INNOVATIVE THERAPY GROUP
TYLER SPEECH IMPROVEMENT SERVICES
401 E. Front, Suite 123 Tyler, TX 75702
Office: 903-531-2581 **Fax:** 93-5312451 innovativetherapygroup@gmail.com

Child Information Packet

Today Date: _____ **Type of Therapy** _____

Dear: _____

Thank you for choosing Innovative Therapy Group. Enclosed you will find the following forms: child information packet, our office policy, disclosure, privacy practices, patient authorization and protected health Information (PHI) packet.

The notice of privacy practices protected health Information (PHI) is for you to keep for your records.

Please complete, sign and bring them with you **on** _____ **time:**_____

Your therapist is _____

We are located in the Fountain Square Building- Building 1, Suite 123 on Front Street just east of Broadway. I look forward to meeting you and _____.

S.C Krause & Associates, LLC
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Parent/ Legal Guardian Consent

The information Innovative Therapy Group is asking to use and share is called "Protected Health Information" (PHI) which includes the following: name, address, birthday, phone numbers, email, social security number, health plan information, photos and health status.

It is protected by the **Privacy Rule** of the Health Insurance Portability and Accountability (ACT) HIPPA. In general Innovative Therapy Group cannot share health information for research or treatment for your child without your permission.

_____ _____
Signature Parent/Guardian **Relationship**

_____ _____
Child name **Date**

Child Information Packet

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Type of therapy: _____ **Today date:** _____
Name of child: _____
Date of Birth: _____ **Age:** _____ **Male or female**
Address of patient: _____
Patient lives with: _____
Email of parent: _____
Cell: _____ **Home:** _____ **Work:** _____
***Mother's Name*:** _____ **Phone:** _____
Address: _____ **Occupation:** _____
***Father's Name*:** _____ **Phone:** _____
Address: _____ **Occupation:** _____
***Guardian's Name*:** _____ **Phone:** _____
Address: _____ **Occupation:** _____

List all children in the family from oldest to youngest

Name	Age	Male/ female	Grade in school	General Health

Has anyone in the family had speech language, hearing, motor coordination or behavioral issues? If yes, please explain: _____
_____

Misc information about family member's history: _____
_____

Birth History of Patient

Weight of child at birth _____ **Was the child full term?** Yes_____ No_____
If no, how many weeks gestation_____ **How long was your child hospitalized after birth?**_____

Today weight of child _____ **Where does your child fall on the growth charts?** _____

Child Information Packet

Were there any unusual factors relating to the pregnancy (such as toxemia, X-ray treatments, RH negative, German measles, other illnesses, drugs or medication, previous miscarriages)?
Yes_____ No_____ If yes, please describe: _____

_____

Type of birth: normal_____ induced_____ forceps_____ caesarean_____
emergency caesarean_____ scheduled caesarean _____ premature; how many weeks_____
length of labor _____

Were there any physical deformities or malformations observed at birth (such as blueness, jaundice, abnormal shape of head)? Yes_____ No_____ please describe:_____

Developmental History

When does your child go to bed at night? _____ **How many hours does he or she sleep?** ____
Does your child sleep through the night? _____ **Does your child snore?** _____

In early childhood, did the child have any feeding problems (such as poor control of sucking, food allergies, and digestive upsets)? Yes_____ No_____ If yes, please describe: _____

_____

Give age of development for the following behaviors:

Holding head up _____	Eating solid foods_____
Rolling over_____	Self feeding_____
Sitting unsupported_____	Feeding with utensil_____
Crawling_____	Self- dressing _____
Standing alone_____	Bladder/ bowel control_____
Walking_____	

Do you feel that the child was late or had difficulty in the development of these behaviors?
Yes_____ No_____ If yes, please explain: _____

_____

Medical History

Has child been hospitalized? If yes, please explain and include dates:

_____

_____

Has the child had any operation? If yes, when please explain and include dates: _____

_____

Has the child been diagnosed with a disease? If yes, please explain: _____

_____

Child Information Packet

Where there any complications with any illness, such as high/ persistent fevers, convulsions, or persistent muscle weakness? Yes_____ No_____ If yes, please explain:

_____

_____

Is the child subject to frequent colds, sore throats? Yes_____ No_____

Has the child seen a specialist for any reason? If yes, please explain: _____

_____

_____

Does the child have any dental problems? If yes, please explain: _____

_____

Has the child ever worn eyeglasses or had any difficulty with vision? If yes, please explain: _____

_____

Has the child had/ have any allergies? If yes, please list them all: _____

_____

_____

Ears Nose and Throat (ENT)

Has the child had tonsils and adenoids removed? When_____

Has the child had any ear trouble (such as earaches, infection, running ears, evidence of hearing loss)? If yes, please describe: _____

_____

Has hearing been tested? _____ **When** _____ **Results** _____

Has the child ever had ear (PE) tubes inserted? When _____ **Still in ear?** _____

Daily Living Information

Current School/ Daycare_____ **City** _____
Grade/Class_____ **Teacher**_____

Describe performance in school and concerns: _____

_____

_____

Child Information Packet

Does the child attend any special classes (such as speech therapy, reading, resource room, special education classroom)? If yes, please describe: _____

_____

_____

What does the child do well in that setting? _____

_____

What does the child have trouble doing in that setting? _____

_____

What are your child strengths? _____

_____

What are your child weaknesses? _____

_____

Does the child prefer to play alone? Yes_____ No_____

Does the child prefer to play with older or younger children? _____

Briefly describe how your child interacts with other children: _____

_____

What is your most frequent discipline or behavioral concerns? _____

_____

_____

What discipline strategies are effective? _____

_____

Does your child adjust well to change? Yes _____ No____ If no, please describe: _____

_____

_____

How does your child calm him/herself? _____

_____

What are your child's interests? _____

_____

Child Information Packet

Please fill out only if your child will be receiving Speech Therapy

Is the child's speech understandable to you? Yes _____ No _____ **Friends?** Yes _____ No_____

Strangers? Yes _____ No _____ **Other family members?** Yes _____ No _____

List sounds or words that the child has trouble saying: _____

_____

How does the child compare with siblings in speech development? _____

_____

Does the child use words in meaningful ways for his/ her age? Yes _____ No _____

Does your child speak in a complete understandable sentence or does your child only speak a few words? _____

Give examples of sentences the child uses by him/herself (not sentences that are repeated after you):

_____

_____

_____

At what age did the child babble? _____ **Say first words?** _____

Put two words in a sentence? _____ **Use three-word sentences?** _____

Does the child seem to understand directions? Yes_____ No_____

Does the child prefer to use speech or gestures when communicating? _____

Does anyone else in the family have speech, language, hearing problems? If yes, please describe:

_____

_____

Child Information Packet

Please fill out only if your child will be receiving Occupational Therapy

What are your child present problems and concerns in relations to Occupational therapy?

_____

_____

_____

Does your child need help with self care examples brushing teeth, brushing hair, getting dressed or undressed, feeding? Please describe: _____

_____

_____

_____

Does your child have fine motor concerns? If yes, please describe: _____

_____

_____

_____

Does your child have gross motor concerns? If yes please describe: _____

_____

_____

_____

Does your child have sensory concerns? If yes, please describe: _____

_____

_____

_____

Child Information Packet

Please fill out only if your child will be receiving Physical Therapy

What are your child present problems and concerns in relations to physical therapy? _____

_____

_____

_____

_____

Does your child walk on his/her toes? Yes_____ No_____

Does your child have fine motor concerns? If yes, please describe: _____

_____

_____

_____

Does your child have gross motor concerns? If yes please describe: _____

_____

_____

_____

Does your child have any health limitations? If yes, please describe: _____

_____

_____

_____

_____

Child Information Packet

Please fill out only if your child will be receiving Feeding Therapy

Was your child breast-fed? _____ how long_____ any problems? _____

When was your child's first bottle? _____ any problems? _____

At what age did your child try cereal? _____ any problems? _____

What age was your child weaned to a cup? _____ any problems? _____

What age did your child eat foods that require biting and chewing? _____ any problems? _____

_____

What foods are easy for your child to eat? _____

What foods are difficult for your child to eat? _____

What consistency of food does your child eat? smooth baby food _____ semi-chunky baby food_____

chunky baby food _____ mashed table food_____ regular table food _____

What kind of liquid does your child drink? _____

Does your child drink juice? _____ how much _____ how often _____

What temperature foods and liquids does your child prefer? _____

How many times a day does your child eat? _____ How long is it between meals? _____

Does your child self-feed? _____ how _____

Who usually feeds your child? _____

Which of theses behaviors does your child exhibit during a meal? Crying_____ spitting out food _____

holding food in mouth _____ gagging_____ vomiting _____ getting down from table ____

throwing food _____ refusing to eat _____ turning head away_____ clamping mouth shut _____

Child Information Packet

Parent/ Guardian Questions

What would you, as a parent/guardian like to see Innovative Therapy to help your child to achieve through therapy? _____

_____

_____

_____

_____

Do you have any further questions or concerns? _____

_____

_____

_____

_____

Child Name _____ **Therapy** _____

Parent/ Guardian _____ **Date** _____

Please read and initial each section of the office policy indicating that you have read and agree to comply with each statement.

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Tyler Speech Improvement Services

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Innovative Therapy Group
Tyler, Texas

Office Policy

Attendance Policy	Parent Initials
Each therapist at Innovative Therapy Group is in private practice and does not get paid for missed appointments. Thank you for understanding and cooperation.	
1. All appointments are expected to be kept as scheduled. **Sessions must begin and end at the scheduled times.** There are no provisions for extending sessions to accommodate late arrival.	
2. For children to benefit from the services provided, **consistent attendance is essential.** Optimal progress occurs when children are seen at the prescribed frequency. This is especially important if your child is seen only once a week or less.	
3. **NO-SHOW**: Your child's appointment is reserved for him/her. We make an effort to prepare for that appointment. It is an "act of courtesy" to call if you will be unable to keep your appointment. Please call as soon as you know you cannot keep the appointment. Two NO –SHOWS in a month will put your child at risk for discharge from therapy or having your child's name at the bottom of the waiting list.	
4. **Parent participation in the therapy session may be required at the therapist's discretion.** If it is necessary for you to leave parents of school aged children may leave the office briefly. Please notify the therapist that you will be away from the office. Be sure we have the following information before you leave. a. **Your cell number** and that your are carrying your phone b. **Where you will be** in case we cannot reach you by phone Please return by **15 minutes before the end of your child's session.** Take traffic into consideration before you leave.	
5. **Cancellations:** Cancellations must be provided 24 hours prior to the scheduled date except for illness or emergency. All cancelled sessions are to be re-scheduled if possible. After three cancellations in two months you may be removed from the list of standing appointments and will need to secure a new schedule with your therapist.	
6. **Therapist Cancellations:** If a therapist must cancel a session, the client is not expected to make up the session. If the parents request a make-up visit, the therapist will make every effort to do so. Sometimes we will ask you if are willing to come in for a re-scheduled visit due to our absence. It is your choice whether to do so or not.	
7. **Holidays:** Missed visits due to holidays do not require make-up visits. **Vacations:** If you are taking a vacation, please notify us ahead of time.	

Please read and initial each section of the office policy indicating that you have read and agree to comply with each statement.

Waiting Area Policy	Parent Initials
8. **Children in the waiting room must be attended by an adult at all times.** We are not responsible for children left unattended in our waiting area. We cannot monitor children who are waiting before or after their treatment sessions.	
9. Please keep children/siblings in the waiting area and out of the therapy rooms, hallway or office space.	
10. **Please do your part to keep noise to a minimum in the waiting area.** Excessive noise in the waiting area is a distraction to those in the treatment rooms.	
11. Out of respect for others please **DO NOT use your cell phone in the waiting or therapy rooms.** If you need to use your phone you may go into the outside hallway or entry area. Cell phones must be turned off before entering the therapy rooms.	
Payment Policy	
12. **All co- payments and private payments are to be paid when services are rendered.** This keeps your overall bill manageable for you.	
13. Be aware that even though we are filling with your insurance company/ Medicaid, the ultimate responsibility for payment of services rendered falls upon the parents, should the insurance carrier decline payment for any reason.	
14. **It is essential that our office be informed immediately of any change in insurance** including transfers from one Medicaid HMO (Amerigroup, UHC- Community, Superior, and CSCHN) to another. The new insurance card must be provided to prevent denials of claims. Failure to inform the office may result in denial of claim in which case the parent/caregiver is responsible for payment.	
15. Please discuss any concerns you may have over payments of visits with us. Many issues can be easily resolved. We will make every effort to assist you.	
Cost of Materials	
16. Most materials used for treatment are provided at no cost to the patient. However, there are some therapy tools which must be purchased by the parents. These tools are sold at cost.	

Speech- Language Pathologist	Occupational Therapist	Occupational Therapy Assistant	Physical Therapist
Andrea Nash	Elizabeth Olivier	Michal Kimball	Tammy Rhyne
Kathleen George	LeAnn Cargile	Tracey Daniels	
Kelsey Dominy	Rivkah Cohen		
Michele Shieldes			
Morgan Beckmon			
Suzanne Krause			
Zalyndia Powell			

I have read, understand and agree to abide by this office policy

_____ _____

Parent **Date**

Prohibition of Disclosure The enclosed information has been disclosed from confidential records which are protected by federal law. A federal regulation (42, CFR part2) prohibits the re-disclosure of the information without the written consent of the person to who it pertains, or as otherwise permitted by such regulations.

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Authorization for Use and Disclosure of Protected Health Information

Patient Information (please print):

This notice describes how medical information about your child may be used and disclosed and how you can get access to this information. Please review it carefully.

I, _____ authorize the following provider(s) to use and/or disclose educational and/or protected health information (PHI) regarding my child.

Childs Name: _____ **Date of Birth:** _____

Other names used by child: _____ **Program Name:** _____

Address: _____ **Phone:** _____

To disclose information and records regarding my child treatment, medical and/or behavioral health condition to the following professional person/ agency, physician and/or facility.

Information to be released or exchanged included:	**Name and address of health care provider authorization to:**
☐ History and physical	☐ Send/ disclose protected health information PHI
☐ Discharge and summary	☐ Send/ disclosed educational information
☐ Behavioral health treatment records	☐ Other
☐ Physical health treatment records	
The authorization purpose (s) for this release are:	**Name and address of program authorized to:**
☐ Diagnosis and treatment	☐ Receive/ use protected health information PHI
☐ Coordination of care	☐ Innovative Therapy Group 401 E. Front Street Suite 123 Tyler, TX 75702
☐ Insurance payment purposes	☐ Other
☐ Other	

I understand that my health and behavioral health records are protected from disclosure under Federal and /or state law. I may revoke this authorization. This authorization is valid until I revoke it or 60 days after I have completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. File copy is considered equivalent to the original.

Confidentiality Statement The documents accompanying this telecopy transmission contains confidential information that is legally privileged. This information is intended only for the use of the individual name above. If you are not your intended recipient, you are hereby notified than any disclosure, copying, distribution, or action taken in the reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of these documents.
Prohibition of Disclosure The enclosed information has been disclosed from confidential records which are protected by federal law. A federal regulation (42, CFR part2) prohibits the re-disclosure of the information without the written consent of the person to who it pertains, or as otherwise permitted by such regulations.

Purpose for Disclosure Speech- Language Pathologist , Occupational Therapist, Physical Therapist
☐ Therapy Services

I understand that:

1. This Authorization is voluntary and I may refuse to sign this authorization without affecting my care or the payment for my care.
2. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (If allowed by state and federal law. See 45 CFR 164.524).
3. I may revoke this authorization at any time by notifying Innovative Therapy Group in writing as set forth in the notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4. Innovative Therapy Group agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPPA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPPA rules.

I consent to the use/disclosure of the above information. I understand that the use of this information for any reason other than the expressed stated above is prohibited. This consent is subject to revocation at any time, expect to the extent that action has been taken based on information that has already been disclosed.

Patient name: _____ **Date:** _____

_____
Signature of Parent or Legal Representative

_____
Printed Name of Patients Representative

Relationship to patient
☐ Parent/ Guardian
☐ Court appointed Guardian
☐ Power of Attorney
☐ Other_____

Notice of clients' refusal to release information: ***Only sign below for refusal

I have reviewed the above release of information form and refuse to authorize release of health and behavioral health information to providers and /or physical health providers.

Patient name: _____ **Date:** _____

_____
Signature of Parent or Legal Representative

_____
Printed Name of Patients Representative

Relationship to patient
☐ Parent/ Guardian
☐ Court appointed Guardian
☐ Power of Attorney
☐ Other_____

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Tyler Speech Improvement Services

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Innovative Therapy Group
Tyler, Texas

Notice of Privacy Practices

You have the right to request that we communicate with you privately about your medical care by alternative means or alternative locations that the contact information of the person who pay your health insurance. Please provide us with your private contact information that you would like us to use. Innovative Therapy group will then take reasonable steps to accommodate this request.

Changes to the terms of this notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office.

Acknowledgment of receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of Innovative Therapy Group's ("provider") Notice of Privacy practices which summarized the ways my child's health information may be used and disclosed by provider and states my rights with respect to my protected health information (PHI). I understand that provider has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event provider changes it's Notice of Privacy Practices, a revised notice will be posted in a convenient location and that I may obtain a current Notice of Privacy Practices at any time from provider's administrative office. I understand that I do not need to sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my child's health insurance information, I can contact the privacy officer or privacy contact, as listed in the Notice of Privacy Practices.

Request for Confidential Communication

I request that Innovative Therapy Group communicates with me confidentially contact me about my child medical care (please select one listed below): Address where you can contact me confidentially:

_____

Email to contact me confidentially: _____

Phone number: _____ Best time to call: _____

_____ _____
Signature **Date**

_____ _____
Relation to patient **Date**

This notice is current and effective as of 5-18-2018

Acknowledgment parent has received our HIPPA Privacy Notice

Innovative Therapy Group is required by law to keep your child's health information safe. This information may include.

- ❖ Notes from doctor, teacher, or other health care provider
- ❖ Medical History
- ❖ Treatment Notes
- ❖ Insurance Information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared. It also tells you how you can look at and comment on your information.

By signing this page, you are saying that you have been given a copy of our privacy notice.

Patients' Name _____ **Date** _____

Parent/ Guardian _____ **Relation to patient**_____

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Patient Authorization---Insurance---

Please initial and sign/date

Definition: "I", "me", and "my" means the patient/guardian. "Clinic" means Tyler Speech Improvement Services and Innovative Therapy Group

_____ I certify that the information I gave in applying for payment of Medicaid/ insurance is correct. I irrevocably assign and transfer to the clinic all Medicaid/ insurance benefits covering the clinic's services for the payment of services rendered. I understand it is my responsibility to comply with all pre-certification requirements and that I am responsible for any health insurance co-payments and deductibles.

_____ I understand that insurance coverage is not a guarantee of payment and I agree that I am ultimately responsible for payment for services rendered at the clinic. I will honor the Clinic's payment policy.

_____ I understand that the office must be informed immediately of any change in insurance including transfers from one Medicaid HMO (Amerigroup, UHC- Community, Superior) or CHIP (Superior, Molina) to another. The new insurance card must be provided to prevent denials of claims. Failure to inform the office may result in denial of claim in which case the parent/guardian is responsible for payment.

_____ _____
Signature Parent/Guardian Relationship

_____ _____
Child name Date

Notice of Privacy Practices
Protected Health Information (PHI)/ HIPPA Privacy Notice

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Your Information-- Your Rights-- Our Responsibilities

Patients have the right to access a copy of their PHI maintained in a designated record set (medical records, billing records, and any other PHI that is used to make decisions about individuals) for as long as the organization maintains the information.
This notice describes how medical information about you may be used and disclosed and how you can access to this information. ***Please review it carefully.***

Know your rights

You have the right to:

- Get a copy of your paper or electronic medical records
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Make choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services and sell your information
- Raise funds

Understand how we use and share information about you

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Conduct research
- Comply with the law

Parent/ Guardian keep this notice for your records

Notice of Privacy Practices
Protected Health Information (PHI)/ HIPPA Privacy Notice

- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government request
- Respond to lawsuits and legal actions

Know your rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record**
  You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
  We will provide a copy or a summary of your health information, usually within 30 days of your request, or in this case of written request made by you for your electronic health record, usually within 15 days of your request. We may charge a reasonable, cost-based fee.

- **Ask us to correct your medical record**
  You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we will tell you why in writing within 60 days.

- **Request confidential communication**
  You can ask us to contact you in a specific way (for example, homes or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

- **Ask us to limit what we use or share**
  You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
  If you pay for a service or health care item out-of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- **Get a list of those with whom we have shared information**
  You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
  We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost–based fee if you ask for another one within 12 months.

Parent/ Guardian keep this notice for your records

Notice of Privacy Practices
Protected Health Information (PHI)/ HIPPA Privacy Notice

- **Get a copy of this privacy notice**
  You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

- **Choose someone to act on your behalf**
  If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

- **File a complaint if you feel your rights have been violated**
  If you feel we have violated your rights, you can file a complaint by contacting us using the information on the first page of this Notice of Privacy Practices – Protected Health Information (PHI). You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, SW, Washington, D.C. 20201, calling 877-696-6775 or visiting www. hhs.gov/ocr/privacy/hipaa/complaints/
  We will never retaliate against you for filing a complaint.

Make choices

For certain health information, you can make choices about what we share.

- **If you have a clear preference for how we share your information in the situations described below, talk to us.**
  Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and the choice to tell us whether to:
  - Share information with your family, close friends, or others involved in your care
  - Share information in a disaster relief situation

- **If you are not able to tell us your preference (for example, if you are unconscious), we may go ahead and share your information if we believe it is in your best interest.**
  We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- **We will never share your information for the following purposes unless you give us written permission:**
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes

  Please note that although we may contact you for fundraising purposes, you can instruct us to remove you from our fundraising mailing list at any time.

Parent/ Guardian keep this notice for your records

Notice of Privacy Practices
Protected Health Information (PHI)/ HIPPA Privacy Notice

Understand how we use and share information about you

We typically use or share your health information in the following ways:

- **To treat you**
  We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks us about your overall health condition.*

- **To run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

- **To bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities. *Example:* We give information about to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. To learn more, visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **To help with public health and safety issues**
  We can share health information about you for the following reasons:
  - To prevent the spread of disease
  - To help with product recalls
  - To report adverse reactions to medications
  - To report suspected abuse, neglect, or domestic violence
  - To prevent or reduce a serious threat to any person's health or safety

- **For research**
  We can use or share your information for health research.

- **To comply with the law**
  We will share information about you if state or federal laws require it. This may include the Department of Health and Human Services to demonstrate our compliance with federal privacy law.

Parent/ Guardian keep this notice for your records

Notice of Privacy Practices
Protected Health Information (PHI)/ HIPPA Privacy Notice

- **To work with a medical examiner or funeral director**
  We can share a deceased individual's health information with a corner, medical examiner, or funeral director.

- **To address workers' compensation, law enforcement, and other government requests**
  We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

- **To respond to lawsuits and legal actions**
  We can share your health information in response to a court or administration order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Parent/ Guardian keep this notice for your records

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