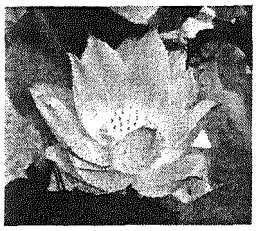

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701 Route 25A
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Phone: (631) 328-5930
Fax: (631) 675-1338

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of same. You may refuse to sign this acknowledgement form.

By signing this form, I confirm that I have received a copy of the office Notice of Privacy Practices.

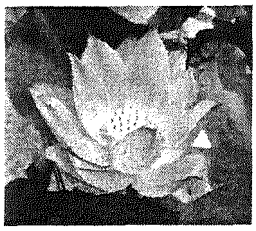
Print Name: _____

Sign Name: _____

Date: _____

Written acknowledgement was not obtained.

- D Patient refused to sign
- D Emergency situation
- D Unable to communicate with patient
- D Other: _____



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Informed Consent for Treatment

I give consent for evaluation and treatment to be provided for myself/my child by:

- **O** Kim Lynn Lehnert, Ph.D.
- **O** Jeanette Lorandini, L.C.S.W.

.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
Obtain payment from third party payers
Conduct normal healthcare operations such as quality assessments and physician certifications

I am aware that the practice of psychotherapy/psychopharmacology is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment. The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

I understand that I may terminate treatment at any time.

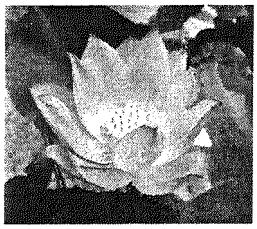
My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

_____ _____
Signature of Patient/Guardian Date

_____
Printed Name

_____
Relationship to Patient (if applicable)

_____ _____
Witness Signature Date



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Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of you Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to view such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

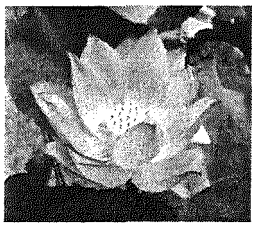
I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____



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RELEASE OF INFORMATION CONSENT FORM

I, _____, authorize _____

To: _____(send) _____(receive) the following_ (to) _____(from) the following agencies or people:

Name	Address	City	State	Zip	Phone

Name	Address	City	State	Zip	Phone

( ) Academic Testing results
( ) Behavior Programs
( ) Case Notes
( ) Intelligence Testing Results
( ) Medical Reports
( ) Personality Profiles
( ) Psychological Reports
( ) Psychological Testing Results
( ) Service Plans
( ) Summary Reports
( ) Vocation Testing Results
( ) Entire Record
( ) Other (specify) _____

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment or Program
( ) continuing Appropriate Treatment or Program
( ) Determining Eligibility for Benefits or Program
( ) Case Review
( ) Updating Files
( ) Other (Specify) _____

I understand that I may revoke this consent at any time by providing written notice. I have been informed what information will be given, its purpose, and who will receive the information.

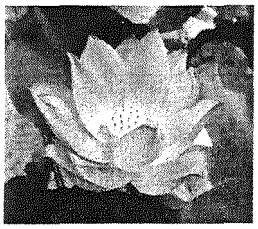
Signature of Client _____Date _____

Signature of Parent/ Guardian _____Date _____

Signature of Witness _____Date_____
(if client is unable to sign)

Signature of Person Informing
Client of rights_____Date_____

Mail to



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Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be release without your signed authorization. Once completed and signed, please give this from to your behavioral health provider.

Section I. The Patient

Last Name:	First Name:	Middle Initial:

Subscriber Number on ID Card:	Insurance Company:	Date of Birth: (MM/DD/YYYY)	Phone Number:

I hereby authorize the disclosure of protected health information about the individual named above.

I am: _____ the individual named above (complete Section 8 below to sign this form)

_____A personal representative because the patient is a minor, incapacitated or deceased (complete Section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following behavioral health provider may disclose the information:

Name: (person or organization if you are naming a practice)	Phone Number:

Section 3. Who Will Be Receiving Information About the Individual?

The information may be disclosed to the following primary care physician·

Name: (person or organization if you are naming a practice)		Phone Number:	
Street Address:	City	State	Zip

Section 4. What information About the Individual Will Be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis and medication(s) if necessary.

Section 5. The Purpose of the Disclosure

To release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

Section 6. the Expiration Date of Event

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information based on this authorization may be disclosed by the recipient and may no longer be protected by Federal or State privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have the right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for the copy at any time by contacting your behavioral health provider named above.

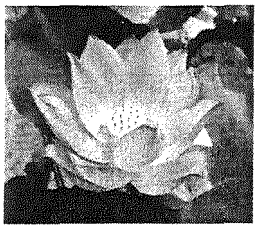
Section 8. Signature of the Individual

Signature:_____Date:_____

Section 9. Signature of Personal Representative (if applicable)

Signature:·_____Date: _____

Relationship to the individual (required) _____



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Authorization to Disclose Protected Health Information to Psychiatrist

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be release without your signed authorization. Once completed and signed, please give this from to your behavioral health provider.

Section I. The Patient

Last Name:	First Name:	Middle Initial:

Subscriber Number on ID Card:	Insurance Company:	Date of Birth: (MM/DD/YYYY)	Phone Number:

I hereby authorize the disclosure of protected health information about the individual named above.

I am: _____ the individual named above (complete Section 8 below to sign this form)

_____A personal representative because the patient is a minor, incapacitated or deceased (complete Section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following behavioral health provider may disclose the information:

Name: (person or organization if you are naming a practice)	Phone Number:

Section 3. Who Will Be Receiving Information About the Individual?

The information may be disclosed to the following primary care physician·

Name: (person or organization if you are naming a practice)		Phone Number:	
Street Address:	City	State	Zip

Section 4. What information About the Individual Will Be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis and medication(s) if necessary.

Section 5. The Purpose of the Disclosure

To release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

Section 6. the Expiration Date of Event

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information based on this authorization may be disclosed by the recipient and may no longer be protected by Federal or State privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have the right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for the copy at any time by contacting your behavioral health provider named above.

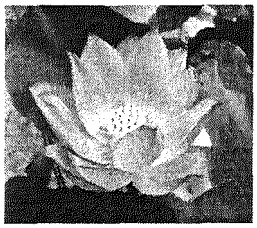
Section 8. Signature of the Individual

Signature:_____Date:_____

Section 9. Signature of Personal Representative (if applicable)

Signature:·_____Date: _____

Relationship to the individual (required) _____



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Communication Consent

It is the policy of Suffolk DBT and its Associates not to release confidential and/or unauthorized information by answer machine, home telephone, voice mail, cellular phone, work telephone and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave any message that would include private / personal information. Also, information will not be left with an unauthorized person who may not have consent to do so.

I authorize Suffolk DBT and/or their Associates and staff to leave confidential information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes. Please fill out all contact information that you authorize for communication.

Please put corresponding phone number or email on dotted line and circle yes or no for each option.

Home Telephone..... Yes No

Answering Machine..... Yes No

Cellular Voice Mail..... Yes No

Work Telephone..... Yes No

Email..... Yes No

Text Message (Cell Phone)..... Yes No

If you authorize information to be released to someone other than yourself, please complete the following:

List of authorized people:

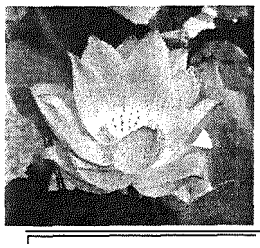
Spouse..... Tel .....

Adult Child..... Tel .....

Other (indicate relation)..... Tel .....

Print Patient Name. .....

Patient Signature. ..... Date: .....



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Statements of Member's Rights

Members have the right to be treated with dignity and respect.

Members have the right to fair treatment; regardless of their race, religion, gender, ethnicity, age, disability or source of payment.

Members have the right to have their treatment and other member information kept private, only where permitted by law, may records be release without member permission.

Members have the right to easily access timely care in a timely fashion.

Members have the right to know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.

Members have the right to share in developing their plan of care.

Members have the right to have a clear explanation of their condition and treatment options.

Members have the right to information about their insurance company, its practitioners, services and role in the treatment process.

Members have the right to information about clinical guidelines used in providing and managing their care.

Members have the right to ask their provider about their work history and training.

Members have the right to give input on the Member's Rights and Responsibilities policy.

Members have the right to know about advocacy and community groups and prevention services.

Members have a right to freely file a complaint or appeal and to learn how to do so.

Members have the right to know of their right and responsibilities in the treatment process.

Members have the right to receive services that will not jeopardize their employment.

Members have the right to list certain preferences in a provider.

Statement of Member's Responsibilities

Members have the responsibility to treat those giving them Care with dignity and respect.

Members have the responsibility to give providers information they need. This is so providers can deliver the best possible case.

Members have the responsibilities to ask questions about their care. This is to help them understand their care.

Members have the responsibility to follow the treatment plan. The plan of care is to be agreed upon by the member and the provider.

Members have the responsibility to follow the agreed upon medication plan.

Members have the responsibility to tell their provider and primary care physician about medication changes, including medications given to them by others.

Members have the responsibility to keep their appointments. Members should call the providers as soon as they know they need to cancel visits.

Members have the responsibility to let their providers know when the treatment plan isn't working for them.

Members have the responsibility to let their provider know about any problems with paying fees.

Members have the responsibility to report abuse and fraud.

Members have the responsibility to openly report concerns about the quality of care they receive.

Patient Name: _____

INS. Policy#: _____

My signature below shows that I have been informed of my rights and responsibilities, and that /understand this information

Member Signature Date:

The signature below shows that I have explained this statement to the patient. I have offered tile member a copy of this form.

Clinician Signature Date: