Notice of Privacy Practices

Handprints and Footsteps Pediatric Therapy, LLC
Phone: 704-413-0968 Fax: 704-626-6614
www.HPFSTherapy.com

Date Revised/Effective: July 15 2013

Handprints and Footsteps Pediatric Therapy is required by Federal law to provide you with this Notice so that you will understand how we may use or share your child's health information. Health information obtained by Handprints and Footsteps Pediatric Therapy may contain financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions or would like additional information about this Notice, please contact Handprints and Footsteps Pediatric Therapy directly.

Understanding Your Health Record and Information

Handprints and Footsteps Pediatric Therapy maintains a record containing health and financial information for every child seen by our therapists. Typically, this record contains information about your child's condition, the treatment we provide and payment for the treatment.

Understanding what is in your child's record and how your child's health information is used helps you to:

- ensure it is accurate
- better understand who may access your child's health information
- make more informed decisions

We will use and communicate your health information only for the purposes covered by this Notice or applicable laws only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time.

How will my Health Information be used?

To Provide Treatment

We will use your health information to provide the best therapy services possible.

To Obtain Payment

We may include your health information with an invoice to collect payment for treatment you receive from a therapist within our company. We may do this with insurance forms or Medicaid forms filed for you in the mail or electronically.

To Conduct Health Care Operations

Your health information may be used during an evaluation by one of our therapists. It is possible that your information may be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews.

In Patient Reminders or Rescheduling Appointments

It is our philosophy that communication is a vital part of effective therapy. We may contact you to follow up on your care, inform you of treatment options, or to reschedule appointments. This may include letters, voicemail messages, or electronic reminders. It is our policy to never leave vital health information on voicemail. (unless you tell us that you do not want these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required by law or with the patient's agreement.

Family Friends, & Caregivers

We may share your health information with those you tell us will be helping your child follow through with his/her therapy practices. We will only share your health information with these individuals with your permission and in many cases your presence.

Therapist Training

Learning in the health profession often comes from the careful study of the histories of prior clients. Again, your health information will never be disclosed to other professionals without your written consent

Authorization to Use or Disclose Health Information

Other than what is stated above or where Federal, State, or Local law requires us, we will not disclose your health information without your written authorization. You may revoke that authorization in writing at any time.

Understanding Your Rights

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. HPFSPT will make every effort to honor reasonable restriction preferences for our clients. Please put your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Confidential Communication

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor reasonable requests.

Inspect & Copy Your Chart

You have the right to read, review, and copy your health information including your complete chart, billing logs & therapy notes. If you would like a copy, please submit a request in writing. We may charge a small amount for copy fees.

Amend your Health Information

You have the right to ask us to update or modify your records if you believe they are incorrect. Please put your request in writing with a description of the reason for the change. Your request may be denied if the health information in question did not originate from Handprints and Footsteps Pediatric Therapy, is not part of our records, or if the records are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment, or health operations. Please let us know in writing the time period for which you are interested.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. You may obtain a copy of this notice at our website: www.HPFSTherapy.com. Please provide a written request for a paper copy.

Out-of-Pocket-Payments.

If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Electronic Copy of Electronic Medical Records.

If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record

Notice of a Breach.

You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to handprintsandfootsteps@yahoo.com

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Handprints and Footsteps Pediatric Therapy or with the Secretary of the Department of Health and Human Services. To file a complaint with Handprints and Footsteps Pediatric Therapy, contact Jennifer Seay. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**

Changes to this Notice

We reserve the right to make necessary changes this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the most recent Notice on our website. The Notice will specify the effective date on the first page, in the Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting Handprints and Footsteps Pediatric Therapy in writing.

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Date Revised: October 01, 2013

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Child's Name: _____ Date of Birth _____

Address:_____

Parent/Guardian's Name: _____

I have been given a copy of Handprints and Footsteps Pediatric Therapy's *Notice of Privacy Practices ("Notice*"), which describes how my child's health information is used and shared. I understand that Handprints and Footsteps Pediatric Therapy has the right to change this *Notice* at any time. I may obtain a current copy by contacting Handprints and Footsteps Pediatric Therapy, or by visiting the Handprints and Footsteps Pediatric Therapy's web site at www.handprintsandfootstepsnc.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Parent or Guardian Date

_____
Relationship to Child