O: (321) 436 – 9792 F: (888) 719 - 7820

E: childrenwin@littlechampionstherapy.com

Little Champions Therapy and Services is honored to provide comprehensive physical, occupational, speech, Early Intervention, and personal care services specialized for your child. Our goal is to provide you with the highest quality care and customer service. We ask that you take a moment to fill out the following forms in order to enable our team to get a better understanding of your needs and goals as well as to establish your personal file. We strive to create a supportive and collaborate environment. Please let us know how we can make your experience most comfortable for you.

We look forward to working with you!

Sincerely,

Little Champions Therapy Staff

Privacy Notice

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountibility Act of 1996 (HIPAA)

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

Little Champions Therapy is dedicated to maintaining the privacy of individually identifiable health information as protected by law, including the Health Insurance Portability and Accountability Act (HIPAA). 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 protectedd health information or PHI. We are required by law to provide you with this notice of our legal duties and the privacy practises 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 this 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 disclose 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 most current Notice at any time.

B. 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 orgination 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. For example, 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 occured 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, and local law.

C. 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
- 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 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, subpeona, 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 may also 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 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 diclosure would otherwise be permitted; (ii) the research could not practicably be conducted withou 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 use and 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.

D. YOUR RIGHTS REGARDING YOUR PHI

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

1. Confidential Communication. 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 accommadate **reasonable** requests.

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 and 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 arrest) 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 Disclosure. All of our persons served have the right to request an "accounting of disclosure." An "accounting of disclosure" 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 disclosure" 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 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.

Little Champions Therapy and Services

* Required

1. **Email address** *

2. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY** *
(Initial box)

☐ I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

3. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS** *
(Initial box)

☐ I hereby authorize and direct payment of my medical benefits to LITTLE CHAMPIONS THERAPY on my behalf for any services furnished to me by the providers.

4. **AUTHORIZATION TO RELEASE RECORDS** *
(Initial box)

☐ I hereby authorize LITTLE CHAMPIONS THERAPY to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

5. **Notice of Privacy Practices (HIPAA Acknowledgement/Consent)** *
(Initial box)

☐ I hereby acknowledge thatI have received a copy of the Notice of Privacy Practices for LITTLE CHAMPIONS THERAPY AND SERVICES, LLC.

6. *
(Initial box)

☐ By entering your name below you agree to the above,

7. **Parent's Name:** *

8. **Child's Name:** *

9. **Child's DOB:** *

10. **Child's Insurance:** *

11. **Contact Phone:** *

12. **Address:** *

At Little Champions Therapy, the health and safety of our clients is top priority. We understand the concerns circling around the Coronavirus outbreak and want to do our part in assisting families who wish to continue services while remaining safe from coming in contact with this virus. We also understand that loss of services can have an adverse reaction on the progress your child has made throughout our face-to-face visits. With that being said, we are offering telehealth therapeutic services. This is an opportunity to continue services in an attempt to prevent loss of abilities your child has gained throughout the course of his/her sessions. This will be temporary at this time. Please consider this opportunity, sign the consent form, and call the office or your therapist should you have any questions or concerns. We look forward to continuing services with your child.

Little Champions Therapy and Services, LLC

10879 Lantana Crest

Clermont, FL 34711

Office 321-436-9792 Fax 888-719-7820

Informed Consent for Telemedicine Services

PATIENT NAME: _____ DATE OF BIRTH: _____

Teletherapy Agreement & Informed Consent

1. You understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations, and education using interactive audio, video, or data communications. You also understand that teletherapy/coaching also involves the communication of your medical/mental health information, both orally and visually.

2. Unless we explicitly agree otherwise, our teletherapy exchange is strictly confidential. Any information you choose to share with me will be held in the strictest confidence. Just like my face-to-face clients, I will not release your information to anyone without your prior approval unless I am required to do so by law.

3. You understand that our teletherapy services are furnished in the state of Florida, (USA), and the services I provide are governed by the laws of that state.

4. You have the right to withdraw or withhold consent from teletherapy services at any time. You also have the right to terminate treatment at any time.

5. You understand that there are risks and consequences with teletherapy services including, but not limited to, the possibility, despite reasonable efforts on my part, that: the transmission of your medical information could be disrupted or distorted by technical failures, the transmission of your information could be intercepted by unauthorized persons, and/or the electronic storage of your medical information could be accessed by unauthorized persons.

6. In addition, you understand that teletherapy based services and care may not be as complete as traditional face-to-face services. While teletherapy is a great way to get the services you need, it may not be as beneficial as face-to-face or hands-on therapy. You understand that teletherapy is neither a universal substitute, nor the same as face-to-face therapy. Finally, you understand that there are potential risks and benefits associated with any form of therapy, and that despite my efforts or the efforts of any such provider, your condition may not improve, and in some cases may even get worse.

7. You understand that you may benefit from teletherapy, but that results cannot be guaranteed or assured.

8. You will be responsible for the following: (1) providing the computer and/or necessary telecommunications equipment and internet access for your teletherapy sessions, (2) arranging a location with enough lighting and privacy that is free from distractions or intrusions for your teletherapy sessions.

9. You understand that while email may be used as a form of communication with me, that confidentiality of emails cannot be guaranteed due to complexities and abnormalities involved with the Internet, including, but not limited to, viruses, Trojans, worms, and other involuntary intrusions that can obtain and disseminate information you wish to keep private.

10. You have the right to access your medical information and copies of your medical records in accordance with HIPAA privacy rules and applicable state law.

11. If you reside out of your e-therapist's state of professional licensure, you understand and agree that you are soliciting the services of a professional outside of your state of residence. By doing this, you agree that the "point-of-service" of therapy is to occur in the therapist's state of professional licensure, and that you are using your computer/telecommunications device to virtually travel to that state. Hence, therapists are accountable to and agree to abide by the ethical and legal guidelines prescribed by their state of professional licensure. By agreeing to solicit the out-of-state therapist's services, you agree to these terms.

I have read and understand the information provided above. I have discussed it with my therapist, and all my questions have been answered to my satisfaction.

Signature of client (or parent/guardian/another authorized signatory) is required below:

Signature: _____

Date: _____