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## Acknowledgement of Receipt of Notice of Privacy Practices

*Growing Steps Physical Therapy LLC*

By signing below, I agree that I have received or been offered a copy of the attached Notice of Privacy Practices, which describes how Growing Steps Physical Therapy LLC (GSPT) will use and disclose my protected health information (PHI), patient rights to access and control such information, and GSPT's legal responsibilities.

-----  
Signature

Date

Circle: Patient

Parent

Legal Guardian

Other Relation:-----

-----  
Printed Name

### FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

---- Individual refused to sign.

---- Communication barriers prohibited obtaining the acknowledgement.

---- In emergency situation prevented us from obtaining acknowledgement.

---- Other (Please Specify): -----  
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## **Notice of Privacy Practices**

### ***Growing Steps Physical Therapy LLC***

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The law requires healthcare providers to disclose how they use and disclose your protected health information, patient rights to access and control such information, and our legal responsibilities. You should review it carefully.

Under HIPAA, protected health information (PHI) is any patient information that may identify you and that relates to your past, present or future physical condition and related health care services, or payment for health care services. PHI includes information about your symptoms, test results, diagnosis, treatment, and related medical information. PHI also includes payment, billing and insurance information.

### **How We May Use and Disclose Your Protected Health Information**

**Treatment:** We will use and disclose your PHI to provide you with treatment, services, case management, and coordination of your care. We may disclose your PHI to medical and other health care service providers who are involved in your treatment. For example we may share your PHI with a physician, a pharmacist, or orthotist to facilitate your plan of care. Unless you object, we may share your PHI with family members or other persons directly identified by you who participate in your care or payment of services.

**Payment:** We may use and disclose your PHI as necessary with third parties such as insurance companies / health plans, government agencies, or billing / collection firms, to facilitate payment. For example, an insurance company may need your PHI to facilitate payment of a claim. In cases where services are paid out of pocket, we would not share any PHI except as you may direct to facilitate reimbursement.

**Operations:** We may use and disclose your PHI to perform various routine business functions, for example: quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice. We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your



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health or for other reasons. We may share your PHI with business associates who assist us in performing routine operational functions. We are committed to protecting PHI and will endeavor to make sure others are safeguarding PHI as we do.

### **How else can we use or disclose your health information?**

Under some circumstances we may be asked and/or required to use or disclose your PHI without your consent. Examples of such circumstances include:

- Threats of imminent harm.
- Suspected abuse or neglect.
- Public health or safety.
- Comply with law or regulation.
- Legal proceedings and court orders.
- Health research.

In each of these cases, legal conditions must be met before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. Any authorization you sign, you can later revoke. If you revoke an authorization, it will not affect any action taken or any information released by us prior to receiving and processing your request to revoke the authorization. Please make these requests in writing.

In considering the use and disclosure of PHI, consistent with HIPAA, we endeavor to adhere to the principle of minimum necessary use and disclosure of your PHI.

### **Patient Rights**

Under HIPAA, patients have certain rights with respect to their PHI. Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.



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**Right to Confidential Communications:** You have the right to request that we communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may request that we communicate only by a certain phone number or not by email. Our practice will accommodate reasonable requests. You do not need to give a reason for your request. We solicit your preferences on our Communications Preference and Consent Form before treatment begins. At any time, you may update your preferences by resubmitting the form or notifying us in writing.

**Right to Request Restrictions on Sharing of PHI:** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. For example, you may request to have your records withheld from your insurance carrier if you pay for your treatment completely out-of-pocket at the time of service. 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 and friends. We are not required to agree with your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing and clearly state (i) the information you wish restricted; (ii) whether you are requesting to limit our use, disclosure or both; and (iii) and to whom you want the restrictions to apply. You may revoke a restriction at any time in writing. We may also terminate our agreement to restriction and would contact you if this situation should occur. Subject to relevant law or other obligations, we will make a good faith effort to adhere to such requests.

**Right to Inspect and Copy Your Medical Record.** You have the right to request to inspect and obtain a copy of the PHI, including your patient medical record and billing records. Please make such requests in writing. We may charge a reasonable fee for the costs of copying, mailing, labor and supplies associated with your request. Subject to certain exclusions described in HIPAA we will provide requested information as soon as possible and no later than 30 days following a written request.

**Right to Correct Your Medical Record.** You may ask 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 practice. Please make such a request in writing. 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 practice; (c) not part of



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the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information. In most cases, we will act upon your request within 60 days. If we deny your request to amend, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please make this request in writing.

**Right to Receive an Accounting of Disclosures.** You may request in writing to receive a list (accounting) of who we have shared your PHI during the previous six years. This right applies to disclosures we have made for purposes not related to treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, to a personal representative, or to disclosures you have specifically authorized. You may also specify a time frame less than six years. The first list you request within a 12-month period is free of charge, but our practice may charge a reasonable fee if you request an additional one within 12 months.

**Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our Notice of Privacy Practices upon request. Our current Notice of Privacy Practices is available on our website: [www.GrowingStepsPT.com](http://www.GrowingStepsPT.com).

**Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint. To file a complaint with our practice, contact us using the information below. All complaints must be submitted in writing. You will not be penalized for filing a complaint. Alternately, you may 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/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).

You may send your written requests and questions to: Karen Trackman at [Karen@GrowingStepsPT.com](mailto:Karen@GrowingStepsPT.com). For mailing instructions please contact us at 202.262.9163.



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## **Our Legal Responsibilities**

We are committed to protecting health information about you. In the course of conducting our medical practice business, we will create records regarding you and the treatment and services we provide to you. Your health record is the physical property of the healthcare practitioner or facility that compiled it, but the content is about you and therefore belongs to you.

- We are required by law to maintain the privacy and security of your protected health information.
- We are required by law to provide you this Notice of Privacy Practices, and to follow the terms of our current Notice of Privacy Practices, as it may be updated from time to time. Our current Notice of Privacy Practices is available at [www.GrowingStepsPT.com](http://www.GrowingStepsPT.com). You may also request a paper copy at any time.
- We are required by law to notify you if a breach occurs that that may have compromised your privacy or security of your PHI.
- We will not use or share your information other than as described here unless you tell us we can in writing. You may change your mind at any time. Let us know in writing if you do.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## **Revision of the Notice of Privacy Practices**

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or change the terms of this Notice of Privacy Practices at any time. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. When the Notice of Privacy Practices has been revised, our practice will post a copy of the revised Notice to our website, [www.GrowingStepsPT.com](http://www.GrowingStepsPT.com). You may request a copy of our most current Notice of Privacy Practices at any time.

***Effective July 15, 2020***