



THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU AND THE SERVICES THAT YOU RECEIVE FROM THE CHILDREN'S HOME SOCIETY OF NEW JERSEY MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

HIPAA NOTICE OF PRIVACY PRACTICES

INTRODUCTION

The Children's Home Society of New Jersey (CHSOFNJ) understands that information that we collect and maintain about you and the services that you engage in are private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" includes any individually identifiable information that we obtain from you or from others that relates to your past, present or future physical or mental health, and the health care you have received or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from the CHSofNJ HIPAA Privacy Officer or you can access it on our website at www.CHSofNJ.org.

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of *treatment, payment and health care operations*. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

1. *Treatment* means the provision, coordination, or management of your health care, including consultations between health care providers relating to your care and referrals for health care from one health care provider to another. For example, your PHI may be shared with the therapist who is providing counseling to you.

2. *Payment* means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third Party Payor about your health condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payor for the services rendered to you, we can provide the Third Party Payor with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially protected health information for payment purposes, and we will ask you to sign a release when necessary under applicable law.

3. *Health care operations* means the support functions of CHSOFNJ, related to *treatment and payment*, such as quality assurance activities, case management, receiving and responding to recipient comments, complaints, service provider reviews, compliance programs, audits, business planning, development, management, and administrative activities. For example, we may use your protected health information to evaluate the performance of our staff when caring for you. We may also combine health information about many recipients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to interns and others for review and learning purposes. In addition, we may remove information that identifies you from your recipient information so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your information for treatment, payment and health care operations, we may use your protected health information in the following ways:

1. We may contact you to provide appointment reminders for treatment or health care.

2. We may contact you to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

3. We may disclose to your family or friends or any other individual identified by you protected health information directly related to such person's involvement in your care or the payment for your care. We may use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. If you are present or otherwise available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not present or otherwise available, we will determine whether a disclosure to your family or friends is in your best interest taking into account the circumstances and based upon our professional judgment.

4. When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

5. We will allow your family and friends to act on your behalf to pick-up forms of protected health information, when we determine that, in our professional judgment, it is in your best interest to make such disclosures.

6. Subject to applicable law, we may make incidental uses and disclosures of protected health information. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

7. We may contact you as part of our fund-raising and marketing efforts as permitted by applicable law.

8. We may use or disclose your protected health information for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all recipients who received a particular type of therapy. All research projects are subject to a special approval process which balances research needs with a recipient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.

9. We will use or disclose protected health information about you when required to do so by applicable law.

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your protected health information:

1. Military and Veterans. If you are a member of the Armed Forces, we may release health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

2. Worker's Compensation. We may release health information about you for programs that provide benefits for work-related injuries or illnesses.

3. Public Health Activities. We may disclose health information about you for public health activities, including disclosures:

- (a) to prevent or control disease, injury or disability;
- (b) to report births and deaths;
- (c) to report child abuse or neglect;
- (d) to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
- (e) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- (f) to notify the appropriate government authority if we believe that an adult recipient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the recipient agrees or when required or authorized by law.

4. Health Oversight Activities. We may disclose health information to Federal or State agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government benefit programs, and compliance with civil rights laws or regulatory program standards.

5. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if CHSOFNJ is given assurances

that efforts have been made by the person making the request to tell you about the request or to obtain an order protecting the information requested.

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

- (a) In response to a court order, subpoena, warrant, summons or similar process;
- (b) To identify or locate a suspect, fugitive, material witness, or missing person;
- (c) About the victim of a crime under certain limited circumstances;
- (d) About a death we believe may be the result of criminal conduct;
- (e) About criminal conduct on our premises; and
- (f) In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

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

8. Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your permission in a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request. To request a restriction, you must make your request in writing to the CHSofNJ HIPAA Privacy Officer.

2. You have the right to reasonably request to receive confidential communications of protected health information by alternative means or at alternative locations. To make such a request, you must submit your request in writing to the CHSofNJ HIPAA Privacy Officer.

3. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other CHSOFNJ records used by us to make decisions about you, except:

- (a) for psychotherapy notes, which are notes that have been recorded by a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;
- (b) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

- (c) for protected health information involving laboratory tests when your access is restricted by law;
- (d) if we obtained or created protected health information as part of a research study, your access to the health information may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;
- (e) for protected health information contained in records kept by a Federal agency or contractor when your access is restricted by law; and
- (f) for protected health information obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect and copy your health information, you must submit your request in writing to the CHSofNJ HIPAA Privacy Officer at our main office. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to protected health information if:

- (a) a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;
- (b) the protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
- (c) the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request an amendment to your protected health information, but we may deny your request for amendment, if we determine that the protected health information or record that is the subject of the request:

- (a) was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;
- (b) is not part of your medical or billing records or other records used to make decisions about you;
- (c) is not available for inspection as set forth above; or
- (d) is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your health information, you must submit your request in writing to the CHSofNJ HIPAA Privacy Officer at our main office, along with a description of the reason for your request.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

- (a) to carry out treatment, payment and health care operations as provided above;
- (b) incident to a use or disclosure otherwise permitted or required by applicable law;
- (c) pursuant to a written authorization obtained from you;
- (d) to persons involved in your care or for other notification purposes as provided by law;
- (e) for national security or intelligence purposes as provided by law;
- (f) to correctional institutions or law enforcement officials as provided by law;
- (g) as part of a limited data set as provided by law; or
- (h) that occurred prior to April 14, 2003.

To request an accounting of disclosures of your health information, you must submit your request in writing to the CHSofNJ HIPAA Privacy Officer at our main office. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

COMPLAINTS.

If you believe that your privacy rights have been violated, you should immediately contact CHSofNJ HIPAA Privacy Officer at the main office. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact **CHSofNJ's HIPAA Privacy Officer, Joseph Rizzello at:**
The Children's Home Society of New Jersey
635 South Clinton Avenue
Trenton, NJ 08611
609-695-6274 ext. 133
JRizzello@CHSofNJ.org

This notice is effective as of December 1, 2002 and was updated on March 16, 2016



NOTICE OF CLIENT'S RIGHTS AND RESPONSIBILITIES

CLIENT RIGHTS

Each client shall be made aware of the rights and privileges in receiving mental health services. CHSofNJ has established a policy statement in this regard. This notice shall be given to clients at or before their first appointment. These rights shall be prominently posted.

- Subject to provisions of law, no client shall be deprived of any civil right solely by reason of his/her receiving mental health services, nor shall services modify or vary any legal or civil right of any client.
- The right to be treated with respect, courtesy, and dignity, including being free of/from any action intended to threaten, intimidate, or hurt you, including the right to be free of corporal punishment.
- The right to the least restrictive conditions necessary to achieve the goals of treatment including to be free from unnecessary and excessive medication, and to be free from restraints or isolation.
- The right to refuse to take part in research, non-standard or experimental treatment procedures, psychosurgery, sterilization, or electroconvulsive therapy without it affecting your ability to continue in treatment. Also, before taking part in any of the above you have the right to give written informed consent and to consult with another other interested party of your choosing.
- The right to confidentiality and privacy within the bounds of applicable law. Exceptions include, but are not limited to, suspected abuse or neglect of a child and a reasonable belief of potential harm to you or others.
- The right to give informed written consent before information regarding you and the services you receive is released within the bounds of applicable law; and to be informed when this information is released when your consent is not required by applicable law unless there is a reasonable belief of potential harm to you or others if you are informed.
- The right to give informed consent regarding treatment or services, and make decisions about treatment and services, including the right to refuse treatment or medication and to understand the consequences of your refusal.
- The right to review and amend your own record, within the bounds of applicable law, by submitting a request in writing to the HIPAA Privacy Officer.
- The right to receive services reflecting an appreciation of your culture, heritage, and identity; and to engage in services in your primary language or language of preference.
- The right to have equal access to program information and technical assistance necessary to participate in all CHSofNJ programs and activities, irrespective of age, gender, sexual orientation, physical handicap or disability. If you feel that your Civil Rights have been violated you may file a written complaint with the Chief Program Officer and your concerns will be reviewed by the Civil Rights Review Committee.
- The right to complain and to be heard if dissatisfied with the services rendered. You are encouraged to first attempt to resolve the problem within the program from which you are receiving services, including the direct service staff, his or her supervisor, and the program director. If you cannot resolve your complaint within the program, you may file a written complaint with the Chief Program Officer, and if necessary the Chief Executive Officer will be the final arbitrator of the complaint.
- To have all program rules with which you are expected to comply given to you clearly and in writing.
- If a client has been adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of N.J.S.A. 30:4-24.2d (2).

CLIENT RESPONSIBILITIES

- To attend scheduled appointments and meetings; frequently not attending appointments and meetings may result in discharge from the program.
- To actively engage in your own treatment to gain the maximum possible benefit.
- To treat staff and other clients with courtesy and respect; continued disrespectful behavior may result in discharge from the program.
- To not harm or threaten to harm any staff or other client; this may result in immediate discharge from the program.
- To follow the rules of the program in which you are receiving services.
- To turn off you cell phone while in treatment. If there is a reason that you must be able to be contacted you must let your therapist know at the beginning of the session.

FEE-FOR-SERVICE PROGRAMS ONLY

- To provide CHSofNJ with accurate insurance information and to advise us of any changes in your coverage.
- To be financially responsible to pay for services that are not covered by insurance.
- To pay all co-pays required by your insurance prior to each session.



GENERAL ACKNOWLEDGEMENT REGARDING SERVICES TO MINORS

I acknowledge that if the services provided by The Children’s Home Society of New Jersey (CHSofNJ) are for a minor child in my care that I am making this acknowledgement on behalf of that child. I also agree, that I will be an active participant in the minor child’s care.

ACKNOWLEDGMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of CHSofNJ Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices. I understand that this notice describes the uses and disclosures of my protected health information that may be made by CHSofNJ, my rights to privacy under HIPAA, CHSofNJ’s legal duties with respect to my protected health information, and my rights to file a grievance if I believe that my rights have been violated. I understand that if I need another copy it will be provided to me upon my request or I can obtain a copy from CHSofNJ’s website (www.CHSofNJ.org).

Client’s Name (please print)

Client’s Signature

Date

ACKNOWLEDGMENT OF RECEIPT - NOTICE OF CLIENT’S RIGHTS AND RESPONSIBILITIES

I acknowledge that I have been provided with a copy of CHSofNJ Notice of Client’s Rights and Responsibilities. I understand that this notice describes the rights that I have as a Client of CHSofNJ, the responsibilities that I must adhere to while receiving services, and my rights to file a complaint if I have a concern about my care. I understand that if I need another copy it will be provided to me upon my request or I can obtain a copy from CHSofNJ’s website (www.CHSofNJ.org).

Client’s Name (please print)

Client’s Signature

Date

CONSENT FOR SERVICES

I acknowledge that the CHSofNJ Staff who provided me with the HIPAA Notice of Privacy Practices and Notice of Client’s Rights and Responsibilities has explained these documents to me and answered any questions that I had regarding them. I also understand that should I have further questions I may discuss the contents of these documents with CHSofNJ’s HIPAA Privacy Officer who is identified on the HIPAA Notice of Privacy Practices.

I acknowledge that the staff person who is providing me services has explained the purpose of the program, the objectives that the services are designed to achieve, and the methods used by the program. I am agreeable with the program’s purpose, objectives, and methods and believe they will help me achieve my goals.

As I have an understanding of the protections of my privacy afforded to me under HIPAA, the limits of this protection, my rights and responsibilities as a Client, and believe that the purpose, objectives, and methods of the program will be beneficial to me I am consenting to receive services from CHSofNJ. I further understand that I can revoke this consent at any time but must inform the program staff in writing that I am doing so.

Client’s Name (please print)

Client’s Signature

Date

ACCOMMODATIONS MADE TO UNDERSTAND CONTENT

I was unable to read these documents but they were explained to me in my preferred language or they were presented to me in a manner that I understand. I have had the opportunity to ask questions about them. By my signature below, I hereby, knowingly, and voluntarily, engage in the services provided by CHSofNJ.

Signature of Client

Date

CHSofNJ Representative who read or interpreted the document

Position

Date