THERA-play PEDIATRICS

Your Child's Evaluation Packet

Instructions:

Complete and return this packet prior to your child's evaluation.

If applicable, also submit:

- A copy of recent hearing/vision test results,
- A copy of his/her IEP or 504,
- A copy of previous therapy evaluations,
- Any additional information your therapist may request.

Packet Content:

Part 1: Face Sheet

Part 2: Case History

Part 3: HIPAA Authorization

Part 4a and 4b: Authorizations, Acknowledgements, Agreements

NOTE: Thera-Play requests this information for the sole purpose of completing your child's evaluation. Completion of this case history is required prior to your scheduled evaluation.
Failure to provide the information will result in an incomplete examination or cancellation of the assessment.

THERA-play PEDIATRICS

Part 1: Face Sheet

Child's Name: _____ Date of Birth: _____

Today's Date: _____Reevaluation Date: _____

Parent/Guardians Names: _____

Contact Information:

Father's email(s):_____Mother's email(s):_____

Address: _____

City: _____ State: _____Zip Code: _____

Home Phone Number: _____

Father's Cell: _____Mother's Cell:_____

Father's Employer: _____

Work Number: _____

Mother's Employer: _____Work Number:_____

Emergency Contacts:

Emergency Contact (1):_____ Phone: _____

Emergency Contact (2):_____Phone:_____

Physician:

Primary Care Physician:_____Clinic:_____

Primary Care Physician Phone Number: _____

Diagnosis:

My Child's Primary Diagnosis: _____

My Child's Secondary Diagnosis: _____

Who diagnosed your child? _____ Date of diagnosis: _____

Primary Insurance:

Insurance Policy Name: _____ Policy Number: _____

Group Number: _____Insured's Name: _____

Insured's DOB: _____Insured's Place of Employment: _____

Insurance Phone #:_____Contact Person: _____

Claims Address:_____

City: _____State:_____Zip:_____

Secondary Insurance:

Insurance Policy Name: _____ Policy Number: _____

Group Number: _____Insured's Name: _____

Insured's DOB: _____Insured's Place of Employment: _____

Insurance Phone #:_____Contact Person: _____

Claims Address:_____

City: _____State:_____Zip:_____

State Funding Sources:

Medicaid Number: _____Effective Date: _____

TEFRA Number:_____Effective Date:_____

AR Kids A Number:_____Effective Date:_____

AR Kids B Number:_____Effective Date:_____

Part 2: Case History

Child's Name:_____ Date of birth:_____

Gender:_____

Child's Address:_____

A. Would like the results of your child's evaluation to be sent to anyone other than

yourself? _____Yes/No

If "yes," to whom would you like the re-evaluations sent (include contact information)?

_____

_____

_____

B. Has your child had his/her hearing and vision tested?_____ Yes/No

If yes, where, when, and what were the
results_____

_____

_____

C. What services are you requesting? (check all that apply)

- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Physical Therapy

D. Has your child participated in Occupational, Physical, Speech in the past?_____ Yes/No

If "**yes**," which therapies, where were they received, and what was the frequency?

E. Therapy Precautions

Questions	YES	NO	Comments
1. Does your child have any food allergies?			Please list allergies:
2. If your child has Down Syndrome, has he/she been diagnosed with Atlantoaxial instability?			
3. Are there any precautions not listed above that we should know about? (latex allergies, dietary restrictions, food allergies, etc….)			Describe:

F. Family & Social History

Father's Name: _____Age:_____ Occupation:_____

Mother's Name: _____Age:_____

Occupation: _____

Is the client adopted? _____Yes/ No

If yes, at what age and from where/what country was he/she adopted?

_____

Who lives in the house with this child, other than the parents? Please list the names and ages of children.

_____

Have there been any instances of the following in your immediate or extended family members:

☐ ADHD ☐ Hearing Loss

☐ Stuttering ☐ Learning Disabilities

☐ Autism/PDD ☐ Communication Disorders

Are there currently any stressful situations in the home or family? _____

Is there any history of abuse? _____

G. Pregnancy and Birth History

Questions	Yes	No	Comments
1. Were there any illnesses, bleeding, or other complications during this pregnancy?			Describe:
2. Was this pregnancy full term?			If no, what was your child's gestational age and weight at time of delivery?
3. Was labor and delivery normal? 3a. Birth Weight_____ 3b. Was delivery vaginal or cesarean? _____			
4. Did the child feel stuck in one position?			
5. Were forceps or a vacuum extractor used?			
6. Did your child experience jaundice?			
7. Was there a need for oxygen or respiratory assistance?			Describe:
8. Were there difficulties feeding?			Describe:
9. Was your child breastfed (or currently breast feeding)?			If "yes" how long? Any breastfeeding problems related to the baby's difficulty turning their head to nurse?
10. Did your child have sucking difficulties?			Describe:
11. Does this child have biological siblings?			How many siblings? _____ Which pregnancy was this child? _____
12. Are there issues with sleep problems?			Describe:

H. Has your child had any of the illnesses, conditions and / or medical conditions below:

ILLNESS/ CONDITION	YES	NO	COMMENTS
1. Meningitis			
2. Chicken Pox			
3. Seizures			
4. Frequent Ear Infections			
5. P.E. Tubes			
6. Excessive vomiting or Reflux			
7. Irritability/fussiness following feeding			
8. Swallowing difficulties (current or previous)			
9. Cleft Palate			
10. Vision Problems			
11. Adaptive equipment			

Please list current and past medications:

_____

_____

_____

Please describe any medical condition not mentioned above (accidents, injuries, surgeries, etc.)

_____

_____

_____

Please provide the dates and descriptions of surgical procedures (if any)

Date: _____ Surgery: _____ Description: _____

Date: _____ Surgery: _____ Description: _____

Date: _____ Surgery: _____ Description: _____

I. At what age did your child achieve the skills below?

Developmental Skills	Age Achieved	Not yet Achieved	Comment
1. Roll from stomach to back			
2. Roll from back to stomach			
3. Crawl			
4. Cruise around furniture			
5. Walk independently			
6. Speak first words			
7. Speak two word sentences			
8. Drink from a cup			
9. Use a spoon			
10. Dress independently			
11. Sit independently			
12. Toilet trained			
13. Toilet trained through the night			

J. Can your child display any of the physical skills below?

Skill	yes	no	N/A	Comments
1. Jump up and down				
2. Hop on one foot				
3. Climb/descend stairs using alternate feet				
4. Skip				
5. Catch a ball				
6. Kick a ball				

K. Describe your child's behavior below.

Questions	YES	NO	N/A	Comments
1. My child is overly active				
2. My child is mostly quiet				
3. My child talks constantly				
4. My child is impulsive				
5. My child is restless				
6. My child is stubborn				
7. My child is resistant to change				
8. My child overreacts				
9. My child fights frequently				
10. My child is usually happy				
11. My child has frequent temper tantrums				
12. My child is clumsy				
13. My child has difficulty separating from caregiver				
14. My child has nervous habits or tics				
15. My child has a poor attention span				
16. My child is frustrated easily				
17. My child has fears				If "yes" please describe
18. My child rocks himself/herself frequently				
19. My child shows difficulty learning new tasks				
20. My child avoids touch				

21. My child craves touch. He/she seeks it out				
22. My child is shy				
23. My child is typically compliant				
24. My child tires easily				
25. My child is easily managed at home				Who manages your child best?
26. My child empathizes with others feelings easily				
27. My child understands punishment and easily shows remorse				
28. My child understands praise and rewards				
29. My child recognizes danger				
30. My child shows concern when separating from parents				
31. My child is affectionate toward familiar adults				
32. My child is affectionate towards strangers				
33. My child has friends				

L. Describe your child's communication below.

Communication Skill	YES	NO	N/A	Comments
1. My child understands simple direction				
2. My child can identify body parts				
3. My child recognizes pictures and objects				
4. My child turns his/her head when his/her name is called				
5. My child communicates with intent				
6. My child answers "wh" questions				
Communication Skills	**YES**	**NO**	**N/A**	**Comments**
7. My child has hearing loss				
8. My child hears and/or uses another language other than English at home				If "yes" which language(s)?

How does your child communicate at home (PECs, augmentative/alternative communication device, American sign- language, gestures, verbal)?

_____

_____

_____

How many words are in your child's speaking vocabulary? _____under 25 _____25 – 75 _____over 75
How many words can your child understand? _____under 25 _____ 25 – 75 _____ over 75

Please describe any communication difficulties/concerns.

_____

_____

When did you first observe any problems (if present)? _____

M. Describe your child's educational background below.

Educational Background	YES	NO	N/A	Comments
1. Does your child attend school/preschool/childcare?				If "Yes," what school/center does your child attend?
2. Does your child receive special education or therapies in his/her school or center?				If "Yes," what is the frequency of OT, ST & PT sessions? How long are the sessions? Are they group or individual sessions?
3. May we communicate with your child's school or center staff?				
4. Has your child ever repeated a grade?				If "Yes," which one?

What grade or age level setting is your child in right now?

_____

What is his/her current teacher's name(s)?

_____

_____

If applicable, what are his/her therapists' name(s)?

_____

_____

N. How concerned are you with the following?

Read the questions and check the appropriate box	Extremely Concerned	Very Concerned	Moderately concerned	Mildly Concerned	Not Concerned
1. Your child's fine motor movement (movement with hands, etc)?					
2. Your child's gross motor movement (full body movement)?					

3. Your child's speech and language development?					
4. Your child's sensory behaviors?					
5. Your child's social behaviors?					
6. Your child's mobility?					
7. Your child's feeding?					
8. Your child's progress at school?					

Please describe any additional concerns or comments you may have that were not discussed in the information above.

Part 3: HIPAA Authorization

This authorization will expire one year from the date signed unless an earlier date is provided here:_____

Child Name: _____DOB: _____

I hereby authorize Thera-Play Pediatrics to release or obtain my individually identifiable information,

Including; contact information, pictures of my child, information about physical health and/or mental

health, physical or mental condition, healthcare or other services, and payment for services.

I understand that:

- I am entitled to a copy of this form.
- A copy of this permission form is as valid as the original.
- I may revoke this authorization at any time by notifying Thera-Play Pediatrics in writing. This will not affect any action Thera-Play Pediatrics took in reliance on this authorization before it was revoked.
- If I refuse to authorize disclosure of my child's unrelated healthcare information, then Thera-Play Pediatrics will not deny services.
- Once information is released to a third party according to this authorization, Thera-Play Pediatrics cannot prevent its re-disclosure.
- This authorization does not limit the ability of Thera-Play Pediatrics to use or disclose my child's health information as otherwise permitted by the state and federal law.
- Disclosed information may be oral or written.

Print Parent/Legal Guardian's Name: _____

Describe Relationship to Patient: _____

Parent/Legal Guardian's Signature: _____ Date: _____

RELEASE:

Disclosure to: _____

Disclosure from: _____

Date: _____

Type of information:

_____

_____

Part 4a: Authorizations, Acknowledgements, Agreements

Child's Name: _____ **Date of Birth:**_____

1. Authorization for Evaluation and Treatment

I, authorize physical (including orthotics), speech, and/or occupational evaluations(s) and treatment for the above said child as ordered by my child's physician.

_____ _____

Signature **Date**

2. Authorization for Release of Medical Information

I, the legal parent/guardian of the above said child, do hereby give my permission to Thera-Play Pediatrics to use my child's medical records for any purpose deemed necessary.

_____ _____

Signature **Date**

3. Authorization to Photograph/Video for Promotional and/or Instructional Use

I, the legal parent/guardian of the above said child, give Thera-play Pediatircs the right and privilege to photograph/video my child for the use of developing and publicly releasing promotional information or for educational and instructional purposes. I understand that my child's image may be viewed in the form of magazines, journals, medical journals, books, posters, television, instructional posters, commercials and/or internet web pages.

_____ _____

Signature **Date**

4. Payment Authorization and Financial Agreement

I authorize payment of medical benefits to be made directly to Thera-Play Pediatrics for services rendered. I agree to either fully pay or set up a payment plan and begin payment for all charges within 30 days of the receipt of my child's patient statement. I agree to be fully responsible for charges, regardless of my insurance company's coverage or lack of coverage of charges.

_____ _____

Signature **Date**

5. Lifesaving Consent

If I, the legal parent/guardian, cannot be reached, I authorize the administration of "life saving" procedures such as x-rays, surgery, transportation, hospitalization, medication, and/or treatment procedure deemed necessary by a medical professional.

_____ _____

Signature **Date**

6. Transportation Consent

I authorize employees of Thera-Play Pediatrics to transport the said child to and from the treatment or rehab site to my home address or child's school.

_____ _____

Signature **Date**

8. Consent for Child Observation and Intern/Student Interaction

I, the legal parent/guardian of the above said child, understand that Thera-Play Pediatrics is a teaching facility. I give permission for my child to be observed through supervised observation undertaken as part of an academic internship, practicum, and/or observation requirement for students. Interns may be used in a support capacity or as administrative assistants. They may participate in partner activities with my child while his/her therapist is in direct supervision.

_____ _____

Signature **Date**

Part 4b: Authorization to Administer Medication

Directions: If you would like Thera-Play staff to administer any prescription OR over the counter Medications, while under the supervision of his/her therapist, please complete the form below.

Child's Name: _____ **Child's DOB:** _____

Today's Date: _____

#1) Name of Medication:

_____

Form of Medication/Treatment:

Tablet/Capsule Liquid Inhaler Injection Nebulizer Other

Instructions (schedule and dose to be given during therapy):

_____

_____

Is the medication for episodic/emergency events only? _____ Yes/No
Are there any restrictions and/or important side effects? _____ Yes/No
If "Yes," please describe:

_____

_____

#2) Name of Medication:

_____

Form of Medication/Treatment:

Tablet/Capsule Liquid Inhaler Injection Nebulizer Other

Instructions (schedule and dose to be given during therapy):

_____

_____

Is the medication for episodic/emergency events only? _____ Yes/No
Are there any restrictions and/or important side effects? _____ Yes/No
If "Yes" please describe:

_____

I give authorization for Thera-Play staff to administer the medications noted above.

Parent or Guardian Signature_____Date_____

THERA-play PEDIATRICS

702 N. Main St. Suite C
Harrison, AR 72601
870-204-5330
870-280-5630 fax

Dear Parent/Guardian:

After an evaluation gets completed from a Therapist a copy will be provided to you. Please choose one of the following options that is best for you:

Preference:

◯ E-Mail
E-mail address: _____

◯ Mail
Mailing Address: _____
_____
_____

There will be communication between the Staff at Thera-Play Pediatrics and the parent regarding your child. Of the following methods which method would you prefer? Please check all that apply:

☐ Voicemail
☐ Text Message
☐ Mail
☐ E-mail

I have agreed and read The Notice of Privacy Practice:

_____ _____
Signature Date

THERA-play PEDIATRICS

702 N. Main St. Suite C
Harrison, AR 72601
870-204-5330
870-280-5630 Fax

ALLERGIES

Today's Date: _____/_____/_____

Patient's name: _____ D/O/B: _____/_____/_____

Please list any and all foods or things that the patient is allergic to:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

THERA-play PEDIATRICS

Name_____ Date_____

Print Patients Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____

Signature of Parent/Guardian (circle one)

THERA-play PEDIATRICS

702 N. Main St.,
Suite C,
Harrison, AR 72601
870-204-5330
870-280-5630 FAX

ATTENDANCE POLICY

Dear Families,

Your child's success is our priority. It is our mission to ensure that all our patients have opportunities to meet their goals. We have made a commitment to your child, family, and your child's doctor to implement and follow their plan of care. We take our commitment very seriously, and in doing so, we must ensure that all the patients at Thera-play are receiving the greatest benefit of our services. We know that consistent structure and routine schedules are very important to all our patient's success at Thera-play. The following policy was developed to help your children thrive during his or her time at Thera-play.

Without exception, any patient holding a therapy spot will be limited to 3 unexcused absences within a 30-day rolling period. If 3 or more sessions are unexcused absences, your child will be reduced to 1 therapy session per week, per discipline. If attendance continues to be an issue after the first reduction of services, we must discharge your child from Thera-Play.

An unexcused absence includes: ALL No shows and no call appointments. If you are unable to provide a letter from your child's doctor, dentist, or Area Agency on Aging (if it is an error by transportation), it is considered an unexcused absence. If you utilize the Medicaid transport system, you are required to schedule trips a minimum of 48 hours in advance. Failure to do so will result in no transport and thus, an unexcused absence.

If your child will be late, make sure you let the office know. Our therapists are only required to wait for a patient for the first 15 minutes of a session; after that they may leave to address other business.

With your support and our commitment, we are confident that your child will have the highest level of success. Thank you for your trust in the professionals of Thera-Play Pediatrics.

I have read and understand the Thera-play Attendance Policy:

…….. ……

Signature Date

……..

THERA-play PEDIATRICS

702 N. Main St.
Suite C,
Harrison, AR 72601
870-204-5330
870-280-5630 FAX

Social Media/Marketing Release

As part of a thriving practice we like to celebrate the progress of our patients, more importantly your child and recognize their achievements from time to time.

Please sign consent slip to give us permission to publish your child's name, image or video in various media.

I.....parent/guardian for

.....(Insert child name)

grant permission for Thera-play Pediatrics to use and publish details from time to time including names event details and outcomes, photographs/images, audio, or video footage of myself or my child/ren for promotional purposes on the clinic and therapists social media sites such as Facebook, Instagram, and Twitter.

I understand that any details, images, video or audio taken may be seen in a public and or clinic environment.

I acknowledge Thera-Play Pediatrics is not obliged to include my child in any related promotional activities.

If you have any concerns at any time, please talk to your therapist.

....

Signature Date

.....

Thera-Play Pediatric Representative

THERA-play PEDIATRICS

702 N. Main St.
Suite C,
Harrison, AR 72601
870-204-5330
870-280-5630 FAX

CLINIC PRIVACY POLICY

Dear Families,

Your child's success is our priority. Keeping your child safe is key during many interactions' children have while they are at Thera-play Pediatrics. A key part of keeping all our patients safe, is protecting all our patient's healthcare information. In order to ensure we protect all our patient's healthcare information, we have developed the following guidelines to ensure security compliance.

1. Attending sessions in the treatment area with a child, should be arranged before the start of each new session. Let the treating Therapist know in advance if you would like to discuss sitting in or being a participant in a treatment session.
    a. Should you want to come back into the treatment area during the middle of a PT/OT/ST session, talk with our receptionist before coming back into the treatment area. The receptionist will then inform you of how to proceed once the treating Therapist has been alerted of your request.
2. If you are attending a session with a child your focus is to help facilitate that child's treatment with direction from your treating Therapist.
    a. Siblings will only be allowed in the treatment area under specific exceptions.
3. In order to keep health information secure for all of our patients, no information will be provided regarding care or diagnosis of any other patient's at Thera-play.
    a. It is imperative we protect our patient's medical information in all circumstances.

Thank you for your consistent understanding as we all work together to protect all our patient's medical information. With your support and our commitment, we are confident that your child will have the highest level of success in their treatments. Thank you for putting your trust in the professionals of Thera-Play Pediatrics. Should you have questions regarding this policy please ask to speak with our Quality Assurance Coordinator.

Sincerely,

Thera-Play Pediatrics
Leadership Team

THERA-play PEDIATRICS

Notice of Privacy Practice

Your Information. Your Rights. Our Responsibilities

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medial record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for services or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice

electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the next page (2)/ back page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting
- www.hhs.gov/ocr/privacy/hipaa/complaint.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our Organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government request

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized y law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not market or sell personal information.

We do not create or maintain psychotherapy notes at this practice.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breech occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you**

may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Medical Associates of Northwest Arkansas (MANA) Privacy Officer:

Paula Maxwell, Chief Operating Officer
3383 N. MANA Court, Suite 201
Fayetteville, Ar. 72703
Phone: (479) 571-6780
Email: privacyofficer@mana.md

Effective Date September 23, 2013