Kids Connect Us™

Occupational, Speech & Feeding Therapy at Home
Throughout Silicon Valley
www.kidsconnectus.com (408) 766-4080

Welcome to Kids Connect Us Therapy!

Thank you for taking the time to print, thoroughly fill-out and return digital copies of the forms on pages 2-10 of this packet.

Please make sure that your writing is legible, so that we have your correct contact and insurance information on file. Please also submit any OT evaluations and IEP reports from the last year, and any diagnostic reports relevant to your child's care.

****Please print and return pages 2-10 of this packet.**
Page 1 and pages 11-15 are for your information only.

Page 1: Welcome page
Page 2: Informed Consent
Page 3: Child Registration
Page 4-5: Developmental History
Page 6: Authorization for Release of Information
Page 7: Insurance Information
Page 8: Reimbursement Questions to Ask Your Insurance Carrier
Page 9-10: Fees, Payment, Cancellation and Superbill Policy
Page 11-15: Privacy Notice (HIPPA)

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INFORMED CONSENT

Movement and use of moving equipment are integral to the therapy program at Kids Connect Us Therapy. We will make every effort to ensure your child's safety. We do, however, want you to be aware that there are inherent risks and that it is possible for accidental injuries to occur in the home or other environments.

We ask that you are particularly aware of your child's safety when speaking with your child's therapist during sessions. It is not realistic, or possible, for your therapist to focus on both you, and your child's safety simultaneously. For this reason, it is recommended that you schedule parent consults outside of therapy time or have another adult who is responsible for your child's safety while you are meeting with the therapist.

Whenever you are present in therapy sessions, we ask that you take an active role of ensuring your child's safety and that you advocate for your child's safety and well-being *in the moment* if you feel this is necessary. We may ask you to sign an additional waiver if the therapist feels there are increased risks in your home environment.

Please also make sure that sharp and/or hard objects, such as corners on tables and hard floors, in the therapeutic area are safely covered to protect your child during sessions.

I acknowledge that I have the full authority to sign this document independently of any other caregivers, parents or individuals, therefore binding this agreement. If not, I acknowledge that all other individuals with authority to sign have also signed this agreement. **Please Initial: _____**

I give permission for my child, _____, to receive therapy at my home through Kids Connect Us. I have received enough information to make an informed decision as to give permission for my child to receive these services. I am legally competent and possess the mental capacity necessary to give said permission.

In the event of the need for emergency medical attention, I give my consent for 911 personnel to provide essential care to my child.

_____
Parent/Guardian 1 Name

_____ _____
Parent/Guardian 1 Signature **Date**

_____
Parent/Guardian 2 Name

_____ _____
Parent/Guardian 2 Signature **Date**

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CHILD REGISTRATION FORM

Child's name:
Gender:
Date of birth:
Age:

Sibling names and ages:

Parent/Guardian 1 Name:
Phone numbers (mobile, home, work):
Email address:
Address (#, Street, City, Zip):
Employer:

Parent/Guardian 2 Name:
Phone numbers (mobile, home, work)
Email address:
Address (#, Street, City, Zip):
Employer:

Child's Pediatrician:
Phone:
I have discussed my concerns with my pediatrician: Yes No

Who referred you to Kids Connect Us Therapy?

I am aware that Kids Connect Us provides home-based therapy.

Would you like to receive an electronic copy of a Superbill monthly? Yes No

I would be interested in learning more about the following (please circle):

1) Social-emotional learning group opportunities
2) Summer events/outings/camps schedule
3) How Therapeutic Rock Climbing can be a great adjunct to occupational therapy in the home?
4) Information regarding child development & health, and relevant cutting-edge research?
5) In-home speech and feeding therapy services?
6) Supporting specialist services: (yoga, mindfulness, meditation)
7) Specialist services? (ILS, SSP, IM, Reflex Integration, etc.)

Clinic Use Only (below)

Diagnostic Codes:

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DEVELOPMENTAL HISTORY (Page 1)

Child's name: **DOB:** **Age:**
Today's Date:

General History:
Current School:
Current Grade/Classroom:
Does your child have an IEP or 504 Plan? **Yes/No**
If so, what services is he/she receiving and what accommodations are in place?
Does your child participate in any after school sports or other activities: If so, please list:

Diagnoses that your child has been given by other professionals:

Services your child has received or is receiving at this time:

Have any family members had developmental challenges similar to your child's?

Prenatal History:
Describe quality and duration of pregnancy and any complications/stressful events/illnesses:
Have you had any miscarriages before or since this pregnancy?

Birth History:
Type of delivery: **Vaginal** **C-Section** **Emergency C-Section**
Induced? **Yes/No**
Swab inoculation following C-Section? **Yes/No** **I don't know_____**
Any birth complications:
Weight/Length at birth:
Treatment received by mother or baby?
NICU Stay? If so, how long:
If your child was adopted, do you have any information about the birth mother's health and pregnancy?

Postnatal History:
Please list and describe any important injuries, illnesses, surgeries or hospitalizations and at what ages they occurred: Attach additional sheets if necessary.
History of ear infections? **Yes/No** Tubes? **Yes/No**
If so, how many, how often, and at what ages did they occur?
Approximately how many times has your child received antibiotics?
Following antibiotics, was your child provided pro-biotic supplementation therapy?
Any other medications your child has been on or is currently on?
Allergies/Sensitivities?

DEVELOPMENTAL HISTORY (Page 2)

Any known history of traumatic events? Death, relocation, abandonment, fire, violence, sexual abuse, etc. we should be aware of?

Nursing History:

Describe the quality and duration of nursing and the transition to formula and/or solid foods:
Did your child latch easily? **Yes/No**
Other (please describe): Were there difficulties with milk flow (e.g. too much, too little)
Colic? Allergies to breast milk or to formula (Rashes? Eczema? Excessive reflux?)

Was nursing an enjoyable experience for you and the child? **Yes/No**

Milestones:

Did your child meet all developmental milestones at expected times? If not, at what age did your child:
Sit alone_____ Crawl (age achieved and duration)_____ Walk_____
Transition to solid foods_____ Drink from a cup_____ Feed self with spoon_____
Speak single words_____ Speak phrases_____ Speak sentences_____

Current Performance:

Please describe your child's strengths and current interests:

Please circle areas of concern for you at this time:

1) Self-care: dressing/tooth brushing/self-feeding/toileting/chores
2) Sensory:
3) Gross motor:
4) Fine motor:
5) Attention:
6) Social:
7) Academic:
8) Mental Health:
9) Stressful environment/events:
10) Communication:
11) Feeding:

Diet

Is your child currently on or have they ever been on a special diet? (GFCF/GAPS/other)
Does your child have any eating problems (resistant eater, limited diet)?
How is your child's digestion? Appetite?
Has your child been tested for food sensitivities? **Yes/No** Is your child constipated? **Yes/no**

Sleep

How is your child's sleep (getting to bed/falling asleep/staying asleep/bedwetting/nightmares)?
If your child has sleep issues, what have you tried?

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AUTHORIZATION FOR RELEASE OF INFORMATION

This form must be completed for every agency you would like us to communicate with. All agencies you work with, including Kids Connect Us, are required by law to keep you and your child's health information confidential. This document gives us permission to communicate with the individual(s) that are affiliated with the agency listed below regarding your child's health care needs and medical records. Please submit one page per agency you would like us to communicate with.

Patient Information:
Name (First, Middle, Last):
Last 4 Digits of Social Security #:
Address (Street address, City, State, Zip):

Release Information to the Following:
Name of Individual(s):
Name of Facility/Agency:
Address (Street address, City, State, Zip):
Phone:
Email:

Purpose of Release:
Continuity of Care, Billing/Payments ☐Other: _____

Dates of service for Release:
☐One year from this date ☐Other date range:

Information for Release
☐OT Evaluation/Assessment
☐Occupational Therapy Treatment
☐Medical concerns
☐Psychiatric concerns
☐Other: _____

Your Rights:
I, the undersigned authorize Kids Connect Us to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness.

This authorization and consent will expire one year from the date of the authorization written below, unless revoked through written notice or another date range is indicated above. Any revocation will not apply to any information that was released previously. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

_____ _____/_____/_____
Signature of Patient or Authorized Representative **Date Signed**

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INSURANCE INTAKE FORM

This information is required in order to complete the Superbill for services.

Patient Information:
Name:
Gender:
Date of Birth:
Address (include # Street, City, Zip code)
Phone Number:
Diagnosis:
Date of Diagnosis (xx/xx/xxxx):
Referring Provider:
Reason for Referral:
Date of authorization for OT evaluation and treatment:

Insurer:
Type of Insurance: □Medicare □Medicaid □Group Health Plan □Other
Insurance Plan Name or Program Name:
Policy Group Number:
I.D. Number:

Insured:
Name (Last, first, middle):
Date of birth:
Gender:
Address (include # Street, City, Zip code):
Telephone Number:

Other Insured:
Is there another health benefit plan? □Yes □No
If yes, please fill out the following (a, b, c):
a) Name of other Insured (Last, first, middle):
b) "Other" insured's policy or group number:
c) Insurance Plan name or program name:

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REIMBURSEMENT QUESTIONS TO ASK YOUR INSURANCE CARRIER

Your Primary Insurance: _____
Secondary Insurance: _____
Member # _____ ID#_____
Member Services Phone #: _____
Date you Called: _____ Who you spoke to: _____

1. Verify with your insurance company if they will cover the following services your child needs (**CPT Codes**): OT: 97535, 97530, 97112, 97150; Speech: 92507, 92508
If there is coverage is there any exclusion? _____
Are there habilitative benefits? _____

2. Do I have a co-payment or is there a percentage of the bill I will be responsible for?
_____

3. Does my plan require a deductible be paid for the calendar year before the coverage begins?
_____ What is the dollar amount? _____

4. Does my child have an out of pocket maximum that I pay per calendar year?
_____

5. Does my insurance plan cover only a limited number of sessions for each calendar year?
_____

6. **Place of Service Codes** (Field 24-B on CMS-1500):
Please find out if your insurer will cover visits in the following place of service locations (codes indicated below): Home (12), Telehealth (02) and any conditions/limitations associated with this location, Other (99) and any conditions/limitations associated with this location.

7. Is there a requirement that I get a prior authorization and/or a referral before I see a clinician?
Yes____ No____ If yes, who do I contact? _____ Phone# _____

8. Is an evaluation with a plan of care required for services? Are progress notes required periodically by the provider?

I understand that I am responsible for any charges that the insurance does not cover. **Please sign below and return this form along with a copy of your insurance card and your completed paperwork.** Failure to complete and return this form may result in a delay in scheduling an appointment.

Patient: _____

Parent/Guardian Signature: _____ Date: _____

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FEES, PAYMENT, CANCELLATION, AND SUPERBILL POLICY (PAGE 1)
Please sign and return Pages 1 and 2

Fee Schedule

Base Rate (OT, ST, FT):	$160.00 hr.
After-Hours Base Rate (sessions ending after 6:30 pm)	$180.00/hr.
Specialist Rate:	$200.00/hr.
Supporting Specialist Rate:	$120/hr.
Weekend Consult	$200/75 min.
Evaluation	See below
Cancellations within 48 hours (without a makeup)	Full charge
Cancellation prior to 48 hours of appointment time	No charge

Documentation: Every session of therapy allows the therapist to have 10 minutes for chart review and documentation (a 60-minute session is 50 minutes; 75-minute session is 65 minutes, etc.). Documentation may be completed on-site at the time of the session, or off-site at the discretion of the therapist.

Reports, Consultations, Letters, Emails: Time spent on outside services requested by the client will be billed for the amount of time spent at the base rate.

Travel Fee: Please note that travel fees may apply. The first 5 miles of travel are free. Each additional mile is accrued at $2/mile (in one-direction only) from Los Gatos (or previous location whichever is closer).

Evaluation fees are charged at billable hourly rate of your therapist or specialist. Fifty percent of payment is due prior to first scheduled evaluation session. Final payment for evaluation is required before evaluation report is provided to client. Evaluations begin at $800 and may be more depending on the complexity. Please discuss this with your treating therapist at your intake session to determine the extent of the evaluation needed.

Payment

At this time, we accept checks and electronic payments. We use the following apps to accept payment: Zelle, Apple Pay, Google Pay, Venmo, and PayPal ("Friends and Family" only). We also accept hand delivered checks. If you need assistance with setting up electronic payment, we are happy to assist you.

Please make payments on the same date of your therapy electronically to Kids Connect Us (707) 260-4926, or directly by check to your child's therapist. Based on the frequency and duration of therapy, and on an established demonstration of family consistency and commitment, monthly payment will be accepted at the discretion of Kids Connect Us Therapy.

Initial _____ *Your initial here indicates you have read and understand this page.*

FEES, PAYMENT, CANCELLATION, AND SUPERBILL POLICY (PAGE 2)

Cancellations:
Consistency is essential to good therapeutic outcomes and to our relationship-based approach. We assure you that we will make 90% of our scheduled visits over a 6-month period and we ask the same from you. Our therapists will accommodate you to schedule make-up sessions that they miss, and we ask that you do the same in return. Clients whose arrival rate falls under 90% due to travel or illness without scheduled makeups will be charged a fee of 50% for all missed sessions at the end of each month. We offer online parent consultations and/or report writing as optional makeups when children are sick for your convenience. We find that these sessions are an excellent opportunity to check in, without distractions, with your child's therapist about any of the following:

1) Developments in your child's life, performance, or behaviors
2) Progress on goals
3) Questions about therapy
4) Parent education
5) Review of assessment/evaluation results
6) Review of or update to home programs
7) Consultation time can also be used for the therapist to write progress reports and implement care coordination activities.

Superbills
Superbills are generated monthly and sent electronically no later than the 10th of the following month. (e.g. January Superbill will be sent by February 10th).

Your signature below indicates you have read and understand pages 1 and 2 of the Fees, Payment, Cancellation, and Superbill Policies form, understand and agree to the fee schedule as described, and agree to the payment, cancellation, and superbill policies set forth by Kids Connect Us.

Signed: _____ Date:_____

Printed Name: _____

PRIVACY NOTICE (PAGES 11-15)

This section is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This section is for your records only.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Kids Connect Us Therapy is dedicated to maintaining the privacy of individually identifiable health information as protected by law, including the Health Insurance Portability and Accountability Act (HIPPA). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. This information is referred to as protected health information or PHI. We are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our organization concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

This notice contains the following required information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our organization. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our organization has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our organization will post a copy of our current Privacy Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our organization may use your PHI to treat you. For example, we may ask you to have evaluations and we may use the results to help us develop an individual plan for services. Many of the people who work for our organization including, but not limited to, our therapists, educators, case managers, doctors, and nurses may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may also disclose your PHI to your primary care physician or other outside health care providers for purposes related to your treatment. Finally, we may disclose your PHI to family members or others who may assist in your care.

2. Payment. Our organization may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer, including Medicaid, to

certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to Medicaid and other payers or providers to coordinate and assist their billing efforts.

3. Health Care Operations. Our organization may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our organization may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our organization. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our organization may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment Options. Our organization may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our organization may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our organization may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a caregiver take an individual to the doctor's office for examination for seizures that occurred while at our organization. We may give the caregiver a copy of a case note for the physician documenting the seizure(s). In this example, the caregiver may have access to this individual's medical information.

8. Disclosures Required By Law. Our organization will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our organization may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect

- preventing or controlling disease, injury or disability

- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult person served (including domestic violence) though we will only disclose this

information if the person served agrees or we are required or authorized by law to disclose this information

2. Health Oversight Activities. Our organization may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our organization may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Persons. Our organization may release PHI to a medical examiner or coroner to identify cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Research. Our organization may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

7. Serious Threats to Health or Safety. Our organization may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. National Security. Our organization may disclose your PHI to federal officials for intelligence and national security activities authorized by law.

9. Workers' Compensation. Our organization may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Program Director or Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our organization will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members, guardians, and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Program Director or Privacy Officer. Your request must describe in a clear and concise fashion:

a. the information you wish restricted;
b. whether you are requesting to limit our organization's internal use, outside disclosure or both; and
c. to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Program Director or Privacy Officer in order to inspect and/or obtain a copy of your PHI. Our organization may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our organization may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to the Program Director or Privacy Officer. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the organization; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our organization, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our persons served have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our organization has made of your PHI, e.g., for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine care in our organization is not required to be documented. For example, the therapist sharing information with the educator; the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer

than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our organization may charge you for additional lists within the same 12-month period. Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact any Program Director or the Privacy Officer.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. To file a complaint with our organization, contact the any Program Director or the Privacy Officer. We urge you to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, however, that we are required to retain records of your care.