

CHILD'S NAME: _____ DATE OF BIRTH: _____
 GUARDIAN'S NAME: _____

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Provide treatment and services
- Bill and collect payment from you, your insurance company, or a third-party payor
- Conduct healthcare operations such as assess my care and outcomes as well as quality assessments.

I understand that I may request in writing that Adapt & Learn, LLC restricts how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if the organization does agree then it is bound to abide by such restrictions.

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Adapt & Learn, LLC. is dedicated to maintaining the privacy of individually identifiable health information as protected by law, including the Health Insurance Portability and Accountability Act (HIPAA). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. This information is referred to as protected health information or PHI. We are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our organization concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

This notice contains the following required information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our organization. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our organization has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our organization will post a copy of our current Privacy Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our organization may use your PHI to treat you. For example, we may ask you to have evaluations and we may use the results to help us develop an individual plan for services. This means providing, coordinating, or managing health care and related services by one or more health care providers. Additionally, we may also disclose your PHI to your primary care physician or other outside health care providers for purposes related to your treatment. Finally, we may disclose your PHI to family members or others who may assist in your care.

2. Payment. Our organization may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members or school districts. Also, we may use your PHI to bill you directly for services and items.

3. Health Care Operations. Our organization may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our organization may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our organization. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our organization may use and disclose your PHI to contact you and remind you of an appointment. We may leave messages on your answering machine/voicemail/text message/email regarding appointment reminders and billing/collections efforts.

5. Treatment Options. Our organization may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our organization may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you. We may contact you in the future via newsletters, mail outs, or other means regarding treatment options, health related information, or other community-based initiatives or activities Adapt & Learn, LLC is participating in.

7. Release of Information to Family/Friends. Our organization may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you.

8. Disclosures Required By Law. Our organization will use and disclose your PHI when we are required to do so by federal, state or local law.

C. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our organization may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult person served (including domestic violence) though we will only disclose this information if the person served agrees or we are required or authorized by law to disclose this information

2. Health Oversight Activities. Our organization may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our organization may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Serious Threats to Health or Safety. Our organization may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. National Security. Our organization may disclose your PHI to federal officials for intelligence and national security activities authorized by law.

D. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Program Director or Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our organization will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members, guardians, and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Adapt & Learn, LLC. Your request must describe in a clear and concise fashion:

- a. the information you wish restricted;
- b. whether you are requesting to limit our organization's internal use, outside disclosure or both; and
- c. to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including medical records and billing records. You must submit your request in writing to the Adapt & Learn, LLC in order to inspect and/or obtain a copy of your PHI. Our organization may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our organization may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to Adapt & Learn, LLC. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the organization; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our organization, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our persons served have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our organization has made of your PHI, e.g., for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine care in our organization is not required to be documented. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure. Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Adapt & Learn, LLC.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. We urge you to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, however, that we are required to retain records of your care.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of my rights and the uses and disclosures of my health information. I understand that Adapt & Learn, LLC has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

SIGNATURE _____

CONSENT TO OBTAIN/RELEASE INFORMATION

I, _____, parent/guardian of minor child, _____, authorize Adapt & Learn LLC to obtain and/or release protected health information (PHI) including medical and/or educational records, written, verbal, and electronic communications. This permission to obtain/release information and communicate with team members will be in direct support of occupational therapy services and consultation practices.

I understand that this authorization may be revoked at any time, except to the extent that action has already been taken in reliance on this authorization. This can be done by writing a letter and mailing it certified mail, return receipt requested, to Adapt & Learn LLC. This authorization shall automatically expire 1 year from the date of signature unless otherwise specified in the space provided here.

SIGNATURE _____
EXPIRATION _____

INFORMATION TO BE OBTAINED/RELEASED FROM/TO

(Please list all/any applicable physicians, clinicians, practitioners, and educators)

	Provider Name / Organization	Provider Name / Organization	Provider Name / Organization	Provider Name / Organization
Address				
Phone				
Email				
Fax				

Do you authorize Adapt & Learn, LLC. to release your child’s PHI to any additional people in your household?

Yes _____ (initial) (Name/Phone) _____
No _____ (initial)

PERMISSION FOR ELECTRONIC OR MOBILE TECHNOLOGY COMMUNICATION

Do you give permission for Adapt & Learn, LLC to leave a detailed voicemail and/or text message?

	Yes	No
Home Phone		

Cell Phone Parent #1:		
Cell Phone Parent #2:		
Email Parent #1:		
Email Parent #2:		

STATEMENT OF NONDISCRIMINATION

Adapt & Learn, LLC complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ACKNOWLEDGEMENT OF THIS INFORMATION:

I have read and understand the information provided here.

Child's Name: _____

DOB: _____

Parent/Guardian/Insured Name: _____

Signature: _____

Date: _____