Children's Therapies, Inc.

Client Information

Today's Date _____

Child's Name _____ Date of Birth _____ Gender_____

Address _____

City _____ State _____ Zip _____

Mom's Phone _____ ◯ Mobile ◯ Home ◯ Work

Dad's Phone _____ ◯ Mobile ◯ Home ◯ Work

May we text you? ◯ Yes ◯ No May we leave you a message? ◯ Yes ◯ No

Email _____

May we email you? ◯ Yes ◯ No

Mother's Name _____ ☐ Check here if address is the same as above

Address _____

City _____ State _____ Zip _____

Mother's Employer _____

Father's Name _____ ☐ Check here if address is the same as above

Address _____

City _____ State _____ Zip _____

Father's Employer _____

Emergency Contact (other than parents) _____

Phone _____ Relationship to Patient _____

Primary Care Physician _____

Address _____

Phone _____ Fax _____

935 Military Trail, Ste 102, Jupiter, FL 33458
561-748-5430, 561-748-5442 fax
cti.ninah@gmail.com www.childrenstherapies.org

Developmental / Health History

Who referred your child to therapy? _____

Primary reason for referral? _____

Has your child received therapy in the past? ◯ Yes ◯ No

☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy

What are your goals for therapy? _____

_____

Has your child been given a diagnosis? ◯ Yes ◯ No

If yes, what is the diagnosis?_____

Who made the diagnosis? _____

Is your child on any medications? ◯ Yes ◯ No

Please list: _____

_____

Birth History

Gestational age: ◯ Full Term ◯ Premature If premature, how many weeks? ____

Were there any complications during pregnancy? ◯ Yes ◯ No

If yes, please describe _____

_____

_____

Delivery: ◯ Vaginal ◯ C-section Birth weight _____ lbs _____oz

APGAR:_____ @ 1 minutes _____ @ 5 minutes

Developmental History

At what age did your child (if does not apply, put NA):

Sit alone _____ Crawl _____ Walk _____

Toilet trained _____ Self dressing _____ Self feeding _____

Babbled _____ First word _____ Put two words together _____

Has your child had his/her hearing checked? ◯ Yes ◯ No

◯ Pass ◯ Did not Pass _____

Has your child had his/her vision checked? ◯ Yes ◯ No

◯ Pass ◯ Did not Pass _____

Medical History

Does your child have a history of or currently experience any of the following, if so please explain in space provided:

Ear Infections ◯ Yes ◯ No _____

Tube Placement ◯ Yes ◯ No _____

Adenoidectomy ◯ Yes ◯ No _____

Tonsillectomy ◯ Yes ◯ No _____

Allergies ◯ Yes ◯ No _____

Asthma ◯ Yes ◯ No _____

Vision Difficulties ◯ Yes ◯ No _____

Hearing Deficits ◯ Yes ◯ No _____

Seizures ◯ Yes ◯ No _____

Head Injury ◯ Yes ◯ No _____

Major Illness ◯ Yes ◯ No _____

Feeding Difficulties ◯ Yes ◯ No _____

Other medical history _____

Has your child ever been hospitalized? ◯ Yes ◯ No If yes, when and why? _____

_____

Social and Academic

Who resides in the child's home? _____

_____

What languages are spoken in the home? _____

What is your child's stronger language? _____

Does your child attend school or preschool? ◯ Yes ◯ No If yes, what grade? _____

Does he/she perform at grade level in

Reading ◯ Yes ◯ No

Math ◯ Yes ◯ No

Does your child currently have an Individualized Education Plan (IEP) and/or receiving special services? ◯ Yes ◯ No

Do you have any concerns with social skills? ◯ Yes ◯ No

If yes, please describe_____

_____

_____

Does your child like to play with others? ◯ Yes ◯ No

Will your child initiate play with others? ◯ Yes ◯ No

Does your child point to what they want? ◯ Yes ◯ No

Does your child demonstrate appropriate turn taking? ◯ Yes ◯ No

Does your child demonstrate appropriate eye contact? ◯ Yes ◯ No

Does your child avoid certain play environments? ◯ Yes ◯ No

Ex: avoid walking over grass, barefoot in the sand, or crowded places.

If yes, please specify _____

What does your child like to do in his/her free time? _____

_____

Does your child have a favorite toy or something he/she enjoys? _____

_____

Is there any additional information you would like to share with us? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

This form was completed by: _____ Relationship to child: _____

Signature: _____ Date: _____

Children's Therapies, Inc.

PEDIATRIC PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES

CLIENT CONTRACT FOR SERVICES

I, _____, do herby agree and give consent for Children's Therapies, Inc. to furnish medical care and treatment considered necessary and proper in evaluating and treating (child's name)_____, DOB_____. I understand that this agreement may be terminated by either party, in writing, at any time.

Billing & Fees for Service (please initial one)

_____ Health Insurance will be billed as my primary means of payment. If claims are denied as a result of changes/limitations in insurance coverage benefits, the private pay rate of $_____per unit (15 minutes) will be charged. I acknowledge that I am responsible for understanding my own insurance plan and the physical, occupational and/or speech therapy benefits that it provides, including benefit limitations, benefit maximums, deductibles, coinsurance, co-payments. Children's Therapies, Inc. will not be held responsible for interpreting the benefit information for me. Children's Therapies, Inc. is also not responsible for the determination of payment or denial by my insurance carrier. It is the responsibility of Children's Therapies, Inc. to collect payment for your deductibles, coinsurance and co-payments. It is my responsibility to inform Children's Therapies, Inc. immediately of any changes in my child's payor source and/or coverage. Any charges denied by the insurance company or other third party pay source due to changes in status will be my responsibility.

OR

_____ Private Pay will be my primary means of payment and charged directly to me. The private pay rate of treatment is $_____ per unit (15 minutes). For evaluations, the private pay rate is $125.00 - $300.00 depending on the type of evaluation performed.

Responsible Party

Name: _____ Relationship to patient:_____

Date of Birth of responsible party:_____ Social Security Number:_____

Primary Insurance Company:_____

☐ Check here if same as responsible party

Policy Holder:_____ Relationship to patient:_____

Date of Birth of policy holder:_____ Policy Number:_____

I understand and agree that I am ultimately responsible and liable for payment of all charges assessed for services rendered and will pay any sum due upon demand. Payments are due within 30 days from date of invoice. Account balances exceeding 30 days will have an additional charge of 2% interest. Accounts exceeding 60 days will accrue 3% interest on the balance due and services may be terminated until payment

arrangements are made. Accounts exceeding 90 days will be referred to collections and services will be terminated. I understand and agree that if it becomes necessary to retain an attorney and/or collection agency for the collection of my outstanding charges, whether or not a lawsuit is filed on my account, I will be responsible for any attorney and/or collection fees and court costs in addition to the outstanding balance.

Signature _____ **Date** _____

Authorization for Credit Card Use

Name on Credit Card: _____ Exp Date: _____CVV:_____

Credit Card Number: _____ Billing Zip Code: _____

I authorize Children's Therapies, Inc. to charge my weekly co-payment/co-insurance, deductible amount for the services rendered and/or any charges accrued on my account to the above credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement. I understand that unless other arrangements have been made, my credit card will be charged the following week after my child receives his/her services (typically on Mondays).

Signature _____ **Date** _____

Medical Information Release

I hereby authorize the release of any medical records, including examinations and treatments rendered, to my insurance company or companies, third party payors, or other health care agencies or individuals listed below for (child's name)_____:

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Signature _____ **Date** _____

Assignment of Benefits

I request that payment of authorized insurance benefits be made on behalf to Children's Therapies, Inc.

Signature _____ **Date** _____

Cancellation Policy (by initialing each line, I agree to the terms of service)

_____ If I am unable to attend an appointment, I agree to contact Children's Therapies, Inc. at least 24 hours in advance at (561) 748-5430. I may call and leave a message anytime during or after Children's Therapies, Inc. regular business hours and leave a message that will be date and time stamped. If I fail to provide 24 hour notice for a cancelled session, I understand that a fee of $50.00 will be charged to my account (with the exception of illnesses and emergencies). I understand that insurance cannot be billed for this fee. I am responsible for paying this fee at my next scheduled appointment and I will notify the office manager if I am in need of a payment plan.

_____ If Children's Therapies, Inc. needs to cancel your appointment due to an illness or emergency we will contact you as soon as possible by phone or email. If cancellation is for any other reason (vacation, meetings, etc.) you will be notified in advance and we will make our best efforts to reschedule your appointment on another day or with another provider at Children's Therapies, Inc.

_____ I agree to notify Children's Therapies, Inc. at least 2 weeks in advance of vacations or extended leave of absence. In addition, I understand that any vacation or leave of absence greater than two weeks could result in the loss of my regular scheduled appointments.

Attendance Policy (by initialing each line, I agree to the terms of service)

_____ I understand that in order to maximize the benefits of therapy, it is very important to attend all scheduled appointments. Consistency of attending therapy sessions assures that my child will attain maximum treatment benefit, and assist in meeting my goals.

_____ I understand that if I miss two (2) consecutive sessions without calling Children's Therapies, Inc. 24 hours in advance or "no call, no show" for my scheduled appointment (excluding serious illness or emergencies), I will lose my standing appointments and I will be charged a cancellation fee for those appointments.

_____ A cancellation rate of 20% or greater over a three (3) month period (to be tracked per calendar quarter) will be considered non-compliance with the attendance policy and treatment plan.

_____ I understand that if I miss a total of three (3) sessions within a 60-day period without calling Children's Therapies, Inc. 24 hours in advance or "no call, no show" for my scheduled appointment (excluding serious illness or emergencies), I will lose my standing appointments and I will be charged a cancellation fee for those appointments.

_____ I understand that if I lose my standing appointments due to non-compliance of the attendance policy. At my request I can be placed on the "schedule based on availability" list. I will be required to call on the day I would like to receive therapy and inquire if there is an available appointment on the same day. Children's Therapies, Inc. will do everything possible to accommodate your scheduling needs.

_____ I understand that if I am more than 15 minutes late to my appointment without notifying the office, my treating therapist may not be available to see my child that day and the appointment may be considered a "no call, no show".

_____ I understand that sessions are scheduled for each client on the same day and time each week. I will only accept a time slot if I am able to attend that day/time on a weekly basis.

_____ I understand that Children's Therapies, Inc. can discharge my child from their services due to non-compliance of treatment plan.

Holiday Closures (by initialing each line, I agree to the terms of service)

_____ Children's Therapies, Inc. does not follow the local school calendar for closings. Please do not assume we are closed when there is no school. If you are unsure, please call us at (561) 748-5430, email at cti.ninah@gmail.com or childrenstherapies@att.net. You can also check google for any holiday closures.

_____ The office will always be closed for the following holidays:

- New Year's Day
- Memorial Day
- Fourth of July
- Labor Day
- Thanksgiving Day
- Christmas Day

Any other closures will be made on a year-to-year basis and you will be informed of any changes.

Patient Illness (by initialing each line, I agree to the terms of service)

_____ I will not bring my child to therapy if they have any of the following:

- Any fever (100 degrees and above)
- Sore throat
- Muscle pain/headaches
- Green or yellow runny nose
- Vomiting or diarrhea due to illness
- Breathing difficulty
- Coughing fits/coughing up mucus
- Any infectious illness such as rash, impetigo, pink eye, chicken pox, etc.

_____ If my child is out sick, I will not resume my services at Children's Therapies, Inc. until all symptoms have been resolved for 48 hours without medication.

_____ I am aware that my child's therapist can at their own discretion choose to cancel or end my child's session early if he/she seems ill at anytime during the session.

Special Policies during COVID-19 (by initialing each line, I agree to the terms of service)

_____ Upon arrival, I will wait in my car or on the bench for my treating therapist to come out and escort my child into the clinic. If I am in a different vehicle or late to my appointment, I will call the office to notify Children's Therapies, Inc.

_____ I have read, understand and agree to the attached COVID-19 update.

Office Etiquette (by initialing each line, I agree to the terms of service)

_____ I understand that when inside Children's Therapies, Inc. there are therapy sessions in progress or therapist/support staff may be on the phone. I will not allow my child to walk/run throughout the clinic.

_____ I understand that if I leave the parking area while my child is receiving therapy, I will be back in the Children's Therapies, Inc. parking lot ten (10) minutes before the end of my child's session. This allows time to receive feedback on my child's session and time for the therapist to clean and sanitize before their next client. After 2 late returns, I will be required to stay on the premises throughout my child's treatment sessions.

Therapy Sessions (by initialing each line, I agree to the terms of service)

_____ I understand that my child's therapy session (e.g. 30 minutes, 45 minutes, or 60 minutes) includes time for discussion with parent/guardian, set up, clean up, and documentation, as well as one on one instruction. During any timed session, 7 minutes is allowed for documentation and clean up without the patient present. (e.g. 30 minute session = 23 minutes, 45 minute session = 38 minutes, 60 minute session = 53 minutes).

_____ If I have specific questions, issues, or concerns that I would like to address, I will let my therapist know at the beginning of the session, so that the proper amount of time can be allotted to speak with me at the end of the session. If I do not notify the therapist at the start of the session that I am requesting additional time for questions, the therapist will address your questions/concerns at your next scheduled appointment.

_____ If my child attends his/her therapy appointment with another caregiver (grandparent, uncle, friend, babysitter, etc.) your therapist will update them regarding your child's session only if they are listed on the release of medical information. If parents are consistently unable to attend sessions, we are unable to provide updates via phone and email on a weekly basis. You may pay a fee of $30.00 for a 30-minute meeting or telephone conversation with my child's therapist during office hours to discuss my child's progress. This fee can not be billed to insurance.

Termination of Therapy (by initialing each line, I agree to the terms of service)

_____ The following reasons may result in termination of our client contract:

- Behavior of client (e.g. repeated tantrums, refusing to engage in therapy, refusing to follow directions or recommendations, verbal or physical abuse). We anticipate that all clients have "bad or off days", however if the behavior continues after implanting strategies, we may recommend a clinician change at this facility or another one.
- Non-compliance with our attendance policy.
- Non-payment on account
- Engaging in behavior that breaches trust such as withholding pertinent information about the case history or asking us to alter our data or diagnosis.

_____ If you need to terminate therapy for any reason, we ask that you give us a written notice (email is sufficient) a minimum of two (2) sessions in advance. This allows us adequate time to wrap-up therapy and complete consultation with you.

_____ Children's Therapies, Inc., reserves the right to cancel or amend this contract, or any part therein without negating the remainder of the contract. Clients will be notified, in writing, of any changes or cancellation of this contract.

Acknowledgement of Receipt of Notice of Privacy Practices (by initialing each line, I agree to the terms of service)

_____ I have received the Notice of Privacy Practices from Children's Therapies, Inc.

Consistent attendance and communication with the staff at Children's Therapies, Inc. will greatly facilitate your child's quality of care. We look forward to working with you and your child to achieve his or her goals.

I have read and accept the terms of this contract

Signed this _____ day of _____, 20_____.

_____ _____

Client/Parent/Guardian

Nina Hidalgo, Office Manager

Children's Therapies, Inc.

Children's Therapies Inc.

PEDIATRIC PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES

Optional

I, _____, give my permission to allow Children's Therapies
(name of parent/guardian)

Inc. to photograph and/or videotape my child, _____.
(name of child)

These pictures/videos may be used for educational, marketing purposes and/or posted on our social media sites.

_____ _____
Parent/guardian signature Date

935 Military Trail, Ste 102, Jupiter, Florida 33458
Telephone (561) 748-5430 • Fax (561) 748-5442

COVID-19 Update

October 10, 2022

We hope this email finds you and your family healthy and safe. It has been almost one year since our last COVID-19 update. To ensure everyone remains safe and healthy we continue to follow guidelines set forth by the Centers for Disease Control (CDC) and the state of Florida. These policies were recently amended (9-23-2022), and our policies have now been updated.

Based on the updated guidelines, the CDC has dropped its universal masking recommendation for healthcare settings, except for areas of high COVID-19 transmission and other special circumstances. We have been monitoring our county for the last week and Palm Beach County COVID-19 Community Level is Low.

On Tuesday, October 11, 2022, we will implement the following:

- The current mask requirement will be removed as long as Palm Beach County COVID-19 transmission rate remains low.
- We will continue to limit individuals entering the clinic. Parents are welcome to attend therapy sessions if they are asymptomatic and have not had an exposure in the last 10 days. If exposed, you will need to mask up to 10 days after exposure and remain asymptomatic.
- In an effort to reduce additional, unnecessary exposures, we will continue to not allow siblings in the clinic.

We understand the reservations some families may have with this change. If you prefer to maintain the masking requirement for you and your child, we will accommodate. Let us know and the therapist will mask and treat your child in a more private room.

Procedure for entering and exiting the office for therapy services.

1. Your child's therapist will come out to your vehicle to greet you and your child and escort you into the clinic. If we are not familiar with your vehicle or you are running late, please call the office at (561) 748-5430.
    a. To limit the number of individuals in the clinic and reduce overall exposure, **one caregiver per child (no siblings) is welcome to observe during the therapy session if there is sufficient space to maintain distancing guidelines.**
2. We will have a staff member at the front desk to monitor the door if you need to enter.
3. Patients will be scheduled in appropriate increments to allow for proper sanitation in-between patients.
4. At the end of your child's scheduled therapy session, your child's therapist will escort them back to your vehicle, review your child's progress, and answer any questions. **Please be sure to be in the parking lot, ready for pick-up at least 10 minutes prior to the end of your child's scheduled therapy session**.
5. The entire clinic will continue a daily scheduled cleaning routine throughout the day at designated times to ensure that all surfaces are sanitized multiple times a day.

To keep our children, families, therapists, and clinic environment safe, it is imperative that everyone follow the exposure, travel, and illness policy.

- **Exposure** – If you or your child have been exposed to someone who tested positive for COVID-19, start precautions immediately.
    - Wear a mask as soon as you find out you were exposed

        - Day 0 is the day of your last exposure to someone with COVID-19
        - **Day 1 is the first full day** after your last exposure
    - After day 5, you and your child may return to the clinic with a mask until after day 10.
    - If you become symptomatic, isolate and follow CDC guidelines for follow-up testing instructions as well as return instructions
    - **You must continue to wear a mask in the clinic for 10 full days after exposure**.

- **Travel** – Travel can increase your chance of getting and spreading COVID-19.
  If you were exposed to someone who tested positive, you may not return to the clinic for 5 days – day one is your last exposure to someone with COVID-19.
    - After day 5, you and your child may return to the clinic with a mask until after day 10.
    - If become symptomatic, isolate and follow CDC guidelines for follow-up testing instructions as well as return instructions.

  Your child can receive telehealth services during the time you are staying home if requested.

- Illness – We continue to enforce our illness policy. Please do not send your child to therapy if you suspect that they are ill. We have some patients with suppressed immune systems and we continue to try to reduce their exposure. A per the therapy agreement you signed during your initial visit, you have agreed to the following:
    - I will not bring my child to therapy if they have any of the following:
        - Any fever (100 degrees and above)
        - Sore throat
        - Muscle pain/headaches
        - Green or yellow runny nose
        - Vomiting or diarrhea due to illness
        - Breathing difficulty
        - Coughing fits/coughing up mucus
        - Any infections illness such as rash, impetigo, pink eye, chicken pox, etc.
    - If my child is out sick, I will not resume my services at Children's Therapies, Inc. until all symptoms have been resolved for 48 hours without medication.
    - I am aware that my child's therapist can at their own discretion choose to cancel or end my child's session early if he/she seems ill at any time during the session.

Do not hesitate to contact Jim Moore, at the office, if you have any additional question regarding this policy change. Mask requirements will return if Palm Beach County COVID-19 Community Level moves to Moderate or above.

Thank you for your continued support and the privilege to be part of your child's medical care.

Stay healthy and safe,

Jim and the CTI staff

NOTICE OF OUR PRIVACY PRACTICES

Our Pledge Regarding Medical Information

The privacy of your medical information and that of your child is important to us. We understand that your child's medical information is personal and we are committed to protecting it. We create a record of the care and services your child receives from us. We need this record to provide your child with quality care and to comply with certain legal requirements. This notice applies to all records of your child's care generated by this office. This notice will tell you about the ways we may use and share medical information about your child. We will also describe your rights and certain duties we have regarding the use and disclosure of medical information. Throughout the notice the terms "your medical information" and "your child's medical information" are one and the same.

Our Legal Duty

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect as of April 14, 2003.

Use and Disclosure of Your Medical Information

This is how we use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. You may, in writing, revoke any specific written authorization you have provided at anytime.

For treatment:

We may use medical information to provide your child with medical treatment or services. We may disclose medical information about your child to doctors, nurses, technicians, medical students, or other people who are taking care of your child. This includes caseworkers and therapists outside our agency who provide services to your child or who will be evaluating your child.

For payment:

We may use and disclose your medical information for payment purposes. We may need to give your medical information to your health plan and to administrative workers in your primary care physician's office for the purpose of obtaining referrals and/or authorizations. We may also tell your health plan

about a treatment your child may or may not receive in the future in order to determine if the plan covers such treatment.

For Health Care Operations:

We may use or disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificate, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes. (You have the right to request a restriction or limitation on the information we disclose. This will be further discussed later in this notice.)

Persons involved in patient's care or payment related to care- For example we may need to disclose certain information to daycare workers, teachers or other care givers if having that information is in the best interest of your child with respect to their handling of your child. We also may give information to a non-custodial spouse who carries the health insurance for the child who needs further information to submit a claim.

As required by law- We will disclose health information about you or your child when required to do so by federal, state or local law.

To avert a serious threat to health or safety- We may use and disclose health information about you or your child when necessary to prevent a serious threat to your health and safety or the health and safety of the public. Any disclosure, however, would only be to someone able to help prevent the threat.

Research in limited circumstances- Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Court orders and judicial and administrative proceedings- We may disclose medical information in response to a court order or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances such as a court order, warrant or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information of a suspect, fugitive, material witness, crime victim or missing person.

Public health activities- As required by the law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration.

Victims of abuse, neglect, or domestic violence- We may disclose medical information to appropriate authorities if we reasonably believe that you or your child are possible victims of abuse, neglect or domestic violence.

Health oversight activities- We may disclose medical information to an agency providing health oversight for oversight activities authorized by the law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Your Individual Rights

You have a right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and postage if you want the copies mailed to you. Ask the receptionist for our fee structure.
2. Receive a list of times we or our business associates shared your medical information for reasons other than treatment, payment, healthcare operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. *We are not required to agree to these additional restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you.* If we do agree to your requested restrictions, we will abide by the agreement (except in the case of an emergency).
4. Request that we communicate with you about your child's medical information by different means or different locations. This request must be in writing.
5. Request that we change your child's medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a written statement of

disagreement, which will be added to the information that you want changed.

6. Obtain a paper copy of this notice by making a written request to our Privacy Officer.

Questions and Complaints

If you have any questions about this privacy notice, please ask the receptionist for help or ask to speak to the Privacy Officer (currently Karen Moore).

If you think that we may have violated your privacy rights contact our Privacy Officer. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.