



Connections Speech and Language Therapy

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www.connectionspeechlanguagetherapy.com

Notice of Privacy Practices and Client Privacy Rights

Our pledge to you: We understand that each client's health information is personal and we are committed to protecting it. We create a record of the care and services each client receives through our practice. We need this record to provide each client with quality care and to comply with certain legal requirements. This notice informs you regarding the ways we may use and share medical information about you and/or your child as our client(s), describes your rights, and outlines our duties regarding the use and disclosure of this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164, the Confidentiality Law, 42 CFR Part 2, and the NC General Statutes 122c protect you and/or your child's healthcare information. Under these Laws:

- 1) Our staff cannot acknowledge their professional relationship with you and/or your child to any person, including your family and friends, without your written authorization or one of the exceptions listed below.
- 2) We may not disclose any information identifying you and/or your child as a client, except as permitted by law.
- 3) We must obtain your written consent before we can disclose information to your health insurer/Medicaid in order to be paid for services rendered. If you do not authorize us to release information to your insurance company, then full payment will be required at the time of service.
- 4) We may use and disclose protected health information for health care operations:
 - a) The owner is authorized to review medical records for the purpose of providing client care and treatment.
 - b) The owner responsible for billing is authorized to view protected health information for the purpose of completing routine duties associated with billing and collections.
 - c) Students, interns and trainees who have signed a confidentiality agreement with us and who are observing and/or working with the owner of Connections may also have access to personal health information.

The law allows use and disclosure of information *without* your written permission:

1. When law requires the use and/or disclosure.
2. When it is necessary for public health activities.
3. We may share information with a physician who referred you to our practice.
4. We may share information with a business associate of Connections. (A business associate is someone who provides services to Connections or provides services on our behalf.)
5. For research, audit or evaluations.
6. To report a crime committed against Connections owner(s).
7. To medical personnel in a medical emergency.
8. If we believe you are a danger to yourself or to others, or if we believe that you are likely to commit a crime, we may share information with law enforcement.
9. To appropriate authorities for the purpose of reporting suspected abuse and/or neglect.
10. As allowed by court of law.

Written Authorization for Disclosure of Information Before we can use or disclose any information about your health in a manner that is not described above or in items 1- 10, we must first obtain your specific written authorization allowing us to make the disclosure. You may revoke any such written authorization in writing except for action that has already been taken.

Contact From Our Office/Your Child's Therapist We may contact you to provide appointment reminders, to discuss billing matters, to assess the quality of our services, or regarding other health-related benefits and services that may be of interest to you. If you choose not to be contacted by us via telephone, letters, or messages, document your objection in writing, and give it to your service provider.

Our Duties We are required by law to maintain the privacy of your and/or your child's health information, to provide you with notice of our legal duties and privacy practices with respect to your and/or your child's health information, and to abide by this notice. If there are any changes made to the terms of this notice, we will provide you with the changes in writing. The owner of Connections has been trained in maintaining confidentiality in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Client Privacy Rights

- 1) Under HIPAA, you have the right to request restriction on certain uses and disclosures of your health information. Connections is not required to agree to any restriction you request, but if we do agree, then we are bound by that agreement and may not use or disclose any information which you have restricted, except as necessary in a medical emergency or as required by law.
- 2) You have the right to request that we communicate with you by alternative means or at an alternative location. We will accommodate such requests that are reasonable and will not request an explanation from you. For example, you may wish for us to call you at a different telephone number.
- 3) You have the right to inspect your record. Inspections must be scheduled with your or your child’s primary therapist and in some circumstances, requests may be denied. You also have a right to request a personal copy of your record for a fee of \$.75 per page for the first 25 pages, \$.50 per page for pages 25 through 100, and \$.25 per page over 100 pages. **A minimum fee of \$10.00 is permitted.** Connections must respond to your request within 30 days.
- 4) You have the right, with some exceptions, to amend healthcare information maintained in our records. All requests for amendments must be made in writing. Connections must respond to your request within 60 days.
- 5) You have the right to request and receive an accounting of disclosures of your health-related information made by Connections during the six years prior to your request. We are required to provide a listing of all disclosures except for the following: for your and/or your child’s treatment, for billing and collection of payment for your treatment, for our health care operations, those made to or requested by you or that you authorized, those occurring as a result of permitted uses and disclosures, those made to individuals involved in your and/or your child’s care, those allowed by law, and if the information released did not identify you.
- 6) You have the right to receive a paper copy of this notice.

Client Grievances: If you have a grievance that cannot be resolved with your therapist, you should request a **Privacy Complaint Form** to document your grievance and forward it to **Connections Speech and Language Therapy at 105A Charlotte Highway Asheville, NC 28803**. You may file a complaint with the Secretary of the United States Department of Health and Human Services if you feel that your privacy rights have been violated under HIPAA. If you file a complaint, we will not take action against you or change our treatment of you in any way.

ACKNOWLEDGEMENT OF PRIVACY NOTICE AND CLIENT PRIVACY RIGHTS

As a client of Connections Speech and Language Therapy, you have certain rights regarding services and the protection of your/your child’s health care information. I acknowledge that I have received a copy of the “Notice of Privacy Practices” and the content has been explained to me in a manner which I understand. A copy of this signed dated document shall be as effective as the original.

Client or Legal Guardian Signature

Date of Signature

I would prefer to be addressed by:
 First Name Only
 Proper Surname
 Other _____

I authorize contact from this office to confirm appointments, treatment and billing information via:
 Cell phone confirmation
 Home phone confirmation
 Work phone confirmation
 Text message
 Email Confirmation
 Any of the above

I authorize information about the client’s health to be conveyed via:
 Phone message
 Text message
 Email
 Any of the above
 None of the above

Office Use Only

As Privacy Officer, I attempted to obtain the client’s or client’s guardian’s signature on this acknowledgement but did not because:

- It was emergency treatment.
- I could not communicate with the client or the client’s guardian.
- The client or client’s guardian refused to sign.
- The client was unable to sign because _____.
- Other (please describe) _____.

Signature of Privacy Officer

Date of Signature