

Psychological Solutions, LLC

Notice of Privacy Practices

Created: 3/01/2006
(Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact one of the representatives named at the end of this Notice.

Who Will Follow This Notice

Psychological Solutions, LLC.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of medical treatment and services you receive from Psychological Solutions, LLC. This notice applies to all of the medical records we maintain. Your other doctors or health care providers may have different policies or notices regarding their use and disclosure of your medical information created in their office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private to the extent required by law;
 - give you this notice of our legal duties and privacy practices with respect to medical information about you;
- and
- follow the terms of the notice that is currently in effect.

How We May Use and Disclose Medical Information about You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, generally the ways we are permitted to use and disclose information will fall within one of the categories. If an additional category applies, we will attempt to discuss it with you prior to disclosing any information.

For Treatment (as described in applicable government regulations).

We may use or disclose medical information about you to provide you with medical treatment or services or facilitate medical treatment or services by other healthcare providers. We may disclose medical information about you to other providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist so that he or she may determine if a pending prescription is contraindicated with prior prescriptions, or we might disclose information to your primary care provider if it is relevant to your care.

For Payment (as described in applicable government regulations).

We may use and disclose medical information about you to determine eligibility for health care plan benefits, to facilitate payment for the treatment and services you receive from Psychological Solutions, LLC. or other health care providers, to determine benefit eligibility under your health care plan, or to coordinate coverage under the plan with other plans and coverages. For example, we may tell your health care insurance company about your medical history to determine whether a particular treatment is medically necessary. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or in order to coordinate benefit payments.

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For Health Care Operations (as described in applicable government regulations).

We may use and disclose medical information about you in connection with the operations of Psychological Solutions, LLC. These uses and disclosures are necessary to run the practice. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to coverage under the Plans; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development, such as cost management; and business management and general administrative activities.

As Required or Allowed By Law.

We may disclose medical information about you when we are required or allowed to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety.

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information you tell us if you state you are going to seriously harm another person.

Other Uses and Disclosures.

We may from time to time contact you to provide appointment reminders and information about treatment alternatives and other health-related benefits and services that may be of interest to you. Also, we, or any health insurance issuer or HMO providing coverage under the Plans, may from time to time disclose medical information about you to the sponsor of the Plans.

Special Situations

Organ and Tissue Donation.

If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans.

If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation.

We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

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Public Health Risks.

We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- 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.
- to notify the appropriate government authority if we believe a patient and/or a child or an elderly or vulnerable adult has been the victim of abuse or neglect. We will only make these types of disclosures if you agree or when we are required or authorized by law to do so. We are required to note in our medical records information that a patient provides us describing domestic violence incidents.

Health Oversight Activities.

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes.

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order.

Law Enforcement.

We may release medical information if asked to do so by a law enforcement official:

- in response to a court order;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at Psychological Solutions;
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities.

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates.

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Certain Limited Research Purposes.

Your medical information may be used for certain limited research purposes, provided that a waiver of the required authorization has been approved by an appropriate privacy board.

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Your Rights Regarding Medical Information about You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy.

You have the right to inspect and copy medical information we have on you. To inspect and copy medical information that we have on you, you must submit your request in writing to the Privacy Officer named at the end of this notice or to your provider. If you request a copy of the information, we may under state law charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Amend.

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the Privacy Officer named at the end of this notice or to your provider. In addition, you must provide a reason that supports your request.

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:

- is not part of the medical information kept by us;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures.

With certain limited exceptions, you have the right to request an “accounting of disclosures” where such disclosure was made for any purpose other than treatment, payment, or health care operations or pursuant to an authorization. To request this list or accounting of disclosures, you must submit your request in writing to one of the representatives named at the end of this notice. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, 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 medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about specific information you have disclosed to us.

We are not required to agree to your request. If, however, we agree to abide by the request, then we are required to adhere to the restriction, except in certain limited circumstances where required or allowed by law. To request restrictions, you must make your request in writing to the Privacy Officer named at the end of this notice or to your provider. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

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Right to Request Confidential Communications.

You have the right to request that we communicate with you about medical 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 must make your request in writing to one of the representatives named at the end of this 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. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please write to one of the representatives named at the end of this notice.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain on the first page, immediately below the title, the effective date.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose medical 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 medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the services provided to you while you are seen by a provider associated with Psychological Solutions.

Who to Contact For More Information

If you have questions about this Notice or would like to submit a request to inspect, copy, amend or restrict medical information, a request for an accounting of medical information disclosures, a request for confidential communications or a request for a paper copy of this Notice, please contact the appropriate representative named below:

Privacy Officer: Rich Weisberg, Psy.D., LLC
Psychological Solutions, LLC

HILLTOP BUILDING
5035 MAYFIELD ROAD, SUITE #201
LYNDHURST, OHIO 44124

To file a complaint with Psychological Solutions, LLC contact the Privacy Officer named above. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Psychological Solutions, LLC. or with the Secretary of the Department of Health and Human Services at the following address:

The U.S. Department of Health and Human Services
Region V Civil Rights Regional Office
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601

Phone: (312) 886-2359

Fax: (312) 886-1807 TDD: (312) 353-5693

PLEASE TURN TO NEXT PAGE AND SIGN AND DATE ATTESTATION

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Please Note:

We are required to either obtain your signature or the signature of someone legally authorized to sign for you, stating that you obtained a copy of this Notice or to make a good faith attempt to obtain your signature or the signature of someone legally authorized to sign for you, after we have provided you with a copy of this Notice.

ATTESTATION

I hereby declare that I have received and reviewed a copy of the Notice of Privacy Practices. I further state that I fully understand and agree to all aspects of this notice and have had the opportunity for further clarification of any and all elements of this notice.

Signature of Patient

Date

Printed Name

Signature of Witness

Date

Printed Name