



NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. The act gives you, the patient, new rights to understand and control how your health information is used.

Since Sensory Kidz Therapy is in the business that requires taking personal health information (PHI) from patients, we are obligated to strictly follow and abide by this law to protect any and all information gotten from patients in the process of rendering our services.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE: You will be asked to provide a signed acknowledgment of receipt of this notice on the patient form. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of therapy services will in no way be conditioned upon our signed acknowledgment.

If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION: "Protected health information" (PHI) is individually identifiable health information. This information includes demographics (for example, age, address), and relates to your past, present, or future physical or mental health or condition and related health care services. Our practice is required by law to do the following: • Keep your PHI private • Give you this notice of our legal duties and privacy practices related to the use and disclosure of PHI • Follow the terms of the notice currently in effect • Communicate to you any changes we may make in the notice.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION: Following are examples of permitted uses and disclosures of your PHI. These examples are not exhaustive.

1. Treatment- We will use and disclose your PHI to provide, coordinate, or manage your therapy and/or related services. This includes the coordination or management of your treatment with a third party. For example, we may disclose your PHI from time-to-time to another physician (for example, your ordering physician, orthopedic physician) and other health care providers who becomes involved in your care for diagnosis or treatment.

2. Payment- Your PHI will be used, as needed, to obtain payment for therapy services provided. This may include certain activities we may need to undertake before your health care insurer approves or pays for the therapy services recommended for you, such as determining eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for speech or physical therapy might require that your relevant PHI to be disclosed to obtain approval of therapy.

3. Practice Operations- We may use or disclose, as needed, your PHI to support our daily activities related to therapy services. These activities include, but are not limited to billing, collections, oversight or staff performance reviews, quality review and improvement, licensing, communications about a product or service, and conducting or arranging for other health care related activities. For example, we may disclose your PHI to a billing agency in order to prepare claims for reimbursement for the services we provide to you. We may disclose your PHI to school level students, that see patients in office for training/educational purposes. We may call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind

you of your appointment via phone, email, or mail. These business associates at our practice will also be required to protect your health information.

4. Required by Law- We may use or disclose your PHI if law or regulation requires the use or disclosure.

5. Legal Proceedings- We may disclose PHI during any judicial or administrative proceeding, in response to a court order or administrative tribunal and in certain conditions in response to a subpoena, discovery request, or other lawful process.

6. Public Health Risks: We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.

7. Regulatory Oversight: We may use or share your information to report to agencies overseeing health care. This may include sharing information for audits, licensure and inspections.

8. Threats to Health and Safety: Your health information may be shared if it is believed that it will prevent a threat to your health and safety or the health and safety of others.

9. Worker's Compensation: We will share your information with Worker's Compensation if your case is being considered as a work-related injury

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSION: In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your PHI. These circumstances will require you to give consent on our authorization for release of information form. Following are examples in which your agreement or objection is required. a member of your family that brings your child to therapy, a teacher or therapist and the child's school, or a relative, a close friend, or any other person you identify that has involvement in your child's therapy, or to someone who helps pay for the services provided. **YOUR RIGHT REGARDING YOU PROTECTED HEALTH INFORMATION:** You may exercise the following rights by submitting a written request to our office manager.

DISCLOSURES AND RIGHTS

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your PHI and how we may use and disclose them as the situation permits.

DISCLOSURES

Treatment means using or disclosing the information provided to us by patient to provide medical services, treatment or supplies. In due course of this process, PHI of patients will be used and disclosed to relevant parties involved in the medical procedures.

Financial information means information provided to us by patient, that are relevant to the finances of the patient. Information like, name, address, insurance coverage, payment history and the likes, can and will be disclosed when necessary to relevant parties like business associates, employees, or others that are in one way or the other involved in providing services for patients.

Payment means information or activities that may be relevant and disclosed for the processing for reimbursement of services, supplies, and other relevant billings as the case may apply. We may use or disclose your health information in order to process claims or make payment for covered services or supplies.

Health Care Operations, the need for quality assessment, auditing functions, cost-management analysis, and the likes are scheduled activities for organizations and for this reason, a disclosure of some of your information may be unavoidable.

There are other instances that may prompt the disclosure of your PHI, situations where;

- The law demands your information through a subpoena or court order.
- A written agreement to provide such information to your family, close friends, caregivers, or a professional to determine how this information might be beneficial to you etc.

It should be stated that the disclosures are not limited to these above statements, therefore, should any need for disclosure not stated in this agreement arise, we are compelled to inform you about such development and, make a decision that protects patient and Sensory Kidz Therapy as the situation permits. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

RIGHTS

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

If you believe that your privacy rights have been violated, please submit your complaint in writing to:

Privacy Officer
Sensory Kidz Therapy
3350 sw 148th ave. Suite 110
Miramar, FL 33027.

You may also decide to file a complaint with the secretary of the Department of Health and Human Services. You will not be retaliated against for filling a complaint.

I have received the Sensory Kidz Therapy Notice of Care Privacy Practices and I am aware of my rights.

Patient Name

Patient or legal representative Signature

Date

Relationship

Date

Sensory Kidz Representative

Date