ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________ acknowledge that I have reviewed a Copy of Orlando psychiatric associate OPA Notice of Privacy Practices. This Notice describes how Orlando Psychiatric Associates may use and disclose my protected health information and certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. I understand at any time I may request a copy of said notice for my personal records. Also, I have read and understood the Patient Complaint or Grievance Policy. These can be found in the OPA website where I can access it at any time.

____ ________________________

(Signature of patient, or Personal Representative) (Date)

____

(Relationship to Patient)

____ FOR OFFICE USE ONLY

We have made every effort to obtain a written acknowledgement of receipt of our Notice of Privacy Practices from the patient or responsible party but could not be obtained because:

_________ Patient refused to sign.

_________ Due to an emergency situation, it was not possible to obtain a signature.

_________ We were not able to communicate with the patient.

_________ Other: ________________________________

__________________ ____

(Date) (Signature of OPA staff)

HIPAA NOTICE OF PRIVACY PRACTICES

(Effective Date July 14, 2003)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

If you have any questions about this notice, please contact our Privacy officer at 407-851-5121

WHO WILL FOLLOW THIS NOTICE?

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In additions, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you;
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab pharmacy, or other health care provider to whom we may refer you for consultation, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

For Payment: We may use and disclose health information about you so that treatment and services you receive from us may be billed to and payment collected from you, or a third party. For example, we may need to give your plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

Research. Under certain circumstances, we may use and disclose health information about you for research purposes for example; a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of

health information, typing to balance the research needs with patients' need for privacy of their health information .Before we use or disclose health information for research, the project will have been approved through this research approval process; but we may disclose health information about you to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, so long as the health information they review does not leave our facility. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

As Required by Law. We will disclose health information about you when required to do by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the public or another person. Any disclosure, however, would only to be someone able to help prevent the threat.

Military and Veterans. If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Public Health Risks. We may disclose health information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability; . To report births and deaths; . To report child abuse or neglect;
- To report reactions to medications or problems with products; . To notify people of recalls of products they may be using;
- To notify person or organization required to receive information on FDA-regulated products.
- To notify a person who may have been exposed to a disease or may be at risk for contacting or spreading a disease or condition.
- To notify the appropriate government authority if believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information to health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, and licensure. These

activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release health information if asked to do so by a law enforcement official:

- In reporting certain injuries as required by law, gunshot wounds, burns, injuries to perpetrators of crime;
- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person:

- Name and address
- Date of birth or place of birth;
- Social security number;
- Blood type or RH factor;
- Type of injury;
- Date and time of treatment and/or death, if applicable; and - A description of distinguishing physical characteristics.

- About the victim of a crime, if the victim agrees to disclosure or under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct; . About criminal conduct at our facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors. We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release health information about you authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official. We may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with healthcare ;(2) to protect your health and safety or the health and safety others; (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU. You have the following rights regarding health information we maintain about you.

Right to inspect and copy. You have the right to inspect and copy health information that may be used to make decisions about your care. Usually; this includes health and billing records. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to OPA. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the reviewed will not be the person who denied your request. We will comply with the outcome of the review.
Right to Amend: If you feel that health information we have about you is incorrect or incomplete; you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information.

To request an amendment, your request must be made in writing, submitted to OPA, and must be contained on one page of paper legibly handwritten or typed in at least 10 point font size. In addition, you must provide a reason that supports your request for an amend information that:
We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for our practice?
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures. You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your requesting writing to OPA your request must state a time period, which may not be longer than six years and may not include dates before March 31st 2005.The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred. We will mail you a list of disclosures in paper from within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not exceed a total of 60 days from the date you made the request.

Right to Request Restrictions. You have the right to request a restrictions or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. Such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Pain your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a location. For example; you can ask that we only contact you at work or by mail to a post office box. To request confidential communications. You must make your request in writing to OPA. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this notice at any time. However, at the time of first service rendered after April 14th, 2003, it is required that you receive a paper copy. To obtain a copy. Please request it from OPA.

CHANGES TO THIS NOTICE We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page. In the top right-hand corner, the effective date. In addition, each time you register for treatment or healthcare services, we will offer you a copy of the current notice in effect.

COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with, contact our privacy officer. All complaints must be submitted in writing. You will not be penalized for filling a complaint.

OTHER USES OF HEALTH INFORMATION. Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health 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 health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of this Notice

We will request that you sign a separate from or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name, and date. This acknowledgement will be filed with your records.

PATIENT COMPLAINT or GRIEVANCE POLICY

PURPOSE: To establish a mechanism for receiving, acting on and responding to complaints from patients, family members, and/or legal representative regarding treatment or care that is (or fails to be) furnished. Feedback from customers is essential to providing good service.

Policy & Procedure:

A. Any individual has the right to voice complaints and recommendations for changes in policies and services to the Administrator, any member of the organization staff, and/others without threat or use of restraint, interference, coercion, discrimination or reprisal. OPA will investigate all grievances made by the patient or the patients representative regarding treatment or care that is (or fails to be) furnished.

B. Alleged violations/grievances relating to, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse will be reported immediately to the Administrator, fully documented, and dealt with immediately (or same day). Appropriate significant allegations will be reported promptly after the ASC concludes its investigation of the grievance to the state authority or the local authority, or both.

C. Each patient, family member, and /or legal representative shall be informed of the mechanism for filing complaints upon admission, and a description of the mechanism shall be posted prominently.

D. Any person wishing to file a complaint can request a complaint/grievance form from any staff member. These forms are located at the Front Desk. If a form is not desired but rather an individual wishes to file a verbal complaint, they should be directed to the office of the Administrator. If the individual choose to verbally express their concerns to a staff member, it is that staff member's responsibility to document the concern as expressed and take it to the Administrator. All complaints/allegations will be immediately reported to the Administrator.

E. Once the Administrator has received the complaint, he/she shall review and analyze the complaint within 48 hours upon receipt. Upon completing the review, with the assistance of appropriate staff from the department which the complaint refers, appropriate corrective action will be taken where indicated. A report of such grievances will be reported to the governing body.

F. The Administrator will review all complaints within (48) hours of receipt of the complaint. The Administrator will then submit a written response to the individual filing the complaint within (5) business days after the review is complete. The response will contain the name of the contact person, steps taken to investigate the grievance, the result of the grievance process and the date the grievance process was completed. The facility president will arbitrate any disagreement past this first step.

G. Additional sources of assistance, such as Florida Abuse Hotline, Americans with Disability Act (ADA), and FL Disability Rights are available to patients and families, etc. Their telephone numbers are available to you upon request and also listed in the Patient Bill of Rights poster.

H. A summary of the complaint received, findings, and any corrective action taken shall be kept on file in the Administrative office.

Orlando Psychiatric Associates complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race color, national origin, age, disability, or sex.

Patient Complaint/Grievance Form

Our patients should have reasonable expectations of care and services provided to him or her while at Orlando Psychiatric Associates (OPA). OPA intends to make available a way to amend any differences and/or disagreements in the areas of ethical and professional conduct that is fair to the interests of all parties. We are committed to addressing situations when those expectations are not met in a timely, reasonable, and consistent manner.

Our Administration and staff are all available to assist you with completing this form, or filing a formal grievance over the phone at (407-851-5121). Please return this form to: Orlando Psychiatric Associates, ATTN: Complaints, 2345 Sand Lake Rd, Suite 200, Orlando, FL 32809. You may also email us at: info@orlandopa.com

Name: ____ Date: _____________
(Last) (First) (MI)

Address: ____

Telephone: ____

Date of Birth: _________________________ Chart Number: __________________________
(Optional)

DETAILS OF YOUR COMPLAINT

(Please be as specific as possible with the following [1] please state your concern; [2] date of event; [3] time of event; [4] staff member(s) involved, and [5] location of event. Use the other side of this form if you need more room).

____

____

____

____

____

____

Date: _________________________ ____
Signature of Patient or Legal Representative

If Legal Representative, state relationship: ____

THIS SECTION TO BE COMPLETED BY THE REVIEWER

Date Received: ___________________________ Reviewer Name:_____________________________

Reviewer's Comments: ____

____

____

Date patient was notified of resolution by mail to address stated above: ____________________________

Date: OPA Representative Signature:____.

Orlando Psychiatric Associates: 2345 Sand Lake Rd, Suite 200, Orlando, FL 32809 Phone: 407-851-5121 Fax: 407-851-0439
Email: info@orlandopa.com
Website: www.orlandopa.com