ANDREA CRONIN
PSYCHIATRIC NURSE PRACTITIONER

Andrea Cronin Family Health PC

200 Katonah Ave Suite 14 B
Katonah NY 10536
(914) 301-7400
Policies and Procedures

Privacy and Release of Information _____ (initials)

Our practice values and upholds the importance of your confidentiality. In addition to your rights as a patient, our practice has duties to protect your confidential information and inform you of changes to protection measures. We are required by law to maintain the privacy of confidential information and provide you with notice of our legal duties and privacy practices with respect to such information. I am required to abide by the terms of this notice currently in effect. There are, however, certain situations in which we must, by law, communicate your confidential information. Here is list of those circumstances:

- We have reason to believe you are a danger to yourself or another person or persons
- We become aware of abuse to child, elder or developmentally disabled person
- We are under court order to release information
- Subpoena of treatment records by an attorney. (We will not immediately release records upon receipt of a subpoena, we will do everything in our power to keep your records private. Usually a court order will be required. You have up to fourteen (14) days to obtain a protective order from the court to avoid disclosure of your records)
- If you are applying for your health insurance benefits, we may be required to provide information to your health plan, including some or all of your patient medical record, in order for them to approve payment. By signing the "Acknowledgement of Policies and Procedures" you consent to release that information to your health plan as applicable.
- If you are party to child custody litigation at any time in the future, the court may order release of information about your treatment.
- In some circumstances, as provided by the state law of New York State, information about your healthcare may be exchanged with other healthcare professionals involved in your treatment.

Disclosure and Confidentiality _____ (initials)

Confidential information may be released for payment and healthcare operations only to health insurance plans and their agents, as well as business associates of the practice. The definition of a health insurance plan does not include life insurance companies, automobile insurance companies, or workers' compensation carriers. These are not covered under HIPAA. If you would like information submitted to one of these companies, an authorization will be required, unless it is already mandated by state or federal law.

The following routine situations necessitate the use of your information:

For Treatment - We may use information about you in order to provide you with proper medical treatment or services. Treatment is when we provide, coordinate, or manage your healthcare and other services related to your

healthcare. An example of treatment is when we consult with another healthcare provider, such as your primary care provider.

For Payment - We may use and disclose information about you so that the treatment and services you receive can be collected from an insurance company, or a third party including a collection agency if necessary to obtain outstanding fees for services. For example, we may give your health insurance plan information about services you received at the practice, so your health insurance can reimburse the services. We may also tell your health insurance plan about a treatment you are going to receive, in order to obtain prior approval or determine if your plan will cover the treatment.

For Healthcare Operations - We may use and share information about you for administrative functions necessary to run the practice and promote quality care. We may share information with business associates who provide services necessary to run the practice, such as transcription companies or billing services. Also, we may permit your health insurance plan or other providers access to your medical records that contain information about you to assist them in improving the quality of service provided to you.

Communicating with You and Others Involved in Your Care - This practice may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. Overall, it is our mission to honor confidentiality of our patients with utmost regard. Information disclosed will be directly relevant to such person's involvement with your care or payment related to your care. In emergencies or other situations in which you are unable to indicate your preference, we may need to share information about you with other individuals or organizations to coordinate your care or notify your family.

Special Circumstances in Release of Private Information _____ (initials)

The following special circumstances necessitate the use of your information:

As Required by Law - We will disclose information about you when required to do so by federal, state or local law. For example, we may release information about you in response to a valid court subpoena.

Health Oversight Activities - We may disclose information to a health oversight agency for activities authorized by law. For example, these oversight activities may include: audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

For Judicial or Administrative Proceedings - If you are involved in a court proceeding, and a request is made for information about the professional services that you have received within our practice and the records thereof, such information may be privileged under state law. We will not release information without the written authorization of you or your legal representative, or in instance of issuance. This may also be the case in the instance of a court subpoena, which requires the provision of such information, which you have been properly notified. In response, you have not opposed the court subpoena within the legally specified format and time frame, or in the instance of the issuance of a court order compelling us to provide Protected Health Information (PHI). This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

To Avert Serious Threat to Health or Safety - We may disclose your confidential mental health information to any person without authorization if we reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual. These disclosures may be to law enforcement officials to respond to a violent crime or to protect the target of a violent crime. For example, threats of harming another individual may be reported to appropriate authorities without your consent.

Worker's Compensation - If you file a worker's compensation claim with certain exceptions, we must make available at any stage of the proceedings, all PHI information in our possession that is relevant to that particular injury in the opinion of the Colorado Department of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.

Public Health Risks - We may disclose information about you for public health activities. These activities generally include, but are not limited to, the following: a. To prevent or control disease, injury, or disability b. To report child abuse or neglect c. To report adult and domestic abuse d. To report reactions to medications or problems with products e. To notify people of recalls of products they may be using f. 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 g. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Law Enforcement - We may release information about you if asked to do so by a law enforcement official: a. In response to a court order, subpoena, warrant, summons, or similar process b. To identify or locate a suspect, fugitive, material witness, or missing person c. If you are suspected to be a victim of a crime, generally with your permission d. About a death we believe may be the result of criminal conduct e. About criminal conduct at the hospital f. In emergency circumstances involving a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

Other uses and disclosures of information not covered by this notice or the laws that apply to our practice will be made only with your written permission. If you provide this practice with specific permission to use or disclose information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that have already been made with your permission and that we are required to retain our records of the care that we provided to you.

Changes to Notices_____ (initials)

We reserve the right to revise or change provisions on this Notice. We will make the new Notice provisions effective for all confidential information we maintain. Our clinic will promptly revise and distribute Notice whenever there is a change to the uses or disclosures, your rights, and our duties, or other privacy practices stated in this Notice. We will mail updates of our notice to all active patients. Patients who are inactive at the time of mailing may receive an updated copy at their next scheduled appointment.

Patient Records_____ (initials)

An electronic record is kept of services you receive in this office. You have a right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected. You may authorize in writing that copies of the record be released to medical providers you designate at no cost and/or may be picked up in person at your expense for a fee, according to charges stipulated by the state law of New York. Under certain circumstances where seeing the record may put a patient or other person at risk, we may redact certain information in the record and/or require that you review the record in consultation with another healthcare provider. You may receive an accounting of non-routine uses and disclosures of your record.

Concerns for Safety_____ (initials)

If as a patient, you are deemed a safety concern for self and/or others or are assessed during evaluation to have declined physically and emotionally to the point that self-care is an issue, it is our legal obligation to inform mental health deputies or officials for further action which may include detainment, treatment in an emergency department or crisis intervention unit or an acute psychiatric inpatient hospitalization. In such events as noted above, your confidentiality and your records will be released to officials and the aftercare facility.

Right to Terminate Treatment_____ (initials)

In certain rare circumstances, our clinic may reserve the right to terminate your treatment at Andrea Cronin Family Health LLC PC. We will immediately notify you if this occurs. In the event of misuse of prescriptions or in the case that your treatment is no longer seen as therapeutic, such that our options are maximized and further rapport and agreement in your care is compromised, then we may terminate our relationship. We will do our best to recommend further referrals. We also reserve the right to terminate your privileges as patient in the event of nonpayment. We will do our best to accommodate any financial difficulties through payment plans if concerns are discussed with us. We also reserve the right to terminate treatment with repeat missed appointments or cancellations not in keeping with our policy.

Payment_____ (initials)

As a patient, you must be aware of current established payment policies. Prior to your established visits, please thoroughly read and acknowledge our established payment guidelines as outlined below. Acceptable methods of payment include credit card, venmo or health savings account. The fee schedule in place for patients making payment directly to the clinic without a third-party payor source (Insurance coverage) is listed on the company website. Fees are subject to change, however, any changes will be communicated to you via notice in the office, on the website and or through discussion. Payment for services is due in full at the time of service. You will be responsible for full amount of payment at the time of your appointment.

Missed Appointments and Late Cancellations_____ (initials)

Failure to keep your scheduled appointment will result in a fee of $50.00 for initial visits and for follow-up visits, unless you cancel at least forty-eight (48) business hours prior to the appointment time. In emergent circumstances, please immediately contact office and if the circumstance is determined to be dire, this fee will be waived. Showing up late (more than 10 minutes) for an appointment may result in cancellation.

ACKNOWLEDGEMENT OF POLICIES AND PROCEDURES AND CONSENT FOR TREATMENT

As a healthcare provider, we are required to make you aware of Andrea Cronin LLC PC policies and procedures. By signing below, you consent to agreement of your rights as a patient and understand that these rights may be limited by certain legal policies implemented to protect your safety, you also understand and agree to all the specified clinic rules and procedures and acknowledge that failure to follow such guidelines on your behalf as a patient may result in termination of your treatment.

Andrea Cronin LLC PC policies and procedures may be subject to change, any changes will be communicated to you via notice in the office, on the website and or through discussion.

I, the patient or patient's legal representative, hereby grant permission for the providers at Andrea Cronin LLC PC to perform such examinations, medical, and therapeutic procedures as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, facsimile, and e-mail for my/the patient's diagnosis, treatment, payment, and healthcare operations.

I am aware that healthcare is not an exact science and that no guarantees or promises have been made to me as to the result of treatment or examination. I understand that there are inherent risks in pharmacologic treatment and that there may be adverse side effects and results that are not anticipated. Hereby, I consent to be treated with knowledge of possible risks and understand that I will be informed of possible adverse effects of pharmacologic treatment when applicable.

I understand and agree to the policies and procedures of New Beginnings Mental Health and consent for treatment:

Patient Signature: _____

Printed Name: _____

Date: _____

_____ Authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Printed Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

2/2020