Pediatric Therapy Links, LLC
Phone: (772) 291-2179 · Fax: (772)-600-8274 · info@pediatrictherapylinks.com

HIPPA – Your Privacy Rights

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

Effective Date: __Updated 01/05/2023___

Pediatric Therapy Links, LLC is required by law to keep your health information safe. This information may include the following:

- Notes from your doctor, teacher, and other health care provider.
- Your medical history
- Your evaluation results
- Treatment/ therapy notes
- Insurance information

A government rule, called the Health Insurance Portability and Accountability Act, or HIPPA requires that you get a copy of this privacy notice. We will ask you to sign a form saying that you have been given this notice. Read and refer to this notice any time to see how your health information can be used and when you can see it.

How your Health Information May Be Used or Shared

We may use or share your health information without your permission for the following reasons:

- **Treatment**. We may share information with doctors and other health care providers who care for you or your child.
- **Payment** We may use and share information about the treatment you or your child receive with your insurance company or other payer to receive payment for the services. This may include sharing important medical information including but not limited to patient treatment notes, evaluations, and referrals. We may share information for any of the following reasons:
    - To get the insurance company's permission to start treatment.
    - To get the insurance company to cover additional therapy sessions or treatment.
    - To get paid for speech language or occupational therapy evaluations and therapy sessions.

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Acknowledgement of Receipt of Our HIPPA Privacy Notice

Pediatric Therapy Links, LLC is required by law to keep your health information safe. This information may include:

- Notes from your doctor, teacher, or other health care provider
- Your or your child's medical history
- Your or your child's evaluation results
- Your or your child's treatment notes
- Your or your child's insurance information

Please indicate how you wish to receive information:

☐ Email _____

☐ Phone _____

☐ Mail _____-

☐ Other (Please specify) _____

We are required by law to give you a copy of our privacy notice. This notice tells you how you or your child's health information may be used and shared. It also tells you how you can look at and comment on your information.

By signing this page, you are saying that you have been given a copy of our privacy notice.

_____ _____

Print Patient Name Date

_____ _____

Patient or Parent/ Guardian Signature Relationship to Patient