THE CARRUTH CENTER
AT THE PARISH SCHOOL

Physical Therapy Intake Packet

- Physical Therapy Case History
- Authorization for Emergency Medical Attention
- Consent for Treatment
- PT Payment Contract & Authorization
- Carruth Center Policies Form
- Authorization to Release or Disclose Protected Health Information
- The Carruth Center Notice of Privacy Practices
- PT Schedule of Fees

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Physical Therapy Case History

Child's Information:

Today's date: _____

Child's name: _____ DOB: _____ Age: _____ M/F: _____

Current diagnosis: _____

Home address: _____ Primary phone: _____

Current school: _____ Grade_____

Previous school(s) attended: _____ Dates: _____

Referral name (e.g., doctor, teacher, parent): _____

Emergency contact: _____ Relationship: _____ Phone: _____

Parent Information:

Parent #1 name: _____ Occupation: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Email: _____

Marital Status: ☐married to child's mother/father (biological or adoptive) ☐single ☐separated ☐divorced ☐widowed ☐remarried

PLEASE NOTE IF YOU ARE DIVORCED WE WILL NEED A COPY OF YOUR DIVORCE DECREE

Parent #2 name: _____ Occupation: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Email: _____

Marital Status: ☐married to child's mother/father (biological or adoptive) ☐single ☐separated ☐divorced ☐widowed ☐remarried

Child's Physician's Information:

Child's primary physician: _____ Phone: _____

Date of your child's last medical checkup: _____

Is your child currently receiving PT services? If so, where? _____

Please list other Healthcare Providers (e.g., Psychiatrist, Developmental Pediatrician, Occupational Therapy, Play Therapy, and Neuropsychologist):

Name: _____Profession: _____Phone: _____

Date of last visit: _____

Name: _____Profession: _____Phone: _____

Date of last visit: _____

Name: _____Profession: _____Phone: _____

Date of last visit: _____

Upcoming evaluations scheduled: _____

Family History:

Child lives with: ____ Parent #1 ____ Parent #2 ____ Both Parents

Who has legal custody of this child? _____

Is this child adopted?_____At what age?_____Is he/she aware of this? _____

Sibling(s)/Age(s): _____ Others living in household: _____

Please check if there is any known history of the following in the immediate or extended family:

Autism/PDD ____ ADHD ____ Learning Disabilities ____

Hearing Loss ____ Anxiety____ Speech/Language Delays ____

Other: _____

Your Child's Personality:

What are your child's interests at home? (e.g., sports, hobbies) _____

_____

_____

What does the child/teacher report as your child's likes and dislikes at school? _____

_____

_____

What things about your child do you enjoy? _____

_____

_____

Describe how your child interacts with siblings or other children. _____

_____

Describe the play activities in which your child engages. _____

_____

Does your child play interactively with peers? _____

_____

Does your child play independently? _____

_____

What are your primary areas of concern/ what are you hoping for the physical therapist to address? (e.g., coordination, clumsiness, toe walking, physical difficulties with activities/play).

_____

_____

What are your goals for physical therapy?

_____

_____

Please list any medical precautions/allergies.

_____

_____

Is your child receiving any other services (i.e. speech, occupational therapy, special education, early intervention)?

_____

What (if any) special equipment does your child use?

Wheelchair: ____ Eye glasses: ____ Hearing Aids: ____ Braces/Orthotics: ____

Walker: ____ Communication Device: ____ Crutches: ____ Other: _____

Medications:

List any medications that your child is currently taking and their purpose:

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Comments: _____

Birth History:

Were there any difficulties before, during, or after birth? ____No ____Yes. If "yes," please specify below:

_____

_____

Length of pregnancy: _____

Birth was: ___vaginal ___cesarean (planned/emergency) ___breech

Please state reason for cesarean birth: _____

Birth Weight_____ lb. _____oz.

How many days did mother stay at the hospital after birth? _____

How many days did child stay at the hospital after birth? _____

Check the following if they apply to your child:

__Vacuum delivery __Preeclampsia/toxemia __ Feeding/latch

__Gestational diabetes __IUGR (Intrauterine growth restriction) __Oxygen at birth

__NICU stay: duration: _____ __Forceps delivery

__Other: _____

_____

Childhood illnesses/health problems:

Please list significant illnesses, hospitalizations, etc.:

_____

_____

Please check any of the following if they apply to your child:

__Chronic ear infections
__Poor sleep
__Asthma
__Lyme Disease
__Abnormal muscle tone (tension)
__Torticollis
__ Mumps
__Bronchitis
__Respiratory problems
__Colic
__Frequent antibiotic use
__Frequent fevers
__Compromised immune system
__Abnormal Lab results
__Cardiac Issues
__Pneumonia
__Allergies
__Tubes in ears
__Tonsils/Adenoid Surgery
__Reflux
__Surgeries: list above
__Poor weight gain
__Measles
__Chicken Pox
__Head Injuries

Other_____

Developmental Milestones: Fill in the blanks to describe your child to the best of your ability:

Rolled over at _____ months/years Sat at _____months/years Crawled at _____ months/years

Stood at _____months/years Walked at _____months/years Talked at _____months/years

Fed self at _____months/years Dressed at _____months/years Toilet trained at _____months/years

If there was anything unusual you noticed in any of the above developmental milestones, please explain: _____

_____

_____

Activities of Daily Living (Routine Activities):

Check the type of assistance that your child requires during the following tasks:

	Independent	Verbal Assistance	Physical Assistance (Minimal - Maximal)
Going up stairs			
Going down stairs			
Walking on smooth surfaces			
Walking on uneven surfaces (like grass)			
Running			
Jumping			

Comments:

_____

_____

_____

Hearing/Vision:

Has your child ever had a vision test? _____ Date of last vision test: _____

Results: _____

Has your child ever had a hearing test? _____ Date of last hearing test: _____

Results: _____

Sensory Development:

Is your child overly sensitive to sensory experiences (e.g., sounds in restaurants, textures, bright lights, smells)? If so, please explain:

_____

_____

Does your child take longer to react or not react to sensory experiences (e.g., appears to be in his/her own world, does not respond to his/her name when called)? If so, please describe:

_____

_____

Does your child seem to actively search or seek out sensory experiences (e.g., constant desire for pushing, pulling, and hanging off things; constantly on the move; seems unable to stop talking; touching people to the point of irritating others)? If so, please describe:

_____

_____

Does your child have a difficult time distinguishing sensory experiences? (e.g., trouble distinguishing objects in pockets, trouble recognizing objects by their shape, trouble differentiating smells). If so, please describe:

_____

_____

Does your child seem clumsy (trips/falls frequently) when executing movement, performing unfamiliar movements or completing tasks with multiple steps? If so, please describe:

_____

_____

Does your child have poor balance during motor activities (e.g., biking, karate, and gymnastics)? If so, please describe:

_____

_____

Does your child have difficulty sustaining adequate posture at a desk/table (slumps, leans on arm, head too close to work, props head on hands)? If so, please explain:

_____

_____

Other Comments:

_____

_____

_____

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Parent Signature _____ Date _____

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Authorization for Emergency Medical Attention

Child's name (print):_____ Date of birth:_____

Mother's cell #: _____ Father's cell #: _____

Mother's work #: _____ Father's work #: _____

Mother's home #: _____ Father's home #:_____

In the event that we cannot be reached to make arrangements for emergency medical attention, we authorize Karen Dickerson, Clinical Director, or a designated staff member to take my child to the location listed below, or to the nearest hospital, and we give our consent for any and all necessary treatment:

Doctor:_____

Address: _____

_____

Phone #: _____

In case of emergency treatment, please inform the medical staff that our child has the following allergies and takes the following medication(s) on a daily basis (include dosage):

Allergies: _____

Medications: _____

Please list two (2) people who we may contact in the event of an emergency:

Name	Phone	Relationship
Name	Phone	Relationship

Signature _____ Date _____

THIS FORM MUST BE KEPT UPDATED AT ALL TIMES

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Consent for Treatment

Client: _____ Date of Birth: _____

Parent/Guardian: _____ Relationship to Client: _____

I, _____, hereby give consent for the above named child and/or myself to receive services at the Carruth Center of The Parish School. This consent is given until I give notice that these services are no longer requested or until Carruth Center of The Parish School professionals notify me these services will no longer be provided. I certify that I have legal responsibility for this child and am authorized to seek and consent treatment for him/her. I understand that all information provided to Carruth Center of The Parish School professionals is confidential and will generally be released to others only with my written consent. I understand that Carruth Center of The Parish School professionals are required to disclose confidential information without my consent in certain circumstances which includes, but is not limited to, 1) if is determined there is a probability of imminent physical injury by my child to himself/herself or other(s), or if there is a probability of immediate mental or emotional injury to my child 2) if the disclosure is required or authorized by law, legal proceedings, or court order 3) to qualified individuals, corporations, or governmental agencies involved in paying or collecting fees for mental or emotional health services for my child 4) to other professionals and personnel, under the direction of Carruth Center of Parish School professionals providing services to my child, who participate in the diagnosis, evaluation, or treatment of my child 5) a judicial or administrative proceeding brought against Carruth Center of The Parish School professionals by myself or my child 6) in the event it is believed my child is the victim of physical abuse, sexual abuse, or neglect, or if my child divulges information about the physical abuse, sexual abuse, or neglect of a child, elder, or disabled person.

The professionals rendering services through Carruth Center of The Parish School are dedicated to using established and empirically supported psychological, behavioral, and educational evaluation and intervention procedures to optimize the social, emotional, and cognitive development of each child. In the event a child presents as an immediate danger to himself/herself, others, or property, the least restrictive intervention shall be utilized to provide safety for the child, others, or property. While verbal mediation will be the primary intervention utilized, at times physical contact may be required to provide safety for the child, others, or property.

My signature on this document indicates I have read the above information and have a clear understanding of the procedures, policies, and therapeutic interventions described. I have been given the opportunity to have my questions answered regarding the above-described information. I understand that I have the right to withdraw treatment for my child at any time.

_____ _____

Signature of Parent/Guardian Date

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Payment Contract and Authorization
Physical Therapy

Client's (Child's) Name: _____

The fees for the Physical Therapy sessions are invoiced on or around the **5th** day of the month following the last session of the previous month. Payment for these sessions will be direct debited from your account or charged to your credit card on or around the **15th** day of the following month (or the next business day), depending on the selection below and payment authorization information provided.

Physical Therapy Evaluation with a report is $400.00.

Individual Physical Therapy is $135.00 per hour-long session.

_____ Please charge my **credit card** (complete the credit card authorization on following page).

_____ Please **direct debit** my account (complete the ACH direct debit on following page).

In consideration for the acceptance and enrollment of _____ in individual treatment, or group program, I (we) the undersigned parent(s), and/or guardian, or other endorser hereof, promise to pay to the order of Carruth Center, Inc. all applicable fees charged for services rendered due on/or before the fifteenth of the month following treatment. Outstanding balances may result in suspension of services until total account balance has been cleared. There will be a $20.00 service charge for NSF checks. Please initial below.

_____I understand that the form or payment on file must be kept current. To update your form of payment on file, submit a new "Payment Contract & Payment Authorization" form to the Carruth Center, Inc. Business Office before the 15th of the month.

_____I authorize the Carruth Center, Inc. to charge the agreed upon credit card or ACH debit on or around the 15th of each month for services provided during the previous months (generally on going individual services) OR on the dates specified in the payment option selected on the signed contract for services (generally group therapy).

_____I agree that if initial payment processing is declined for any reason, Carruth Center, Inc. may continue to process the payment against the card on a regular basis, until the payment is successfully processed and the balance is resolved. Reoccurring payment declines will result in payments being due at the time of service. In this circumstance acceptable form of payment would be exact cash or a credit card that can be successfully processed at the time of service.

_____I acknowledge and understand the cancellation, late arrival, and late pick-up policies. See Carruth Center Policies form.

See reverse side for payment authorization form
Carruth Center, Inc. must have a current form of payment on file for all clients.

Credit Card Authorization:

____ Visa ____ MasterCard ____ American Express ____ Discover

Credit Card Number: _____

Expiration Date: _____ Card Security Code (CSC): _____

Name on Card: _____

Address: _____

_____

ZIP Code: _____

Phone Number: _____

ACH Direct Debit Authorization:

____ Checking Account ____ Savings Account

Depository Name _____ Branch _____

City _____ State _____ Zip _____

Routing Number _____ Account Number _____

_____I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

Attach a blank voided check

Signature Authorization

This Authorization is to remain in full force and effect until Carruth Center, Inc. has received written notification from me (I or either of us) of its termination in such time and in such manner as to afford Carruth Center, Inc. and DEPOSITORY a reasonable opportunity to act on it.

Print Name: _____

Date: _____ Signature: _____

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Carruth Center Policies Form

Client's (Child's) Name: _____

Please read carefully, and initial each line.

____ Clinic Visitation Policy:

- Children in the lobby must be accompanied by an adult at all times.
- Please check in with The Carruth Center office before entering the therapy area. All parents and visitors must wear a visitor badge while in The Carruth Center therapy area.
- Group observations must be scheduled through The Carruth Center business office at least 24 hours in advance.

____ Cancellation Policy:

Any cancellation, not due to illness or family emergency, must be made by notifying the treating clinician 24 hours in advance. Failure to cancel without 24 hours notice will result in a charge of 100% of the session fee. The Carruth Center reserves the right to dismiss a client from therapy for inconsistent attendance and withhold all test results and reports when professional fees are not paid.

____ Late Start Policy:

Late arrivals will not be accommodated by extending therapy time, and full session fees will apply. For example: If a client is 5 minutes late to their scheduled appointment time, the result will be a 30-minute session fee, even though it was only a 25-minute therapy session. Clients are encouraged to arrive 5 minutes prior to their scheduled session time.

____ Late Pick-up Policy:

Parents are expected to be in The Carruth Center lobby or front porch area prior to the end of their child's therapy session. **The Carruth Center late pick-up policy is as follows:**

- Client families will be given two "passes" (no charge assessed) per fiscal year (August 1st – July 31st) for late pick-up not to exceed 5 minutes.
- Late pick-ups **beyond 5 minutes or post two "passes"** will be charged by the quarter-hour at the standard individual therapy rate. See list of therapy rates below.
- Chronic tardiness may lead to parent being required to remain on campus throughout therapy session.

- Late fees will be included in monthly invoices. Failure to resolve fees with regularly scheduled monthly payment processing, on or around the 15th of every month, will result in suspension of client services.
- Late pick-up fees are not eligible for insurance reimbursement.

Breakdown of Late Fees

	Speech, OT, PT and Music Individual Therapy Rates ($135.00)	Mental Health Individual Therapy Rates ($140)
5-15 Minutes	$33.75	$35.00
16-30 Minutes	$67.50	$70.00
31-45 Minutes	$101.25	$105.00
46-60 Minutes	$135.00	$140.00

____ **Policy on Insurance:**

- The Carruth Center is a fee-for-service facility and families are responsible for all payments.
- The Carruth Center does not guarantee coverage and/or the ability to gain coverage of services. Coverage is determined by your individual insurance policy.
- The Carruth Center is considered out-of-network. Therefore, we ask that families act as the liaison for any direct communication with their insurance companies.
- The Carruth Center does not submit claims on behalf of the client.
- The Carruth Center provides invoices and/or services descriptions on forms with necessary codes, clinician information, and clinic information for your convenience and ease of filing claims.
- The Carruth Center does not accept payment from insurance companies. All insurance checks issued to The Carruth Center are returned to the insurance company with a request to issue payment to the insured. The insured is then notified by letter and provided a copy of the check for their records.

Parent Name (Print): _____ Date: _____

Signature: _____

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Authorization to Request or Disclose Protected Health Information

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to release or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

This form contains four (4) sections that authorize The Carruth Center to request or disclose protected health information. **Please complete sections that apply to you. Please mark N/A through sections that do not apply to you.** Both parents must complete this form unless a divorce decree is produced to show otherwise.

Information regarding patient for whom authorization is made:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Email (*Optional*): _____

I. Permission to Release or Obtain Protected Health Information

I hereby authorize The Carruth Center to request protected health information from and/or disclose protected health information to the following entities **(initial all that apply):**

The Parish School: _____ initials _____ initials	Spectrum of Hope: _____ initials _____ initials
Dr. Randi Raizner: _____ initials _____ initials	Holy Spirit Episcopal School: _____ initials _____ initials
Other Name: Phone Number: Address: _____ initials _____ initials	
Other Name: Phone Number: Address: _____ initials _____ initials	
Other Name: Phone Number: Address: _____ initials _____ initials	

The information to be disclosed or requested (initial any that apply):

_____ ST, OT, PT or Music Therapy client therapeutic/progress notes
_____ Diagnoses
_____ ST, OT, PT or Music Therapy assessment or evaluation results
_____ Mental Health records (except psychotherapy notes)
_____ **Entire record**

Reason for request or disclosure of protected health information (choose all that apply):

☐ Treatment/coordination of care ☐ Legal purposes
☐ Personal use ☐ School
☐ Employment ☐ Other (specify): _____

II. Insurance

I hereby authorize The Carruth Center to disclose protected health information to my child's insurance company for the purpose of claims processing when a request is made by his/her parent or guardian, or when a request is made from the insurance company directly.

Insurance Company: _____

The information to be disclosed or requested (initial any that apply):
_____ ST, OT, PT or Music Therapy client therapeutic/progress notes
_____ Diagnoses
_____ ST, OT, PT or Music Therapy assessment or evaluation results
_____ Mental Health records (except psychotherapy notes)
_____ **Entire record**

III. Caregivers and/or Family Members

I hereby authorize The Carruth Center to disclose protected health information regarding my child to the following caregivers or family members:

Name: Address: Phone: Fax/Email:

_____

_____

_____

The information to be disclosed or requested (initial any that apply):
_____ ST, OT, PT or Music Therapy client therapeutic/progress notes
_____ Diagnoses
_____ ST, OT, PT or Music Therapy assessment or evaluation results
_____ Mental Health records (except psychotherapy notes)
_____ **Entire record**

Reason for request or disclosure of protected health information (choose all that apply):
☐ Treatment/coordination of care ☐ Legal purposes
☐ Personal use ☐ School
☐ Employment ☐ Other (specify): _____

IV. Pick Up Release

The following people have permission to pick up my child from therapy. If I have included their information in Part 3 of this form, my child's therapists may share information about therapeutic progress or session results at the end of my child's therapy session(s). Please note, if a person not on this list brings your child to therapy, your child will be released to that same person upon the completion of their therapy session.

<u>Person 1</u>
Full Name: _____ State ID#: _____

State of issuance: _____ Phone Number: _____

Providing Premier Pediatric Assessments and Therapy
www.carruthcenter.org | 713-935-9088
11001 Hammerly Blvd., Houston, TX 77043

Person 2
Full Name: _____ State ID#: _____

State of issuance: _____ Phone Number: _____

The individual(s) signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
(ii) **Effective Time Period:** This authorization shall be in effect from the date of your signature below until authorization is revoked, in writing, by you. Any changes to the information on this form should be reported to The Carruth Center office in writing.
(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization in full or in part at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and by initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.
(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Parent/Legal Representative: _____ Date: _____

Printed Name of Parent/Legal Representative: _____

If Legal Representative, relationship to Patient: _____

Parent/Legal Representative: _____ Date: _____

Printed Name of Parent/Legal Representative: _____

If Legal Representative, relationship to Patient: _____

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THE CARRUTH CENTER
AT THE PARISH SCHOOL

THE CARRUTH CENTER
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

EFFECTIVE August 1, 2017

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your personal health information ("*PHI*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to The Carruth Center including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of your PHI, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to PHI about you;
- Notify affected individuals following a breach of unsecured PHI under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE PERSONAL HEALTH INFORMATION ABOUT YOU:

The following categories describe the different reasons that we typically use and disclose PHI. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your PHI. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your PHI.

A. For Treatment: We may use and disclose PHI about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose PHI about you to health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another provider of a specialty outside of the Practice, we may provide that provider with your PHI in order to aid the provider in his or her treatment of you.

B. For Payment: We may use and disclose PHI about you so that we or may bill and collect from you. This may also include the disclosure of PHI to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send an invoice for payment to you, and that invoice may have a code on it that describes the services that have been rendered to you.

C. For Health Care Operations: We may use and disclose PHI about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice, to promote quality care, and to contact you when necessary. For example, we may need to use or disclose your PHI in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities.

D. Appointment Reminders and Health-Related Benefits and Services: We may use and disclose PHI, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose PHI to tell you about health-related

benefits or services that we believe may be of interest to you. We may use email to contact you about your health care invoice or payment.

E. **Business Associates:** There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your PHI to our business associate so that they can perform the job we have asked them to do. To protect your PHI, however, we require the business associate to appropriately safeguard your information.

F. **As Required by Law:** We will disclose PHI about you when required to do so by federal, state, or local law or regulations. This may include sharing your PHI with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

G. **Individuals Involved in Your Care or Payment for Your Care:** We may disclose PHI about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

H. **To Avert an Imminent Threat of Injury to Health or Safety:** We may use and disclose PHI about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

I. **Public Health Risks:** We may disclose PHI about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child or elderly or disabled abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a child or adult has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

J. **Health Oversight Activities:** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

K. **Disaster Relief Situation:** We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your case, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can.

L. **Facility Directories:** We may use or disclose certain aspects of your PHI in order to maintain a directory of individuals in the facility. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can.

M. **Legal Matters:** If you are involved in a lawsuit or a legal dispute, we may disclose PHI about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your PHI,

such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

N. **Law Enforcement, National Security and Intelligence Activities:** In certain circumstances, we may disclose your PHI if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your PHI to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

O. **Fundraising:** We may use or disclose certain limited amounts of your PHI to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

P. **Electronic Disclosures of Medical Information:** Under Texas law, we are required to provide notice to you if your PHI is subject to electronic disclosure. This Notice serves as general notice that we may disclose your PHI electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

Q. **Mental Health Information:** We will not disclose mental health records containing your identity, diagnosis, evaluation, or treatment unless authorized by law or upon your written consent.

II. YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

A. **Authorization Required: Psychotherapy Notes, Marketing, and Sale of Medical Information.** There are times we may need or want to use or disclose your PHI for reasons other than those listed above, but to do so we will need your prior authorization. In these cases, we will never use or share your information absent written authorization by you:

- Most uses and disclosures of "psychotherapy notes";
- Marketing purposes; and
- Sale of medical information.

B. **Right to Revoke Authorization:** Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us with written authorization to use or disclose your PHI for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION:

Federal and state laws provide you with certain rights regarding the PHI we have about you. The following is a summary of those rights.

A. **Right to Inspect and Copy:** Under most circumstances, you have the right to inspect and/or copy your PHI that we have in our possession, which generally includes your medical and billing records. To inspect or copy your PHI, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

We may also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

If your requested PHI is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) we will provide you with the requested PHI in the electronic form and format requested, unless you agree to accept it in another format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your PHI. We will give you any such denial in writing. If you are denied access to PHI, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend: If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your PHI. This is a list of the disclosures we have made for up to six years prior to the date of your request of your PHI, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions: You have the right to request a restriction or limitation on the PHI we use or disclose about you for Treatment, Payment, or Health Care Operations. You also have the right to request a restriction or limitation on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide

emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the PHI relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification: In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your PHI has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE:

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS:

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

The Carruth Center
Attn: HIPAA Officer
11001 Hammerly Blvd.
Houston, Texas 77043
(713) 935-9088

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS:

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____Date: _____

Printed Name: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Physical Therapy

Schedule of Fees

• Physical Therapy Consultation (per hour)	$135.00
• Physical Therapy Evaluation (up to 2 hours with a report)	$400.00
• Individual Session (30 minutes)	$67.50
• Individual Session (45 minutes)	$101.25
• Individual Session (60 minutes)	$135.00
• Group Session (per hour)	$85.00
• Parent Conference (30 minutes)	$67.50