my CHILD'S therapy

Client Name: _____ **Client DOB:** _____

As a client of My Child's Therapy Inc, I understand that my healthcare information may be used and/or disclosed by My Child's Therapy Inc for purposes of carrying out treatment, obtaining payment, and carrying out other health care operations of the organization.

I acknowledge that I have received a copy of My Child's Therapy Inc's Notice of Privacy Practices, which provides a more complete description of possible uses and disclosures of my health information. I understand that it is my right to review the Notice of Privacy Practices, and that the terms of the Notice of Privacy Practices may be updated in the future. I also understand that I may obtain a copy of the Notice of Privacy Practices that is in effect at any given time by requesting a copy from my doctor, therapist, case worker, etc. or through the office manager or medical records supervisor at My Child's Therapy Inc.

I have read and I understand the information contained on this Healthcare Information Acknowledgement Form.

_____ Date: _____
Client Signature (if 18 years or older)

_____ Date: _____ _____
Parent/Guardian Signature Print Name and Relationship

_____ Date: _____
Staff/Witness Signature

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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.

The Health Insurance Portability and Accountability Act (IPAA) of 1996 and its implementing regulations, as amended, is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse protected health information (PHI).

This HIPAA Notice of Privacy Practices describes how we may use and disclose your PHI to carry out treatment, payment, or health care operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment, or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, public health issues required by law, communicable diseases; health oversight; abuse or neglect; US Food and Drug Administration requirements; legal proceedings; law enforcement, coroners, funeral directors, and organ donation; research; criminal activity; military activity, national security: workers' compensation; inmates; required uses and disclosures/; Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of HIPAA.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. Use and disclosures of PHI for marketing purposes, as well as disclosures that constitute a sale of PHI, require authorization from you.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. If such information is maintained in an electronic health record (EHR), your access rights include the right to a copy in an electronic format. We have the right to charge you a fee for the

copying of paper records, and, in the case of a request for an electronic copy of your PHI maintained in an EHR (or a summary or explanation of such information), we have the right to charge you the amount of labor costs in responding to your request. Your right to inspect and obtain a copy of your PHI extends only to your PHI contained in our Designated Record Set for you. A "Designated Record Set" is the HIPAA term for medical and billing records and any other records that we use for making health care decisions about you.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this HIPAA Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Any such request for restrictions must be in writing, be addressed to the Privacy Officer, and state the specific restriction requested and to whom you want the restriction to apply. However, we are not required to comply with your request, unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or healthcare operation purposes and such information you wish to restrict pertains solely to a healthcare item or service for which you have paid us "out of pocket" in full.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. However, we may condition this accommodation by asking you for information as to how payment will be handled or a specification of an alternate address or other method of contact. We will not request an explanation from you as to the basis for the request. Your request must be in writing, be addressed to the Privacy Officer and state the specific alternate means or location.

You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You may have the right to have your physician amend your protected health information contained in your Designated Record Set if you believe it is incorrect or incomplete. However, we are not required to make any such amendments. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. All of these documents will be placed in the appropriate part of your Designated Record Set. If you are requesting that we amend your records because you believe that you are a victim of medical identity theft, we will use reasonable efforts to assist you in making corrections to your record which are determined to be appropriate under the circumstances.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Affected individuals have the right to be notified in the event of a breach of unsecured PHI. We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice. To exercise any of your rights above, please contact our privacy officer in writing.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. **We will not retaliate against you for filing a complaint**.

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Photography and Video Release

_____(initial for NO) I, _____, DO NOT give My Child's Therapy permission to photograph or video tape my child, _____, for promotional purchases, including but not limited to social media, Facebook, Instagram and print material, such as mailers and flyers.

_____(initial for YES) I,_____, give permission for My Child's therapy to photograph and or video tape my child, _____, for promotional purchases, including but not limited to social media, Facebook, Instagram and or print material, such as mailers and flyers. I understand that no royalty, fee, or compensation will be provided for the use of these photographs, videos, or images.

Parent/Guardian Name:_____

Parent / Guardian Signature:_____

Date:_____

Child's Name: _____

Phone Number:_____

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PRIVACY POLICY

I give My Child's Therapy permission to contact me using text messaging, voicemail, and email unless I stated below:

_____

For appointment reminders, please text me at _____.

My Child's Therapy may also contact (name)_____ at the following numbers:

Phone:_____

Text:_____

E-Mail:_____

Patient: _____

Guardian Name:_____

Guardian Signature: _____ Date: _____

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Patient Information

Patient Name: _____

Date of Birth: _____ Age: _____ Sex: M or F

Who does the patient live with? _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent #1 Name: _____ D.O.B.: _____
Address: _____
Phone #1: _____ Phone #2: _____
Email address: _____
Employer: _____ Work Phone: _____
Driver's License #: _____ State: _____ SS#: _____

Parent #2 Name: _____ D.O.B.: _____
Address: _____
Phone #1: _____ Phone #2: _____
Email address: _____
Employer: _____ Work Phone: _____
Driver's License #: _____ State: _____ SS#: _____

Primary Physician: _____ Physician Phone: _____
Primary Physician Practice Name:_____Location:_____

Primary Insurance-Policy Holder: _____Employer:_____
Relationship:_____ DOB: _____
Policy Holder Address: _____Police Holder Phone: _____
Insurance Provider: _____Insurance ID #: _____Group #: _____

Secondary Insurance-Policy Holder: _____Employer:_____
Relationship:_____ DOB: _____
Policy Holder Address: _____Police Holder Phone: _____
Insurance Provider: _____Insurance ID #: _____Group #: _____

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Scheduling and Cancellations/Lateness

MCT will also be removing all patients' recurring appointment slots who have had four (4) or more cancels within a 90-day period and reassigning to a Rotating Schedule. Having a therapist reserved during a presumed booked time that is unexpectedly cancelled is unfair to the families who have been waiting for recurring time slots to open during their availability.

If you are reassigned to Rotating Appointment Scheduling due to cancellations, your child can be placed back onto the Recurring Appointment Schedule by attending all of his or her weekly sessions, for 30 consecutive days.

Cancellations include those with or without 24-hour notice.

If you have two (2) or more cancellations with less than 24-hour notice within a 30-day rolling period, your child will be removed from the Recurring Appointment Schedule and arrangements will be made to be placed on a Rotating Schedule.

While we understand that lateness is sometimes unavoidable due to various conditions, frequent lateness (7 or more minutes past scheduled start time) also impacts our ability to reserve appointment times. Attending late 4 or more times within a 90 period will result in reassignment to a Rotating Schedule.

My Child's Therapy (MCT) prides itself on being able to offer superior therapy services to its clients on a Recurring Appointment Schedule. Because of this commitment, MCT can ensure that the best treatment methods are delivered as recommended in order to achieve optimal results. To do this, MCT must ensure all patients are present for their scheduled appointments as we designate a therapist to be prepared and present for your child's session. This is a commitment we work very hard on meeting one hundred percent of the time.

We know not all families can commit to a routine and recurring schedule. Therefore, we also offer a second method for scheduling, "Rotating Scheduling." If this method fits our clients' needs more closely, MCT will provide clients the ability to schedule their child's treatment sessions in advance for the next 2 weeks that follow. This will ensure the best and highest results for those families with varying schedules and availability.

We thank you for your cooperation in this matter.

My Child's Therapy

_____ _____

Patient Name Date

_____ _____

Guardian Name Guardian Signature