1601 E Main Street, Unit G, Saint Charles IL 60174
2018 Larkin Avenue, Elgin, IL 60123

630.880.0993 (office)
630.480.4049 (fax)
info@myrecess.com

2024 MY RECESS FORM LIST

_____
Name

- ☐ AUTHORIZATION OF RELEASE OF INFORMATION
- ☐ VIDEO AND PHOTO RELEASE
- ☐ SICK POLICY & HYGIENE
- ☐ PHYSICIANS ORDER FOR THERAPY SERVICES
- ☐ THERAPY SERVICES AGREEMENT
- ☐ STANDARD THERAPY SERVICE FEE SCHEDULE
- ☐ FINANCIAL RESPONSIBILITY AND AUTOMATIC PAYMENT FORM
- ☐ CLINIC ETIQUETTE AGREEMENT
- ☐ HIPAA NOTICE OF PRIVACY PRACTICES
- ☐ COPY OF INSURANCE CARD

Please complete the following forms electronically or be printed and completed manually. Please print legibly. Send completed and signed forms to My Recess PRIOR to scheduling your initial appointment or consultation. If forms are not completed prior to your evaluation, your appointment may be canceled. Completed and signed forms maybe printed and faxed to 630.480.4049 or scanned and emailed to info@myrecess.com. All signatures are required to validate forms. Accepted and valid signatures can be **digital certified signatures** or physically signed, scanned, and faxed documents. My Recess Therapy does not guarantee coverage by your insurance and requires a 50% payment of services until insurance has verified payment. My Recess Therapy will refund any money charged once the insurance company has paid within 30 days of receipt of insurance payment.

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AUTHORIZATION OF RELEASE OF INFORMATION

I _____, parent or legal guardian for _____ authorize permission for My Recess Therapy, Inc. to exchange information. Who would you like your therapist to be able to talk with? (i.e. Family Relationships, School, Physicians, other therapy service providers.) This information will only be released upon parent/legal guardian request. Information to be released to:

NAME	RELATIONSHIP	CONTACT	INFORMATION TO BE RELEASED
	Parent/Guardian (spouse)		
	(Pediatrician)		
	(School Teacher)		

Please list any other team members (psychologist, counselor, ...)

_____

_____

_____

_____

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Witness Date

_____ _____
Child Signature Date

If over age 12 for mental health/developmental disability records, if child is age 12 or older, but less than 18

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VIDEO AND PHOTO RELEASE

By signing this agreement, I have given permission to have my son/daughter video-taped and/or photographed. By signing below I certify that I am the parent or legal guardian of the child, a minor. I release My Recess Therapy, its parent, affiliates, officers, directors, agents and employees, and those acting under its authority, from all debts, claims and liabilities of any kind arising out of or in connection with the use and publication of the photograph/likeness referred to above. The undersigned does hereby agree to hold My Recess Therapy, its parent, affiliates, officers, directors, agents, and employees, and those acting under its authority, against loss from any claim, action, or demand that may be brought at any time by the above-named minor or by anyone acting on the minor's behalf for the purpose of enforcing a claim for damages on account of the use and publication of the minor's likeness and photograph.

Permission of these videos or photos is limited to the educational uses only.

Child's Name _____ Date _____

Parent or Guardian's Signature _____ Date _____

☐ Photo & Video Release Opt Out

SOCIAL MEDIA/WEB : CELEBRATING ALL THE VICTORIES

As part of our goals and mission at My Recess Therapy, we would like to share all of our victories, big and small with others.
Not only to celebrate your child's accomplishments, but to help our community grow in awareness and support for our kids.

I further agree to have my son/daughter's photographs to be displayed on my therapists' website, social media (pictures, videos, and treatment progress), or used in publications related to My Recess Therapy, Inc. in order to share my child's accomplishments and demonstrate the work done at their clinic as indicated by my signature below. I certify that I am the parent or legal guardian of the child, a minor. I release My Recess Therapy, its parent, affiliates, officers, directors, agents and employees, and those acting under its authority, from all debts, claims and liabilities of any kind arising out of or in connection with the use and publication of the photograph/likeness referred to. The undersigned does hereby agree to hold My Recess Therapy, its parent, affiliates, officers, directors, agents, and employees, and those acting under its authority, against loss from any claim, action, or demand that may be brought at any time by the named minor or by anyone acting on the minor's behalf for the purpose of enforcing a claim for damages on account of the use and publication of the minor's likeness and photograph.

Parent or Guardian's Signature _____ Date _____

☐ Social Media / Web Opt Out

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SICK POLICY

My Recess Therapy is a multi-disciplinary pediatric therapy clinic. Due to the medical needs of our clients and in consideration of health of our staff/therapist, we require that parents/caregivers cancel treatment sessions for the following reasons:

- Illness symptoms within the last 24 hours
- Fever: temperature of 100° F or 38° C or greater within the last 24 hours
- Diarrhea: Five or more loose, watery stools within 24 hours
- Vomiting within the last 24 hours
- Sore throat or difficulty swallowing
- Rash or spots on skin; ringworm infection
- Severe itching
- Mouth sores
- Eye discharge
- Unusual nasal discharge
- Uncontrolled coughing
- Difficulty breathing, wheezing
- Wounds that are not properly covered
- Head lice, if not clear for at least seven (7) days.

My Recess Therapy will not bill your insurance carrier for non-attended sessions.

HYGIENE POLICY

SOILED CLOTHING

If you child has child has urinated or defecated in their clothing during a treatment session and does not have a proper change of clothes, the session will be ended at that time.

HEAD LICE

My Recess Therapy supports the Head Lice Policy of the American Association of Pediatrics. If you know your child has live crawling head lice, **begin a treatment to kill live lice before coming to therapy.** We advise seeking professional care of lice and nit removal. Child must be cleared of nits and lice for at least seven days prior to returning to therapy clinic to support containment of lice and reduce risk of spreading to other and on therapy equipment.

Please sign to acknowledge, accept, and abide by the terms of the above sick and hygiene policy. I agree to contact my therapist directly via phone or email to cancel and reschedule my upcoming appointment. I agree to the terms, policies and procedures found within the above My Recess sick and hygiene policies.

_____ _____

Parent or Legal Guardian's Signature Date

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PHYSICIANS ORDER FOR THERAPY SERVICES

Date: _____ DOB: _____

Name: _____

Medical Diagnosis Related to Therapy (ICD-10 Code): _____

- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Physical Therapy
- ☐ Evaluation
- ☐ Treatment
- ☐ TX DX (ICD-10) Codes: _____

Physicians Signature _____ DEA# _____

Physician's Name (print) _____ Physician's Phone _____

Physician's Address _____ Physician's Fax _____

HIPAA CONSENT

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from m insurance companies, and for health care operations such as quality review. I have been informed that I may review the practice/clinic's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent. I understand that this practice/client has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic. I understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction, they must follow the restrictions. I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

These services are prescribed and considered medically necessary. The therapy evaluation and follow up treatment if determined appropriate at the time of evaluation. Frequency and duration to be determined based on plan of care by treating therapist. Please sign and fax completed form to My Recess Therapy.

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THERAPY SERVICES AGREEMENT

SECTION ONE: Consent to Evaluate and Treat

I, Parent/Guardian, _____ acting on behalf of _____ consent to evaluate and treat in-clinic or via telehealth the necessary care and/or treatment of the patient by therapist(s) doing business for My Recess Therapy. I acknowledge that no guarantee has been made to me as the result of evaluation and/or treatment.

By signing this form, I acknowledge that I have read and understand the contents and am competent to execute it or if executed on behalf of another, I am authorized to execute it on behalf of that person.

_____ _____

Parent or Legal Guardian's Signature Date

RECEIVING OUTSIDE THERAPY SERVICES? ☐ YES ☐ NO

If yes, please list therapies and frequency.

_____

_____

_____

_____

_____

SECTION TWO: Terms of Service

My Recess Therapy is honored you chose our clinic for your family's therapy and care.

My Recess Therapy strives to provide quality treatment services for your child. Regular attendance for both in-clinic and Teleheatlh care is necessary to establish a positive treatment routine and ensure progress is made in meeting your child's goals. These policies have been created to support opportunities for children on our waitilst for therapy services. By allowing adequate time for your canceled session, we are able to open these positions to these families for evaluation and care.

The My Recess Therapy environment cultivates acceptance and kindness to all children and families working on toward individual goals and navigating challenges. We acknowledge and respect families, therapists, and staff. If we feel an action occurs outside of our My Recess culture and policies, you will be asked to leave the My Recess family in effort to support all families in our space.

ALL CANCELLATIONS REQUIRE A 24 HOUR NOTICE*

_____
Initial

CANCELLATIONS	FEES / ACTIONS
1 cancellation less than 24 hours	$40.00
3 consecutive cancellations	Placed on a flexible schedule (appointments will be scheduled during openings per week).
Holiday* late cancellation	$65.00
NO SHOW	**FEES / ACTIONS**
1 No show appointment	$65.00
2 No show appointments in 1 month	Placed on waiting list
3 No show appointments	Discharged
Holiday* no show appointments	$75.00
RESCHEDULED	**FEES / ACTIONS**
Should you need to cancel for any reason, we offer the following options:	
Telehealth	Virtual telehealth option during your normally scheduled session time or at a time determined with your therapist.
Private Parent Meeting	Meeting between therapists and parent to discuss treatment plan, goals, and progress to continue and develop treatment plan.

Although we understand extenuating circumstances may occur and will be placed under consideration with your therapy team and My Recess Therapy administration. Application of any fee or action is at the discretion of your therapist. Thank you for allowing My Recess Therapy to care for the therapy needs of your child. Contacting your therapist directly via e-mail, phone or other forms of communication that you have arranged as a point of contact.

By signing below, I the parent/guardian of _____ agree to the above therapy services agreement.

_____ _____
Parent or Legal Guardian's Signature Date

***Cancellation or no show appointments related to Holiday weeks or inclement weather are subject to the discretion of your therapist. If weather conditions prevent you from traveling to our offices, please notify your therapist within the required 24 hour period or as soon as possible in order to avoid cancellation or no show fees. Holiday weeks are the weeks preceding or following any national holiday. National holidays are holidays recognized by the government.**

SECTION THREE [A]: Appointment Reminders from Fusion Web Clinic

☑ I agree to receive communication text or email reminders from Fusion Web Clinic for My Recess Therapy and are responsible for any data rates that apply.

Cell Phone _____ Email _____

SECTION THREE [B]: Communication and Correspondence

Please check which methods of communication are acceptable for discussing treatment appointments.

☐ Cell Phone ☐ Text Message ☐ Email ☐ Home Phone

☐ I agree to receive email updates regarding My Recess Therapy announcements, services and programs, community activities, and clinic operations. I understand that I can opt-out of these emails at any time.

SECTION FOUR [C]: Session Wrap-Up

We will share your child's progress as well as discuss other information about your child's treatment after their therapy session.

We want to ensure your child's privacy and be considerate of any confidential information that may be part of this discussion. Please check which methods of communication you feel are appropriate for a wrap-up conversation. If you select the phone or email option, we will end your child's session a few minutes early to allow for adequate time to communicate with you.

☐ My Recess Lobby ☐ Exterior Clinic (hallway) ☐ Email ☐ Phone

I agree to receive communication and unencrypted emails to discuss my child's progress with My Recess Therapy outlined in the above sections. I understand I am responsible for additional data charges imposed by my service provider and acknowledge My Recess Therapy is not liable for any compromised privacy by my email provider/host, Internet service, cell-phone or data service.

_____ _____

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STANDARD THERAPY SERVICES FEE SCHEDULE AND PAYMENT POLICY

_____ Initial

My Recess Therapy is an in-network provider for Blue Cross Blue Shield of IL PPO along with Blue Cross Blue Shield Blue Choice billing directly to your PPO insurance plan for services.

My Recess Therapy is an out-of-network provider for Aetna and United Healthcare. Cigna families contact the office directly for our policy.

If you have another insurance carrier, fees must be paid at the time of services. We provide receipts for each therapy session to submit to your insurance company for reimbursement (rates are based on your specific plan).

Families are responsible for all co-pays, co-insurances and applicable uncovered charges. We will notify you if your services are being denied, while actively working with the insurance company for payment, however, review your EOB's as they arrive also. You may be notified before My Recess Therapy.

_____ Initial

Insurance companies are complicated and all employer plans are different. Many insurance plans cover our services, however, it is important that you check your own insurance policy to determine your benefits. Subscriber/Member involvement may be necessary to ensure payment. We will make every effort to accommodate your child and assist you when having trouble understanding what benefits are available to you. Some plans require prior authorization before treatment can begin. Please note, that according to all insurance companies, authorization is not always a guarantee of payment so unpaid balances will be your responsibility within a 60 day time period. We will reconcile an account when reimbursed from the insurance provider. Additionally, a non-billable administrative service fees may be applied to your account if extensive research occurs.

PAYMENT OPTIONS

_____ Initial

Services are also available for families paying out of pocket for those services not covered by insurance at discounted billing rates. Please contact the office to discuss our various payment options.

My Recess Therapy accepts payments by debit/credit card, if using an HSA/FSA account another credit card has to be on file for when the account has non-available funds.
Those paying by personal check have to have an active credit card on file.

My Recess Inc. THERAPY

STANDARD THERAPY SERVICES

(BILLABLE*)

	OCCUPATIONAL/ PHYSICAL THERAPY	SPEECH THERAPY
YEARLY EVALUATIONS & THERAPY SERVICES	$315.00 – $475.00	$250.00 – $410.00
Evaluations are billed at a set rate, fees include test administration and scoring, evaluation write-up and therapist treatment. Re-evaluations can occur once a year per therapy discipline, rates vary on testing, during the session and insurance reimbursement.		
EVALUATION FOLLOW-UP MEETING	$160.00 per hour	$160.00 per session
Review of evaluation report and development of treatment plan and goals.		
TREATMENT/THERAPY SESSION	$160.00 per hour	$160.00 per session
This fee includes a full treatment session, parent education and home programs.		
SENSORY INTEGRATION & PRAXIS TESTS (SIPT)	$800.00 per one SIPT	
This fee includes three (3) testing hours, three (3) hours for scoring. Depending on the timing testing involved duration and fees may fluctuate.		
SPEECH SPECIALTY		
Augmentative/Alternative Communication - AAC Evaluation		$250.00
Teaching AAC Device		$120.00

** Rates vary on testing, duration of session, and insurance reimbursement.*

***Teaching of the AAC Device may or may not be a covered services with your insurance provider. Please contact your provider for benefit coverage. This charge may accompany a speech therapy service.*

ANCILLARY SERVICES

(NON-BILLABLE)

	OCCUPATIONAL/ PHYSICAL THERAPY	SPEECH THERAPY
THERAPY CONSULTATION - INCREMENTAL FEE	$40.00	
This fee is applied for services rendered beyond a typical treatment session in 15 minute increments. These charges are not covered by insurance.		
INSURANCE RECOVERY FEE	$45.00	
This fee is for any records and/or reports requested by your insurance company that are above and beyond the normally requested billing information.		
SCHOOL OBSERVATION AND CONSULTATION	$125.00 per hour	$125.00 per session
This fee includes phone or personal consultations with service providers, teachers, daycare workers, school or community observations and treatment, peer facilitation activities. This charge is not covered by insurance.		
REPORT WRITING	$100.00 per hour	
Hourly rate for any report writing about and beyond what is typical in a treatment session. This charge is not covered by insurance.		
TRAVEL	Up to $25.00	
This fee is for any travel associated with home, school, or other therapy services which require a therapist on-site. This charge is not covered by insurance.		
GROUP, YOGA, AND SPECIALIZED CLASSES (OUT-OF-POCKET PAY ONLY)		
Please call for current rates per individual session.		

The above is the current fee schedule and financial policy for services provided by My Recess Therapy, Inc. My Recess Therapy reserves the right to change or modify the fee schedule listed above at any time. You will be notified 30 days in advance of prior fee changes. Be advised pending insurance payments typically pay within 30-45 days. An itemized statement will be provided to you for therapy sessions (upon request only) and can be used to submit to your insurance for reimbursement. **Reimbursement from your insurance is not guaranteed by My Recess Therapy.**

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FINANCIAL RESPONSIBILITY AND AUTOMATIC PAYMENT FORM

I understand that although my insurance may cover a portion of the cost of the therapy services, I am ultimately responsible for the complete payment of all charges. I agree to provide complete credit card information as a security of payment to My Recess.

Payment in full is required for self-pay clients and non-billable services at the time of service. If My Recess Therapy is billing my insurance, I agree to pay any unmet deductible, non-covered services, co-insurance, and/or co-payments at this time. I am also obligated to pay any late-cancellation, no show, late arrival, and non-sufficient funds fee(s) which cannot be billed to insurance.

_____ Initial

PAYMENTS PENDING INSURANCE COVERAGE

I understand that my insurance may not fully cover the services my child receives and I am responsible for all services charged at the standard rate.** Although My Recess Therapy makes every attempt to prevent this, I understand I may be charged 50% of the fee until insurance has verified payment. My Recess Therapy will refund any money charged once my insurance has paid within 30 days of receipt of insurance payment.

PAYMENT METHOD AND BILLING CYCLE

I understand I have the option to determine when my credit card on file will be charge for payments. Select the best payment type for your financial situation. Non-billable client payment is due weekly.

_____ Initial

Please automatically bill my card on file	**Non-Billable (required)**
____ Weekly	____ Weekly
____ Bi-Monthly	

I understand that regardless of insurance coverage, I must complete credit card information below. This provides security of payment to My Recess and our therapists.

_____ Initial

INSUFFICIENT FUNDS

I understand that if my account balance is past due by 30 days, My Recess Therapy will automatically charge the credit card on file to cover the out-standing balance. A $35.00 service fee will be charged for any checks or payments returned for insufficient funds. All invoices unpaid after 45 days will be subject to the maximum interest penalty/finance charge allowed by law. My Recess Therapy reserves the right to cancel treatment if payment for services is not received, and to use whatever means necessary including an attorney, small claims court, or collection agency in an attempt to secure payment. Balances exceeding $1000.00 will result in services placed on hold until a payment plan has been established. This form will remain in effect until bill is satisfied and future services may not be reinstated.

CREDIT CARD INFORMATION *REQUIRED

CARD TYPE* HSA/FSA _____ Visa _____ Mastercard _____ Discover _____

Name on Card: _____

Card Number*: _____ Expiration Date*: _____ CVV*: _____

Additional Card: _____ Expiration Date: _____ CVV: _____

I, _____authorize, My Recess Therapy to charge the credit card indicated in this authorization form according to the terms outlined above. I understand, that this authorization will remain in effect until the designated expiration date or until I cancel it in writing, which ever comes first, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment date falls on a weekend or holiday, I understand that the payments may be executed on the next business day. This payment authorization is for the type of bill indicated above. I certify, that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company provided the transaction correspond to the terms indicated in this authorization form.*

I understand and agree to the terms of the financial responsibility policy.

_____ Parent or Legal Guardian's Signature

_____ Date

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CLINIC ETIQUETTE

My Recess Therapy is honored that you have chosen our clinic to meet the needs of your child and family. We continually try to create a space and an atmosphere that is true to our heart - fun and inviting for kids and their families.

We hope that you are comfortable here and always feel welcome. In order to make for a comfortable and safe place for all of our families, staff, vendors and visitors, we ask that families follow clinic etiquette plan. Please read and become familiar with the following expectations:

My Recess clinic locations have shared commerical spaces. Our shared spaces are for all incoming clients, please be respectful of all the common areas shared with those business. Do not enter office spaces unless you have a business relationship.

Before entering My Recess Therapy treatment areas, we ask that you remove your children's shoes as well as your shoes. There is a space near the door to leave shoes along with coats/jackets. Many families have small children so please be aware of children already in play around the lobby.

Closely monitor your children's behavior in the waiting room to ensure that they are playing safely and appropriately with other children. We are all working on something, please be kind to one another. Do not allow children to climb on, jump from or disassemble the waiting room in any way. Damages incurred may result in parent/guardian responsibility for replacement.

Please clean up after your children in the waiting room. Help put away and used items and throw away any trash that may have accumulated.

Accompany younger children and those needing assistance or supervision to the restroom; this includes using the restroom for hand washing.

If you have children in diapers or pull-ups, please bring a diaper bag to therapy and be prepared to change your child if necessary. Changing area in the largest bathroom stall for both bathrooms. We share the building with other business' please take your soiled diapers with you and not throw out in the trash, receptacle is just for hand towels.

Do not allow your children to enter the treatment area unaccompanied.

Please be mindful of the content/volume discussed in your conversations (on-phone or in-person) or viewed on your electronic devices. Please only discuss topics or select websites, videos, music, which are appropriate to discuss/view in the presence of children.

Children must be accompanied into the clinic with parents, please do not drop your child at the building door, contact needs to be made with the therapists. My Recess Therapy will not be held responsible for children not attending their session when dropped off without making contact with their treating therapist.

Typically, the therapist will allocate 5 minutes at the end of the session time to briefly discuss the session with the client's parents. If a parent would like more time to discuss their child's progress, they should let the therapist know beforehand so it can be planned for accordingly and still allow for an on-time end to the session. Parents are encouraged to schedule a consultation meeting if they have a number of issues they would like to discuss. During therapy, parents are welcome to observe, wait in waiting room, or run errands.

Our clinic strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, please discuss schedule changes at the end of your therapy session.

If you would like a formal report written about your child, please ask your child's therapist via email or in writing. Please allow 2 weeks for this report to be completed. If you would like the report to be sent out to other professionals (school, outside therapists), please indicate that in your request.

Failure to comply with these expectations will result in dismissal from the My Recess practice. We will provide you alternative therapy recommendations and/or options that may be a better fit.

_____ _____

Parent or Guardian Signature Date

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HIPAA NOTICE OF PRIVACY PRACTICES FOR 2024

In compliance with the Health Insurance Portability and Accountability Act's Privacy Rule (HIPAA), your child's private health information (PHI) will be protected in his/her medical records, in consultation with other professionals involved in your child's care and with payers, HIPAA requires that your child's PHI be kept private and that you are notified of the privacy practices with respect to your child's PHI. A summary of the policies follows.

MEDICAL INFORMATION

Your child's PHI may consist of evaluations, diagnosis, daily notes, progress notes, Individual Family Service Plan (IFSP) Individualized Educational Plan (IEP), insurance information, physician prescriptions, and correspondences to your other medical and educational providers (e.g., physician, therapists, service coordinators, psychologists, social worker, school personnel, etc.)

COLLECTION, STORAGE, DISCLOSURE AND DISPOSAL OF MEDICAL INFORMATION

- Your child's medical record is only accessible to your child's therapist and members of the My Recess team.
- Correspondence with others regarding your child's PHI will only include other members or your current child's healthcare provider team to discuss your child's course of treatment. In addition, your insurance provider may request information about your child to determine eligibility and provide payment.
- At your request, correspondence with outside consultants or educational personnel will be made. Your written consent is required for this communication to take place.
- All phone correspondence with other members of your child's healthcare team or payer will be conducted on a private phone line in a confidential manner, so others cannot hear the conversation.
- All faxed information about your child will include a fax coversheet with a confidentiality statement. No confidential information about your child will be included on the fax cover sheet.
- Correspondence by mail will be addressed to specific individuals for the purpose outlined above.
- A written record of all disclosures of your child's PHI will be kept.
- Only the Minimum Necessary Requirements will be disclosed to the entity requesting information. This means that only the minimum amount of information necessary to complete the task for which the entity is requesting the information will be provided, rather than sending the entire file.
- Your child's individual therapist/s is your child's Privacy Officer. Each therapist will be responsible for protecting your child's PHI and following these guidelines.
- Your child's medical record will be kept and stored for a minimum of 6 years. After this time, the records will be shredded to protect privacy.

YOUR RIGHTS UNDER HIPAA

- You have the right to inspect and copy your child's personal health information. The request must be made in writing.
- Your child's PHI will be used strictly for evaluation and treatment planning.
- You have the right to request information about who PHI has been released to.
- You have the right to take away permission to disclose information to any party at any time. This must be requested in writing.
- You have the right to complain if you believe your privacy rights have been violated. if you feel your rights have been violated, please contact us. You may also file a complaint with the U.S. Department of health and Human Services Office of Civil Rights on hhs.gov/ocr/privacy/hipaa/complaints/, 877.696.6775, or U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, SW; Washington, D.C., 20241. We will not retaliate against you for filing.

SUMMARY OF 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 will give you a hard copy of this notice and follow the duties and privacy practices described in this notice. We will not use or share your information other than as described here unless you tell us we can in writing that we can. You may also change your mind at any time and let us know in writing if you do. Additional information is available at hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

TERMS OF CHANGE

We can change the terms of this notice. Any changes to this notice will be available to you upon request, on our website, or office. These changes will apply to your information we have on file.

Effective Date: 01/01/2024
Privacy Officer: Brooke S. Backsen

I have read the above information and understand it.

_____ _____
Parent or Guardian Signature Date

_____ I would like a copy of this privacy protection statement.

_____ I would not like a copy of this privacy protection statement, but realize that this is available for review in my child's medical record and I may request a copy in the future.

_____ _____
Parent or Guardian Initials Date