to Psychotherapy Notes. If any question about the nature of the health benefits, contact the group that provides the benefits.

This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it.

Once we have all of the information about insurance coverage, we may discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end sessions. It is important to remember that the patient/responsible party always has the right to pay for services out of pocket to avoid the problems described above.

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COUPLES BIOGRAPHICAL INFORMATION FORM

To be completed by each person in the relationship.

INSTRUCTIONS: To assist us in helping you, please fill out this form as fully and openly as possible. Your answers will help plan a course of couple's therapy that is most suitable for you and your partner. Do not exchange this information with your partner at this time.

Personal History

1) Name: _____

2) Age: _____ 3) Gender_____ 4) Refer to me as: _____

5) Weight: _____ 6) Height: _____ 7) Race/Ethnicity: _____

8) Religious/Spiritual Identifiction: _____ 9) Date of Birth: _____

10) Years of Education: _____ 11) Occupation: _____

12) Marital/Relationship Status: _____ 13) Number of Children: _____

14)

Child's Name	Age	Sex	Whose Child?	Lives with Whom?
a)				
b)				
c)				
d)				
e)				

15) Have you been married/partnered before? _____If yes, how many previous times? _____

16) Have you and your partner been in couple's counseling before? _____ Result? _____

17) List five present positive attributes of your partner. Do you often praise your partner for this trait?

a) _____ _____
b) _____ _____
c) _____ _____
d) _____ _____
e) _____ _____

18) List five present negative attributes of your partner. Do you often nag your partner for this trait?

a) _____ _____
b) _____ _____
c) _____ _____
d) _____ _____
e) _____ _____

19) List five things that you do (or could do) to make your relationship Do you often implement more fulfilling for your partner. Do you often implement this behavior?

a) _____ _____
b) _____ _____
c) _____ _____
d) _____ _____
e) _____ _____

20) List five things that your partner does (or could do) to make the relationship more fulfilling for you.

Do your partner often implement this behavior?

a) _____ _____
b) _____ _____
c) _____ _____
d) _____ _____
e) _____ _____

21) Which of the following issues or behaviors of you and/or your partner may be attributable to your relationship or personal conflicts? If an item does not apply, leave it blank.

CIRCLE THE APPROPRIATE RESPONSES.

M = My behavior, **P** = Partner's behavior, **B** = Both

a)	Alcohol consumption	M P B		p)	Past failures	M P B	
b)	Caffeine consumption	M P B		q)	Past marriage(s)/relationship(s)	M P B	
c)	Childishness	M P B		r)	Perfectionist	M P B	
d)	Controlling	M P B		s)	Possessive	M P B	
e)	Defensiveness	M P B		t)	Spends too much money	M P B	
f)	Degrading	M P B		u)	Steals	M P B	
g)	Demanding	M P B		v)	Stubbornness	M P B	
h)	Drugs	M P B		w)	Uncaring	M P B	
i)	Flirts with others	M P B		x)	Unstable	M P B	
j)	Gambling	M P B		y)	Violent	M P B	
k)	Irresponsibility	M P B		z)	Withdrawn	M P B	
l)	Lies	M P B		aa)	Works too much	M P B	
m)	Nicotine/Tobacco use	M P B		bb)	_____	M P B	
n)	Other's advice	M P B		cc)	_____	M P B	
o)	Outside interests	M P B		dd)	_____	M P B	

22) On a scale of 1 to 5 rate the following items as they pertain to: the present state of the relationship; your need or desire for it; and, your partner's need or desire for it.

CIRCLE THE APPROPRIATE RESPONSE FOR EACH. (If not applicable, leave blank.)

		Present State of the Relationship Low High	Your Need or Desire Low High	Partner's Need or Desire Low High
a)	Affection	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
b)	Childrearing rules	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
c)	Commitment together	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
d)	Communication	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
e)	Emotional closeness	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
f)	Financial security	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
g)	Honesty	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
h)	Housework shared	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
i)	Love	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
j)	Physical attraction	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
k)	Religious commitment	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
l)	Respect	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
m)	Sexual fulfillment	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
n)	Social life together	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
o)	Time together	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
p)	Trust	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
	Other (specify):			
q)	_____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
r)	_____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

23) FOR COUPLES LIVING TOGETHER: How is the work shared around the home?

CIRCLE THE APPROPRIATE RESPONSE FOR EACH. (If not applicable, leave blank.)

M = Me, **P** = Partner, **E** = Equal time

				Is this equitable (fair)?	
a) Auto repairs	M	P	E	_____Yes	_____No
b) Child care	M	P	E	_____Yes	_____No
c) Child discipline	M	P	E	_____Yes	_____No
d) Cleaning bathrooms	M	P	E	_____Yes	_____No
e) Cooking	M	P	E	_____Yes	_____No
f) Employment	M	P	E	_____Yes	_____No
g) Grocery shopping	M	P	E	_____Yes	_____No
h) House cleaning	M	P	E	_____Yes	_____No
i) Inside repairs	M	P	E	_____Yes	_____No
j) Laundry	M	P	E	_____Yes	_____No
k) Making bed	M	P	E	_____Yes	_____No
l) Outside repairs	M	P	E	_____Yes	_____No
m) Recreational events	M	P	E	_____Yes	_____No
n) Social activities	M	P	E	_____Yes	_____No
o) Sweeping kitchen	M	P	E	_____Yes	_____No
p) Taking out garbage	M	P	E	_____Yes	_____No
q) Washing dishes	M	P	E	_____Yes	_____No
r) Yard work	M	P	E	_____Yes	_____No
s) Other _____	M	S	E	_____Yes	_____No
t) Other _____	M	S	E	_____Yes	_____No

24) In the remaining space please provide additional information that would be helpful:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I, _____, hereby give my permission for _____ to share the information that I provide on this form to _____ (partner) when it is deemed appropriate by an agreement between my partner, our provider, and me. This sharing of information may take place only during a joint counseling session (both partners present).

_____ _____

Patient's Signature Date

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PATIENT CONTACT INFORMATION

Please print carefully:

PATIENT INFORMATION

Name (First Name, Middle, Last) _____
Date of Birth _____
Gender _____
Refer to patient as? _____
Social Security Number _____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient _____
Name (First Name, Middle, Last) _____
Date of Birth _____
Gender _____
Social Security Number _____

Billing Address 1 _____
Billing Address 2 _____
City, State, Postal Code _____

CONTACT INFORMATION (Primary Phone will be called first)

Primary Phone Number _____
Type (cell, home, etc.) _____
Secondary Phone Number _____
Type (Mom's work, etc.) _____
Email Address _____
Type (patient, work, etc.) _____

EMERGENCY CONTACT INFORMATION

Relationship to Patient _____
Name (First and Last) _____
Primary Phone Number _____
Type (Cell, home, work, etc.) _____
Email Address _____
Type (personal, work, etc.) _____

PRIMARY CARE PHYSICIAN

Name (First Name, Middle, Last) _____
Phone Number _____

PHARMACY

Name _____
Address/ZIP _____
Phone Number _____

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PATIENT ACKNOWLEDGMENTS AND AUTHORIZATION

Print Patient's Full Name: _____

Date of Birth (mm/dd/yyyy): _____

Please *initial* each line and sign at the bottom of the page.

_____ I acknowledge receipt of *Patient Forms Checklist*.

_____ I authorize Affiliates in Clinical Services (ACS) to evaluate and provide treatment as appropriate and I have legal responsibility to do so.

_____ I acknowledge receipt of the *HIPAA Privacy Notice*, and agree to the contents.

_____ I acknowledge receipt of *Payment Contract for Services* and agree to the contents.

_____ I acknowledge receipt of *Provider-Patient Services Agreement Informed Consent,* and agree to the contents.

_____ I acknowledge copy of any signed form will be considered as an original.

_____ I acknowledge I will be charged a No Show/Late Cancelation Fee for appointments not canceled one business day in advance.

_____ I acknowledge standing appointments will be removed after three (3) missed appointments and will be rescheduled based on availability.

_____ I acknowledge the above and that I have had the opportunity to ask any questions considering ACS policies and practices.

_____ _____
Printed name Relationship to patient

_____ _____
Signature Date

_____ _____
Form received by Date

Affiliates in Clinical Services Coordination of Care Form

Patients: With your permission, this information will be forwarded to your healthcare provider.

Practitioner/Provider Information		Patient Information
Provider/PCP Name		Patient Name
Contact Person for Provider		Responsible Party Name
Phone	Fax	Patient Date of Birth

Patient's Release of Personal Health Information (PHI)	
From (Provider Name) Affiliates in Clinical Services	To (Provider Name)
Member's Signature	Date of Member's Signature

Expiration: I understand that I may cancel this authorization at any time by sending my healthcare provider(s) my cancellation notice in writing. I understand that my healthcare provider(s) may have already released records according to this authorization, prior to receiving my written notice to cancel. Unless cancelled, this authorization expires on (date) _____.

If Member Does Not Authorize Release of PHI	
I **do not** authorize information about my physical and/or behavioral health treatment to be released.	
Member's Signature	Date of Member's Signature

You are not required to share this information. Please check this box if the reason you are not releasing information is because you do not have a primary care provider: ☐ Thank you.

Information to Be Released

The only information this Coordination of Care Form authorizes for release is this one-page Notification of Treatment, including the information below. No additional records will be released without a signed Authorization for Release of Information.

Healthcare Coordination Information to be completed by treating provider	Medications, If Known	Dosages
Treatment Start Date:	1.	
	2.	
Medication Managed by:	3.	
	4.	
ICD-10-CM:	5.	
	6.	
Treatment Plan:		

Confidential Protected Health Information (PHI) enclosed*. PHI is personal and sensitive information related to a person's healthcare. It is being delivered to you after appropriate authorization from the patient/member or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.*

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PAYMENT CONTRACT FOR SERVICES

Please read the following carefully:

FOR PATIENTS WHO DO NOT HAVE INSURANCE

- Patients who do not have any insurance coverage are expected to pay for services rendered at the time of check-in for the visit.
- For those that qualify due to financial hardship, there may be a reduced fee available (Sliding Scale) or a payment plan. Services would be paid for in advance, not after the fact.

FOR PATIENTS WHO ARE CURRENTLY COVERED BY INSURANCE

- The patient is responsible to provide us with valid health insurance information, and should bring insurance card to each visit.
- If insurance coverage changes for existing patients and we are not informed prior to the visit, the patient will be financially responsible for all visits billed to an incorrect insurance company or plan.
- Our office participates with numerous insurance companies and managed health care programs. We will submit electronic claim forms to primary insurances, secondary insurances, and out of network insurance plans.
- We will not submit paper claim forms.

*If the provider is **"in network":***

- The patient is responsible to ensure that any required referrals for treatment are provided to the office prior to the time of check-in for the visit. Intakes may be rescheduled or the patient may assume financial responsibility for the visit if prior authorization is not obtained.
- The patient is financially responsible for any co-payment or portion of the charges as specified by the plan at the time of check-in for the visit. This includes any individual or family deductible amounts according to the plan.
- Any services not covered by the plan are the patient's financial responsibility and payment in full is due at check-in for the visit. For specific coverage issues call the insurance company's member services department (telephone number on insurance card).
- If patient receives reimbursement directly from insurance company in error, the benefits have been assigned to the provider and the check and Explanation of Benefits (EOB) should be forwarded to us immediately to prevent double billing.

*If the provider is **"out of network"**:*

- If a patient has insurance and the provider is "out of network" we will submit an electronic claim form, but services must be paid in full at the time of check-in for the visit.
- If patient payment is made and the insurance company pays us for the claim for out of network benefits, a refund will be issued to the patient based on the "Explanation of Benefits" from the insurance company.

OTHER

- We reserve the right to charge for completion of forms.
- Any outstanding patient balance not under a payment plan will be referred to an outside collection agency or small claims court for payment.
- Any cost of collection will be added to the patient account balance.
- Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and are receiving treatment, you are responsible for payment of the service. We will not bill any other personal party.
- Regardless of any personal arrangements that a patient might have outside of our office, for minor patients with parental financial agreements, the accompanying parent or responsible party must pay for services at time of check-in for that visit.
- Patients with outstanding balances not under a payment plan will not be seen until balance paid in full or under a substantial repayment plan.
- There will be a $25.00 service charge for returned checks in addition to our bank charges for processing the returned payment item.

COORDINATION OF BENEFITS

- If patient does not have insurance benefits or has only primary insurance, coordination of benefits is not an issue.
- If patient has Medicare coverage and secondary insurance benefits, the patient is responsible to notify the office of such coverage and if Medicare is Primary or Secondary.
- If patient has secondary coverage, the patient is responsible to notify the office of such coverage and which is Primary and which is Secondary and obtain any and all prior authorizations required prior to the visit.
- If information is not provided or improper information is provided, the patient is financially responsible for all services.

HIPAA PRIVACY NOTICE

This Health Insurance Portability and Accountability Act (HIPPA) 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. Effective Date is April 14, 2003. Affiliates in Clinical Services (ACS) protects the privacy of your health information and follow state and federal laws. This notice tells you about privacy rights and what we may do with your health information.

Health Information Rights

- Right to Inspect and Copy: You have the right to see and have a copy of the health information ACS has about you. It will not include information needed for civil, criminal, administrative actions and proceedings, or psychotherapy notes.
- Right to Request an Amendment: If you feel the health information we have about you is wrong or incomplete, you may ask us in writing to fix the information. We may say no to your request if it is not in writing and it does not include a reason, or the information was not created by us, or the information is not determined to be correct and complete.
- Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures", a list of the names we gave your health information to, other than disclosures for purposes of treatment, payment, or operations. Your request must not go back more than six years and must not include dates prior to April 14, 2003.
- Right to a Paper Copy of this Notice: You have the right to ask for a paper copy of this notice. You may also print a copy of this notice from our website.

Requests or questions must be made in writing to: Affiliates in Clinical Services, 305 Roseberry Street, Suite 8. Phillipsburg, NJ 08865.

How ACS may use and disclose health care information

Your health information may be used and given by ACS for treatment, payment and operational needs. ACS provides many services; therefore, not all types of uses and releases can be given in this notice. We have listed below some common ways that are allowed for uses and releases.

- For Treatment: Caregivers, such as nurses, doctors, therapists and social workers may use your health information to determine your plan of care. Individuals and programs within ACS may share health information about you to manage your services.
- For Payment: ACS may give information about you to your health plan or health insurance carrier to pay for your services. We may also share your information with other government programs such as Workers' Compensation, Medicare, or Indian Health Services in order to better manage your benefits and payments.
- For Operations: ACS may use and give information about you to make sure that the services and benefits you get are correct and high quality. We may share your health information with business partners who perform work for ACS. ACS requires that our business partners use the same level of privacy and security as we do when handling your health information.
- To Other Government Agencies Providing Benefits or Services: ACS may give your health information to other government agencies that are providing you with benefits or services when the information is necessary for you to receive those benefits and services.
- For Health Oversight Activities: ACS may share your health information with other divisions within the agency and with other agencies for oversight activities as required by law. Examples of these oversight activities include audits, inspections, investigations and licensure.
- For Law Enforcement: ACS may give health information to a law enforcement official, subject to applicable federal and state law and regulations, for purposes that are required by law or in response to a court order or subpoena.
- Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, ACS may give health information about you in response to a court or administrative order. We may also give health information about you in response to a subpoena, discovery request, or other lawful process.
- To Coroners, Medical Examiners and Funeral Directors: ACS may release health information to a coroner, medical examiner or funeral director, as necessary to carry out duties as authorized by law.
- To Avert a Serious Threat to Health or Safety: ACS may give your health information if it is necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person.
- To the Military: If you are a veteran or a current member of the armed forces, ACS may give your health information as required by military command or veteran administration authorities.
- As Required By Law: We will give health information about you when required to do so by federal, state or local law.

State and Federal laws require ACS to maintain the privacy of your health information and to give you this notice of our legal duties and privacy practices. By law, we will follow the terms of this notice. ACS has the right to change this notice. We keep the right to make any changed notice effective for the health information we already have about you, as well as any information we create or get in the future. We will give you a copy of any new notices within 60 days. We will also post a copy of the current notice.

If you believe your privacy rights have been violated, you may file a complaint by writing to Secretary of Health and Human Services, 200 Independence Avenue, SW, Washington, D.C. 20201, or call toll free 877-696-6775. You need to do this within 180 days of when the problem that caused concern happened. There will be no punishment for filing a complaint.

AFFILIATES IN CLINICAL SERVICES, PC
305 Roseberry Street, Suite 8
Phillipsburg, NJ 08865-1600
(908) 454-7244 – Fax (908) 859-2109

DIRECTIONS TO OUR OFFICE

Coming from the East (NJ), going west on Route 78:

- Take the last NJ exit (Exit 3) for Phillipsburg, Route 22
- Follow directions Coming from the East on Route 22 below

Coming from the East on Route 22:

- Follow Route 22 West following signs to Hospital
- Passing on the right Toby's Hotdogs and Dunkin Doughnuts
- Take the turn before next traffic light onto Roseberry Street
- At stop sign, bare right to traffic light and go through light
- After traffic light our building is on the right (across from Church), one story brick building, Attorneys Winegar, Wilhelm, Glynn, and Roemersma
- Turn right at corner of Corliss Avenue (if you pass St. James and St. Phillips's school sign, you went too far)
- Turn right into our parking lot
- Our entrance is a single glass door at the right of the building
- At the end of the first hallway is our waiting room, Suite 8

Coming from the West (PA) going East on Route 22:

- Cross the toll bridge into Phillipsburg, staying on Route 22 East (stay in right lane), passing: McDonalds, Exxon, AutoZone Auto Parts
- Take the U-turn to Roseberry Street after AutoZone Auto Parts
- At the Stop sign make a right, stay in the right lane
- Go through two stop lights, our building is on the right (across from Church), one story brick building Attorneys Winegar, Wilhelm, Glynn, and Roemersma
- Turn right at corner of Corliss Avenue
- Turn right into our parking lot
- Our entrance is a single glass door at the right of the building
- At the end of the first hallway is our waiting room, Suite 8