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SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

June 22, 2015

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Koock Elan Jung, M.D.
Psychotherapy Center
597 Bay Road
Queensbury, NY 12804

Re: License No. 117083

Dear Dr. Jung:

Enclosed is a copy of the New York State Board for Professional Medical Conduct (BPMC) Order No. 15-156. This order and any penalty provided therein goes into effect June 29, 2015.

If the penalty imposed by this Order is a surrender, revocation or suspension, you are required to deliver your license and registration within five (5) days of receipt of this Order to: c/o Physician Monitoring Unit, NYS DOH - OPMC, Riverview Center, Suite 355, 150 Broadway, Albany, NY 12204-2719.

If your license is framed, please remove it from the frame and <u>only send the parchment paper on which your name is printed</u>. Our office is unable to store framed licenses.

If the document(s) are lost, misplaced or destroyed, you are required to submit to this office an affidavit to that effect. Please complete and sign the affidavit before a notary public and return it to the Office of Professional Medical Conduct.

Please direct any questions to: NYS DOH - OPMC, Riverview Center, Suite 355, 150 Broadway, Albany, NY 12204-2719, telephone # (518)402-0855.

Sincerely,

Katherine A. Hawkins, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

cc: Michael P. McDermott, Esq.
O'Connell & Aronowitz
54 State Street
Albany, NY 12207

Enclosure

BPMC No. 15-156

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF KOOCK JUNG, M.D.	CONSENT ORDER

Upon the application of (Respondent) KOOCK JUNG, M.D. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and

it is further

ORDERED, that this Consent Order shall be effective upon issuance by the Board, either

by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR

upon facsimile transmission to Respondent or Respondent's attorney,

whichever is first.

SO ORDERED.

DATE: 6/19/2015

[redacted]

ARTHUR S. HENGERER, M.D.
Chair
State Board for Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF KOOCK JUNG, M.D.	CONSENT AGREEMENT

KOOCK JUNG, M.D., represents that all of the following statements are true:

That on or about August 17, 1973, I was licensed to practice as a physician in the State of New York, and issued License No. 117083 by the New York State Education Department.

My current address is 597 Bay Road, Queensbury, New York 12804, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct (Board) has charged me with one or more specifications of professional misconduct, as set forth in a Statement of Charges, marked as Exhibit "A", attached to and part of this Consent Agreement.

I cannot successfully defend against at least one of the acts of misconduct alleged, and agree to the following penalty:

Effective July 20, 2015, and pursuant to N.Y. Pub. Health Law § 230-a(2), my license to practice medicine in New York State shall be suspended for six (6) months.

Pursuant to N.Y. Pub. Health Law § 230-a(9), I shall be placed on probation for thirty six (36) months, subject to the terms set forth in attached Exhibit "B."

I shall be subject to a Condition that I comply with attached Exhibit "C," "Requirements for Closing a Medical Practice Following a Revocation, Surrender, Limitation or Suspension (Of 6 Months or More) of a Medical License."

Respondent shall obtain a clinical competency assessment performed by a program for such assessment as directed by the Director of OPMC. Respondent shall complete the assessment to the satisfaction of the Director of OPMC, and shall cause a written report of such assessment to be provided directly to the Director of OPMC within sixty (60) days of the effective date of this Order.

a. Respondent shall be responsible for all expenses related to the clinical competency assessment and shall provide to the Director of OPMC proof of

full payment of all costs that may be charged. This penalty shall not be satisfied in the absence of actual receipt, by the Director, of such documentation, and any failure to satisfy shall provide a basis for a violation of this Order.

At the direction of the Director and within 60 days following the completion of the clinical competency assessment (CCA) the Respondent shall identify a Preceptor, preferably a physician who is board certified in the same specialty, to be approved in writing, by the Director of OPMC. The Respondent shall cause the Preceptor to:

b. Develop and submit to the Director of OPMC for written approval a remediation plan, which addresses the deficiencies /retraining recommendations identified in the CCA. Additionally, this proposal shall establish a timeframe for completion of the remediation program. Should the remediation program involve the clinical practice of medicine, Respondent shall not commence that aspect of the program until the conclusion of Respondent's period of license suspension.

c. Submit progress reports at periods identified by OPMC certifying whether the Respondent is fully participating in the personalized continuing medical education program and is making satisfactory progress towards the completion of the approved remediation plan.

d. Report immediately to the Director of OPMC if the Respondent withdraws from the program and report promptly to OPMC any significant pattern of non-compliance by the Respondent.

e. At the conclusion of the program, submit to the Director of OPMC a detailed assessment of the progress made by the Respondent toward remediation of all identified deficiencies.

Respondent shall be subject to any further terms of probation as may be imposed by Director, as the Director deems necessary based upon the outcome of the Clinical Competency Assessment. Respondent, by making this Application, stipulates that the Director shall be so authorized.

Respondent shall be solely responsible for all expenses associated with these terms, including fees, if any, for the clinical competency assessment, the personalized continuing medical education program, any directed evaluation resulting from the Clinical Competency Assessment, or to the monitoring physician.

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall comply with each and every penalty imposed by this Order pursuant to N.Y. Pub. Health Law § 230-a.

That Respondent shall remain in continuous compliance with all requirements of N.Y. Educ Law § 6502 including but not limited to the requirements that a licensee shall register and continue to be registered with the New York State Education Department (except during periods of actual suspension) and that a licensee shall pay all registration fees. Respondent shall not exercise the option provided in N.Y. Educ. Law § 6502(4) to avoid registration and payment of fees. This condition shall take effect 120 days after the Consent Order's effective date and will continue so long as Respondent remains a licensee in New York State; and

That Respondent shall remain in continuous compliance with all requirements of N.Y. Pub. Health Law § 2995-a(4) and 10 NYCRR 1000.5, including but not limited to the requirements that a licensee shall: report to the department all information required by the Department to develop a public physician profile for the licensee; continue to notify the department of any change in profile information within 30 days of any change (or in the case of optional information, within 365 days of such change); and, in addition to such periodic reports and notification of any changes, update his or her profile information within six months prior to the expiration date of the licensee's registration period. Licensee shall submit changes to his or her physician profile information either electronically using the department's secure web site or on forms prescribed by the department, and licensee shall

attest to the truthfulness, completeness and correctness of any changes licensee submits to the department. This condition shall take effect 30 days after the Order's effective date and shall continue so long as Respondent remains a licensee in New York State. Respondent's failure to comply with this condition, if proven and found at a hearing pursuant to N.Y. Pub. Health Law § 230, shall constitute professional misconduct as defined in N.Y. Educ. Law § 6530(21) and N.Y. Educ. Law § 6530(29). Potential penalties for failure to comply with this condition may include all penalties for professional misconduct set forth in N.Y. Pub. Health Law §230-a, including but not limited to: revocation or suspension of license, Censure and Reprimand, probation, public service and/or fines of up to $10,000 per specification of misconduct found; and

That Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204-2719, with the following information, in writing, and ensure that this information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required

information. This condition shall take effect 30 days after the Order's effective date and shall continue at all times until Respondent receives written notification from the Office of Professional Medical Conduct, Physician Monitoring Program, that OPMC has determined that Respondent has fully complied with and satisfied the requirements of the Order, regardless of tolling; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Consent Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Consent Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State.

I stipulate that my failure to comply with any conditions of this Consent Order shall constitute misconduct as defined by N.Y. Educ. Law § 6530(29).

I agree that, if I am charged with professional misconduct in future, this Consent Agreement and Order shall be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to the N.Y. Pub. Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Consent Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first. The Consent Order, this agreement, and all attached Exhibits shall be public documents, with only patient identities, if any, redacted. As public documents, they may be posted on the Department's website. OPMC shall report this action to the National Practitioner Data Bank and the Federation of State Medical Boards, and any other entities that the Director of OPMC shall deem appropriate.

I stipulate that the proposed sanction and Consent Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board and OPMC have the requisite powers to carry out all included terms. I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and I ask that the Board adopt this Consent Agreement.

I understand and agree that the attorney for the Department, the Director of OPMC and the Chair of the Board each retain complete discretion either to enter into the proposed agreement and Consent Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

DATE 6/16/2015

[redacted]

KOOCK JUNG, M.D.
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 6/16/15

[redacted]

MICHAEL P. McDERMOTT, ESQ.
Attorney for Respondent

DATE: June 17, 2015

[redacted]

CINDY M. FASCIA
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 6/17/15

[redacted]

KEITH W. SERVIS
Director
Office of Professional Medical Conduct

EXHIBIT A

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF KOOCK JUNG, M.D.	STATEMENT OF CHARGES

KOOCK JUNG, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 17, 1973 by the issuance of license number 117083 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided psychiatric care to Patient A (patients are identified in the attached appendix), on various occasions at 597 Bay Road, Queensbury, New York 12804 (hereinafter "Respondent's office") from on or about February 24, 2010, through on or about September 27, 2012. Patient A received psychotherapy from another provider during on or about the same time period. Respondent deviated from the standard of care and/or engaged in inappropriate behavior toward Patient A, in that:

1. Respondent, on more than one occasion during his treatment of Patient A and despite his belief that Patient A had been sexually abused, took hold of and/or stroked Patient A's hand.
2. Respondent, on more than one occasion during his treatment of Patient A, and despite his belief that Patient A had been sexually abused, placed his hand on and/or rubbed Patient A's knee.
3. Respondent, on more than one occasion during his treatment of Patient A, at the end of an appointment and despite his belief that Patient A had been sexually abused, reached his arm out to hug Patient A and/or hugged Patient A.

4. Respondent, on or about February 24, 2010, failed to perform an adequate initial intake and evaluation of Patient A, and/or failed to adequately document such intake and evaluation.
5. Respondent, on more than one occasion during his treatment of Patient A, prescribed Patient A medications without an adequate basis, and/or failed to document such basis.
6. Respondent failed to maintain a medical record which accurately reflected his evaluation and/or treatment of Patient A.

B. Respondent provided psychiatric care to Patient B on various occasions at Respondent's office from on or about January 9, 2010, through on or about August 29, 2012. From on or about June 2011 through on or about August 2012, Patient B received psychotherapy from another provider. Respondent deviated from the standard of care and/or engaged in inappropriate behavior toward Patient B, in that:

1. Respondent, on more than one occasion during his treatment of Patient B, at or near the end of Patient B's appointment, hugged Patient B.
2. Respondent, on more than one occasion during his treatment of Patient B, slapped Patient B's leg with his hand and/or put his hand on Patient B's leg.
3. Respondent, on more than one occasion during his treatment of Patient B, grabbed and/or took hold of Patient B's hand with his hand.
4. Respondent, on or about August 15, 2012, asked Patient B if she ever "touched herself", or words to such effect, and/or encouraged Patient B to "touch herself" and be comfortable with her body, or words to such effect, and/or told Patient B "You're a beautiful girl. You should touch yourself and experiment," or words to such effect.
5. Respondent, on or about August 15, 2012, after he had asked Patient B whether she ever touched herself and/or encouraged Patient B to touch herself, told Patient B not to tell her therapist that Respondent had had this conversation with Patient B, or words to such effect.

6. Respondent, on or about August 15, 2012, in his care of Patient B, failed to perform an adequate initial intake and evaluation of Patient B, and/or failed to document such intake and evaluation.
7. Respondent, on more than one occasion during his treatment of Patient B, prescribed Patient B medications without an adequate basis, and/or failed to document such basis.
8. Respondent, on or about March 28, 2012, asked Patient B about her relationship with Patient G, who was also a patient of Respondent. Patient B told Respondent that she and Patient G had broken up and that they were not together, or words to such effect. Respondent told Patient B that she was "better off without" Patient G and/or "didn't need Patient G" and/or shouldn't be with Patient G because Patient G was on Suboxone, or words to such effect.
9. Respondent failed to maintain a medical record for Patient B which accurately reflected his evaluation and/or treatment of Patient B.

C. Respondent provided psychiatric care to Patient C on various occasions at Respondent's office from on or about February 24, 2012 through on or about July 28, 2012. Patient C received psychotherapy from another provider during on or about the same time period. Respondent deviated from the standard of care and/or engaged in inappropriate conduct toward Patient C, in that:

1. Respondent, on more than one occasion during his treatment of Patient C, despite knowing that Patient C had been sexually abused, held Patient C's hand and/or squeezed Patient C's hand.
2. Respondent, on more than one occasion during his treatment of Patient C, despite knowing that Patient C had been sexually abused, rubbed his hand and/or placed his hand on Patient C's arms and/or legs.
3. Respondent, on more than one occasion during his treatment of Patient C, despite knowing that Patient C had been sexually abused, told Patient C, "Oh, you look beautiful. Give me a hug", or words to such effect, and/or hugged Patient C.

4. Respondent, on one or more occasions during his treatment of Patient C, despite knowing that Patient C had been sexually abused, asked Patient C if she "took care of herself" sexually and/or if she masturbated, or words to such effect.
5. Respondent, on one or more occasions during his treatment of Patient C, despite knowing that Patient C had been sexually abused, told or encouraged Patient C to engage in sexual contact with her husband even if she did not want to because it was her duty, or words to such effect, and/or encouraged Patient C to have sex with her husband even if she just laid there, or words to such effect.
6. Respondent, on one or more occasions during his treatment of Patient C, despite knowing that Patient C had been sexually abused, talked to Patient C about Respondent's sex life with his wife, or words to such effect.
7. Respondent, on or about July 28, 2012, despite knowing that Patient C had been sexually abused, rubbed Patient C's thigh with his hand up to her crotch area.
8. Respondent, on or about February 24, 2012, failed to perform an adequate initial intake and evaluation of Patient C, and/or failed to adequately document such intake and evaluation.
9. Respondent, on more than one occasion during his treatment of Patient C, prescribed Patient C medications without an adequate basis, and/or failed to document such basis.
10. Respondent failed to maintain a medical record for Patient C which accurately reflected his diagnosis and/or treatment of Patient C.

D. Respondent provided psychiatric care to Patient D on various occasions at Respondent's office from on or about January 7, 2010, to on or about February 11, 2010. Patient D received psychotherapy from another provider on or about February 4, 2010. Respondent deviated from the standard of care and/or engaged in inappropriate behavior toward Patient D, in that:

1. Respondent, on more than one occasion during his treatment of Patient D, touched, patted and/or rubbed Patient D's hand and/or arm.

2. Respondent, on more than one occasion during his treatment of Patient D, placed his hand on Patient D's leg.
3. Respondent, on or about February 11, 2010, hugged Patient D.
4. Respondent failed to maintain a medical record for Patient D which accurately reflected his evaluation and/or treatment of Patient D.

E. Respondent provided psychiatric care to Patient E on various occasions at Respondent's office from on or about July 24, 2008, through on or about March 12, 2012. Patient E received psychotherapy from another provider during on or about the same time period. Respondent deviated from the standard of care and/or engaged in inappropriate behavior toward Patient E, in that:

1. Respondent, on more than one occasion during his treatment of Patient E, despite knowing that Patient E had been sexually abused, took hold of Patient E's hand and held and/or stroked Patient E's hand and/or arm.
2. Respondent, on more than one occasion during his treatment of Patient E, told Patient E that she was fat because she had been sexually abused and/or told Patient E that most fat people had been sexually abused, or words to such effect.
3. Respondent, on more than one occasion during his treatment of Patient E, despite knowing that Patient E had been sexually abused, at or near the end of Patient E's session, asked Patient E to give him a hug, and/or said "Why don't you give me a hug?", or words to such effect.
4. Respondent, on more than one occasion during his treatment of Patient E, despite knowing that Patient E had been sexually abused, said to Patient E after she had lost weight, "Oh, you look so good. Give me a hug," or words to such effect.
5. Respondent, on more than one occasion during his treatment of Patient E, despite knowing that Patient E had been sexually abused, asked Patient E about the details of her sex life with her husband and/or asked Patient E how often she had sex with her husband.

6. Respondent, on one or more occasions during his treatment of Patient E, despite knowing that Patient E had been sexually abused, told and/or encouraged Patient E that she should engage in sexual contact with her husband even if she did not want to and/or told Patient E she should have sex with her husband more frequently because "a man has needs", and/or because "a man needs to relieve himself", or words to such effect.
7. Respondent, on or about July 24, 2008, failed to perform an adequate initial intake and evaluation of Patient E, and/or failed to adequately document such intake and evaluation.
8. Respondent, on more than one occasion during his treatment of Patient E, prescribed Patient E medications without an adequate basis, and/or failed to document such basis.
9. Respondent, on or about July 24, 2008, prescribed a combination of two serotonergic antidepressants at significant dosages for Patient E, without adequately advising the patient regarding risks/benefits and/or side effects, and/or without documenting any discussion of same.
10. Respondent failed to maintain a medical record which accurately reflected his diagnosis and treatment of Patient E.

F. Respondent provided psychiatric care to Patient F on various occasions at Respondent's office from on or about April 4, 2012 through on or about November 20, 2012. Patient F received psychotherapy from another provider during on or about the same time period. Respondent deviated from the standard of care and/or engaged in inappropriate behavior toward Patient F, in that:

1. Respondent, on one or more occasions during his treatment of Patient F, told Patient F that she was "fucking nuts", or words to such effect.
2. Respondent, on more than one occasion during a his treatment of Patient F, despite knowing that Patient F had been sexually abused, held Patient F's hand and/or rubbed her hand and/or rubbed Patient F's arm with his hand.

3. Respondent, on or about August 29, 2012, after learning that Patient F had been sexually abused as a child, asked Patient F explicit questions about what her sexual abuser had done to her, and/or asked Patient F if certain specific sexual acts had occurred.
4. Respondent, on or about August 29, 2012, despite knowing that Patient F had been sexually abused, asked Patient F to give him a hug, or words to such effect, and/or hugged Patient F.
5. Respondent, on or about August 29, 2012, despite knowing that Patient F had been sexually abused, placed his hand on Patient F's inner thigh.
6. Respondent, on or about April 4, 2012, failed to perform an adequate initial intake and evaluation of Patient F, and/or failed to document such intake and evaluation.
7. Respondent, on more than one occasion during his treatment of Patient F, prescribed Patient F medications without an adequate basis, and/or failed to document such basis.
8. Respondent failed to maintain a medical record which accurately reflected his diagnosis and treatment of Patient F.

G. Respondent provided psychiatric care to Patient G on various occasions at Respondent's office from on or about December 5, 2009 through on or about May 11, 2011. Respondent failed to meet the standard of care in his treatment of Patient G, in that:

1. Respondent, on or about August 11, 2010, prescribed Suboxone for Patient G without obtaining adequate information to ascertain whether Patient G in fact had a diagnosis of opioid dependence and/or without documenting sufficient information to support a diagnosis of opioid dependence for Patient G.
2. Respondent, on or about August 11, 2010, prescribed Suboxone to Patient G without adequate discussion with or education of Patient G regarding risk/benefits and/or potential for withdrawal and/or the importance of tapering off an opiate; and/or failed to adequately document that such discussion and/or education occurred.

3. Respondent, on more than one occasion during his prescribing a Suboxone regimen for Patient G, failed to follow an appropriate treatment strategy for and/or failed to appropriately monitor Patient G.
4. Respondent, failed to maintain a medical record for Patient G which accurately reflected his diagnosis and treatment of Patient G.

H. Respondent provided psychiatric care to Patient H on various occasions at Respondent's office from on or about January 27, 2011 through on or about September 4, 2013. Respondent deviated from the standard of care and/or engaged in inappropriate behavior toward Patient H, in that:

1. Respondent, on or about August 5, 2013, exited his office with his prior patient, Patient I, and brought Patient H into his office for her session. Respondent, referring to his prior patient, Patient I, asked Patient H: "Do you know who that was?", or words to such effect. When Patient H said she did not know who it was, Respondent proceeded to reveal Patient I's name, and also revealed details of Patient I's personal situation, including but not limited to details about the loss of Patient I's business, and that Patient I "wasn't doing well", or words to such effect.
2. Respondent, on or about January/ February 2012, brought Patient H from the waiting room into his office for her session. Patient H told Respondent that she had seen a woman she knew in the waiting room, Patient J. Respondent proceeded to reveal details regarding Patient J's personal situation, including but not limited to a telephone conversation with Patient J's mother about Patient J and Patient J's children.
3. Respondent, on more than one occasion during his treatment of Patient H, prescribed Patient H medications without an adequate basis, and/or failed to document such basis.
4. Respondent failed to maintain a medical record for Patient H which accurately reflected his evaluation and treatment of Patient H.

I. Respondent provided psychiatric treatment to Patient I on various occasions at Respondent's office from on or about February 25, 2012 through on or about October 8, 2014. Respondent deviated from the standard of care in his treatment of Patient I, in that:

1. Respondent, on or about February 25, 2012, failed to perform an adequate initial intake and evaluation of Patient I, and/or failed to document such intake and evaluation.
2. Respondent, on more than one occasion during his treatment of Patient I, failed to obtain and/or document sufficient clinical information to support his diagnoses of attention deficit disorder and dysthymia for Patient I.
3. Respondent, on more than one occasion during his treatment of Patient I, failed to obtain and/or document an adequate history for Patient I, including but not limited to a drug and/or alcohol history.
4. Respondent, on more than one occasion during his treatment of Patient I, prescribed Patient I controlled substances with potential for addition and abuse without having obtained or documented an adequate history.
5. Respondent, on more than one occasion during his treatment of Patient I, prescribed Patient I medications without an adequate basis, and/or failed to document such basis.
6. Respondent failed to maintain a medical record which accurately reflected his diagnosis and treatment of Patient I.

J. Respondent provided psychiatric treatment to Patient J on various occasions at Respondent's office from on or about January 18, 2012 through on or about April 26, 2012. Respondent deviated from the standard of care in his treatment of Patient J, in that:

1. Respondent, on or about January 18, 2012, failed to perform an adequate initial intake and evaluation of Patient J, and/or failed to document such intake and evaluation.
2. Respondent, on more than one occasion during his treatment of Patient J,

prescribed Patient J controlled substances with potential for addiction and abuse without having obtained an adequate history for Patient J, including but not limited to a drug or alcohol history.

3. Respondent, on more than one occasion during his treatment of Patient J, prescribed Patient J medications without an adequate basis, and/or failed to document such basis.
4. Respondent failed to maintain a medical record which accurately reflected his diagnosis and treatment of Patient J.

K. Respondent provided psychiatric treatment to Patient K on various occasions at Respondent's office from on or about August 17, 2013, through on or about September 11, 2013. Respondent deviated from the standard of care in his treatment of Patient K, in that:

1. Respondent, on or about August 17, 2013, failed to perform an adequate initial intake and evaluation of Patient K, and/or failed to document such intake and evaluation.
2. Respondent, on more than one occasion during his treatment of Patient K, failed to obtain and/or document an adequate history, including but not limited to a drug and/or alcohol history; prior to prescribing Patient K controlled substances which had potential for addiction and/or abuse.
3. Respondent, on or about August 17, 2013, made an initial diagnosis and treatment decisions for Patient K without obtaining and/or documenting objective and/or adequate information to support said diagnosis and/or treatment decisions.
4. Respondent failed to maintain a medical record for Patient K which accurately reflected his evaluation and treatment of Patient K.

L. Respondent provided psychiatric care to Patient L on various occasions at Respondent's office from on or about August 8, 2012 through on or about October 24, 2012, and from on or about August 29, 2013 through on or about October 3,

2013. Respondent deviated from the standard of care in his treatment of Patient L, in that:

1. Respondent, on or about August 8, 2012, failed to perform an adequate initial intake and evaluation of Patient L, and/or failed to document such intake and evaluation.
2. Respondent, when Patient L returned to him on or about August 29, 2013, failed to adequately ascertain and/or document Patient L's history and functioning during the time period after she stopped treatment in 2012 until she returned in 2013.
3. Respondent, on more than one occasion during his treatment of Patient L, failed to obtain a prior drug and/or alcohol history prior to prescribing Patient L controlled substances which had potential for addiction or abuse, and/or failed to document such history.
4. Respondent, on more than one occasion during his treatment of Patient L, made diagnoses and treatment decisions for Patient L without obtaining and/or documenting objective and/or adequate information to support said diagnoses and/or treatment decisions.
5. Respondent failed to maintain a medical record for Patient L which accurately reflected his diagnosis and treatment for Patient L.

SPECIFICATION OF CHARGES

FIRST THROUGH TWELFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5 and/or A.6.
2. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or B.5 and/or B.6 and/or B.7 and/or B.8 and/or B.9.
3. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6 and/or C.7 and/or C.8 and/or C.9 and/or C.10.
4. The facts in Paragraphs D and D.1 and/or D.2 and/or D.3 and/or D.4.
5. The facts in Paragraphs E and E.1 and/or E.2 and/or E.3 and/or E.4 and/or E.5 and/or E.6 and/or E.7 and/or E.8 and/or E.9 and/or E.10.
6. The facts in Paragraphs F and F.1 and/or F.2 and/or F.3 and/or F.4 and/or F.5 and/or F.6 and/or F.7 and/or F.8.
7. The facts in Paragraphs G and G.1 and/or G.2 and/or G.3 and/or G.4.
8. The facts in Paragraphs H and H.1 and/or H.2 and/or H.3 and/or H.4.
9. The facts in Paragraphs I and I.1 and/or I.2 and/or I.3 and/or I.4 and/or I.5.
10. The facts in Paragraphs J and J.1 and/or J.2 and/or J.3 and/or J.4.

11. The facts in Paragraphs K and K.1 and/or K.2 and/or K.3 and/or K.4.

12. The facts in Paragraphs L and L.1 and/or L.2 and/or L.3 and/or L.4 and/or L.5.

THIRTEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

13. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5 and/or A.6.

14. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or B.5 and/or B.6 and/or B.7 and/or B.8 and/or B.9.

15. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6 and/or C.7 and/or C.8 and/or C.9 and/or C.10.

16. The facts in Paragraphs D and D.1 and/or D.2 and/or D.3 and/or D.4.

17. The facts in Paragraphs E and E.1 and/or E.2 and/or E.3 and/or E.4 and/or E.5 and/or E.6 and/or E.7 and/or E.8 and/or E.9 and/or E.10.

18. The facts in Paragraphs F and F.1 and/or F.2 and/or F.3 and/or F.4 and/or F.5 and/or F.6 and/or F.7 and/or F.8.

19. The facts in Paragraphs G and G.1 and/or G.2 and/or G.3 and/or G.4.

20. The facts in Paragraphs H and H.1 and/or H.2 and/or H.3 and/or H.4.

21. The facts in Paragraphs I and I.1 and/or I.2 and/or I.3 and/or I.4 and/or I.5.

22. The facts in Paragraphs J and J.1, and/or J.2 and/or J.3 and/or J.4.

23. The facts in Paragraphs K and K.1, and/or K.2 and/or K.3 and/or K.4.

24. The facts in Paragraphs L and L.1, and/or L.2, and/or L.3, L and/or L.4 and/or L.5.

TWENTY-FIFTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of any two or more of the following:

25. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5 and/or A.6; B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or B.5 and/or B.6 and/or B.7 and/or B.8 and/or B.9; C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6 and/or C.7 and/or C.8 and/or C.9 and/or C.10; D and D.1 and/or D.2 and/or D.3 and/or D.4; E and E.1 and/or E.2 and/or E.3 and/or E.4 and/or E.5 and/or E.6 and/or E.7 and/or E.8 and/or E.9 and/or E.10; F and F.1 and/or F.2 and/or F.3 and/or F and F.4 and/or F.5 and/or F.6 and/or F.7 and/or F.8; G and G.1 and/or G.2 and/or G.3 and/or G.4; H and H.1 and/or H.2 and/or H.3 and/or H.4; I and I.1 and/or I.2 and/or I.3

and/or I.4 and/or I.5 and/or I.6; J and/or J.1 and/or J.2 and/or J.3 and/or J.4; K and K.1 and/or K.2 and/or K.3 and/or K.4; L and L.1 and/or L.2 and/or L.3 and/or L.4 and/or L.5.

TWENTY-SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts any two or more of the following:

26. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5 and/or A.6; B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or B.5 and/or B.6 and/or B.7 and/or B.8 and/or B.9; C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6 and/or C.7 and/or C.8 and/or C.9 and/or C.10; D and D.1 and/or D.2 and/or D.3 and/or D.4; E and E.1 and/or E.2 and/or E.3 and/or E.4 and/or E.5 and/or E.6 and/or E.7 and/or E.8 and/or E.9 and/or E.10; F and F.1 and/or F.2 and/or F.3 and/or F.4 and/or F.5 and/or F.6 and/or F.7 and/or F.8; G and G.1 and/or G.2 and/or G.3 and/or G.4; H and H.1 and/or H.2 and/or H.3 and/or H.4; I and I.1 and/or I.2 and/or I.3 and/or I.4 and/or I.5 and/or I.6; J and J.1 and/or J.2 and/or J.3 and/or J.4; K

and K.1 and/or K.2 and/or K.3 and/or K.4; L and L.1 and/or L.2 and/or L.3 and/or L.4 and/or L.5.

TWENTY-SEVENTH THROUGH THIRTY-SECOND SPECIFICATIONS

HARASSING, ABUSING OR INTIMIDATING A PATIENT PHYSICALLY OR VERBALLY

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(31) by willfully harassing, abusing, or intimidating a patient either physically or verbally, as alleged in the facts of the following:

27. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3.
28. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or B.5.
29. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6 and/or C.7.
30. The facts in Paragraphs D and D.1 and/or D.2 and/or D.3.
31. The facts in Paragraphs E and E.1 and/or E.2 and/or E.3 and/or E.4 and/or E.5 and/or E.6.
32. The facts in Paragraphs F and F.1 and/or F.2 and/or F.3 and/or F.4 and/or F.5.

THIRTY-THIRD THROUGH THIRTY-EIGHTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

33. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3.
34. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or B.5.
35. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6 and/or C.7.
36. The facts in Paragraphs D and D.1 and/or D.2 and/or D.3.
37. The facts in Paragraphs E and E.1 and/or E.2 and/or E.3 and/or E.4 and/or E.5 and/or E.6.
38. The facts in Paragraphs F and F.1 and/or F.2 and/or F.3 and/or F.4 and/or F.5.

THIRTY-NINE THROUGH FIFTIETH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

39. The facts in Paragraphs A and A.4 and/or A.5 and/or A.6.

40. The facts in Paragraphs B and B.6 and/or B.7 and/or B.9.

41. The facts in Paragraphs C and C.8 and/or C.9 and/or C.10.

42. The facts in Paragraphs D and D.4.

43. The facts in Paragraphs E and E 7 and/or E.8 and/or E.9 and/or E.10.

44. The facts in Paragraphs F and F.6 and/or F.7 and/or F.8.

45. The facts in Paragraphs G and G.1 and/or G and G.2 and/or G.3 and/or G.4.

46. The facts in Paragraphs H and H.3 and/or H.4.

47. The facts in Paragraphs I and I.1 and/or I.2 and/or I.3 and/or I.4 and/or I.5 and/or I.6.

48. The facts in Paragraphs J and J.1 and/or J.3 and/or J.4.

49. The facts in Paragraphs K and K.1 and/or K.2 and/or K.3 and/or K.4.

50. The facts in Paragraphs L and L.1 and/or L.2 and/or L.3 and/or L.4 and/or L.5.

FIFTY-FIRST AND FIFTY-SECOND SPECIFICATIONS

REVEALING OF PERSONALLY IDENTIFIABLE FACTS, DATA, OR INFORMATION OBTAINED IN A PROFESSIONAL CAPACITY WITHOUT THE PRIOR CONSENT OF THE PATIENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530 (23) by reason of his revealing of personally identifiable facts, data or information obtained in a professional capacity without the prior consent of the patient, as alleged in the facts of:

51. The facts in Paragraphs B and B.8.

52. The facts in Paragraphs H and H.1 and/or H.2.

DATE: May 14, 2015
Albany, New York

MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct

EXHIBIT "B"

Terms of Probation

1) Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by N.Y. Educ. Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to N.Y. Pub. Health Law § 230(19).

2) Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

3) Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but not limited to: the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law § 171(27); State Finance Law § 18; CPLR § 5001; Executive Law § 32].

4) The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30 day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in Exhibit "A" or as are necessary to protect the public health.

5) Within thirty days of the resuming the active practice of medicine, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Any medical practice in violation of this term shall constitute the unauthorized practice of medicine.

    a) Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 20) of records maintained by Respondent, including patient records, prescribing

information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b) Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c) Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

d) Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

6) The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

7) Respondent shall adhere to federal and state guidelines and professional standards of care with respect to infection control practices. Respondent shall ensure education, training and oversight of all office personnel involved in medical care, with respect to these practices.

8) Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

9) Respondent shall enroll in and successfully complete a continuing education program in the areas of physician/patient boundaries, appropriate prescribing of controlled substances, and record keeping. These three (3) continuing education programs are subject to the Director of OPMC's prior written approval and shall be successfully completed within the first 90 days of the probation period.

10) Respondent shall comply with this Consent Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.

EXHIBIT "C"

Requirements for Closing a Medical Practice Following a Revocation, Surrender, Limitation or Suspension of a Medical License

1. Effective July 20, 2015, Licensee shall immediately cease and desist from engaging in the practice of medicine in New York State, or under Licensee's New York license, in accordance with the terms of the Order. In addition, Licensee shall refrain from providing an opinion as to professional practice or its application and from representing that Licensee is eligible to practice medicine.

2. Within 5 days of July 20, 2015, Licensee shall deliver Licensee's original license to practice medicine in New York State and current biennial registration to the Office of Professional Medical Conduct (OPMC) at Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204-2719.

3. Within 15 days of July 20, 2015, Licensee shall notify all patients of the cessation or limitation of Licensee's medical practice, and shall refer all patients to another licensed practicing physician for continued care, as appropriate. Licensee shall notify, in writing, each health care plan with which the Licensee contracts or is employed, and each hospital where Licensee has privileges, that Licensee has ceased medical practice. Within 45 days of July 20, 2015, Licensee shall provide OPMC with written documentation that all patients and hospitals have been notified of the cessation of Licensee's medical practice.

4. Licensee shall make arrangements for the transfer and maintenance of all patient medical records. Within 30 days of July 20, 2015, Licensee shall notify OPMC of these arrangements, including the name, address, and telephone number of an appropriate and acceptable contact persons who shall have access to these records. Original records shall be retained for at least 6 years after the last date of service rendered to a patient or, in the case of a minor, for at least 6 years after the last date of service or 3 years after the patient reaches the age of majority, whichever time period is longer. Records shall be maintained in a safe and secure place that is reasonably accessible to former patients. The arrangements shall include provisions to ensure that the information in the record is kept confidential and is available only to authorized persons. When a patient or a patient's representative requests a copy of the patient's medical record, or requests that the original medical record be sent to another health care provider, a copy of the record shall be promptly provided or forwarded at a reasonable cost to the patient

(not to exceed 75 cents per page.) Radiographic, sonographic and similar materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of an inability to pay.

5. In the event that Licensee holds a Drug Enforcement Administration (DEA) certificate for New York State, Licensee shall, within fifteen (15) days of July 20, 2015, advise the DEA, in writing, of the licensure action and shall surrender his/her DEA controlled substance privileges for New York State to the DEA. Licensee shall promptly surrender any unused DEA #222 U.S. Official Order Forms Schedules 1 and 2 for New York State to the DEA. All submissions to the DEA shall be addressed to Diversion Program Manager, New York Field Division, U.S. Drug Enforcement Administration, 99 Tenth Avenue, New York, NY 10011.

6. Within 15 days of July 20, 2015, Licensee shall return any unused New York State official prescription forms to the Bureau of Narcotic Enforcement of the New York State Department of Health. If no other licensee is providing services at Licensee's practice location, Licensee shall properly dispose of all medications.

7. Within 15 days of July 20, 2015, Licensee shall remove from the public domain any representation that Licensee is eligible to practice medicine, including all related signs, advertisements, professional listings (whether in telephone directories, internet or otherwise), professional stationery or billings. Licensee shall not share, occupy, or use office space in which another licensee provides health care services.

8. Licensee shall not charge, receive or share any fee or distribution of dividends for professional services rendered by Licensee or others while Licensee is barred from engaging in the practice of medicine. Licensee may be compensated for the reasonable value of services lawfully rendered, and disbursements incurred on a patient's behalf, prior to the Order's effective date.

9. If Licensee is a shareholder in any professional service corporation organized to engage in the practice of medicine, Licensee shall divest all financial interest in the professional services corporation, in accordance with New York Business Corporation Law. Such divestiture shall occur within 90 days of July 20, 2015. If Licensee is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within 90 days of July 20, 2015.

10. Failure to comply with the above directives may result in a civil penalty or criminal penalties as may be authorized by governing law. Under N.Y. Educ. Law § 6512, it is a Class E Felony, punishable by imprisonment of up to 4 years, to practice the profession of medicine when a professional license has been suspended, revoked or annulled. Such punishment is in addition to the penalties for professional misconduct set forth in N.Y. Pub. Health Law § 230-a, which include fines of up to $10,000 for each specification of charges of which the Licensee is found guilty, and may include revocation of a suspended license.