David J. Schopick, M.D.
118 Maplewood Avenue
Portsmouth, New Hampshire 03801
603-430-9085

DIRECTIONS TO OUR OFFICE:

Our office is located across from the old Portsmouth Herald building in downtown Portsmouth.

FROM I-95: Exit at the Portsmouth Traffic Circle (Exit 5 "Portsmouth Circle"). Enter the traffic circle and take the Route 1 Bypass North heading towards Maine. Take the 2nd exit, marked "Maplewood Avenue". At the end of the off-ramp, take a right onto Maplewood Avenue. Approximately 0.2 miles later, you will cross a small bridge that passes over water. The third property on the right is 118 Maplewood Avenue. A sign reading "118" hangs over the sidewalk. We have off-street parking. We are located in Building "B".

FROM THE SPAULDING TURNPIKE: Proceed to the Portsmouth Traffic Circle and follow the directions above.

FROM THE ROUTE ONE BYPASS TRAVELING FROM MAINE: Exit at the Maplewood Avenue exit. At the end of the ramp, take a right onto Maplewood Avenue. Approximately 0.2 miles later, you will cross a small bridge that passes over water. The third property on the right is 118 Maplewood Avenue.

FROM DOWNTOWN PORTSMOUTH: Follow Congress Street to where it ends and becomes Islington Street (one-way traffic ends at this point). Turn Right onto Maplewood Avenue. Shortly after the second traffic light is a cemetery followed by a group of houses. "118" is on the left.

FROM MIDDLE STREET IN PORTSMOUTH: When Middle Street ends, it becomes Maplewood Avenue after you have crossed Congress Street. Shortly after the second traffic light (counting after the light at Congress and Islington Street) is a cemetery followed by a group of houses. "118" is on the left.

FROM WOODBURY AVENUE IN PORTSMOUTH: At the Marshalls/K-Mart Plaza turn right at the traffic light (continuing on Woodbury Avenue). At approximately 0.3 miles, turn left onto Maplewood Avenue. Approximately ¾ miles later, you will pass over a small bridge. After the bridge, the third property on the right is 118 Maplewood Avenue.

UPON REACHING 118 MAPLEWOOD AVENUE **there is a blue and white sign reading "118" that hangs over the sidewalk. The property is made up of two white colonial buildings. We are located in Building B (up the stairs or ramp, enter main door). If you find the outside door locked, there is a doorbell to the upper left which you can press to alert us of your presence.**

David J. Schopick, M.D.

PATIENT INFORMATION - *Please complete all information. Thank you.*

Name of Person who referred you to our office: ______________________________

Today's Date: ____________

PATIENT FULL NAME:____

PATIENT DATE OF BIRTH: _________________

SOC SEC #: ____

PATIENT EMPLOYER/SCHOOL:

____

PATIENT OCCUPATION: _____________________

PATIENT MARITAL STATUS: ____________

If patient is a minor child, parents' names:

Mother____

Father ____

Mailing Address:

____

Street Address Town/City Zip

Telephone Number:

(h) __________________ (w)__________________(c)________________________

If parents are: ______ Divorced ______ Separated

** This is the ____mother's ___ father's information:

Other parent's mailing address:

____

Street Address Town/City Zip

Telephone Numbers

(h) _____________________ (w)_____________________(c)__________________

RESPONSIBLE PARTY (person responsible for charges/ins co-payments, etc.):

Name: ____________________________________Phone #: _________________________

Address if Different from above:

____

PRIMARY INSURANCE COMPANY: (Please call your ins co to determine your benefits).

Name of Company: ________________________Effective Date(s): _______________

INSURANCE ID#: ________________________GROUP/ACCT #: ________________

Subscriber's Name: ______________________ Relation to pt. _______________

Subscriber's DOB: _________________________________

Subscribers SS#: (*necessary) ________________________

Subscribers Address:____

Street Address Town/City Zip

Subscriber's Telephone:

(h) ___________________ (w) __________________ (c)___________________

Subscriber's Employer:

____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS: I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the undersigned physician.

** PLEASE BE SURE TO NOTIFY OUR OFFICE IF ANY INFORMATION ABOVE CHANGES.

____ Date: _______________________
Patient or Parent/Guardian of Minor Patient

David Schopick MD *118 Maplewood Avenue* *Portsmouth, NH 03801*

Dear Parents: Please complete the questionnaire prior to the first appointment.
Attach a recent photo of your child on the back of this page if one is readily available.

Child's Name____ Age:_______ Date of Birth: _____/_____/_____

Address: ____ State: __________ Zip:___________________

Person completing this form:_____________________________ Relationship to Child: _____________________

In 15 words or less, why are you here and what would you like help with?

___

___

Please elaborate on the current circumstances and why you are concerned about your child.

___

___

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Mother's Name: ___________________________ Age:_______

Occupation: ________________________________ Education: _________________________

Work Phone: ___________________ Home Phone: _____________________ Cell Phone: ______________________

Father's Name: ____________________________ Age:________

Occupation: ________________________________ Education: _________________________

Work Phone: ___________________ Home Phone: _____________________ Cell Phone: ______________________

Who referred you here? ____

Has your child received inpatient or outpatient treatment for this problem? Yes No

If yes, please provide the following information for hospitals, psychiatrists, or therapists.

Name	Dates	Address	Phone Number

Is your child adopted? Yes ☐ No ☐ If yes, please describe the circumstances of the adoption.

How long have you been married? __________ Dates: ____

Divorced? __________ Dates: ____

Separated ? _________ Dates: ____

Living together but unmarried? Dates: ____

Name of your child's school: ____ Phone: _____________________________

Teacher's Name: ____ Grade: __________________________

Overall School Performance:

Ever Expelled? _____, If yes, number of times and reasons why:

Grades repeated: ______________________ Grades skipped: _______________________

Does your child receive any special education services? Yes No If yes, please explain:

How does the school describe your child's behavior?

____

____

What are your child's strengths in school?

____

____

____

Does your child participate in sports? If yes, please describe.

____

____

____

Check any of the following behaviors that apply to your child:

Poor Attention	Distractibility	Incomplete homework
Forgets Assignments	Makes careless mistakes	Forgetful
Messy work	Disorganized	Loses things
Forgets to flush	Fidgets often	Hyperactive
Unable to sit still	Always on the go	Interrupts frequently
Impatient	Impulsive	Blurts out answers
Aggressive	Risk taker	Test Anxiety
Worries a great deal	Separation Anxiety	Social Anxiety
Obsessions	Compulsions	Rituals
Poor reading skills	Poor spelling	Poor math skills
Poor handwriting	Teased by peers	Bullied by peers
Poor social skills	Legal Problems	

Additional comments on schoolwork, homework, peer relations, social interactions:

____

____

____

Family Psychiatric History:

____

____

What has your child's mood appeared like most of the time for the past month?

____

Has your child been experiencing any of the following symptoms?

Sadness	Irritability	Anxiety
School refusal	High Energy with decreased need for sleep	Euphoria
Suicidal comments	Crying	Social Isolation
Anger	Recent decline in school performance	Substance abuse
Recent changes in friends	Has your child been giving away personal items more than usual?	
Sexual Acting out	Binging	Purging
Excessive exercise	Excessive calorie or carb counting	Aggression
Insomnia		

Has your child abused drugs or alcohol? Yes No If yes, please describe.

____

____

____

____

____

Your child's medication history:

	Medication	Medication
Medication Name		
Prescriber		
When started		
When stopped		
Target Symptoms		
Dose		
Benefits		
Side effects		
Results		

	Medication	Medication
Medication Name		
Prescriber		
When started		
When stopped		
Target Symptoms		
Dose		
Benefits		
Side effects		
Results		

(Continued)	**Medication**	**Medication**
Medication Name		
Prescriber		
When started		
When stopped		
Target Symptoms		
Dose		
Benefits		
Side effects		
Results		

Were there any complications during pregnancy?

____

____

Did you drink alcohol, smoke cigarettes, or use drugs during the pregnancy? If yes, please describe.

____

____

Mother's age at birth: _______ Father's age at birth: _______

Child's weight at birth: _______ pounds _______ ounces

Was the baby premature? __________ If so, how premature? ______ weeks

APGAR score at birth: _______ APGAR at 5 minutes: _______

Developmental History:

(Check appropriate box)	Normal	Fast	Slow
Motor Development (Sitting, crawling, walking)			
Speech and Language			
Handedness			
Personal skills (dressing, brushing, toileting, hygiene)			

Your child's Medical History:

Dates:

Seizures ____________________

Head Injury ____________________

Loss of consciousness ____________________

Cardiac problems ____________________

Strep throat ____________________

Hearing problems ____________________

High fever ____________________

Chicken Pox ____________________

Diphtheria ____________________

High Fever ____________________

Frequent ear infections ____________________

Tubes in ears ____________________

Allergies to Medications ____________________

Food allergies ____________________

Hypertension ____________________

Hypothyroid ____________________

Hyperthyroid ____________________

Asthma ____________________

Meningitis ____________________

Encephalitis ____________________

Other illnesses or injuries ____________________

Please elaborate on your child's illnesses or medication allergies:

____

____

Does your child take medication for medical diagnoses? Yes No If yes, please describe:

____

____

Has your child shown signs of puberty yet? Yes No For girls, at what age did menses, breast development, sexual interest begin? For boys, at what age(s) did pubic and armpit hair, testicular enlargement, sexual interest, and deepening of the voice begin?

____

____

Please explain anything else you would like me to be aware of regarding your child?

____

____

____

____

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____

____

Signature ____ Date ________________

David J. Schopick, M.D.

American Board of Psychiatry and Neurology
Child, Adolescent, Adult and Forensic Psychiatry
118 Maplewood Avenue, Portsmouth, New Hampshire 03801
Tel: (603)431-5411 Fax: (603)430-9085

Please read this Policy carefully. It will help answer some of your questions, and reduce paperwork and time consuming telephone calls in the future. This agreement must be reviewed, signed, and on file prior to the start of your initial appointment. There is no need to return this document to us prior to your initial appointment - please bring it with you.

CONSENT TO TREATMENT POLICY

From the clinical perspective, this is how I typically proceed: I provide a thorough and careful evaluation that gathers information not only about the patient's current problem, but also their past mental health treatment, medical history, social and school history, and family mental health history. This gives me a comprehensive picture of the patient and allows me to recommend a suitable treatment.

All treatment options are discussed with the patient in detail, so they can participate in choosing the option they feel most comfortable with. The patient is always a partner in the decision-making process when it comes to selecting a course of treatment.

I base my treatment planning on what is called the “biopsychosocial model,” meaning that during treatment, I address biological, psychological, and social factors that may be influencing the patient's current difficulties. This comprehensive approach is most effective in helping people restore their mental health.

Treatment options may range from medication to various methods of psychotherapy, provided by my colleagues. I can and do refer to other mental health providers if the situation warrants. Regular follow-up visits are scheduled to ensure that treatment proceeds safely and effectively.

OFFICE / FINANCIAL POLICY

Our office accepts assignment for Blue Cross and Blue Shield plans including Federal BC/BS, and Matthew Thornton, Harvard Pilgrim, United Behavioral Health policies. If you subscribe to one of these insurance plans, payment of your deductible and co-payment is expected at the time of service. For other insurance plans not covered, please be prepared to pay in full at the time of service. If you do not have insurance, or choose not to use insurance, payment in full is due at the time of service.

As a courtesy to our patients we bill the above insurance companies. However, we will not be able to bill your insurance company as a service to you if we are not provided with the following:

1. Patient’s full name and date of birth;
2. The complete name, address, telephone number, current ID #, and Group # of your insurance company or company handling mental health claims for your insurance company; and,
3. Subscriber’s name, address, date of birth, and social security number.

You should also be aware that some insurance companies will not pay for medical services that they decide are “Not Medically Necessary” or consider uncovered services. We have no control over the workings of the insurance companies and assume no responsibility for their policies. In the event your insurance company considers a service “Not Medically Necessary” or uncovered, this in no way can be construed to mean that medical treatment and care was not rendered. You will still be expected to make payment for the service within thirty (30) days. When an insurance company refuses to make payment for medical services, the patient is then responsible for payment of these services he/she has received. If you are not satisfied with your insurance company’s decision to deny payment, you are entitled to contest that denial with the

insurance company. Payment for services rendered is required; however, if you pursue and win a reversal of that decision from your insurance company, we will make reimbursement for the appropriate amount when we receive the insurance payment.

Please be particularly aware, to assist you, we will gladly bill your primary insurance company for services rendered; however, most insurance company policies require notification and authorization *prior to your initial appointment* for services to be covered. Regardless of whether you believe it is required for your policy, please call your insurance company *prior to your initial appointment* to confirm coverage, and request proper authorization for services. If this is not completed prior to services being rendered, the session fee(s) will be the responsibility of the responsible party/patient.

PATIENTS/PARENTS ARE EXPECTED TO BE FAMILIAR WITH THE DETAILS OF THEIR HEALTH INSURANCE/MENTAL HEALTH COVERAGE. PLEASE TAKE THE TIME TO CALL YOUR INSURER AND BECOME FAMILIAR WITH THE DETAILS OF YOUR POLICY. THIS MAY INCLUDE WHETHER AUTHORIZATION AND/OR A REFERRAL IS NEEDED, WHETHER OR NOT YOU HAVE A DEDUCTIBLE, THE AMOUNT OF YOUR DEDUCTIBLE, THE AMOUNT OF YOUR CO-PAY OR CO-INSURANCE, AND THE NUMBER OF VISITS YOUR PLAN ALLOWS FOR.

**Please note that an authorization from an insurance company is not a guarantee of payment. Insurance companies may issue an authorization, but wait until receipt of the claim to either accept the claim and make payment, or deny the claim. If a claim is denied, payment of that claim becomes the patient's responsibility. We have no control over an insurance company who issues an authorization, but then denies payment of a claim.

Because of the time demands involved in completing forms and miscellaneous paperwork to be submitted to schools, camps, workers' compensation carriers, social security/disability, attorneys, etc., responsible parties/patients are responsible for the costs incurred as a result of a request to complete miscellaneous forms, retrieve and copy closed out charts, preparation of letters, or any other paperwork requested.

Payment is expected in advance for services requested outside of an appointment, including, but not limited to:

- Attendance at meetings with attorneys, schools, court appearances, depositions, and any other non-treatment time spent at the patient's request;
- Travel time to and from such meetings of any nature, court appearances, depositions, and any request for attendance;
- Preparation time to review records or any other preparation time needed for such meetings, court appearances, or meetings of any nature.

When calling to reserve time for such events as described above, please ask for the current expert witness/forensic fee schedule.

Payment for a session, whether from an insurance company or self paid, covers the session time only. Please recognize we receive many requests for letters or the completion of forms. Please plan ahead as it is often difficult to accommodate last minute requests. Requests for form/letter completion is most efficiently done in conjunction with your appointment while you are here in the office. With this in mind, please make us aware at the beginning of the session that you have such a request and we will do our best to finish your request before you leave. Please understand I cannot take another patient's appointment time to complete a form or letter on your behalf.

If your insurance company, school, attorney, or other party or facility requests a copy of the patient's records or requests communications and information from this office, the cost of such a request is the responsible party/patient's responsibility.

INSURANCE APPEALS:

If you request an appeal to your insurance company for denial of a session or prescription coverage, the appeal paperwork can be completed by either scheduling an appointment at which time the appeal documents will be completed, or the time spent on the appeal can be billed at an hourly rate if you choose to not schedule an appointment. If requesting an appeal, please provide us with all paperwork you have received from your insurance company (including the address, telephone number, facsimile number, and complete name of the insurance company handling the appeal). Appeals are extremely time consuming and often require numerous contacts with the insurance company. Please allow ample time for the paperwork to be completed and processed.

CONFIDENTIALITY:

Pursuant to New Hampshire state law, R.S.A. 329:26 "Confidential Communications" are defined as follows: "The confidential relations and communications between a physician or surgeon licensed under provisions of this chapter and his patient are placed on the same basis as those provided by law between attorney and client, and, except as otherwise provided by law, no such physician or surgeon shall be required to disclose such privileged communications. Confidential relations and communications between a patient and any person working under the supervision of a physician or surgeon that are customary and necessary for diagnosis and treatment are privileged to the same extent as though those relations or communications were with such supervising physician or surgeon ..."

The Federal law (HIPAA) also requires a minimum level of confidentiality guidelines to be followed. If an individual state has a more comprehensive policy, then clinicians must adhere to the stricter of the two. HIPAA Guidelines defer to state law when practicable. Our policy regarding Confidentiality will be based on and adhere to New Hampshire state law which is much more comprehensive.

In order to communicate with anyone (physicians, therapist, school personnel, personal representatives, spouses, etc.) regarding your treatment, we will require a written release on file authorizing our office to speak to or provide records to another party. The only exceptions to the requirement to have a written release on file is as follows:

1. Communications with your insurance carrier regarding information needed to process your claims, obtain authorization for prescription(s), or authorize additional sessions, and will be viewed as acceptable to you by signing this Policy;
2. In the event we are contacted by emergency personnel (including, but not limited to hospital staff or police) for a medical emergency and information is needed to treat you and you are not available to provide authorization;
3. Information is needed by your pharmacy in order to fill prescription(s);
4. Parents have access to their child's records unless a Court Order exists that states otherwise; or,
5. Communication to state agencies regarding suspicion of abuse and/or neglect, or concerns regarding the potential harm to self or others. If there is a concern you may be a danger to self and/or others, this office may determine it is necessary to call the authorities and/or the intended victims to alert them of a potential danger.

REMINDER CALLS:

Reminder calls will be made to the home or cellular telephone number you have provided to us on the Patient Information sheet. If you want a reminder call made to a different number, you must advise us in writing, and this document will be kept in your patient chart for reference. Unless otherwise advised, reminder call(s) will be made to the number you have provided to us.

As stated above, we will make every effort to provide a courtesy reminder call prior to your scheduled appointment. However, as there are three separate areas of our practice, there are days when we are not in the office, and therefore not able to place reminder calls. It is the patient's/parent's responsibility to keep track of scheduled appointments and to not rely solely on a reminder call. A reminder card will be issued when rescheduling to assist you in keeping track of your appointment(s).

LATE CANCELLATION – NO SHOW POLICY:

An important element for an effective outcome in treatment is that you set your/your child's appointment time as a priority. Cancellations and missed appointments are strongly discouraged for both therapeutic and scheduling reasons.

We require 24 hours notice if you are unable to keep an appointment. If notification is not made within 24 hours, or if the appointment is missed, you will be charged for the late cancellation or missed appointment. Notification after 3:00pm on a Friday or on a Saturday or Sunday of a Monday cancellation will not be considered timely. The charge for a missed medication management session is $50.00, and a missed initial/full session is $250.00. The fee should not be considered a penalty for missing the appointment; it is only in place to recuperate the time we had reserved for you from our schedule at your request. Insurance companies will not pay for a missed appointment or late cancellation, and payment is expected before rescheduling.

Exceptions to this policy of charging for appointments not kept and not canceled with 24 hours notice will take place only when the weather is severe enough to close public schools or an illness requires a visit to a physician.

PRESCRIPTION REFILLS:

Due to a past experience of a high number of patients calling for medication refills after not following the recommended follow-up time, or missing appointments, our policy for medication refills is as follows:

Prescriptions will be refilled during your appointment only. You are expected to follow the recommended schedule for follow-up appointments. You will not be able to pick up a prescription at the office or have our office renew a prescription by telephone. The only exceptions to this policy are in the event of a true medical emergency, a medically necessary medication or dose change, or if we have had to reschedule your appointment and your current prescription will lapse prior to the re-scheduled appointment. This policy will assist in our efforts to maintain a high level of patient care.

PATIENT BALANCES:

We are a small practice and therefore unable to allow patients to carry a large outstanding balance on their account(s). Please come to your appointment prepared to pay your balance in full. If a third party is paying your bill, please obtain the amount due prior to your appointment to reduce the time spent on paperwork and telephone calls to collect your balance. We appreciate your assistance with this policy as it will allow us more time to focus on your needs and requests, and will help eliminate the time spent attempting to collect overdue balances.

RETURNED CHECKS:

If your check is returned to us by the bank as unpaid for any reason, a returned check fee of $35.00 will be added to the amount of the check written. The $35.00 fee represents the fee the bank charges us and the administrative cost to handle the extra processing and will be paid in full within ten (10) business days.

CASE CLOSURE:

If there has been no clinical contact after a period of four months, we will assume you have decided to discontinue treatment. At this point, you will no longer be considered a current patient and your chart will be closed and placed in storage. If you wish to resume your treatment, you may simply contact the office and request an appointment.

Your signature below indicates that you understand and agree to our Consent to Treatment/Office / Financial / Confidentiality Policy in its entirety, including, but not limited to your agreement that: you assign all insurance benefits directly to our office; will pay deductibles, co-insurances, co-payments, any requested service not covered by insurance as explained above; will pay for late cancellations or no show appointments, and for returned checks.

The office staff will be happy to speak with you about any questions you may have.

Signature____ **Date** ___________________________

Patient or Responsible Party

David J. Schopick, M.D.
Board Certified
American Board of Psychiatry and Neurology
Child, Adolescent, Adult and Forensic Psychiatry
118 Maplewood Avenue, Portsmouth. New Hampshire 03801
Tel: (603) 431-5411 - Fax, (603) 430-9085

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.

This notice takes effect on _______ , _____________________ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive atour organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and Your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use of disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. <u>We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization.</u> <u>Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.</u>

FOR TREATMENT: We may use medical information about YOU to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical student's, or other people who are taking care of You. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purpose's. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings. inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding You of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $________ for each page. and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different

locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.

5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons, If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed, If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. if you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees., conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms: your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share. or give you the opportunity to refuse permission In case of emergency, and if you are not able to give or refuse permission. we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional Judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner. medical examiner, funeral director, or an organ Procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order. warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with, a law enforcement official concerning the medical information of a Suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.
Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food arid Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or
a communicable disease or otherwise be at risk of contracting or spreading a
disease or condition.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

118 Maplewood Avenue
Portsmouth, NH 03801

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not, retaliate in any way if you choose to file a complaint.

David J. Schopick, M.D.
Board Certified
American Board of Psychiatry and Neurology
Child, Adolescent, Adult and Forensic Psychiatry
118 Maplewood Avenue, Portsmouth. New Hampshire 03801
Tel: (603) 431-5411 - Fax, (603) 430-9085

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name ______________________________ Birthdate ______________

Signature ____

Date ____

David J. Schopick, M.D.
118 Maplewood Avenue, Portsmouth, New Hampshire 03801
Telephone: (603)431-5411 / Facsimile (603)430-9085

AUTHORIZATION FOR RELEASE OF MEDICAL/PSYCHIATRIC INFORMATION

Patient Name____DOB:______/_________/_______

____
Street Town/City State Zip

I hereby request and authorize: David J. Schopick, M.D. or his staff,

To obtain from/exchange with (including telephone or facsimile):

Name of Person/Provider: ____

Agency____

Address____
Street Town/City State Zip

Telephone #:_________________________________ Fax #_________________________________

I am hereby authorizing and approving the release of the following type(s) of confidential psychiatric information pertaining to me to the individual and/or agency listed above:

_______ All records, notes, or any other information requested without any limitation;

or, only the following records:

_______ Drug and Alcohol History
_______ Progress Notes
_______ Treatment Plans
_______ Initial Psychiatric Evaluation
_______ Lab Reports
_______ Discharge Summary
_______ Summaries
_______ Records from the following dates of service: Start date ___________ to end date ___________
_______ Other____

I understand that all information I have authorized to be obtained or exchanged will be held strictly confidential and cannot be released by either of the two parties names above without my written consent. I have been advised to inform Dr. Schopick's office if this release should be withdrawn and considered void at a future date.

This release expires one year from the signature date below unless a shorter period is specified here ____.

____ _________________________
Signature of Patient/Parent/Guardian **Date**

David J. Schopick, M.D.

Board Certified

American Board of Psychiatry and Neurology

Child, Adolescent, Adult and Forensic Psychiatry

118 Maplewood Avenue, Portsmouth. New Hampshire 03801

Tel: (603) 431-5411 - Fax, (603) 430-9085

As of: November 1, 2003

Dear Patients/Parents:

Due to an increasing number of patients canceling or missing their appointments and then calling in for prescription refill(s), **the office policy is now that prescriptions will only be provided at an appointment.**

There are only two exceptions to this policy:

1. If a medically necessary medication change is needed, or a medically necessary dose change is needed; or

2. If we need to reschedule your appointment and your appointment is moved beyond the time your current prescription is active.

We appreciate your assistance in adhering to this policy. We will ask that you sign this form acknowledging your understanding and agreement to abide by this policy. We welcome any questions you may have. Adhering to this policy will allow me to continue to provide a high level of patient care.

Dated: ______________________ , 20 ____

____

Patient

____

Parent or Guardian, if Patient is a Minor