Client ID#______________

Episode #____________

*JEWISH FAMILY SERVICE ATLANTIC & CAPE MAY COUNTIES*
*607 North Jerome Avenue*
*Margate, NJ 08402-1527*

*(Please print clearly)*

Client Last Name: ___________________________ MI _____ First Name: ______________________________

Date of Birth: ______________________ Gender: ___________ Social Security #:______________________

Home Address: ____________________________________________________________________
*Street* *City* *State* *Zip*

Home Phone: ________________________________ Cell Phone:________________________________

Parent/Guardians name if under 18 years age: ________________________________________________

Parent/Guardian address if different than above :______________________________________________

Primary Language: _______________________ Do you need an interpreter? ❒ Yes ❒ No

## MEDICAL INSURANCE INFORMATION

### PRIMARY INSURANCE

Name of Insurance: ______________________________________________________________

Insurance ID number: ____________________________________ Group #: ______________________________

Policy Holder: ______________________________________ Date of Birth:______________________________

**Relationship to Consumer** ❒ Parent ❒ Spouse ❒ Partner ❒ Guardian ❒ Other ______________________

Address: *(If different from consumer)* ______________________________________________________
*Street* *City* *State* *Zip*

### SECONDARY INSURANCE

Name of Insurance: ______________________________________________________________

Insurance ID number: ____________________________________ Group #: ______________________________

Policy Holder:______________________________________ Date of Birth: ____________________

**Relationship to Consumer**: ❒ Parent ❒ Spouse ❒ Partner ❒ Other ______________________

Address: *(If different from consumer)* ______________________________________________________
*Street* *City* *State* *Zip*

### EMERGENCY CONTACT*:

Name ____________________________________________ Telephone # ________________________________

**Relationship to Consumer**: ❒ Parent ❒ Spouse ❒ Partner ❒ Other ______________________

***Please be advised that you are consenting to allow the agency to contact this individual in the event of an emergency.***

**Scan as: OP Demographics**

Client ID#_______________

Episode #_____________

*Jewish Family Service of Atlantic & Cape May Counties*

***FINANCIAL POLICY***

Insurance supplements the difference between the full fee for a service and your payment. Your payment is determined by your insurance policy's copayment/coinsurance amount or an individualized self-payment agreement.

I authorize my insurance company to make payments directly to Jewish Family Service (JFS). Should the insurance company send payments to me; I agree to endorse any and all checks pertaining to services to JFS or to reimburse JFS for any amounts received.

Payment is expected at each session. In the event a balance due is determined, you are expected to pay in full upon receipt of a statement from JFS, before your next scheduled appointment.

I have read and agreed to the terms above.

SIGNATURE: ______________________________________ Date: _____________
CLIENT/PARENT/GUARDIAN

Please Print Name: ______________________________________

SIGNATURE: ______________________________________ Date: _____________
JFS Staff Reviewed with Client

Scan as: Financial

**Client ID#______________**

**Episode #____________**

***Jewish Family Service of Atlantic & Cape May Counties***

***CONSENT TO RECEIVE SERVICES***
***OUTPATIENT THERAPEUTIC & PSYCHIATRIC SERVICES AND***
***ACKNOWLEDGMENT FORM***

I hereby consent to receive Outpatient Counseling and/or Psychiatric Services from Jewish Family Service of Atlantic & Cape May Counties.

I acknowledge that Jewish Family Service has provided me with copies of their:

- ***Notice of Privacy Practices***
- ***Complaint/Confidentiality/Grievance Procedure***
- ***Consumer Rights Policy***

I acknowledge that I have been given the opportunity to review this notice with a staff member assigned to work with me.

**Signature of the Consumer** ______________________________________ Date___________________
***(14 years of age or older)***

**Signature of Parent/Guardian**_____________________________________ Date___________________
***(Children younger than 18 years)***

JFS Staff Reviewed with Client: _______________________________ Date___________________

**Scan as: OP Consent**

## Telemental Health Informed Consent

I ________________________________________, (name of client/parent or guardian) hereby consent to participate or for my child __________________________ (name of child) to participate in telemental health with Jewish Family Service as part of my psychotherapy/psychiatry/case management or other service. I understand that telemental health is the practice of delivering clinical health care services via technology-assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and will not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, I will call you to finish the session by phone or reschedule.

7) I understand that my therapist/psychiatrist/case manager or other provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

8) I understand that I need to provide my location at the beginning of each session in case of an emergency.

9) I understand that I am being provided telehealth services due to the current public health situation and recommendations to practice social distancing. Telemental health services will be available as long as the situation demands for the service. Once the public health situation is resolved, I understand that I will return to office visits or be referred to another health care provider if I am unable to return to office visits.

**Emergency Contact**
Please provide a contact person who can be contacted on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

Name:________________________________________ Phone:___________________________________

I have read the information provided above and discussed it with my therapist/case manager. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____________________________________________ _______________
Signature of Client Date

_____________________________________________ _______________
Signature of Parent/Guardian (If client is under 18) Date

_____________________________________________ _______________
Signature of Therapist/Case Manager Date

Client ID#_______________

Episode #_____________

*Jewish Family Service of Atlantic & Cape May Counties*

## *Mental Health Advance Directive Sign Off*

I acknowledge that a representative of Jewish Family Service has offered me the opportunity to work to develop an Advanced Directive for Mental Health Care. I understand that the Advanced Directive Form, developed by the State of New Jersey, will offer me the opportunity to determine both who will make decision on my behalf if I am deemed unable to make my own decisions, as well as the kind of mental health care that I do and do not want. I also understand that I am not forced to do this and the decision to develop an Advanced Directive is mine alone.

***My decision at this time is as follows:***

1. I possess a registered Advance Directive and I:

   a. Give consent for JFS to obtain it. ❒ Yes ❒ No

   b. Do not want JFS to obtain it. ❒ Yes ❒ No

2. I will work at this time to develop an Advanced Directive and my Advanced Directive can be entered in the State of New Jersey's Registry.

3. I would like to have a JFS staff member approach me about an Advanced Directive and can be entered in the State of New Jersey's Registry.
   ❒ Yes ❒ No

4. I am interested in developing an Advanced Directive at this time.
   ❒ Yes ❒ No

**Signature of Consumer** ________________________________________ Date____________________

JFS Staff Reviewed with Client:____________________________________ Date____________________

**Scan as: Advance Directive Signoff**

Client ID#______________

Episode #____________

*Jewish Family Service of Atlantic & Cape May Counties*

***AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO INSURANCE AND PRIMARY CARE PHYSICIAN***

***(I understand that I may revoke this authorization at any time. It will expire in 1 year.)***

I authorize Jewish Family Service to submit pertinent private health information with my insurance company to allow for payment of services. I authorize my insurance company to make payments directly to Jewish Family Service. If the insurance company sends payment to me, I agree to endorse any and all checks pertaining to services to Jewish Family Service.

I authorize Jewish Family Service ***(PLEASE CHOOSE ONE)***:

- ❒ To release any applicable mental health/substance abuse information to my primary care physician.
- ❒ To release ***only*** medication information to my primary care physician.
- ❒ I **DO NOT** give my authorization to release any information to my primary care physician.

**Primary Care Physician**: Name: ______________________________________________

Phone Number: _____________________________________

Address: _________________________________________________________________

**Signature of Consumer** ***(14 years of age or older):***

_________________________________________________________________________

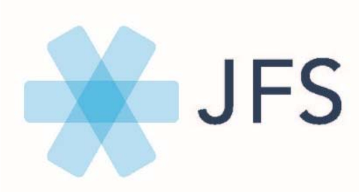
**Signature of Parent/guardian** ***(Consumer less than 18 years of age):***

_________________________________________________________________________

Relationship to Consumer: ____________________________ Date _____________________

JFS Staff Reviewed with Client: ___________________________ Date___________________

**Scan as: Authorization Release PCP**




Client ID#______________

Episode #____________

**Date:** ______________________________

**Client Name:** ______________________________

**Client ID:** ______________________________

**APPOINTMENT CONFIRMATION**

Jewish Family Service of Atlantic County will contact you for the purpose of appointment confirmation.  If you do not wish to be contact or would like confirmation, please indicate your preference below:

**PLEASE CHECK THE APPROPRIATE LINE:**

❐ Jewish Family Service is **NOT** authorized to contact me to confirm appointments.

❐ Jewish Family Service **IS** authorized to contact me to confirm appointments.

Please indicate how you prefer to be contacted ***please select only one).***

❐ **English** ❐ **Spanish**

❐ Phone #______________________________

❐ Text Message #______________________________

❐ E-Mail ______________________________________________

**I have read and agreed to the terms above.**

**Name:** ______________________________________________
**Please Print**

**Signature:** ______________________________________________
**Staff Reviewed with Client**

**Scan As: Appointment Confirmation**

**Client Copy**

POLICY AND PROCEDURE

Jewish Family Service of Atlantic County

**TITLE:** **CONSUMER RIGHTS**

**AUTHORIZED BY:** **Board of Directors**

**EFFECTIVE DATE:** **January 2017**

JFS strives to protect and promote the rights of all persons served._It is the policy of Jewish Family Service of Atlantic & Cape May Counties to comply with N.J.A.C. 10:37- 47 (2014)* by providing clients with the following rights and posting the same information at all Agency locations.

Consumers/Clients have the right to:

- Have your information kept private and confidential in compliance with HIPAA and HITECH except in the limited exceptions described in Jewish Family Service of Atlantic & Cape May Counties' Privacy Statement.
- Access consumer's own records.
- Be treated with respect, dignity and courtesy inclusive of freedom from abuse, exploitation, retaliation, humiliation or neglect.
- Be listened to and have staff work with you to make a plan to address your concerns and needs including coordination with concurrent services.
- Receive service in an accessible manner.
- Get information and support to help you make decisions related to your participation in the Agency's programs.
- Be served without discrimination.
- Discuss your service with designated JFS staff to discuss how to best work with you and express any questions or complaints that you may have. This includes, but is not limited to the right to share concerns about your services with your designated JFS staff member/ supervisor or JFS's Ombudsperson at 609.822.1108, as stated in the *Grievance Policy* furnished and explained to you.
- Request the annual Quality Assurance Report, which includes, but is not limited to, JFS program highlights, agency trainings, compliance highlights for the year, unusual incidents reported, and analysis of the Agency's annual Consumer Satisfaction Survey and goals for the upcoming year.
- Request a change of staff member if there is another staff person available who can address your service plan goals and the request is reasonable -- discriminatory requests will not be considered.
- Be free from unnecessary or excessive medication. (See N.J.A.C. 10:37-6.54.).
- Not be subjected to non-standard treatment or procedures, experimental procedures or research, or provider demonstration programs, without written informed consent, after consultation with counsel or interested party of the client's choice. (See N.J.A.C. 10:37-6, Article XV.)

- Be free from presumptions of incompetence because she/he has been examined or treated for mental illness, regardless of whether such evaluation or treatment was voluntarily or involuntarily received.
- The least restrictive conditions necessary to achieve the goals of treatment/services.

Jewish Family Service of Atlantic & Cape May Counties' programs and services are voluntary. Participation in service is considered consent for service since consumers are at liberty to withdraw from service at any time.

All consumers will be provided a copy of the Consumer Rights policy at time of intake. The consumer will be asked to read the information and sign a form indicating that they understand those rights. Interpretation, translation, reading or explanation of documents will be available.

If the consumer or authorized representative refuses to authorize receipt of the consumer rights document the JFS staff member shall document this in the consumer's electronic health record. Whenever a consumer declines to acknowledge receipt of the Consumer Rights document, they will be directed to the posted copy of the document and offered the opportunity to have the rights read to them. This status will be reviewed with the program supervisor.

08/2018

**I have read and acknowledge the receipt of the above.**

Signature: ______________________________________ Date: _______________
Consumer

Signature: ______________________________________ Date: _______________
JFS Staff reviewed with Client

Client ID#______________

Episode #____________

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- Receive service in an accessible manner.
- Get information and support to help you make decisions related to your participation in the Agency's programs.
- Be served without discrimination.
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- Be free from unnecessary or excessive medication. (See N.J.A.C. 10:37-6.54.).
- Not be subjected to non-standard treatment or procedures, experimental procedures or research, or provider demonstration programs, without written informed consent, after consultation with counsel or interested party of the client's choice. (See N.J.A.C. 10:37-6, Article XV.)

**Scan as: Consumer Rights**

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08/2018

**I have read and acknowledge the receipt of the above.**

Signature: ______________________________________ Date: _______________
Consumer

Signature: ______________________________________ Date: _______________
Staff Reviewed with Client

**Client ID#______________**

**Episode #____________**

**JFS OUTPATIENT ATTENDANCE POLICY AGREEMENT**

Regular attendance is an important component of successful treatment. In addition, there is a high demand for services at this agency with a waiting list for therapy. As a result, it is necessary for JFS to have a standard practice about discharging cases when an individual is unable to make and keep regular appointments. By initialing each item and signing you indicate that you understand and agree to the below attendance policy. The expectations are as follows and apply to *both* therapy and psychiatry services:

- ❒ *I understand that I will be charged $25 for "no show" appointments or appointments that are cancelled with less than 24 hours notice.*
- ❒ *I understand that if I cancel two appointments in a row, my appointment time may not be held for me and I may be discharged from all Outpatient services.*
- ❒ *I understand that if I "no show" or cancel an appointment without 24 hours notice twice in two months, I will be discharged from Outpatient services.*
- ❒ *I understand that if I cancel four appointments, even with proper notice, within a two-month period I will be discharged from Outpatient services. This includes any combination of cancellations and "no shows" that amount to four missed appointments within a two-month period.*
- ❒ *I understand that if I am not seen for therapy in 30 days or more and do not respond to JFS once contacted, I will be discharged from all Outpatient services.*

If you or your child are closed due to an above attendance policy violation but become interested in resuming treatment with JFS at any time in the future, you are welcome to contact the Intake Department at 609-822-1108. You will return to the waiting list and would be offered the first available appointment.

________________________________ ________________________
Signature of Consumer Date

________________________________
Please print name

________________________________ ________________________
Consumers (14 Years and older) Parent/Guardian (Consumers less than 18 years old

________________________________ ________________________
JFS Staff Reviewed with Client Date

**Scan As: Attendance Policy Agreement**

# POLICY AND PROCEDURE

Jewish Family Service of Atlantic County

**TITLE:** **Consumer/Client Complaint/Grievance Policy**

**AUTHORIZED BY:** **Board of Directors**

**REVISION DATE:** **December 2014**

**EFFECTIVE DATE:** **January 2017**

Jewish Family Service consumers/clients have the right to state concerns and bring them to a grievance process, which assures a serious consideration of their issues.

- **Scope of Complaint and Review Procedure:**
  This policy shall apply to any question(s) related to service delivery, denial or termination of services.

  Explanation of Complaint and Review Procedure to clients:
  - ❒ Each consumer/client will be made aware of this complaint review process at the time of admission into a JFS service and at the time a complaint is filed.
  - ❒ A written copy of the complaint and review procedures shall be given to consumers/clients during the admission process and upon request.
  - ❒ Consumers/clients not accepted for service shall be given appropriate alternate referrals and they may initiate a grievance process to address their denial.
  - ❒ A list if known external advocacy services, which are available to consumers/clients, will be stated in this policy and procedure.

  Posting of Policy:
  - ❒ A statement denoting the availability of the above captioned policies will be posted at JFS offices

- **Complaint and Review Procedure/Designation of a Jewish Family Ombudsperson to receive complaints:**

  Jewish Family Service's Chief Operating Officer is designated as the agency's ombudsperson. His/her responsibilities are:
  - ❒ To receive complaints either in writing or in person.
  - ❒ To serve to facilitate the resolution process within Jewish Family Service for consumers/clients who make complaints.
  - ❒ To act as a de facto advocate for consumers/clients who are making complaints.

  A complaint will be forwarded to the agency's Chief Operating Officer who will offer a meeting within five working days of the complaint and will discuss the resolution of said complaint.

  - ❒ The Chief Operating Officer will submit a written report of findings, resolutions and/or recommendations to the consumer/client and Chief Executive Officer within seven working days of this complaint.
  - ❒ A copy of this report will be maintained by the agency.

- ❒ If a complaint has been resolved to the consumer/client's satisfaction, the grievance process will end at this juncture. If it has not, the additional procedures described below will be implemented.

- **Further Internal Agency Complaint Resolution:**

- ❒ The agency will permit and encourage consumers/clients who object to the decision of the ombudsperson to consult with and obtain the opinion of a second person either within or outside the agency.
- ❒ If the complaint has not been resolved by the agency ombudsperson to the consumer/client's satisfaction, they may request either in writing, in person, or by phone, that the agency's Chief Executive Officer reviews the findings for reconsideration.
- ❒ The agency's Chief Executive Officer will respond to this request as quickly as possible, optimally within five working days.

Board Appeal:

- ❒ If the complaint has not been resolved to the consumer/client's satisfaction, they may request review by the Jewish Family Service Board of Directors. This appeal will be directed to the agency's Program and Planning Committee chairperson for a response. That committee shall respond in writing within ten working days of the application.
- ❒ The Jewish Family Service Board of Directors Program Committee will review all consumer/client grievances, even those resolved at a different level.
- ❒ The Board of Directors Planning Committee is the final internal appeal option for a consumer/client with a grievance.

- **Specific Client Grievance Options for Consumer/Clients Utilizing Community Mental Health Programs:**

County Mental Health Board:

- ❒ For consumers/clients served in mental health programs, the County Mental Health Board, through its administrator, shall receive and review unresolved complaints referred from agency directors or from those receiving agency services within five working days of the establishment or the fact that the grievance is irreconcilable.

  Further, consumers/clients may also utilize the New Jersey Division of Mental Health & Addictions Services for review.

- **General Provisions of Complaint Procedures at Jewish Family Service:**

- ❒ Procedures not to limit access or other remedies:
  These procedures are intended to be in addition to, rather than replacement of alternative remedial actions available to clients for the negotiation of complaints regarding service delivery.
- ❒ No suspension of agency action during review:
  Jewish Family Service's actions, which are the subject of a consumer/client complaint, will not be suspended pending review under all of the above-captioned procedures. A consumer/client, however, may request an expedited direct review by the agency's administrator or other parties.
- ❒ Confidentiality:
  A consumer/client who requests assistance with a review of the complaint by the agency's ombudsperson, Chief Executive Officer, board of directors, Mental Health Advisory Board of the Division of Mental Health Services, should they be involved, will be required to consent to the disclosure of records in order to authorize persons reviewing the matter to discuss the subject of the complaint with relevant agency staff if necessary.

- **External Advocacy Services Available to Jewish Family Service Clients:**
  Clients participating in some agency programs may avail themselves of the following external resources:

  Division of Mental Health Advocacy
  Trenton, NJ 08625
  Phone No: (609) 826-5090

  Atlantic County Mental Health Administrator
  Phone No: (609) 625-7000, ext. 4307

  Community Health Law Project, Inc.
  Station House Office Building
  Suite #400
  900 Haddon Avenue
  Collingswood, NJ 08108
  Phone No: (609) 858-9500

  Program Analyst, Atlantic County
  NJ Division of Mental Health & Hospitals
  Evergreen Hall
  Ancora, NJ
  Phone No: (609) 567-7353

  Adult Protective Services of Atlantic County ***(for adult abuse)***
  Phone No: (609) 345-6700

  Division of Mental Health & Addiction Services (DMHAS)
  Ombudsperson: Ms. Margaret Molaner
  Phone No: (609) 777-0717

08/2018

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

**Please notify us in writing (at the address listed at the top of the Notice) if you do not wish to be contacted at a particular telephone number or address. JFS will accommodate reasonable requests to communicate health information by alternative means or at an alternative address.**

### Permitted Uses and Disclosures

JFS provides a broad range of services through a wide variety of health and human service programs. If you receive services from a JFS program, our staff may use your protected health information and disclose it to other health and human service programs outside JFS for the following purposes:

***For Treatment*:** We may use health information about you to provide you with behavioral health, counseling and social services. We may disclose health information about you to social workers, psychiatrists, psychologists, office staff and other personnel who are involved in providing these services to you.

For example, information obtained by a social worker or psychiatrist, or member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. This information may be shared with other program staff if it is necessary to determine the most appropriate care for you.

***For Payment*:** A bill may be sent to you or any private or public source of health coverage you have identified. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, treatment, and services provided. We may also tell your health plan insurer about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover or continue the treatment.

***For Healthcare Operations*:** We may use and disclose health information about you in order to run the office and make sure that you and our other clients receive quality care. For example, members of a quality assurance team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

We may contact you by mail or telephone if we need to reach you, for example to confirm or change an appointment.

***Other Treatment, Programs, and Services*:** We may tell you about or recommend other treatment options that may be of interest to you. We may tell you about related programs or services that may be of interest to you.

**Business Associates**. There are some services provided by JFS through contracts with business associates for example, record storage, billing services, and vendors of computer software for client information systems. When these services are contracted, JFS may disclose your health information to our business associate so that they can perform the job we have asked them to do. However, we require the business associate to appropriately safeguard your information.

### Uses and Disclosures with Opportunity to Agree or Object.

Informal permission may be obtained by asking the individual outright, or by circumstances that clearly give the individual the opportunity to agree, acquiesce, or object. Where the individual is incapacitated, in an emergency, or not available, covered entities generally may make such uses and disclosures, if in the exercise of their professional judgment, the use or disclosure is determined to be in the best interests of the individual.

***For Notification and Other Purposes.*** A covered entity also may rely on an individual's informal permission to disclose to the individual's family, relatives, or friends, or to other persons, whom the individual identifies, protected health information directly relevant to that person's involvement in the individual's care or payment for care.[26] This provision, for example, allows a pharmacist to dispense filled prescriptions to a person acting on behalf of the patient. Similarly, a covered entity may rely on an individual's informal permission to use or disclose protected health information for the purpose of notifying (including identifying or locating) family members, personal representatives, or others responsible for the individual's care of the individual's location, general condition, or death. In addition, protected health information may be disclosed for notification purposes to public or private entities authorized by law or charter to assist in disaster relief efforts.

## SPECIAL SITUATIONS

Subject to all applicable legal requirements and situations we may use or disclose health information about you without your permission for the following purposes:

**1. To Avert a Serious Threat to Health or Safety.** When necessary, we may use and disclose health information about you when necessary to prevent a serious threat to your health and to the safety of the public or another person.

**2. Required By Law.** We will disclose health information about you when required to do so by federal, state or local law (including by statue, regulation or court order).

**3. Research.** We may disclose information to researchers when the information is de-identified or when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

**4. Essential Government Functions.** When necessary we may use or disclose protected health information for certain essential government functions. Such functions include: assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees, protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.

**5. Workers' Compensation.** We may release health information about you to workers' compensation or similar programs if your condition was the result of a workplace injury for which you are seeking workers' compensation.

**6. Public Health Risks.** We may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**7. Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

**8. Judicial and Administrative Proceedings.** 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. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

**9. Law Enforcement.** We may disclose protected health information to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if the covered entity suspects that criminal activity caused the death; (5) when a covered entity believes that protected health information is evidence of a crime that occurred on its premises; and (6) by a covered health care provider in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.[3]

**10. Decedents.** With the possible exception of certain information concerning mental health disorders and/or treatment, drug & alcohol abuse and/or treatment, and/or HIV status (for which we may need a client's specific authorization or a court order), we are also permitted to provide some health information to the coroner or a funeral director, if necessary, after a client's death, and/or to the appropriate organ procurement organization, if the client wished to make an eye, organ or tissue donation after their death.

**11. Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

## OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous

sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you but we cannot take back any uses or disclosures already made.

If we have HIV or substance abuse information about you, we cannot release that information without a specific authorization from you. In order to disclose these types of information for purposes of treatment, payment or healthcare operations, we will have to have your signed *Authorization*, which complies with the law governing HIV or substance abuse records.

**YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU**

You have the following rights regarding protected health information we maintain about you.

**Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as counseling, social work and billing records that we use to make decisions about your care. You must submit a written request to the Privacy Officer contact listed at the top of the Notice in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies, as allowed by New Jersey state law. We may deny your request to inspect and/or copy in certain limited circumstances. If we deny your request, we will tell you, in writing, our reasons for the denial. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

**Right To Amend.** If you believe 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 as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Privacy Officer contact listed at the top of this Notice. 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:

(a) We did not create, unless the person or entity that created the information is no longer available to make the amendment. (b) Is not part of the health information that we keep (c) You would not be permitted to inspect and copy. (d) Is accurate and complete.

Our written denial will state the reasons that your request was denied and explain your right to file a statement of disagreement with us. If you do not wish to do so, you may ask that we include a copy of your request form, and our denial form, with all future disclosures of that health information. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of health information about you for purposes other than treatment, payment and healthcare operations. To obtain this list, you must submit your request in writing to the Privacy Officer contact listed at the top of the Notice. It must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). 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 that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or healthcare 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 it, like a family member or friend.

**We are Not Required to Agree to Your Request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the Request For Restriction on Use/Disclosure of Health Information to the Privacy Officer contact listed at the top of the Notice.

**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 certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Health Information and/or Confidential Communication to the Privacy Officer contact listed on the top of the Notice. 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 a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain such a copy, contact the Privacy Officer contact listed on the top of the Notice.

**CHANGES TO THIS NOTICE**

We reserve the right to materially change this notice, and 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 summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect. Should our privacy practices change, we will provide you with a revised notice at the time of your first appointment following the change or mail you a copy to the address you have supplied us if you so request.

**COMPLAINTS**

If you believe your privacy rights have been violated, you can file a compliant with our Privacy Officer contact listed on the top of this Notice or with the Secretary of the United States Department of Health and Human Services. You will not be penalized for filing a complaint.

08/2018

**NOTICE OF PRIVACY PRACTICES**

**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 questions and would like additional information, you may contact:
Privacy Officer
Jewish Family Service
607 N. Jerome Avenue
Margate, NJ 08402-1527
(609) 822-1108

**WHO WILL FOLLOW THIS NOTICE**

This notice describes information about privacy practices followed by all Jewish Family Service (JFS) employees.

**YOUR HEALTH INFORMATION**

This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive at this office. We are required by law to give you this notice to maintain the privacy of protected health information. It will tell you how we may use and disclose health information about you, and describes your rights and obligations regarding the use and disclosure of that information. The JFS staff will not use or disclose your protected health information except as described in this notice, or as otherwise authorized by law.

***SAFETY OF CONSUMERS & STAFF***

The safety of consumers and staff is a priority for Jewish Family Service (JFS). JFS recognizes the right to self-determination when persons served establish goals and make choices for their own lives. At times, JFS may decide that services delivered in the community need to be reduced or managed in a manner that ensures safety of both the consumer and the staff member (s) assigned. Safety considerations may include environmental factors, substance use, and the presence of unknown individuals during the delivering of services.

08/2018