

CAPITAL CITY THERAPY GROUP, LLC
NOTICE OF PRIVACY PRACTICES

This notice describes how medical/ protected health information about you may be used and disclosed and how you can get access to this information. Please read carefully.

Summary: By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed to us. It also tells you how you can obtain access to this information.

I understand that as part of my healthcare, this organization originates and maintains health records describing my child's health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my child's care and treatment
- a means of communication among health professionals who contribute to my child's care
- a source of information for applying my child's diagnosis information to my bill
- a means by which a third-party payer can verify that services billed were actually provided **As a patient with Capital City Therapy Group you have the following rights:**

1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to request confidential communications
5. The right to a report of disclosures of your information
6. The right to terminate therapy services
7. The right to a paper copy of this notice if you so desire

We want to assure you that your medical and protected health information is secure with us. This Notice contains information about how we will insure your information remains private.

Capital City Therapy Group, LLC will maintain a professional relationship with the client. Capital City Therapy Group, LLC will maintain all records in a confidential manner and will not release information without written consent; unless the client is a danger to self or others, child abuse, court order and diagnosis for insurance billing.

If you have any questions about this notice, you may contact the persons listed on this contract.

Effective Date of Notice: _____

Contact Person: Christine Speegle or Robin Vance Ray

Phone Number: 803- 479-1758

Acknowledgement of Notice of Privacy Practices

"This acknowledges that I have received a copy of this practice's Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer the updates to this Notice of Privacy Practice should it be amended, modified or changed in any way."

"I authorize Capital City Therapy Group to use and or disclose my protected health information to physician's payers of health care services and other health care providers to help provide appropriate treatment for my child."

Patient or Representative Name (PRINT)

Patient or Representative Signature

Date

