Suburban **P**sychiatric **A**ssociates, L.L.P.

Adult History & Personal Data Questionnaire

Patient Name: _____

Address: _____

City: _____ State: _____ Zip:_____ Age: _____

Home Phone # _____ Work Phone # _____ Cell Phone #_____

Date of Birth: _____ SS#:_____ Gender: Male Female

Employer / School: _____

Marital Status (check one) Married____ Single____ Separated____ Divorced____ Widowed____

Emergency Contact: _____ Phone: _____

Relationship to Patient:_____

Are you active military or a veteran? Yes _____ No _____ Status _____

Are you here for a work related injury or illness? Yes _____ No _____

Are you here for a car accident or a no fault claim? Yes _____ No _____

Primary Physician: _____

Address: _____ City: _____ Zip:_____

Referring Physician: _____

Address: _____ City: _____ Zip:_____

Therapist/Counselor: _____

Insurance Provider: _____

Main reason for seeking help at this time: _____

_____

_____

Allergies: (Please Circle One) Yes No - If yes, please list allergies (including medications)

_____

_____

_____

WE DO NOT ACCEPT WORKERS COMPENSATION OR NO FAULT CLAIMS

Phone 716.689.3333

85 Bryant Woods South • Amherst, New York 14228
4535 Southwestern Blvd • Bldg 700, Suite 704 • Hamburg, NY 14075

Fax 716.689.9695

Suburban **P**sychiatric **A**ssociates, **L.L.P.**

OFFICE POLICIES

Please familiarize yourself with our office policies. If you have any questions please call during normal office hours which are Monday through Friday from 8:00 a.m. until 5:00 p.m. Our office is open on Saturday from 8:00 a.m. until 2:00 p.m. but the office phone is not on. Office visits are by appointment only and vary according to each practitioner's schedule.

CANCELLATION POLICY

Because the appointment time has been reserved for you, you will be charged for cancellations with less than 24-hours notice, or for a no show A fee of $150.00 will be charged for a new patient missed appointment, or appointment cancelled with less than 24 hours notice will be charged the full cost of the session. ***These charges are not covered by your insurance and are due and payable prior to any further appointments.*** In the event you must cancel and cannot reach the office personnel, please leave a message on the office voice mail system. Our answering machine will date and time your call. You will also receive an automated call reminding you of your appointment and you may cancel your appointment using this automated system. No fee will be charged if your call is received within the above time frame.

PATIENT RECORD FEES

There is a fee of $10.00 for NYS disability forms, as well as for other disability forms that are 1 page or less. More complex forms will be charged up to $25.00, depending on the length and time involved to complete the form.

Your records, if copied, will cost $0.75 per copied page. Records requested by other physicians or health professionals rendering active treatment are free of charge.

Dictated reports by your clinician will incur a charge based on the amount of time spent on producing the document.

Court appearances are charged by the half day and will differ from clinician to clinician.

I have read and understood the above policies.

Patient name: _____

Signature:_____

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EMERGENCY CALLS

For calls that are an emergency during office hours, please ask to speak to the nursing staff. For emergency calls after business hours, please page your doctor. For calls in which you have questions for the doctor that is non- emergent please ask to speak to our nursing staff, who will take a message and notify the doctor of your call. Remember when the doctors are in session with a patient, they cannot be disturbed. Doctors will be told of your phone call in-between patients and calls will be returned either at the end of business day or in-between patients if time allows. If you call the doctor after office hours and your telephone **CallerID** does not accept "Private or Blocked Calls" the doctor may not be able to return your phone call. The doctor may be calling from home or from a cell phone and **WILL NOT** allow the number to be shown. Please **UNBLOCK** your **CallerID** prior to placing your call to the doctor.

PRESCRIPTION POLICY

WE REQUIRE 5 BUSINESS DAYS TO PROCESS YOUR PRESCRIPTION REQUEST.

WE DO NOT ACCEPT PRESCRIPTION RENEWAL REQUESTS FROM PHARMACIES.

ALL PRESCIPTIONS MUST BE ELECTRONICALLY PRESCRIBED PER NYS LAW.

When calling for a prescription refill, or any questions relating to your prescriptions, your call will always go to voicemail. You can call for a prescription refill request 24 hours a day 7 days a week.

If you have been given a prescription for a medication that is regulated by our state government (controlled medications) please be aware that we are required to review your prescribing history via the NYS Physician Monitoring Program prior to refilling your medication. Please be aware that this process may delay your refill.

Take all medications as prescribed. As with all medications, these have been prescribed for you exclusively, based on knowledge of your personal needs and medical background. Sharing these medications is both medically contraindicated and is illegal. Your cooperation is appreciated.

INSURANCE POLICY

CO-PAYS ARE TO BE PAID AT THE TIME OF YOUR APPOINTMENT, PER YOUR INSURANCE CONTRACT.

Co-pays for mental health coverage do vary from one carrier to another, review the back of your insurance card. If you have any questions regarding your co-pays or authorizations, call your insurance carrier.

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Suburban Psychiatric Associates, L.L.P.

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____

Patient's Date of Birth: _____ Patient's SS #: _____

Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

(*To Be Completed by Patient or Patient's Representative)*

I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations, as described in the notice of privacy practices.

_____ _____

Patient's Signature or Signature of Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Lisa M. Peinkofer
Practice Address: 85 Bryant Woods Amherst, New York 14228
Phone: 716.689.3333 • Fax: 716.689.9695 • E-Mail: LisaP@suburbanpsych.org

Suburban Psychiatric Associates, L.L.P.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
For Suburban Psychiatric Associates, LLP

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

- ❒ *The patient refused to sign.*
- ❒ *Due to an emergency situation it was not possible to obtain an acknowledgement.*
- ❒ *We weren't able to communicate with the patient.*
- ❒ *Other (Please provide specific details)*

_____

_____

_____

_____

_____ _____

Employee Signature Date

This form does not constitute legal advice and covers only federal, not state law.

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Limits of Confidentiality

In the event the practice or mental health professional must telephone the patient for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the practice or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the patient (or legal guardian) without identifying the name of the practice. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the practice (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

PLEASE CHECK PLACES WHERE YOU MAY BE REACHED BY PHONE. Include phone numbers and how you would like us to identify ourselves when phoning you.

_____ **HOME** _____ _____ _____ **YES** _____ **No**
Phone number How should we identify ourselves? May we say the practice name?

_____ **WORK** _____ _____ _____ **YES** _____ **No**
Phone number How should we identify ourselves? May we say the practice name?

_____ **OTHER** _____ _____ _____ **YES** _____ **No**
Phone number How should we identify ourselves? May we say the practice name?

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____ _____
Patient's Name (please Print) Patient (or Legal Guardian) Signature Date

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1. Over the last two weeks how often have you been bothered by any of the following problems. Read each item carefully, then place an "X" in the appropriate box.

		Not at all	Several days	More than 1/2 the days	Nearly everyday
		0	1	2	3
A.	Little interest or pleasure in doing things				
B.	Feeling down, depressed, or hopeless				
C.	Trouble falling asleep, staying asleep or sleeping too much				
D.	Feeling tired or having little energy				
E.	Poor appetite or overeating				
F.	Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
G.	Trouble concentrating on things such as reading the newspaper or watching television				
H.	Moving or speaking so slowly that other people could have noticed, Or being so fidgety or restless that you have been moving a lot more than usual				
I.	Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals					

GAD-7

	Over the last two weeks, how often have you been bothered by any of the following problems. (circle the best answer)	Not at all	Several days	More than 1/2 the days	Nearly everyday
1.	Feeling nervous, anxious or on edge	0	1	2	3
2..	Not being able to stop or control worrying	0	1	2	3
3..	Worrying too much about different things	0	1	2	3
4..	Poor appetite or overeating	0	1	2	3
5.	Trouble relaxing	0	1	2	3
6..	Being so Restless that it is hard to sit still	0	1	2	3
7..	Feeling afraid as if something might happen	0	1	2	3

a. Weight loss in the last month ____ lbs.: weight gain ____ lbs.

b. Sex drive ____ decreased ____ increased

c. Withdrawing from others ___ yes ____ no

d. Decreased need for sleep ____ yes ____no

e. Periods of increased energy so others find you different ____yes ____no

f. Recurrent / persistent ideas or thoughts that are unwanted ____ yes ____no

g. Having to repeat the same ritual or action when not necessary i.e. checking washing, etc ____ yes ____no

h. Have you ever tried to cut down on your drinking of alcohol ____ yes ____ no

i. Have you ever been annoyed by others' complaints about your drinking ____ yes ____ no

j. Have you ever felt guilty about your drinking ____ yes ____ no

k. Have you ever taken an 'eye opener' drink ____ yes ____no

l. Have you ever heard voices, or seen things that others don't experience ____ yes ____ no

m. Have you ever believed that others may want to harm you in some way ____ yes ____ no

n. Have you ever had thoughts about harming someone else ____yes ____ no

Have you or anyone that knows you, felt gambling was an issue for you? _____

Any difficulty with excessive snoring, daytime fatigue and low-energy? _____

2. Previous Mental Health Treatment

Year	Problem	Therapist/Location	Hospitalization/Medical Treatment

3a. Medical Information

All Current Medications	Dosage	Schedule	Doctor

3b. Have you ever been diagnosed as having the following: (Please check all that apply to you)

_____ Heart trouble
_____ Ulcers
_____ Seizure disorder
_____ Head injury / L.O.C.
_____ Diabetes
_____ Liver disease
_____ Asthma / Bronchitis
_____ Vascular (circulation) disease
_____ Thyroid disease
_____ Allergies
_____ High blood pressure
_____ Motor vehicle accidents
_____ Special diets
_____ Surgeries (years / procedures)

Date of Last Physical ____/____/____

Explanation of Medical Problems _____

_____

_____

_____

4. Sexual / Reproductive History

a. Sexual dysfunction/difficulties (include fertility problems) _____

_____

b. History of pregnancy (please include miscarriages / abortions) _____

_____

c: Present birth control method _____

d. Menstrual irregularities _____

e. Date of last menstrual period _____

f. Are you presently pregnant? _____

5. Substance Use/Abuse

Please indicate use, if applicable, and frequency of the following:

a. Alcoholic beverages _____

b. Street drugs (heroin, marijuana, diet pills)_____

c. Tobacco _____

d. Caffeine (coffee, tea, soda) _____

6. Background Information (please complete all that apply)

a. Education (highest grade completed, general performance in school, plans for future education _____

_____

_____

b. Employment (current job, problems related to present job, frequency of job changes, future employment goals, any disability)

_____

_____

_____

c. Military Service (branch of service, disciplinary action, service connected disability) _____

_____

_____

d. Legal problems (DWI's, past or present convictions, litigations, etc.) _____

_____

_____

7. Family Background - ages of parents and siblings (indicate if deceased)_____

_____

_____

a. Please list any family members (parents, siblings, extended family) who have had any history of emotional or psychiatric illness, alcohol or substance abuse problems - include deceased members _____

_____

_____

_____

b. Please describe your current marriage or relationship (include length of relationship, occupation, marital problems, and drug, alcohol or emotional problems) _____

_____

_____

_____

c. Children (include names, ages, disabilities, school problems, alcohol, drug or behavior problems) _____

_____

_____

8. Provider Comments - _____

_____

_____

_____

_____

_____

_____

Suburban Psychiatric Associates, L.L.P.

NOTICE OF PRIVACY PRACTICES

Effective 7/1/2013

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 - Following are examples of permitted uses and disclosures of your protected health information. These examples are not exhaustive.

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 timetotime 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. Any such communication will tell you how you may opt out of receiving future fundraising communications from us. We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, emails, phone calls, voicemail messages, text messages or letters.

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 postmarketing 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. Following are examples in which your agreement or objection is required.

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.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION - You may exercise the following rights by submitting a written request to our Privacy Officer. Our Privacy Officer can guide you in pursuing these options. Please be aware that our Practice may deny your request; however, in most cases you may seek a review of the denial.

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 Alternative Confidential Communications You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

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, view or download it electronically at our Practice's website at www.suburbanpsych.org, or, if you agree, by email.

Special Protections This Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIVrelated 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.

CONTACT INFORMATION - Our Privacy Officer is Lisa M. Peinkofer and can be contacted at this office or by calling our telephone number 716-689-3333. You may contact our Privacy Officer for further information about our complaint process or for further explanation of this Notice of Privacy Practices.