**Metamorphosis Therapy, LLC**
301 S. Tubb Street
Oakland, FL 34760
*Phone: (407)395-9976*
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# Notice of Protected Health Information Privacy Practices
# Generalized Consent for Treatment

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.* ***PLEASE REVIEW IT CAREFULLY***

When we refer to "you" or "your" below, it represents your child or the patient receiving services from Metamorphosis Therapy, LLC.

As part of the healthcare service you receive from Metamorphosis Therapy, LLC health records are generated and maintained describing your child's care including, but not limited to, your name, address, phone number, social security number, health history, symptoms, examination and test results, diagnoses, procedures, treatments, and plans for future care or treatment. This information is called "Protected Health Information" (PHI). This Notice of Privacy Practices describes how from Metamorphosis Therapy, LLC may use and disclose your information and the rights that you have regarding your health information.

## Uses and Disclosures of Health Information Without Authorization

When you obtain services from Metamorphosis Therapy, LLC, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment, and to support the operations of the entity and other involved providers. The following categories describe ways that we use or disclose your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

- Your health information will be used for treatment: For example: Disclosure of medical information about you may be made to therapists, doctors, nurses, technicians, or others who are involved in treating you. This information may be disclosed to other physicians who are treating you or to other healthcare facilities involved in your care. Information may be shared

with pharmacies, laboratories, or radiology centers for the coordination of different treatments.

- Your health information will be used for payment: For example: Health information about you may be disclosed so that services provided to you may be billed to an insurance company or a third party for reimbursement of services rendered. Information may be provided to your health plan about treatment you are going to receive in order to obtain prior approval or to determine if your health plan will cover the treatment.
- Your health information will be used for health care operations: For example: This information in your health record may be used to evaluate and improve the quality of the care and services we provide.

**Disclosures Required by Law or Otherwise Allowed Without Authorization or Notification**

The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement. When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or for law enforcement; examples would be reporting gunshot wound or child abuse, or responding to court orders

- For public health purposes, such as reporting information about births, deaths, and various diseases, or disclosures to the FDA regarding adverse events related to food, medications, or devices
- For health oversight activities, such as audits, inspections, or licensure investigations
- To organ procurement organizations for the purpose of tissue donation and transplant
- To avoid a serious threat to the health or safety of a person or the public
- Contacting you to provide appointment reminders or to recommend treatment alternatives
- Notifying you of health-related benefits and services that may be of interest to you

Required Uses and Disclosures: Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with federal privacy law.

**Uses and Disclosures Requiring Authorization**

Any other uses or disclosures of your health information not addressed in this Notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

## YOUR INDIVIDUAL RIGHTS UNDER HIPAA

- You have the right to request restrictions on certain uses and disclosures of your Protected Health Information. For example, you may wish to restrict your employer from knowing about a medical condition. Regardless of your request, please know that the HIPAA rules allow our office to share your Protected Health Information with the Covered Entities. If you wish to restrict your PHI please make this request in writing to us and discuss with your therapist.
- You have the right to receive your Protected Health Information in a confidential communication from our office, such as the US mail. If you have a specific request for communication please discuss this with your therapist or Bridgett Dimant, M.S. CCC-SLP, Owner. You have the right to inspect and copy your Protected Health Information. Copies of your Protected Health Information are available for a reasonable fee paid to our office to cover our expenses of reproducing them. You may request this information at any time via your therapist, the office manager, or Bridgett Dimant, M.S. CCC-SLP, Owner.
- You have the right to request that we amend your Protected Health Information. In some cases, we may require that these requests be in writing and be supported by a reason for the change. Generally, this will not apply to such routine changes as address or phone number listings.
- You have the right to receive, upon request, an accounting of your Protected Health Information that we have provided to Non-Covered entities.
- If you have read and responded to this notice through electronic media such as our website or email, you have the right to receive a paper copy of this notice upon request.

If you would like to exercises any of these rights, please contact Bridgett Dimant, M.S. CCC-SLP, at (407) 395-9976 and we will make any necessary arrangements for you.

Metamorphosis Therapy, LLC is required by law to maintain the privacy of your Protected Health Information and to provide you with this notice of our legal duties and privacy practices as they apply to your Protected Health Information. We are also required to abide by the terms of this notice, which is currently in effect as of December 15, 2008.

In the future, we reserve the right to change the terms contained in this notice and make any new provisions effective for all of the Protected Health Information we maintain. In the event we elect to change the terms of this notice, a new notice will be posted in our office. In addition, you may receive notification by direct mail, email, or other such communication as our practice may implement from time to time.

Should you ever believe your privacy rights have been violated, we request you to file a complaint with our office by contacting us at (407) 395-9976 or by mail to: 13750 Winter Garden Vineland Road STE 350-121 , Winter Garden, FL 34787. You may also register your complaint with the Secretary of the US Department of Health and Human Services, Office of Civil

Rights. As part of our commitment to you, we value your privacy and take every precaution in our practice to preserve your right to that privacy. Any complaint you file will be used strictly to improve our operating procedures and in no way will you be retaliated against for filing a complaint.

Should you have any questions or concerns, please contact us directly at (407) 395-9976 to obtain further information.

**Generalized Consent for Treatment**

*I have read and understand the Notice of Protected Health Information Privacy Practices for Metamorphosis Therapy, LLC. I understand that if I do not sign this consent form my child cannot be evaluated or treated by Metamorphosis Therapy, LLC.*

When Metamorphosis Therapy, LLC examines, diagnoses, treats, or refers your child, we will be collecting what the law calls Protected Health Information (PHI) about your child. We need to use this information to decide on what treatment is best for your child, provide treatment to your child, and collect payment. We may also share this information with others who provide treatment to your child or need it to arrange payment for your child's treatment or for other business or government functions.

***By signing this form, you are agreeing to let us use your child's Protected Health Information (PHI) for the purposes of payment, treatment, and health care operations.***

**Patient's printed name:** _____

**Parent/Guardian's Printed Name:** _____

**Parent/Guardian's Signature:** _____

**Date Signed:** _____