



Date: _____ Email address: _____

Home Phone: _____ Cell Phone: _____

Name: _____, _____
(Last) (First)

Address: _____

City: _____ State: _____ Zip: _____

Birth date: _____ SSN: _____ Gender: M or F (circle)

Marital Status: (circle) Single Married Divorced Separated Widowed Registered Partnership

Employer: _____

Employer Address: _____

Occupation: _____ Work Phone: _____

IS THIS VISIT RELATED TO MVA OR WORKERS COMP? (Circle) Yes or No

If yes, what is the date of injury? _____

Insurance: _____

Claim Address: _____

Claim #: _____

Adjustor: _____ Phone: _____

PRIMARY INSURANCE: _____

Claims Address: _____

Subscriber's Name: _____ DOB: _____

ID#: _____ Group#: _____

SECONDARY INSURANCE: _____

Claims Address: _____

Subscriber's Name: _____ DOB: _____

ID#: _____ Group#: _____

How Did You Hear About Us? _____

Primary Doctor: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

PHARMACY INFORMATION

Pharmacy: _____ Phone: _____

Address: _____

Mail Order Pharmacy: _____ Phone: _____

Address: _____

CONSENT FOR EXTERNAL PRESCRIPTION HISTORY

I, the undersigned, hereby authorize New Jersey Sports Medicine to receive all external prescription history from my pharmacy. This information is required by the practice to obtain in order to appropriately prescribe any medications to the patient in the future.

Patient Signature: _____

Date: _____

ASSIGNMENT OF BENEFITS

****Please complete this section if we take your insurance****

I, the undersigned, hereby authorize the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependants. I further agree to acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____
(Name of Insured) (Name of Insurance)

to pay and hereby assign directly to New Jersey Sports Medicine LLC all benefits, if any, otherwise payable to me for services provided. I understand that I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to New Jersey Sports Medicine LLC will be credited to my account, in accordance with the above said assignment.

(Signature of Insurance Subscriber or Patient) DATE: _____

NEW JERSEY SPORTS MEDICINE, LLC

Notice of Privacy Practices Notice and Designation of Disclosure

Patient Receipt Acknowledgement

I, _____ acknowledge that I have received the Notice of Privacy Practices. I have been given the opportunity to ask questions about this notice and to request additional restrictions of the Practice's use and disclosure of my individually identifiable health information, or request additional confidential treatment of communications between the Practice and myself or others.

Signature of Patient/Parent/Guardian

Date

Witness

Relationship

I wish to be contacted in the following manner (check all that apply)

A. Home/Cell Telephone (Circle one)

- OK to leave a message with detailed information
 Leave message with a call back number only

B. Written Communication

- OK to mail to home
 OK to mail to work/office
 OK to fax to: _____

C. Work Telephone

- OK to leave a message with detailed information
 Leave message with a call back number only

D. Other: _____

- OK to leave a message with details
 Leave message with call back # only

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that NJSM may disclose certain health information to a family member, close personal friend, or other caregiver because such person is involved with my healthcare or payment relating to my healthcare. In that case, NJSM will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of NJSM making the limited disclosures described above. I understand that I am not required to list anyone, and that I may change this list at anytime in writing. I also understand this form is only valid for one year from the date signed.

Printed Name: _____ Relation: _____

Printed Name: _____ Relation: _____

Printed Name: _____ Relation: _____

Signature of Patient/Parent/Guardian

Date

NEW JERSEY SPORTS MEDICINE, LLC

PAYMENT POLICY

Thank you for choosing our practice. It is our goal to provide you with quality and affordable health care. In order to avoid any confusion regarding our policies and your responsibility for services rendered, we have set forth below our payment policy. Please read it, ask any questions you may have and then sign in the space provided below.

Copayments and Deductibles: All copayments (deductibles) must be paid in full by you at the time services are rendered.

Patients without Insurance: If you do not have any type of health insurance you will be required to pay in full for services rendered at the time services are rendered.

Methods of Payment: We accept payment in the form of cash, check, or credit card. We accept Visa, Mastercard, Discover and American Express. For larger out of pocket expenses, New Jersey Sports Medicine also accepts healthcare credit cards that offer convenient finance options to patients. More information on these healthcare credit cards are in the waiting room or you can ask the office manager.

Insurance, Noncovered Services: We participate in some insurance plans. Please speak to us to determine whether we participate in your insurance plan. It is your responsibility to notify us if your insurance changes. We will bill your insurance company as a courtesy to you, however, you may be required to supply additional information directly to your insurance company. Any portion of our fee that is not paid by your insurance company remains your responsibility. Your insurance benefit is a contract between you and your insurance company and we are not a party to that contract. Additionally, certain services provided by us may not be covered by your insurance or may not be considered reasonable or necessary by your insurance company. In such event, you are responsible for payment for such services.

Minors: If a patient is younger than 18 years of age, a parent or guardian must be responsible for payment of services in accordance with these policies.

Missed appointments: We reserve the right to charge \$25.00 for missed appointments not canceled more than 24 hours in advance. This charge is your responsibility and will be billed directly to you. Your insurance company will not pay for this charge.

Returned Checks: Checks that are returned from the bank for any reason will be charged a \$30 returned check fee in addition to the amount that you owe. If your check is returned from the bank for any reason in the future you must pay by cash or credit card.

Proof of Insurance: You must complete a patient information form before services are rendered. We are required to obtain a copy of your driver's license and current valid insurance card.

Referrals: Your insurance plan may require that you obtain a referral for our services at or prior to the time services are rendered. It is your responsibility to know if your insurance company requires a referral and you must obtain the referral prior to your appointment. Many primary care physicians' offices will not issue a referral if not given 24-72 hours. We will accept a faxed referral, but some primary care physicians will not fax a referral as per their own office policy. If you do not bring a valid referral, you may pay for services rendered and submit a claim to your insurance company for reimbursement. However, it is possible that your insurance company will not reimburse you. In the alternative, you may reschedule your appointment.

Authorizations: Authorizations for outside diagnostic tests such as MRI, x-rays, etc. may be obtained by our office staff. However, insurance companies do not guarantee coverage or payment of these services. The patient is responsible for contacting their insurance company to dispute if coverage or a claim is denied for these services.

Medical Records; Completion of Forms: If you require copies of your medical records, you must submit a request in writing. We may charge a reasonable copying fee. If we are requested to complete any forms for you (i.e. - forms from patient's insurance carriers, employer, etc.) we charge \$10 per page. This excludes DMV handicap parking certificates and forms for disability. Payment is required at the time forms are submitted to us.

Past due balances: Past due balances are due at the earlier of your next office visit or the end of the month. Our billing company, Resolutions, will send you a statement so that you are aware of the amount that you owe. You must make a payment of at least 50% of your past due balance before your next office visit or at the time of your next scheduled office visit. This does not include that day's fee-for-service which must also be paid that same day. If you do not make any effort to pay your past due balance of \$50 or more and >120 days old; we may refer your account to a collection agency and you will be responsible for all collection expenses and attorney fees. We may also not be willing to provide future services except on an emergency basis for a previously treated injury or problem.

Alternative arrangements: Other payment arrangements must be discussed with our Practice Administrator. If an agreement is made, it will be put forth in writing and signed by you.

Questions: New Jersey Sports Medicine, LLC utilizes an outside billing company for our billing purposes. The staff at NJSM is not responsible for submitting claims to your insurance company. If you have a billing question or question regarding a statement received, you may call Resolutions Billing Company at 1-877-632-9292.

I have read and understand the above payment policy and accept the terms and conditions.

Patient Signature

Date

Witness

Date

NEW JERSEY SPORTS MEDICINE HISTORY AND PHYSICAL

Please be as thorough as possible when filling out the information asked on the following 4 pages. All of the information asked is vital to your care in this office. It will help us to better understand your prior medical history, conditions, and previous treatments so that the staff and physicians can better determine the best course of treatment for you.

Name: _____ Sex: _____ Age: _____

Handedness: Right or Left

Primary Care Physician (PCP): _____

What's the reason for this visit? _____

Complaints/Symptoms: _____

Precipitating Event: _____

Date of Onset: _____

Pain Intensity (0-10 scale) - Average pain: (0- no pain, 10 worst) _____

What makes your pain worse? _____

What makes your pain better? _____

Other symptoms (weakness, numbness, tingling, etc.) _____

Previous Tests (X-rays, CT scans, MRI's, Bone scans, EMG) Please give approximate dates and results if known:

Prior Treatments:

Medications: _____

Any relief? _____

Therapy (PT/OT, etc.): _____

Any improvement? _____

Bracing Used? _____

Procedures (injections, surgery): _____

Any improvement? _____

Name: _____

Your Past Medical History (circle):

High Blood Pressure	Diabetes Mellitus	Cardiac Disease (Type: _____)
Peripheral Vascular Disease	Stomach Ulcers	Depression/Anxiety Psychiatric
Thyroid Disease	Cancers Type: _____	Stroke Osteoporosis
Joint Disease (Rheumatoid, osteoarthritis, etc.)	Asthma	Substance Abuse Drug: _____

Other: _____

Surgical History:

_____ Appendix
_____ Gall Bladder
_____ Neck or Back surgery (specify) _____
_____ Carpal Tunnel Release
_____ Joint replacements/repairs (specify) _____
_____ Other/please specify: _____

Medications (Please List **All** the **Pills** you are taking):

Anti-inflammatory (NASIDs) (specify) _____
Opioid (specify) _____
Tricyclics (specify) _____
Anticonvulsants (specify): _____
Vitamins/Supplements: _____
Other: _____

*****Allergies/Intolerances to Medications:** _____

Social History:

Alcohol: Yes No How much caffeine do you consume? _____ Cups/day
Smoker: Yes No Quit: _____
Non-prescription Drugs (Marijuana, Cocaine, Vitamins, herbs, etc.) Yes No
Occupation: _____ or on Disability (for how long) _____
Marital status (circle): Single Married Divorced Separated Widowed Partnership
Children: _____

Family History (circle):

High Blood Pressure	Diabetes Mellitus	Cardiac Disease
Peripheral Vascular Disease	Stomach Ulcers	Stroke
Thyroid Disease	Cancers Type: _____	Psychiatric (Anxiety/Depression/Etc)

Joint Disease (Rheumatoid, Osteoarthritis, Connective tissue disease) Osteoporosis

Functional History (circle):

Activities of Normal Daily Life: Independent Need Assistance Dependent on Help
Difficulty walking Yes No Difficulty Sleeping Yes No
Transfers Problems Yes No
Assistance Equipment (i.e., cane, walker, tub bench, etc.) _____
Do you exercise routinely (circle): Yes No
Type of Exercise: _____ Frequency: _____

Name: _____

Review of Systems- Do you have any of the following:
 (Please indicate YES or NO).

• Constitutional

Generally Good Health Yes No
 Recent Weight Change Yes No
 Fever Yes No
 Fatigue Yes No
 Headaches Yes No

• Eyes

Eye disease or Injury Yes No
 Wear Glasses/Contact Lenses Yes No
 Blurred Vision/Double Vision Yes No
 Glaucoma Yes No

• Ears/Nose/Throat

Hearing Loss or Ringing Yes No
 Chronic Sinus Problems/Rhinitis Yes No
 Nose Bleeds Yes No
 Mouth Sores Yes No
 Bleeding Gums Yes No
 Bad Breath or Bad Taste Yes No
 Sore Throat or Voice Change Yes No
 Swollen Glands in Neck Yes No

• Cardiovascular

Heart Trouble Yes No
 Chest Pain or Angina Yes No
 Palpitations Yes No
 Shortness of Breath w/Walking Yes No
 Shortness of Breath w/Lying Flat Yes No
 Swelling of Feet/Ankles/Hands Yes No

• Respiratory

Chronic or Frequent Coughs Yes No
 Spitting Up Blood Yes No
 Shortness of Breath Yes No
 Asthma or Wheezing Yes No

• Gastrointestinal

Loss of Appetite Yes No
 Change in Bowel Movements Yes No
 Nausea or Vomiting Yes No
 Frequent Diarrhea Yes No
 Painful Bowel Movements Yes No
 Constipation Yes No
 Rectal Bleeding Yes No
 Abdominal Pain or Heartburn Yes No
 Stomach Ulcer Yes No

• Genitourinary

Frequent Urination Yes No
 Burning or Painful Urination Yes No
 Blood in Urine Yes No
 Change in Force or Straining w/Urinating Yes No
 Incontinence or Dribbling Yes No
 Kidney Stones Yes No
 Sexual Difficulty Yes No
 Male- Testicle Pain Yes No
 Female- Pain w/Periods Yes No
 Female- Irregular Periods Yes No
 Female- Vaginal Discharge Yes No
 Female #Pregnancies _____ #Miscarriages _____
 Female- Date of Last Pap Smear _____

• Musculoskeletal

Joint Pain Yes No
 Joint Stiffness or Swelling Yes No
 Weakness of Muscles or Joints Yes No
 Muscle Pain or Cramps Yes No
 Back Pain Yes No
 Cold Extremities Yes No
 Difficulty Walking Yes No

• Integumentary

Rash or Itching Yes No
 Change in Skin Color Yes No
 Change in Hair or Nails Yes No
 Varicose Veins Yes No
 Breast Pain Yes No
 Breast Lump Yes No
 Breast Discharge Yes No

• Neurologic

Frequent or Recurrent Headaches Yes No
 Lightheaded or Dizzy Yes No
 Convulsions or Seizures Yes No
 Numbness/Tingling Sensations Yes No
 Tremors Yes No
 Paralysis Yes No
 Stroke Yes No
 Head Injury Yes No

• Psychiatric

Memory Loss or Confusion Yes No
 Nervousness Yes No
 Depression Yes No
 Insomnia Yes No

• Endocrine

Glandular or Hormone Problems Yes No
 Thyroid Disease Yes No
 Diabetes Yes No
 Excessive Thirst or Urination Yes No
 Heat or Cold Intolerance Yes No
 Skin becoming Dryer Yes No
 Change in Hat/Glove Size Yes No

• Hematologic/Lymphatic

Slow to Heal after Cuts Yes No
 Bleeding or Bruising Tendency Yes No
 Anemia Yes No
 Phlebitis Yes No
 Past Blood Transfusion Yes No
 Enlarged Glands Yes No

Doctor Reviewed: _____

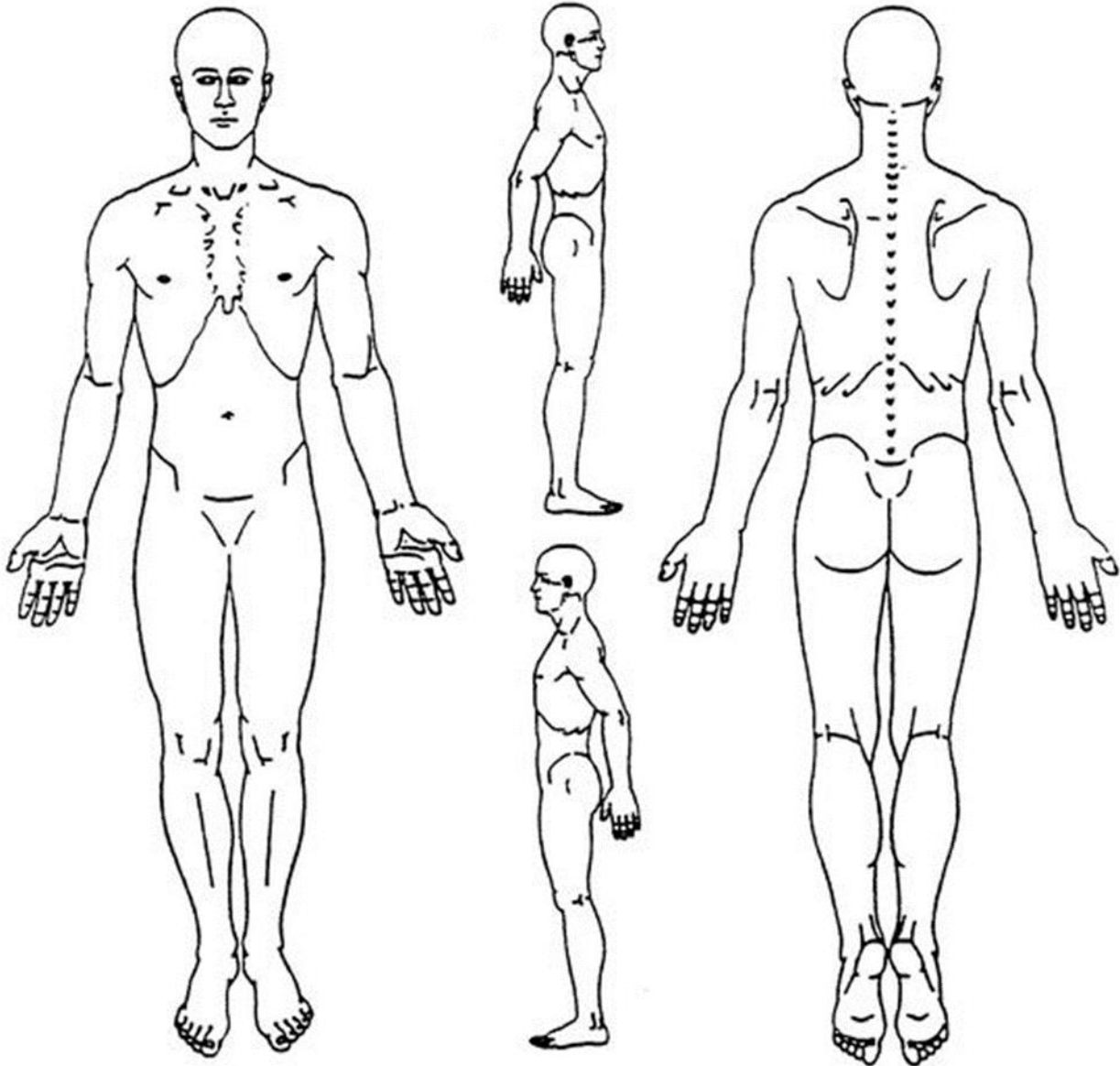
Date: _____

Name: _____

PAIN DRAWING

Using the symbols given below, mark the area on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
△△△△	=====	○○○○○	XXX	/////



Doctor Reviewed: _____ Date: _____

NOTICE OF PRIVACY PRACTICES NEW JERSEY SPORTS MEDICINE LLC

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.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability & Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This Notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our Practice except when the release is required or authorized by law or regulation.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE - You will be asked to provide a signed acknowledgment of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information in accordance with law.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION - "Protected health information" is individually identifiable health information and includes demographic information (for example, age, address, etc.), and relates to your past, present or future physical or mental health or condition and related health care services. Our Practice is required by law to do the following: (1) keep your protected health information private; (2) present to you this Notice of our legal duties and privacy practices related to the use and disclosure of your protected health information; (3) follow the terms of the Notice currently in effect; (4) post and make available to you any revised Notice; and (5) notify affected individuals following a breach of unsecured protected health information. We reserve the right to revise this Notice and to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. The Notice's effective date is at the top of the first page and at the bottom of the last page.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Required Uses and Disclosures - By law, we must disclose your health information to you unless it has been determined by a health care professional that it would be harmful to you. Even in such cases, we may disclose a summary of your health information to certain of your authorized representatives specified by you or by law. We must also disclose health information to the Secretary of the U.S. Department of Health and Human Services (HHS) for investigations or determinations of our compliance with laws on the protection of your health information.

Treatment - We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we may disclose your protected health information from time-to-time to another physician or health care provider (for example, a specialist, pharmacist or laboratory) who, at the request of your physician, becomes involved in your care. In emergencies, we will use and disclose your protected health information to provide the treatment you require.

Payment - Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities we may need to undertake before your health care insurer approves or pays for the health care services recommended for you, such as determining eligibility or coverage for benefits. For example, obtaining approval for a surgical procedure might require that your relevant protected health information be disclosed to obtain approval to perform the procedure at a particular facility. We will continue to request your authorization to share your protected health information with your health insurer or third-party payer.

Health Care Operations - We may use or disclose, as needed, your protected health information to support our daily activities related to providing health care. These activities include billing, collection, quality assessment, licensing, and staff performance reviews. For example, we may disclose your protected health information to a billing agency in order to prepare claims for reimbursement for the services we provide to you. We may call you by name in the waiting room when your physician is ready to see you.

We will share your protected health information with other persons or entities who perform various activities (for example, a transcription service) for our Practices. These business associates of our Practice are also required by law to protect your health information. We may use or disclose your protected health information as necessary to contact you in order to raise funds for our Practice. We do not sell protected health information.

Required by Law - We may use or disclose your protected health information if law or regulations requires the use or disclosure.

Public Health - We may disclose your protected health information to a public health authority who is permitted by law to collect or receive the information. For example, the disclosure may be necessary to prevent or control disease, injury or disability; report births and deaths; or report reactions to medications or problems with medical products. We may provide proof of immunization without authorization, to your school if (i) the school is required by State or other law to have proof of immunization prior to admission and (ii) we obtain and document your permission or, for a minor, the permission of the parent, guardian or other person acting *in loco parentis* for the individual.

Communicable Diseases - We may disclose your protected health information, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, or other regulatory programs.

Food and Drug Administration - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events; track products, enable product recalls; make repairs or replacements; or conduct post-marketing review.

Legal Proceedings - We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement - We may disclose protected health information for law enforcement purposes, including information requests for identification and location; and circumstances pertaining to victims of a crime.

Coroners, Funeral Directors, and Organ Donations - We may disclose protected health information to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose protected health information to funeral directors as authorized by law. Protected health information may be used and disclosed for cadaver organ, eye or tissue donations.

Research - We may disclose protected health information to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Threat to Health or Safety - Under applicable Federal and State laws, we may disclose your protected health information to law enforcement or another health care professional if we believe in good faith that its 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. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission, including determination of fitness for duty; or to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information, under specified conditions, to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

Workers' Compensation - We may disclose your protected health information to comply with workers' compensation laws and similar government programs.

Inmates - We may use or disclose your protected health information, under certain circumstances, if you are an inmate of a correctional facility.

Parental Access - State laws concerning minors permit or require certain disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State (or, if you are treated by us in another state, the laws of that state) and will make disclosures following such laws.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSION - In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

Individuals Involved in Your Health Care - Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. If you should become deceased, we may disclose your protected health information to a family member or other individual who was previously involved in your care, or in payment for your care, if the disclosure is relevant to that person's prior involvement, unless doing so is inconsistent with your prior expressed preference. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

Right to Inspect and Copy - You may inspect and/or obtain a copy of your protected health information that is contained in a "designated record set" for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that our Practice uses for making decisions about you. This right does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. You will be charged a fee for a copy of your record and we will advise you of the exact fee at the time you make your request. We may offer to provide a summary of your information and, if you agree to receive a summary, we will advise you of the fee at the time of your request.

Right to Request Restrictions - You may ask us not to use or disclose any part of your protected health information for treatment, payment or health care operations. Your request must be made in writing to our Privacy Officer. In your request, you must tell us: (1) what information you want restricted; (2) whether you want to restrict our use or disclosure, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date. If we believe that the restriction is not in the best interests of either party, or that we cannot reasonably accommodate the request, we are not required to agree to your request. If the restriction is mutually agreed upon, we will not use or disclose your protected health information in violation of that restriction, unless it is

needed to provide emergency treatment. You may ask us not to disclose certain information to your health plan. We must agree with that request only if the disclosure is not for the purpose of carrying out treatment (only for carrying out payment or health care operations) and is not otherwise prohibited by law and pertains solely to a health care item or service for which we have been paid out of pocket in full by you or by another person on your behalf other than your health plan. You may revoke a previously agreed upon restriction, at any time, in writing.

Right to Request Amendment - If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

Right to an Accounting of Disclosure - You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment or health care operations as described in this Notice and excludes disclosures made directly to you, to others pursuant to an authorization from you, to family members or friends involved in your care, or for notification purposes. The accounting will only include disclosures made no more than 6 years prior to the date of your request. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this Notice.

Rights Related to an Electronic Health Record - If we maintain an electronic health record containing your protected health information, you have the right to obtain a copy of that information in an electronic format and you may choose to have us transmit such copy directly to a person or entity you designate, provided that your choice is clear, conspicuous, and specific. You may request that we provide you with an accounting of the disclosures we have made of your protected health information (including disclosures related to treatment, payment and health care operations) contained in an electronic health record for no more than 3 years prior to the date of your request (and depending on when we acquired an electronic health record).

Right to Obtain a Copy of this Notice - You may obtain a paper copy of this Notice from us. Please ask the office staff for a copy of this document to be provided to you at any time.

Special Protections - This Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIV-related information, family planning information, mental health information, psychotherapy notes, and substance abuse information. These laws have not been superseded and have been taken into consideration in developing our policies and this Notice. Psychotherapy notes, release of protected health information for marketing purposes or sale of protected health information, are all specifically subject to more strict privacy standards and most uses and disclosures require express authorization from you.

Complaints - If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint. Our Privacy Officer can be contacted at this office or by calling our telephone number 973-998-8301. You may contact our Privacy Officer for further information about our complaint process or for further explanation of this Notice of Privacy Practices.