NOTICE OF PRIVACY PRACTICES

This practice uses and discloses health information about you/your child for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices and your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. You can request a copy of this notice at any time. Please contact our office at 918-214-8028 if you have any questions.

Treatment, Payment, Health Care Operations

Treatment: We are permitted to use and disclose your medical information to those involved in your treatment. For example, the therapists working within this practice are specialists. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions if any.

Payment: We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as description of medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations: We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional or "Business Associate" to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law. Also, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and services we offer.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight: We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reaction to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Oklahoma law requires physicians and healthcare specialists, to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement: We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed. If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information a) Is released pursuant to a legal process, such as a warrant or subpoena b) Pertains to a victim of crime and you are incapacitated c) Pertains to a person who has died under circumstances that may be related to criminal conduct d) Is about a victim of crime and we are unable to obtain the person's agreement e) Is released because of a crime that has occurred on these premises f) Is released to locate a fugitive, missing person, or suspect. We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Required by Law: We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations: The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions: You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances. To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the

request to the address and person listed below. You may also request that we limit disclosure to family members, other relatives, or close personal friends that may not be involved in your care.

Receiving Confidential Communications by Alternate Means: You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information: You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Oklahoma law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your requests to the person listed below. We can refuse to provide some of the information you ask to inspect or ask to be copied if the information: a) Includes psychotherapy notes b) Includes the identity of a person who provided information if it was obtained under a promise of confidentiality c) Is subject to the Clinical Laboratory Improvements Amendments of 1988 d) Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Oklahoma law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Oklahoma State Board of Medical Licensure and Supervision (OSBLMS) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the lower of the fee permitted by HIPAA or the fee permitted by the OSBMLS will be charged.

Amendment of Medical Information: You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information: a) Wasn't created by this practice b) Is not part of the Designated Record Set c) Is not available for inspection because of an appropriate denial d) If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures: The HIPAA privacy regulations permits you to request, and us to provide, an accounting of disclosures of your health care information other than for payment, treatment and healthcare operations. Please submit any request for an accounting to the privacy officer. Your first accounting of disclosure (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. We will notify you of any charges and you may choose to withdraw or modify your request before the costs are incurred.

Appointment Reminders, Treatment Alternative, and Other-Health-Related-Benefits: We may contact you by text, telephone, mail, or email to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

COPMLAINTS: If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Human Services is:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

Our Promise to You: We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Request: If you have any questions or want to make a request pursuant to the rights described above, please contact:

Move Strong Pediatric Physical Therapy
548 SE Washington Blvd
Bartlesville, OK 74006 Phone: 918-214-8028 Fax: 918-214-8518

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. IF or when we change our notice, we will post the new notice in the office where it can be seen.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed the office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Parent/Legal Guardian

_____

Date

_____

Printed Name of Patient

_____

Relationship to Patient