KidSPOT pediatric therapies

Notice of Privacy Practices

801 Main St. Suite 10, Louisville, CO 80027
Phone: 303.604.6441 • Fax: 303.957.1955
www.boulderkidspot.com

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

YOUR RIGHTS

You have certain rights to your health information. These include:

- The right to get an electronic or paper copy of your medical record. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a cost-based fee.
- The right to ask us to correct your medical record. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- The right to request confidential communications (for example, send mail to a different address). We will say "yes" to all reasonable requests.
- The right to request a restriction of your protected health information for the purposes of treatment, payment, or healthcare operations. We are not required to agree to your request, except if you request that we do not disclose health information to your health insurer for which you have paid in full, out of pocket, at the time of service.
- The right to get a list of those with whom we've shared information. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures.
- The right to receive a printed copy of this notice.
- The right to choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can make choices about your health information.
- The right to file a complaint if you feel your rights are violated. You can file a complaint by contacting us using the information on the top of page 1 or with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

You can make choices for certain health information. If you are not able to tell us your preference, we may share your information if we believe it is in your best interest or if we need to lessen a serious and imminent threat to health or safety.

You have the choice to request for us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts
  We may contact you for fundraising efforts, but you can ask us not to contact you again.
- Fax, email, or text your health information as an alternative communication
  By providing us with this information, you are guaranteeing that you have sole access to the fax, email or phone with text messaging. We are not responsible for patient health information viewed by others if it is a shared fax, email or phone, as you requested that it be sent there.

Unless you give us written permission, we will never use your information for:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

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

- Treatment
  We can use your health information and share it with other professionals who are treating you.
- Healthcare Operations
  We can use and share your health information to run our practice, improve your care, and contact you.
- Payment
  We can use and share your health information to bill and get payment from health plans or other entities.

We may use or disclose your protected health information in the following situations without your authorization. As required by law, these situations include, but are not limited to: reporting communicable disease, public health reporting, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act.

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 and let us know in writing.
- 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, and on our website.

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

If you have further questions or concerns, please contact our privacy officer by calling 303-604-6441 or emailing Info@Boulderkidspot.com.

Consent & Attendance

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Notice of Privacy Practices Acknowledgement

I hereby acknowledge that I have received and read the Notice of Privacy Practices explaining:

- How this practice will use and disclose my protected health information
- My privacy rights with regard to my protected health information
- This practice's obligations concerning the use and disclosure of my protected health information

I authorize and consent to KidSPOT Pediatric Therapies using and disclosing my protected health information for the purposes of treatment, payment and healthcare operations as described in the Notice of Privacy Practices. I give KidSPOT Pediatric Therapies permission to use written, verbal, and electronic forms of communication to collect and release health related information among physicians, healthcare providers, other appropriate organizations including school districts, and myself as it relates to my care or payment for services.

Consent to Treat

I give KidSPOT Pediatric Therapies permission to provide Occupational, Physical, and/or Speech Therapy services. This will include examination, evaluation, intervention as well as outcome tracking and other activities as they relate to the delivery of Therapy services.

Benefits, Payment, & Insurance Payments

I acknowledge that I have provided information that is current and accurate. If at any time coverage information changes I will notify KidSPOT Pediatric Therapies. As a courtesy to our patients we will verify your insurance benefits. THIS IS NOT A GUARANTEE OF BENEFITS. Please refer to your employer's policy manual or contact your insurance carrier if you have questions about your coverage.

PLEASE NOTE THAT ALL DISPUTED OR PENDING CLAIMS WILL IMMEDIATELY BECOME YOUR RESPONSIBILITY. In an event that a credit balance reflects on your account due to insurance or patient payment, we will hold any refund until the account has been paid in full. If your insurance company HAS NOT paid us within 45 DAYS the account will be billed to you, and it becomes your responsibility to pay us. You will then need to work with your insurance company for reimbursement to you.

Attendance Policy

I understand that I am being asked to make a commitment on my child's behalf, of attending at least 3 out of every 4 consecutively scheduled appointments at KidSPOT Pediatric Therapies. We require at least a 24-hour notice of cancellation. In addition, if I am more than 15 minutes late for a scheduled appointment, it may be considered a "no show" per discretion of the treating therapist. I acknowledge that therapy will be discontinued and my child's appointments will be removed from the schedule, should our attendance rate fall below this number.

I have read and understand that the statements in this document take effect the day that I sign it.

Parent/Guardian Signature Date

Therapist Signature Date