Patient Intake Form

Speech Language Therapy Services LLC
3501 Denali St, Suite 101
Anchorage, AK 99503
Please print legibly

Patient Name *(REQUIRED)*: _____

Patient's DOB *(REQUIRED)*:_____Patient's Gender *(REQUIRED)*: M ☐ F ☐ NB ☐

Patient's Address *(REQUIRED)*:_____

City *(REQUIRED)*: _____State *(REQUIRED)*: ____Zip Code *(REQUIRED)*:_____

Home Telephone Number *(REQUIRED)*:_____

Parent/Guardian Printed Name *(REQUIRED)*:_____DOB*(REQUIRED)*:_____

Cell Phone Number:_____

Email Address *(REQUIRED)*:_____

Parent/Guardian Printed Name:_____DOB:_____

Cell Phone Number:_____

Email Address:_____

Primary Care Physician:

Provider Name *(REQUIRED)*:_____

Practice Name: *(REQUIRED)*:_____

Address:_____

City: _____State: _____ Zip Code:_____

Physician Phone Number *(REQUIRED:* _____Fax:_____

Primary Insurance Information:

Primary Insurance Name *(REQUIRED)*:_____

Address: _____

City: _____State: _____ Zip Code:_____

Telephone Number:_____Fax:_____

Subscriber's Name *(REQUIRED)*:_____

Subscriber's DOB *(REQUIRED)*:_____Relationship to Patient *(REQUIRED)*: _____

Group Number *(REQUIRED)*:_____Subscriber's Policy Number *(REQUIRED)*:_____

Subscriber's Address (if different from patient):_____

City: _____State: _____ Zip Code:_____

Subscriber's Employer:_____

Secondary Insurance Information:

Secondary Insurance Name *(REQUIRED)*:_____

Address: _____

City: _____State: _____ Zip Code:_____

Telephone Number:_____Fax:_____

Subscriber's Name*(REQUIRED)*:_____

Subscriber's DOB *(REQUIRED)*:_____Relationship to Patient *(REQUIRED)*: _____

Group Number *(REQUIRED)*:_____Subscriber's Policy Number *(REQUIRED)*:_____

Subscriber's Address (if different from patient):_____

City: _____State: _____ Zip Code:_____

Subscriber's Employer:_____

Tertiary Insurance Information (If Medicaid, Attach Sticker):

Tertiary Insurance Name *(REQUIRED)*:_____

Address: _____

City: _____State: _____ Zip Code:_____

Telephone Number:_____Fax:_____

Subscriber's Name *(REQUIRED)*:_____

Subscriber's DOB *(REQUIRED)*:_____Relationship to Patient *(REQUIRED)*: _____

Group Number *(REQUIRED)*:_____Subscriber's Policy Number *(REQUIRED)*:_____

Subscriber's Address (if different from patient):_____

City: _____State: _____ Zip Code:_____

Subscriber's Employer:_____

Patient Authorization and Acknowledgment

I authorize **Speech Language Therapy Services, LLC** to provide evaluation and treatment services for _____ **(Patient Name,** *REQUIRED***)**.

I authorize the assignment of insurance benefits directly to [Business Name] for services rendered and understand that I am financially responsible for any amounts not covered by insurance in accordance with clinic financial policies.

Notice of Privacy Practices *(Acknowledgement REQUIRED)*

I acknowledge receipt of Speech Language Therapy Services, LLC's Notice of Privacy Practices (NPP), or I have been given the opportunity to receive a copy and have declined at this time. I understand that I may request a copy at any time.

☐ **I received a copy of the NPP**
☐ **I declined a copy of the NPP at this time**

Student Observation Consent (Optional) *(Acknowledgement REQUIRED)*

I understand that Speech Language Therapy Services, LLC, may occasionally have students, trainees, or clinical observers present during therapy sessions for educational and training purposes.

If applicable, I understand that:

- Student observers are required to maintain confidentiality of all patient information in accordance with HIPAA and clinic policies
- Observers may be present in the treatment environment and may observe therapy activities
- Observers may become aware of limited identifying information (such as the patient's first name) during clinical sessions

Participation in student observation is voluntary. I understand that I may decline or withdraw consent for student observation at any time without affecting my child's access to services or quality of care.

☐ **I consent to student observation when applicable**
☐ **I do not consent to student observation**

Signature of Acknowledgement

By signing below, I affirm that I am the legally authorized individual who can consent to services on behalf of the patient and that no other individuals must consent.

Parent/Guardian Name (PRINTED, *Required*): _____

Signature (*Required*): _____

Date (*Required*): _____

Financial Agreement

Speech Language Therapy Services LLC

Client Name (REQUIRED): _____

Date of Birth (REQUIRED): _____

General Financial Responsibilities

The undersigned acknowledges responsibility for all charges incurred for services provided by Speech Language Therapy Services, LLC, including any amounts not covered by insurance. This includes deductibles, copayments, coinsurance, non-covered services, and any other patient-responsible balances as determined by the insurance carrier or fee schedule.

The undersigned understands that insurance benefits are a contract between the patient and the insurance carrier, and that eligibility, coverage determinations, and reimbursement decisions are solely the responsibility of the insurance company.

Insurance Billing and Responsibilities

Speech Language Therapy Services, LLC will submit claims to the patient's insurance carrier on behalf of the patient when applicable and will make reasonable efforts to follow up on submitted claims as part of standard billing operations.

The undersigned understands that insurance processing timeframes and coverage determinations are controlled solely by the insurance carrier. In some cases, additional information, clarification, or cooperation from the patient may be required by the insurance company to process claims.

If delays occur in claim processing beyond standard timeframes, the undersigned agrees to reasonably cooperate with requests from the practice or insurance carrier, which may include providing information or contacting the insurance company if necessary to facilitate resolution of the claim. The practice will not require patient involvement as a condition of continued treatment, except where necessary to resolve insurance-related delays.

The undersigned is responsible for providing information on any changes to insurance coverage. If a claim is rejected because you fail to update insurance information, or insurance has expired or is no longer available, the undersigned is responsible for all charges.

Speech Language Therapy Services, LLC is an in-network provider only for select insurance plans, including Aetna, Alaska Medicaid, Premera Blue Cross, and Tricare/Tricare West, unless otherwise stated. All non-covered services and out-of-network balances remain the responsibility of the undersigned.

Electronic Billing and Communication

The undersigned acknowledges and agrees that Speech Language Therapy Services, LLC may provide billing statements, invoices, payment reminders, and account-related communications electronically, including via email, text message, phone, or secure billing platforms such as Square.

The undersigned consents to receive such communications electronically and understands that these communications may include billing or protected health information as permitted under HIPAA.

The undersigned is responsible for providing and maintaining accurate contact information, including email address, phone number, and mailing address, and agrees to promptly notify the practice of any changes. The practice is not responsible for delayed or missed communications due to incorrect or outdated contact information.

Attendance Policy

The undersigned acknowledges that the patient is scheduled for recurring therapy appointments and that attendance is required for continuity of care.

A cancellation or no-show fee of $50.00 will be charged if the clinic is not provided with at least 24 hours' notice of cancellation, except in cases of illness occurring within the 24-hour notice window. This fee is not billable to insurance and is the responsibility of the undersigned.

Cancellation fees are due prior to the next scheduled appointment unless otherwise arranged with billing staff.

Delinquent Accounts, Suspension and Collections

Payment is due within seven (7) days of invoice receipt unless otherwise agreed in writing.

Accounts not paid within thirty (30) days may accrue interest only to the extent permitted by applicable state law.

Accounts with balances over sixty (60) days past due may result in temporary suspension of services until the balance is resolved or a payment arrangement is established.

If payment is not resolved within thirty (30) days following suspension, services may be terminated.

Accounts referred to collections will be responsible for all associated collection costs, fees, and reasonable attorney fees if applicable.

Patient Cooperation with Insurance Processing

The undersigned acknowledges that Speech Language Therapy Services, LLC will handle insurance submissions and routine follow-up.

The undersigned understands that insurance carriers may occasionally require additional information directly from the patient to complete claim processing. The patient agrees to reasonably cooperate when such requests arise.

Authorization to Release Information

The undersigned authorizes Speech Language Therapy Services, LLC to release necessary medical and billing information to insurance carriers, payers, or third-party administrators as required for claim submission, payment processing, and care coordination.

Assignment of Benefits

The undersigned authorizes insurance benefits to be paid directly to Speech Language Therapy Services, LLC for services rendered. If the undersigned receives any payments from insurance that are for services provided by Speech Language Therapy Services, LLC, they must forward such payments to billing staff. Any overpayments or duplicate payments will be refunded or credited as appropriate.

Financial Acknowledgement

By signing below, the undersigned acknowledge that they have read, understood, and agree to the terms of this Financial Agreement and accept financial responsibility for services rendered.

Parent/Guardian Signature (REQUIRED)_____

Parent/Guardian printed name (REQUIRED) _____

Date (REQUIRED)_____

Communications Policy

Speech Language Therapy Services, LLC

General Communication Standards

Speech Language Therapy Services, LLC may use telephone calls, voicemail, text messaging, email, facsimile, and telehealth platforms to provide services and communicate with patients for treatment, payment, and healthcare operations purposes, as permitted under applicable federal and state law.

All communications will be limited to the minimum necessary information required to accomplish the intended purpose. Reasonable safeguards will be implemented to protect the privacy and security of protected health information (PHI), including verification of contact information and limiting disclosures to authorized individuals.

While reasonable safeguards are used, electronic communications may carry inherent privacy and security risks, including potential interception or unauthorized access. Patients may request alternative methods of communication or request restrictions on certain forms of communication, where feasible.

Phone and Voicemail

When Speech Language Therapy Services, LLC contacts patients via phone for appointment reminders or other administrative matters, reasonable steps will be taken to avoid conveying protected health information (PHI) to any party other than the patient or the patient's representative. Voicemail messages will be limited to minimal information necessary for scheduling or care coordination

Text Messaging (SMS) Communications

Speech Language Therapy Services, LLC may use text messaging for limited administrative and care coordination purposes, such as appointment reminders, scheduling changes, and other non-sensitive communications. Text messaging will not be used by the practice or patient to transmit detailed clinical information, diagnostic results, or sensitive protected health information (PHI) unless explicitly authorized and appropriate safeguards are in place.

Consent Standard: Text messaging will only be used with patient consent. Patients may opt in or opt out of text messaging at any time by notifying the clinic. Opt-out requests will be documented and honored without impact on care.

Content Limitations: Text messages will be limited to the minimum necessary information required for scheduling or administrative coordination. No detailed clinical evaluations, diagnoses, treatment plans, or billing details will be transmitted via text unless required and appropriate safeguards are in place.

Security and Risk Disclosure: Standard text messaging (SMS) is not encrypted end-to-end and may be intercepted, accessed, or viewed by unauthorized individuals if a device is lost, shared, or compromised. Patients acknowledge these risks when consenting to text communication.

Workflow and Use Controls: Text messaging will be conducted only by authorized staff using designated clinic communication systems or approved devices. Personal devices should not be used to transmit PHI unless explicitly authorized under clinic policy. Text communications related to patient care will be documented in the medical record when clinically relevant or when used for care coordination decisions.

Telehealth Services and Electronic Care Delivery

Speech Language Therapy Services, LLC may provide services via telehealth platforms when clinically appropriate and permitted by applicable state and federal law. Telehealth visits may include audio and/or video communication to support evaluation, treatment, and care coordination.

Consent and Patient Acknowledgment: Telehealth services are provided with patient consent, which may be obtained verbally or in writing prior to or at the initiation of services. Patients may decline telehealth services and request in-person care when available and clinically appropriate. Telehealth consent is documented in the patient's medical record.

Security Safeguards: Telehealth services are conducted using platforms that implement reasonable administrative, technical, and physical safeguards to protect protected health information (PHI). However, no electronic communication system is fully secure, and patients should be aware that there is a potential risk of interception or unauthorized access.

Documentation Requirements: Telehealth encounters are documented in the patient's medical record in the same manner as in-person visits, including relevant clinical findings, treatment provided, and any limitations of the virtual format when applicable.

Clinical Limitations: Patients are informed that telehealth may have limitations compared to in-person evaluation and treatment, and clinical judgment will be used to determine when in-person services are necessary for appropriate care.

Email

Speech Language Therapy Services, LLC may use email to transmit patient-related communications through systems configured in accordance with HIPAA security requirements. Email communications are used only when appropriate for administrative or clinical coordination purposes. While we take reasonable safeguards to protect electronic communications, there is a risk that protected health information (PHI) contained in email may be intercepted or disclosed to unauthorized third parties.

In accordance with applicable state and federal laws, we will use the minimum necessary amount of PHI when responding to inquiries.

If you do not wish to receive communications via email, you may notify our office in writing to update your communication preferences at any time.

Record Retention and Legal Status of Communications

Use of electronic mail is a part of the business practices of Speech Language Therapy Services, LLC. When clinically or administratively applicable, electronic communications will be made part of the designated medical record and are maintained in accordance with HIPAA record retention requirements.

Confidentiality of Email

When email is used for communication of individually identifiable health information (PHI):

- All email recipients must be verified prior to sending, particularly when autofill or stored contacts are used.
- All outgoing emails containing PHI will include the following confidentiality notice: ***This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed. If you have received this email in error, please notify the system manager. This message contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute, or copy this email. Please notify the sender immediately by e-mail if you have received this email by mistake and delete this email from your system. If you are not the intended recipient you are notified that disclosing, copying, distributing or taking any action in reliance on the contents of this information is strictly prohibited.***
- Do not utilize group mailing or other distribution lists.
- Any unnecessary information should be removed from the email to ensure that the minimum necessary information is disclosed.
- Store incoming and outgoing messages in a manner consistent with their privileged or statutorily protected nature and segregated from non-privileged or non-statutorily protected material.

Fax Policy

At times, Speech Language Therapy Services, LLC utilizes facsimile to transmit patient related communications. There is some risk that PHI contained in a fax may be disclosed to, or intercepted by, unauthorized third parties. We will use the minimum necessary amount of PHI to respond to queries and will make every effort to keep patient PHI secure.

Speech Language Therapy Services, LLC sends and receives faxes electronically through a HIPAA compliant fax server. When a fax is received electronically through a computer system, it will be password protected. Senders will be notified of any discrepancies.

Voicemail, email, text and fax should not be used for emergency situations. In the event of an emergency, you should contact 911 or visit your nearest emergency department

By signing below, I acknowledge that I have read, understand and agree to the terms of the Communications Policy.

Signature *(REQUIRED)* Printed Name *(REQUIRED)* Date *(REQUIRED)*

Attendance Policy

Speech Language Therapy Services LLC

1. The date and time agreed upon is a standing appointment for your child's weekly speech therapy services and regular attendance is **required**.
2. Unless unavoidable, families are encouraged to prioritize therapy appointments when scheduling other obligations to support consistent attendance.
3. Providers must be given at least **24 hours' notice** of cancellation so that they have adequate time to make adjustments to their schedules, unless circumstances, such as a family emergency or onset of illness, prevent you from doing so.
4. Attendance rate is calculated based on scheduled therapy sessions within a **rolling sixty (60) day period**, including completed visits and excluding provider-canceled sessions. If your child's attendance rate drops below **75%** the provider will discuss with you the circumstances surrounding the attendance issues and attempt to come to an agreed upon probationary intervention plan to establish concrete goals for improved attendance over a **sixty (60) day period**. After the **sixty (60) day** probationary intervention period has concluded the provider will reassess the attendance rates. If it is determined that the goals for improved attendance have not been met, then a determination will be made regarding suspension or termination of services. Any decision regarding suspension or termination of services will include consideration of clinical needs and referral options to ensure continuity of care.
5. Failure to contact the provider within the required time window (24 hours in advance), or not showing up for an appointment, will result in a **$50 fee**, due prior to your child's next visit. This fee is not billable to insurance and is a standard administrative fee for reserved clinical time. If payment or payment arrangements for the fee(s) has not been made prior to the following visit, the session will be canceled.

Our office always holds a sizable waitlist, so this courtesy makes it possible for us to meet the growing need for services in our community as well as best serve our current clients.

By signing below, I acknowledge that I have read, understood, and agree to the terms of this Attendance Policy and understand that failure to comply with attendance and cancellation requirements may result in financial charges, service suspension, or termination of services as outlined in the practice's Financial Agreement.

Printed Name *(REQUIRED)*: _____

Signature *(REQUIRED)*: _____

Date *(REQUIRED)*: _____

Speech Language Therapy Services, LLC
3501 Denali St. Suite 101
Anchorage, AK 99503

SPEECH LANGUAGE THERAPY SERVICES

Immunization and Vaccination Policy

Speech Language Therapy Services, LLC

Speech Language Therapy Services, LLC maintains an immunization and vaccination policy to support a safe clinical environment for patients, families, and staff, in alignment with applicable state public health guidance and recommendations from the Centers for Disease Control and Prevention (CDC) and local health authorities. Our patients and their families may have sensitive medical conditions or be immuno-compromised and this policy ensures their safety. We have chosen to adopt a policy in accordance with The State of Alaska Child-Care and School Immunization Requirements (**4 AAC 06.055. Immunizations required**) which requires all children attending a state public school district or non-public school offering pre-elementary education to be immunized against:

- diphtheria, tetanus, polio, pertussis, measles, mumps, hepatitis A, hepatitis B, and rubella, except rubella is not required in children 12 years of age or older; and
- beginning July 1, 2009, varicella.

This policy is intended to guide service delivery procedures and documentation requirements and is not intended to restrict access to medically necessary therapy services.

Immunization Requirements and Documentation

Where applicable, immunization records may be requested as part of patient intake or ongoing clinical documentation. Records are typically provided by the referring physician; however, if not available, the clinic may request documentation directly from the primary care provider or ask the parent/guardian to provide records.

Acceptable documentation may include:

- Immunization records from a licensed healthcare provider
- Official state immunization registry records
- Written documentation from a licensed medical provider

Exemptions and Special Circumstances

The clinic recognizes that some patients may not meet standard immunization schedules due to medical or situational factors.

The following may be accepted when appropriately documented:

- **Medical exemption:** Documentation from a licensed healthcare provider (MD, DO, PA, or APRN) stating that immunization is medically contraindicated
- **Religious exemption:** Where permitted under applicable state law and properly documented
- **Temporary or transitional status:** Including situations such as recent relocation, foster care placement, or other verified transitional circumstances, as applicable under state or federal guidance

The clinic may request updated documentation as clinically appropriate.

Impact on Service Delivery

Speech Language Therapy Services, LLC, does not deny medically necessary therapy services based solely on immunization status.

However, in situations where immunization documentation is incomplete or unavailable, the clinic may adjust the mode or setting of service delivery to support health and safety considerations and continuity of care.

Possible service modifications may include:

- Transition to teletherapy services when clinically appropriate
- Temporary modification of in-person scheduling or location
- Additional health and safety precautions for in-person visits

All decisions regarding service delivery are made based on clinical judgment, applicable public health guidance, and individual patient circumstances.

Continuity of Care

The clinic is committed to supporting uninterrupted access to clinically necessary therapy services. When adjustments to service delivery are required, efforts will be made to ensure continuity of care through appropriate alternative service options whenever feasible.

COVID-19 Vaccination Policy

COVID-19 vaccination is not required to receive services at Speech Language Therapy Services, LLC.

This policy may be updated in response to changes in guidance from public health authorities, including the CDC and FDA.

Compliance and Documentation Review

Immunization documentation, when applicable, may be reviewed at intake or during ongoing care as part of standard administrative and clinical record-keeping procedures.

If submitted documentation is found to be incomplete or inconsistent, the clinic may request clarification or updated records. Any concerns regarding documentation accuracy will be reviewed on a case-by-case basis in accordance with clinic policies and applicable law.

Acknowledgement

By signing below, I acknowledge that I have read and understand this Immunization and Vaccination Policy.

I understand that failure to provide required documentation, when applicable, may result in modifications to service delivery, including transition to alternative service formats, in accordance with clinical judgment and clinic policy.

Printed Name *(REQUIRED)*: _____ Date *(REQUIRED)*: _____

Signature *(REQUIRED)*:
_____

SPEECH LANGUAGE THERAPY SERVICES

Release of Information Authorization Form

Patient Name *(REQUIRED)*:	**SSN:**
AKA Name(s):	**DOB** *(REQUIRED)*:

People and entities I authorize to RECEIVE my personal health information (PHI)

Name of person(s) or entity(s) *(REQUIRED)*:	Contact Information (address, phone, email) *(REQUIRED)*:

Please list medical practitioner(s), spouse, caregiver(s), guardian(s), etc. you are authorizing to receive your PHI from our practice

People and entities I authorize to RELEASE my personal health information (PHI)

Name of person(s) or entity(s) *(REQUIRED)*:	Contact Information (address, phone, email) *(REQUIRED)*:

Please list medical practitioners, educational institutions, hospitals etc. you are authorizing your PHI to be released to our practice.

The purpose for this Release of Information Authorization:

I hereby authorize the use or disclosure of my health care and/or other information within my patient record to the entities stated above and that my records may contain sensitive information. I understand that this authorization is voluntary and that I may revoke this authorization at any time by signing the revocation section at the bottom of this form, or by notifying Speech Language Therapy Services, LLC in writing. I acknowledge that revoking this authorization will not affect actions taken on this authorization prior to the date the revocation was received. I understand that Speech Language Therapy Services, LLC, will not condition my treatment, payment, or eligibility for services based on whether I provide this authorization.

I understand that if the person(s) or entities I authorize to receive my protected health information are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipients of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

SPEECH LANGUAGE THERAPY SERVICES

THIS RELEASE OF INFORMATION EXPIRES (1) ONE YEAR AFTER SIGNATURE DATE

Signature of Patient or Personal Representative *(REQUIRED)*: **(Or witness if signature is by mark)**	**Date** *(REQUIRED)*:
Printed name of Patient or Personal Representative *(REQUIRED)*:	

COMPLETE ONLY WHEN REVOKED

This authorization was revoked on: _____ (date)

Signature of Patient or Personal Representative:

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

Provider Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can gain access to this information. Please review it carefully.

Key Issues

Uses and Disclosures: Health information pertaining to you is utilized for the provision of treatment, to secure payment for such treatment, for administrative operations, and for the evaluation of the quality of care received. Continuity of care constitutes an element of treatment, and your records may be shared with other healthcare providers to whom you are referred. Information may be disseminated via physical mail, electronic mail, facsimile and other media. We may use electronic communication, including telehealth platforms, email, and text messaging, to provide services and communicate with you. While we take reasonable safeguards, electronic communication may carry privacy risks. Identifiable health information concerning you may be used or disclosed without your explicit authorization under specific, defined circumstances. Outside of these specified circumstances, your written authorization will be requested prior to the use or disclosure of any of your identifiable health information. We shall never use or disclose your information for marketing purposes or sell your information without your express written authorization. We restrict the uses and disclosures of your information to the minimum necessary required to achieve the intended purpose.

Our Responsibilities: We are legally obligated to safeguard the confidentiality of your information, furnish this notice detailing our information utilization and disclosure procedures, adhere to the practices outlined this Notice, and obtain acknowledgment of receipt of this notice. We will notify you promptly if a breach occurs involving your unsecured protected health information. Should any modifications be made to these policies, a revised notice will be posted within our clinic. Furthermore, you may request a copy of this notice at any time. For further inquiries concerning our privacy practices, please contact us at the address and phone number provided below:

Privacy Officer: Nancy Lovering, CCC-SLP (Owner)

Practice Name: Speech Language Therapy Services, LLC

Address: 4325 Laurel Street, Suite 103, Anchorage, AK 99508

Email: nancy@speechalaska.com

Phone: (907) 569-5666

SPEECH LANGUAGE THERAPY SERVICES

Complaints: If you believe your privacy rights have been violated, or if you object to a decision regarding access to your records, you may contact us using the address and phone number provided above. Additionally, you retain the right to file a formal complaint with the U.S. Department of Health and Human Services via their website, https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf. You will not be penalized or retaliated against for filing a complaint.

1. **Further Details**
    a. **Uses and Disclosures of Protected Health Information:** Following are examples of the types of uses and disclosures of your protected health care information that the provider is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be possible:
        i. **Treatment:** We will utilize and disclose your protected health information for the purpose of providing and coordinating your health care and all associated services. For instance, your protected health information may be conveyed to a consulting physician

to ensure they possess the requisite data for diagnosis or treatment. Specific categories of information, such as behavioral or mental health data, may be afforded supplementary safeguards under pertinent legislation.

ii. **Payment:** Protected health information shall be utilized as requisite for activities pertinent to securing remuneration for healthcare services rendered. For instance, obtaining authorization for treatment may necessitate the disclosure of relevant protected health information to the patient's health insurance provider.

iii. **Healthcare Operations:** Protected health information may be utilized or disclosed as necessary to facilitate the administration of the practice and ensure the provision of high-quality care to all patients. Examples include, but are not limited to, quality improvement reviews, licensing or credentialing activities, compliance audits, and training programs for healthcare students undergoing supervised instruction.

iv. **Business Associates:** We may disclose your protected health information to third-party 'business associates' who perform various activities on our behalf (e.g., billing and transcription services). Any such arrangement with a business associate that necessitates the use or disclosure of your protected health information will be governed by a written contract containing provisions designed to safeguard the privacy of your protected health information. Business associates are required to implement appropriate safeguards to protect your information in accordance with HIPAA.

v. **Other:** We may utilize or disclose certain health information to furnish you with data concerning treatment alternatives, health-related services, or to issue appointment reminders. You may contact us to formally request that these materials not be transmitted to you.

b. Written Authorization

i. Other uses and disclosures of your protected health information shall be made only with your written authorization, unless otherwise permitted or required by law as described in this Notice. You retain the right to revoke this authorization, at any time, in writing; however, any information released prior to the receipt of your revocation is subject to further disclosure by the receiving party.

c. Opportunity to Object

i. We may utilize and disclose your protected health information in the following circumstances. You retain the right to object. Should you be absent or unable to register an objection, your provider may, utilizing professional judgment, ascertain whether the disclosure aligns with your best interests.

1. **Others Involved in Your Healthcare:** Unless you object, we may disclose health information that directly pertains to a member of your family, a relative, a close friend, or another person you have identified regarding that person's involvement in your healthcare.

d. Without Opportunity to Object

i. We may use or disclose your protected health information in the following situations without your authorization or opportunity to object:

1. **Public Safety and Health:** We may share your information when necessary to protect public health or safety, including:
    a. Reporting certain diseases or health conditions to public health authorities.
    b. Preventing or controlling the spread of disease.
    c. Reporting suspected child abuse, neglect, or domestic violence when required by law.
2. **Legal and Law Enforcement Purposes:** We may disclose your information when required or permitted by law, including:
    a. Court orders, subpoenas, or other legal proceedings
    b. Law enforcement requests related to investigations, victims of

crimes, or crime prevention
c. Compliance with federal or state legal requirements

3. **Government Oversight and Administrative Functions: We may share your information with government agencies or authorized entities for:**
    a. Health oversight activities such as audits, inspections, and investigations
    b. Workers' compensation claims processing
    c. Food and Drug Administration (FDA) reporting requirements
    d. Military and national security activities when required by law
    e. Correctional institutions when individuals are incarcerated
    f. Organ donation or coroner/medical examiner duties
    g. Research approved by an Institutional Review Board (IRB)

In general, we may use or disclose your protected health information as required by law and limited to the relevant requirements of the law. These disclosures are rare and only occur when required or permitted by law to protect safety, comply with legal obligations, or support public health.

2. Your Rights:

a. The following is a statement outlining your rights concerning your protected health information, along with a brief description of the procedure for exercising these rights:

i. **Your Right to Inspect and Copy Protected Health Information.** You are entitled to inspect and receive a copy of your protected health information. This request may include an electronic format if your records are maintained electronically. However, access to certain information may be denied if such restriction is mandated by law or is necessary for a civil or criminal proceeding. Furthermore, you possess the right to request that we transmit your records directly to an individual or organization you designate on the signed authorization for release of information form. We shall respond to your request within 15 to 30 days, as required by law. Should you request paper copies, you will only be assessed standard reproduction fees. You may request an accounting of disclosures of your PHI, including electronic disclosures, and excluding disclosures for treatment, payment, and healthcare operations. If you believe any information within your record is inaccurate, you have the right to request an amendment of the data you deem erroneous.

ii. **Right to Request Restriction of Protected Health Information.** You possess the right to request a restriction on the use or disclosure of your protected health information. You may request that we refrain from utilizing or disclosing specific portions of your protected health information for the purposes of treatment, payment, or healthcare operations. Furthermore, you may request that information not be disclosed to family members or friends who are involved in your care. Your request must explicitly state the specific restriction sought and the individuals to whom you wish the restriction to apply. We are not obligated to honor every restriction you request; however, if a restriction is agreed upon, we are then bound to comply with its terms.

iii. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** You possess the right to formally request the receipt of confidential communications from us via alternative means or at a specified alternative location. We shall accommodate all such reasonable requests. We reserve the right to condition this accommodation by requesting information regarding the method of payment or the specification of an alternative address or other contact method.

We will not solicit an explanation from you concerning the basis for this request.

iv. **Right to Request Amendment of Protected Health Information.** You may submit a request to your provider to amend your protected health information. Should we deny your request for amendment, you retain the right to file a statement of disagreement with us, and your medical record will reflect the existence of the disputed information.

v. **You possess the right to obtain an accounting of certain disclosures that we may have made.** This right is applicable to disclosures for purposes other than treatment, payment, or healthcare operations. It does not include disclosures made to you, family members, or friends involved in your care, or for notification purposes. You are entitled to receive specific information regarding these disclosures. The right to receive this information is subject to certain stipulated exceptions, restrictions, and limitations.

vi. **You possess the right to obtain a paper copy of this notice.** A paper copy will be provided upon request, irrespective of any prior agreement to receive the notice electronically.

Effective date: 08/11/2026
End of Notice of Privacy Practices