New Frontiers Psychiatric S.C and New Frontiers TMS L.C.C

2675 N Mayfair Rd, Suite 400 (414) 763-6910 FAX (414) 763-6911 nfpsychiatric.com

Patient Forms and Disclosures

Thank you for considering New Frontiers Psychiatric for your medical care. Please find included forms for patient intake and regulatory disclosures.

If you are completing this form online through Adobe Sign, all fields marked with a * are mandatory before Adobe will allow form to be sent back to us. A small icon on the TOP RIGHT of the screen allows you to jump to 'Next required field' that needs to be completed.

- General Consent for Treatment
- Authorization for Disclosure of Protected Health Information
- Assignment of Benefits/ Right to Payment Authorization and Release of Information for Payment Form
- Patient Responsibility
- Credit Card Policy and Authorization
- Notice of Privacy Practices and Patient Rights

New Frontiers Psychiatric S.C. and New Frontiers TMS, L.L.C

General Consent for Treatment

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **TODAY'S DATE:** _____

I understand that the term "Facility" in this General Consent for Treatment ("Agreement") is inclusive of New Frontiers Psychiatric S.C. and New Frontiers TMS, L.L.C

1. **CONSENT FOR TREATMENT SERVICES:** I voluntary consent to the services and treatment that may be provided to me by Facility and its employees and contractors ("Health Care Practitioners"). I understand that my treatment is under the direction and supervision of Health Care Practitioners who are responsible for discussing with me the nature of my care, the treatment I will receive and information concerning the benefits of the treatment proposed for me, the way it is to be administered, the expected side effects or risks of the treatment and medications, alternative treatments and the probable consequences of no treatment. I also understand I have the right to participate in the development and implementation of my treatment plan of care with Health Care Practitioners.
   I understand there may be circumstances under which information about me may need to be disclosed or reported including, but not limited to information regarding HIV, TB, viral meningitis, and other diseases that must be reported to organizations such as the Health Department or Center for Disease Control and Prevention. I understand that Facility is obligated by the State of Wisconsin to report any suspicion of child abuse and/or neglect that becomes evident to them. I am aware that the practice of medicine is not an exact science, and I further acknowledge that no guarantees have been made to me as to the results of examinations, treatments or services provided to me by Facility.

2. **STATUS OF HEALTH CARE PRACTITIONERS:** I understand that the Health Care Practitioners providing services to me may be independent providers who are not employees of Facility. I understand that it is the responsibility of Facility personnel to carry out such Health Care Practitioners' instructions but that Facility is not liable for any act or omission when following the instructions of such Health Care Practitioners. I further understand that services provided by some Health Care Practitioners may be a financial responsibility separate and apart from Facility's billing and collections.

3. **RESPONSIBILITY FOR FOLLOW UP CARE:** I understand that I may be released as a patient from Facility before all my problems are known or treated and that it is my responsibility to make arrangements for follow-up care.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS AGREEMENT, I HAVE BEEN PROVIDED AN OPPORTUNITY TO STUDY IT, DISCUSS IT, AND SEEK ADDITIONAL INFORMATION, I HAVE RECEIVED A COPY IF REQUESTED. I CONSENT TO THE TERMS AND CONDITIONS CONTAINED WITHIN THIS DOCUMENT.

This consent shall remain in effect until my termination from all Facility's treatment programs or until replaced by another agreement, but with the understanding that I may revoke consent to treatment at any time by providing a written revocation.

_____ _____ _____

Patient Signature | Home Phone | Cell Number

_____ _____ WI _____

Street Address | City | State | Zip

If form being completed by someone other than the patient:

Legal Guardian / Guarantor Signature: _____
(Legal Guardian Signature if Patient under 18 year)

_____ _____ _____

Relation to Patient | Printed Name | Phone Number

Authorization for Disclosure of Protected Health Information

PLEASE COMPLETE ALL SECTIONS ON THE FORM OR WE CANNOT DISCLOSE INFORMATION

NOTE: Federal and state law permit disclosure of a patient's protected health information from general medical and mental health care records ("Health Records") for treatment, payment and health care operations purposes without a patient's authorization. This form does not need to completed with respect to such disclosures.

I authorize New Frontiers Psychiatric, S.C. and New Frontiers TMS, L.L.C. (each, the "Facility") to:
Disclose to and obtain from

1. PATIENT INFORMATION:

PATIENT NAME | PATIENT DOB | TODAY'S DATE

STREET ADDRESS

CITY | STATE (WI) | ZIP CODE

HOME PHONE | CELL PHONE

2. NAME RELEASE TO / OBTAINED FROM:

AGENCY/FACILITY/PERSON | RELATIONSHIP TO PATIENT

STREET ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE NUMBER | FAX NUMBER

3. SPECIFY THE INFORMATION TO BE DISCLOSED EITHER VERBALLY OR IN WRITING:

THE FOLLOWING INFORMATION CONTAINED IN MY HEALTH RECORD: *(Check all that apply.)*

- ☑ Psychiatric and Psychological Evaluations/Findings
- ☑ Medications
- ☑ History and Physical/ Medical Evaluation
- ☐ Discharge Instructions and Summary
- ☑ Verbal and Written 2 Way Communications
- ☐ Psychosocial Assessment (PSA)
- ☐ Educational Planning Information
- ☑ Other
- ☐ Legal Status/Court Records
- ☐ Treatment Plans
- ☐ Diagnostic Test

MY ENTIRE HEALTH RECORD FOR THE FOLLOWING DATE(S) OF SERVICE FROM _____ **TO** Present

I understand this disclosure may include health records related to STDs or genetic testing unless I indicate otherwise. For continuing care purposes, an Abstract will be sent including Discharge Summary, Psychiatric Findings, History &Physical, Consultations, Medications, Personal Recovery Plan (Discharge Instructions) and Diagnostic tests (Lab, X-ray, EKG) if performed.

THE FOLLOWING INFORMATION WILL NOT BE RELEASED UNLESS SPECIFICALLY CHECKED BELOW:

☐ **HIV test results** ☐ **Sexually transmitted diseases** ☐ **Genetic Testing**

4. RELEASE VIA: ☐ US MAIL ☑ FAX ☐ SECURE EMAIL ☐ PICK UP

5. EXPIRATION: This authorization expires on _____ *(insert date, time period or event)*. Unless otherwise designated, this authorization will expire at midnight one year from the date of my signature below.

6. PURPOSE OF DISCLOSURE: *(Check all that apply.)* ☐ Continuing care ☐ Insurance eligibility/payment of claims ☐ Personal reasons ☐ Verify compliance with treatment ☐ Other: _____ *(Specify purpose)*

7. YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I authorize the release of copies of the Health Record described above. I understand that I may revoke this authorization but that I must do so in writing and present my written revocation to the Facility. I understand that any revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the authorization was a condition to obtaining insurance coverage. I understand that I have the right to inspect and/or receive a copy of certain Health Records. **I understand that I may be charged a fee for copying, postage and preparation of records associated with fulfilling this request.** I understand that the Facility may not condition treatment, payment, enrollment or eligibility for benefits upon execution of this authorization unless the services are being provided solely for the purpose of disclosing the information to a third party. **Redisclosure notice:** I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Privacy Regulations. This authorization will be effective for Health Records generated during the time frame specified above, up to and including the date of expiration of the authorization. By signing this Authorization for Disclosure of Protected Health Information, I am authorizing the release of all records applicable to this request that are maintained as part of the Facility's Health Record regarding me. **Photocopy/facsimile copy is as valid as the original document**.

8. SIGNATURE OF PATIENT: _____ **DATE:** _____

SIGNATURE OF LEGAL REPRESENTATIVE: _____ **DATE:** _____

If signed by a Legal Representative, complete the following

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care

TO BE COMPLETED BY FACILITY

The requested information was: ☐ US MAIL ☐ FAX ☐ SECURE E-MAIL ☐ PICK UP by _____ on date _____
(Name of staff member processing request)

New Frontiers Psychiatric S.C. and New Frontiers TMS, L.L.C

Assignment of Benefits/Right to Payment Authorization, Release of Information for Payment Form

In consideration of the services rendered or to be rendered to me, I hereby irrevocably assign any insurance benefits otherwise payable to me for this treatment directly to New Frontiers Psychiatric, S.C and New Frontiers TMS, L.L.C. ("Provider"). I understand that this document is a direct assignment of my rights and benefits under all my insurance plans, including Medicare (together, "Plan"). I acknowledge and agree that this assignment cannot be revoked without the Provider's consent.
I authorize my insurance company or any third party payor to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I agree and understand that any funds I receive from my insurance company or other third party payor for services rendered by Provider are owed to Provider, and I agree to remit those funds directly to Provider on a timely basis.

Patient Responsibility

I acknowledge and agree that I am fully responsible for all charges for services provided to me which are not covered by a Plan or for which I am responsible for payment under any Plan. To the extent no coverage exists under my Plan, I acknowledge that I am completely responsible for all charges for services provided and agree to pay all charges not covered by my Plan to the Provider.

Should the account be referred to an attorney or collection agency for collection, I agree to pay actual attorney's fees and collection expenses. I understand and agree that my 3 expenses for services with Provider are a family purpose obligation incurred in the interest of the marriage or family such that a financial obligation incurred by one spouse becomes a financial obligation of the other spouse. I also recognize that insurance claims may be completed at my request as a courtesy but that the Provider does not accept responsibility for collecting funds from my insurance

Medicare-Medicaid Patient's Certification- Authorization to Release Information and Payment Request

As applicable, I certify that the information given by me in applying for payment under the Title XVIII or XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and the Social Security Administration (collectively, Agencies), and the agents of these Agencies, any information needed to determine these benefits or benefits for related services. I request that payment of authorized Medicare benefits be made on my behalf for any services, including any health care practitioner services. If I am a Medicare beneficiary, I understand I am responsible for any health insurance deductible and co-payments, as designated by the current Medicare regulations.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment/Authorization shall be considered as effective and valid as the original.

Signature of Patient/ Person Legally Responsible: _____ **Date:** _____

Printed Name of Patient/ Person Legally Responsible: _____

Relationship to Patient (if other than patient): _____

New Frontiers Psychiatric S.C. and New Frontiers TMS, L.L.C

Authorization to Use Electronic Communication

I authorize, New Frontiers Psychiatric S.C and New Frontiers TMS, L.L.C, including its agents, assigns and independent contractors who may work on its behalf, to service my account or to collect any amounts I may owe, to contact me by: 1) telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me; 2) sending text messages; or 3) e-mail, using any e-mail address I provided. I understand such contact may include using pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable.

Patient Signature Date

STATEMENT OF PATIENT RESPONSIBILITIES

New Frontiers Psychiatric, S.C. and New Frontiers TMS, L.L.C. ("Provider) are dedicated to providing the highest quality care and services to all persons. We seek to provide care based on respect for the dignity of each patient and to meet their psychosocial, cultural, and spiritual needs to the highest extent possible. Just as we have responsibilities to you as a patient, you have responsibilities to your doctor and our staff. We ask that you be direct and honest about everything that relates to you as a patient.

YOUR RESPONSIBILITIES ARE AS FOLLOW

1. To follow facility rules affecting safe patient care and conduct.
2. To provide a complete and accurate medical and psychiatric history, reporting perceived risks in their care as unexpected changes.
3. To participate in the development of your treatment plan.
4. To follow your physician's treatment recommendations or openly discuss any questions or concerns you may have.
5. To be responsible for the outcome if you refuse to follow the instructions of your healthcare providers.
6. To inform your physician if you do not understand your treatment plan, or what is expected of you.
7. To give your physician information about changes in your condition during treatment.
8. To show respect for the rights of other patients, their visitors, staff, and our property.
9. To give us accurate and timely information about payment sources and discuss concerns you may have regarding your financial responsibilities.
10. To understand and acknowledge that if you intentionally damage our property, you will be held financially responsible.

PAYMENT: payment is expected at the time of your visit and upon receipt of your invoices. We accept cash, check, or credit card. Payment includes any unmet deductible, co-insurance, co-payment, or non-covered charges from your insurance company. If you do not carry insurance or do not provide us with your updated insurance benefits, payment will be due at the time of service and may be subject to our out of pocket rate if insurance benefits are unable to be verified.

I understand I am responsible for paying all fees in full at the time of services, and New Frontiers Psychiatric S.C. and New Frontiers TMS LLC has the right to reschedule, cancel, and/or terminate services due to therapeutic or payment noncompliance.

INITIALS:

INSURANCE: As a courtesy, we use our best efforts to verify your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, and sometimes the claim may process differently from the benefits quoted. While we will do our best to assist you in verifying insurance coverage, it is ultimately your responsibility to understand your benefits.

I understand that I am responsible for understanding my benefits and whether New Frontiers Psychiatric S.C. and New Frontiers TMS LLC services are covered by my insurance plan. It is my responsibility to provide New Frontiers Psychiatric S.C. and New Frontiers TMS LLC with updated insurance information so they may file my claim. If my insurance company does not pay the practice within a reasonable period of time, the balance may be transferred to me, and I will be billed. I am ultimately responsible for payment of services.

INITIALS:

MISSED APPOINTMENTS: I understand that unless cancelled at least 24 business hours in advance, I will be charged $50 for the first missed appointment, $100 for the next missed appointment, and $150 for each missed appointment afterwards. Insurance plans will not cover these charges and I am responsible for this payment. Missed appointments may result in being discharged from the practice.

INITIALS:

To avoid missed appointments, I agree to have the practice send me text message reminders unless otherwise indicated in the following comments:

INITIALS:

Comments:

ACCOUNTING PRINCIPLES: I understand payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

INITIALS:

OVERDUE BALANCES/ CREDIT CARD POLICY AND AUTHORIZATION: I understand that payment on my account is due immediately after a statement/invoice is issued. After three statements/invoices, failure to make payment in full or make payment arrangements with the office will result in my account being subject to collections and a collection fee will be added to my bill.

INITIALS:

To avoid having my account sent to collections, I agree to allow the Practice to save my payment information per the credit card policy and charge my payment method in the full balance that is overdue by 90 days unless otherwise indicated in the following comments. I am providing credit card information below or will provide to front desk on my first visit to save for their record. I understand my credit card information is kept confidential and secure, and the card will be processed solely for the purpose of making payments on balance due more than 90 days to the practice. This is to prevent sending bills to collection and assessing additional charges.

CREDIT CARD POLICY

I authorize the Practice to charge my credit card as indicated above for the balance due for services rendered that my insurance company identifies as my responsibility and for 'NO SHOW' charges. I understand New Frontiers Psychiatric will send me a bill indicating the amount and date of transfer for all charges (10) days in advance of date that I am charged. This authorization remains in effect until I cancel this authorization. To cancel, I must provide sixty (60) days advance notice in writing and the account must be in good standing.

Comments:

Cardholder Name:

Card Number:

Billing Zip:

Expiration (Month/ Year):

ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been informed of my RESPONSIBILITIES AS A PATIENT and CREDIT CARD POLICY FOR 90+ DAYS PAST DUE BALANCES.

Patient/ Legal Guardian Signature:

Date:

New Frontiers Psychiatric S.C. and New Frontiers TMS, L.L.C.

2675 N Mayfair Rd, Suite 400 (414) 763-6910 FAX (414) 763-6911 nfpsychiatric.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/ PATIENTS RIGHT AND GRIEVANCE POLICY

By signing below, I acknowledge that I have been provided a copy of NFP's Notice of Privacy Practices on the date indicated.

Print Name of Patient *(or Authorized Legal Representative)*

Date

Signature of Patient (*or Authorized Legal Representative)*

Authority of Legal Representative
(parent/legal guardian, health care agent)

(For office use only)

Documentation of Good Faith Efforts to Obtain
Acknowledgement of Receipt of Notice of Privacy Practices

Patient refused to sign

Patient was unable to sign

There was a medical emergency, and an attempt will be made to obtain an Acknowledgement of Receipt at the next available opportunity

Print Name of Employee

Date

Signature of Employee

This acknowledgement will be maintained in the medical record for safekeeping.

New Frontiers Psychiatric S.C. and New Frontiers TMS, L.L.C.

NOTICE OF PRIVACY PRACTICES/ PATIENT RIGHTS AND GRIEVANCES

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.

If you have any questions about this Notice or would like further information concerning your privacy rights please contact Hong Yin M.D. at 414-763-6910 or support@nfpsychiatric.com.

We are required by law to protect the privacy and security of your protected health information and to provide you with notice of our legal duties and privacy practices and your privacy rights with respect to your health information. Health information is information we have created and/or received about you that may identify you (such as your name, address, phone number), as well as your symptoms, examinations, test results, diagnosis, treatment, and plans for further care or treatment. This health and billing information is protected by law and is frequently required by law to follow the terms of the notice that is currently in effect.

WHO WILL FOLLOW THIS NOTICE

New Frontiers Psychiatric S.C. and New Frontiers TMS, L.L.C. (together, "NFP") as dedicated to compliance with the Health Insurance Portability and Accountability Act ("HIPAA") and State Privacy laws. NFP is a clinically integrated setting in which patients receive care from NFP staff and, sometimes, from independent practitioners. As part of this arrangement, we share your health information with each other as necessary for your treatment, to get paid for our services, and to carry out other health care operational activities. This Notice of Privacy Practices ("Notice") provided to you will also satisfy the HIPAA requirements.

This Notice will be followed by all NFP's workforce members, including employees, contractors, volunteers, and students (if any).

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose health information about you without your authorization. For each category of uses or disclosures we will generally explain what we mean. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose health information will fall within one of the categories. We will make reasonable efforts to use, disclose and request only the minimum amount of health information needed to accomplish the intended purpose or task.

- **For Treatment**. We may use health information about you to provide you with medical treatment or services. We may disclose your health information to physicians, nurses, students (and their preceptor/instructor), and other health care personnel who provide you with health care services or are involved in your care.

- **For Payment**. We may use or disclose health information about you so that the treatment services you receive may be billed to, and payment may be collected from you, an insurance company or third party. For example, we may provide portions of your health information to our billing staff and your health plan to get paid for health care services provided to you.

- **For Health Care Operations**. We may use and disclose your health information as necessary for our individual and permitted health care operations which may include quality assurance and improvement activities, evaluating the performance of health care providers, risk management, and business planning. For example, we may use your health information to work to improve the quality of the services we provide. Some services may be provided through contracts with our business associates, such as a billing service, a transcription company or legal or accounting consultants. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, we require our business associates to enter into a written agreement that requires them to appropriately safeguard your information. We may also disclose your health information to other health care providers to assist in their health care operations if you have also received care from those providers.

- **Appointment Reminders**. We may use and disclose health information to contact you or to provide appointment reminders.

- **Treatment Alternatives and Health-Related Benefits and Services**. We may use and disclose health information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. An example of this would be a mailer about an educational class being offered.

- **Communication with Family and Friends or Others**. If people such as family members, relatives, or close personal friends are involved in your treatment or payment for health services you receive, we may release important health information about you to those people unless you object. The information released to these people may include your general condition.

- **Required by Law**. We will disclose your health information when required to do so by federal, state, or local law. For example, we may have to report child or elder abuse or neglect, or respond to a court order.

- **Public Health Activities**. We may disclose information about you for public health activities subject to the provisions of applicable law for reporting public health activities. These activities generally include the following: prevention or control of disease, injury or disability; reporting reactions to medications or problems with products; to enable product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Health Oversight Activities**. We may disclose your health information to agencies authorized by law to conduct audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system and government programs.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose your health information in order to prevent a serious and imminent threat to the health or safety of you, another person or the public. Disclosure is usually limited to law enforcement personnel or persons able to prevent or reduce such harm and to the information needed to prevent or reduce such harm.

- **Specific Government Functions**. If required by law, we may disclose your health information to authorized federal officials or state agencies, including for intelligence, counter-intelligence and other national security activities authorized by law. For example, we may disclose your health information for national security purposes, such as protecting the President of the United States.

- **Correctional Institutions**. If you are an inmate of a correctional institution or under the control or custody of a law enforcement official, we may disclose to the institution or its agents health information as permitted by State law.

- **Judicial and Administrative Proceedings**. We may disclose health information in the course of a judicial or administrative proceeding in response to a court order.

- **Law Enforcement**. We may disclose your health information to a law enforcement official for purposes such as: to report crimes on our premises; to investigate a certain reported deaths, to comply with a court order; or for other legally permitted law enforcement purposes.

WHEN WE ARE REQUIRED TO OBTAIN AN AUTHORIZATION TO USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in this Notice, we must obtain your written authorization for any other release of your health information. For example, your authorization is required for most uses and disclosures of psychotherapy notes, uses and disclosures of health information for marketing purposes and the sale of health information. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization). If you wish to withdraw your authorization, please contact Hong Yin M.D. or Isa Martinez (clinic coordinator) to assist you with your written withdrawal or submit your written request to support@nfpsychiatric.com.

WHAT RIGHTS YOU HAVE REGARDING

YOUR HEALTH INFORMATION

1. **The Right to Request Restrictions on Certain Uses and Disclosures**. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations as described previously in this Notice. Additionally, you have the right to request restrictions on disclosure of information to individuals involved in your care. We are not required to agree to your requested restrictions in most cases. If we do agree, we will comply with your restriction unless the information is needed to provide you emergency treatment, or until the agreement is terminated. We must, however, agree to your request to restrict disclosure of your protected health information to a health plan for the purpose of carrying out payment or health care operations, if it is not otherwise required by law, and, the information pertains solely to a health care service or item that you, or a third party other than the health plan, have paid us for in full. To request a restriction please contact Hong Yin M.D. or Isa Martinez (clinic coordinator) at support@nfpsychiatric.com. You may not limit the uses and disclosures that we are legally required to make.

2. **The Right to Choose How We Send Health Information to You**. You have the right to request that we communicate with you about your health information in a certain way or at a certain location. For example, you may ask that we only contact you at work or by U.S. mail. These requests may be made at the time of registration or you must make your request in writing to support@nfpsychiatric.com. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests. You do not need to give a reason for your request.

3. **The Right to Inspect and Copy**. With few exceptions, you have the right to inspect and obtain a copy of your health information. If you request copies of your health information, we may charge for the reasonable costs of providing the copies. If you agree, we may provide you with a summary of the information instead of providing you with access to it, or with an explanation of the information instead of a copy. Before providing you with such a summary or explanation, we first will obtain your agreement to pay and will collect the fees, if any, for preparing the summary or explanation. In the rare event that we deny your request to review or obtain a copy of your health information, you may have a right to submit a written request for a review of that decision. To inspect or obtain a copy of your health information, contact Hong Yin M.D. or Isa Martinez (clinic coordinator). You may also talk with your care provider. If we have all or any portion of your medical information in an electronic format, you may request an electronic copy of those records or request that we send an electronic copy to any person or entity you designate in writing.

4. **The Right to a List or an Accounting of Disclosures**. You have the right to request a list of certain types of disclosures we made within the past six (6) years of your health information for purposes other than treatment, payment, and health care operations, disclosures authorized by you or made to you, and disclosures from our facility directory. This list also does not include disclosures made for national security or intelligence purposes or to correctional institutions or law enforcement officials. To request this list of disclosures, you must submit your request in writing to support@nfpsychiatric.com and include the time period you would like the accounting to include, not longer than 6 years prior to the date of your request. We will provide the first list you request within a 12-month period at no charge. For additional lists, we may charge for the cost for providing the list. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs. We may collect the fee before providing the accounting of disclosures to you.

5. **The Right to Amend Your Health Information**. If you believe that your health information is incorrect or incomplete, you have the right to request that it be amended. We are not required to change your health information and may deny your request in writing if the health information is correct and complete, not created by us, not allowed to be disclosed, or not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and our denial be attached to all future disclosures of your health information. If we approve your request to amend, we will make the change to your health information and make reasonable efforts to inform others about the change to your health information. To request an amendment to your health information you must submit a written request to support@nfpsychiatric.com and include a reason for your request. Changes to non-clinical information such as changes of address, insurance information, date of birth, etc. are not amendments and may be routinely processed.

6. **The Right to Get a Paper Copy of this Notice**. This Notice is available upon your request for a written copy. Upon your request, you may at any time also receive a paper copy of this Notice even if you earlier agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact support@nfpsychiatric.com.

7. **Right to Notification of a Breach**. You have the right to be notified if your unsecured protected health information has been the subject of a breach.

8. **Right to Complain**. If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, you may file a complaint with the practice by writing to NFP. We request that you file your complaint in writing so that we may better assist you in the investigation of your compliant. You also may send a written complaint to the Secretary of the Department of Health and Human Services. **There will be no retaliation against you in any way for filing a complaint.**

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We also reserve the right to apply any changes to this Notice to the health information that is already in our possession as well as to any future information. If we change our notice, you may choose to review our revised notice by requesting a written copy.

CONTACT INFORMATION

Hong Yin M.D.

Phone: 414-763-6910

THE EFFECTIVE DATE OF THIS NOTICE IS January 1, 2019.

NEW FRONTIERS PSYCHIATRIC, S.C. and NEW FRONTIERS TMS, L.L.C.

PERSONAL RIGHTS

The following are your rights as a voluntary patient receiving outpatient mental health treatment.

- You must be treated with consideration, dignity, respect, free from any verbal, emotional, sexual or physical abuse and recognition of your own individuality and personal needs including the need for privacy in treatment.
- You may not be treated unfairly because of your race, creed, color, national origin, sex, age, religion, disability, sexual orientation, ancestry, marital status, newborn status, handicap or source of payment.
- Your surroundings must be kept safe and clean.
- You have the right to receive treatment in a psychologically and physically humane environment.
- You have the right not to be subjected to experimental research.
- You have the right to inspect all treatment records kept in confidence and to inspect these documents in the presence of a staff member.
- You have a right to examine your bill and receive an explanation of the bill, regardless of source of payment.
- You have the right not to be filmed or taped without your informed written consent.
- You have the right to have an individual treatment plan and be an active member in its planning.
- You have the right to access protective and advocacy services.
- You have the right to a qualified interpreter services at no cost to you. You have the right to not be required to rely on your minor children, other relatives, or friends as interpreters. You have the right to file a grievance about the language access services provided to you.
- You have the right to know who has overall responsibility for your care and make informed decisions regarding your care.

TREATMENT & RELATED RIGHTS

- You or your representative shall receive information about your illness, course of treatment and prognosis for recovery in terms you can understand.
- You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate for your condition, within the limits of available funding.
- You must be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.
- No treatment or medication may be given to you without your written, informed consent, unless it is needed in an **emergency** to prevent physical harm to you or others, or if **a Court orders it**.
- You may not be given unnecessary or excessive medication.
- You may not be subject to electro-convulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
- You may not be restrained or placed in a locked room (seclusion) **unless in an emergency** when it is necessary to prevent physical harm to you or to others or when it is part of a treatment program to which you or your guardian have consented**.**
- You may refuse treatment to the extent permitted by law, except if you are a danger to yourself or others.

If at any time you believe your rights have been violated, you may file a grievance with us by contacting: Hong Yin M.D. or Isa Martinez (clinic coordinator) at support@nfpsychiatric.com or 414-763-6910. Grievances may also be filed with the Wisconsin Department of Health Services:

The Wisconsin Department of Health Services
Division of Quality Assurance
1 Wilson Street
P.O. Box 2969
Madison, WI 53701
608-266-8481 or 800-642-6552 http://www.dhs.wi.gov