Welcome to FUNctionabilities[1]. We are excited to help your child learn to play and play to learn. Thank you for choosing us to provide therapy services for your child! Our therapists bring professional knowledge and expertise to every session to help your child progress with his/her individualized goals. Our highly-qualified therapists utilize the best, evidence-based methods to ensure your child has fun while gaining or refining skills to improve function in everyday life.

What can I expect at the evaluation?
At FUNctionabilities we promote a safe, healthy, fun environment beginning with removing shoes and wearing clean socks prior to treatment to maintain a clean therapy gym and maximize sensory input during treatment. During the evaluation, the therapist will meet with you to better ascertain your concerns and then utilize assessment tools with your child such as: games, activities, observations, interviews, and written work to better understand the core problems and provide the most advanced, productive therapy possible. A typical evaluation lasts 45-60 minutes for speech therapy and 45-90 minutes for occupational therapy; unless you desire a more comprehensive assessment. Your child's age and ability to attend to these activities play a role in how long it takes to complete our evaluations. While the therapist and your child are completing testing, the care coordinator and/or the therapy liaison will present three options for assessments to you in the lobby based upon the complexity of your child's condition, the goals you want to achieve, and the clinical observations that the therapist has completed. The difference between the three options is the more testing we can do up front the better we can pinpoint all the areas that are affecting your child; however, no matter what you choose we are able to gather information throughout treatment sessions and adjust plans of care accordingly it just requires more time.

The cost of your child's highly individualized evaluation depends on your choice of Good, Better, or Best evaluation and will be reviewed with you so that the therapist can complete the evaluation. <u>It is your responsibility to understand what your policy covers and pays before the time of service for anything that is not covered by insurance (see page 6).</u> These days there is typically a portion of therapy services for which you are responsible. We do not like to give you unexpected bills so please be familiar with your health coverage. Once the payment method is determined and the evaluation has been completed, it's time to turn up the level of FUN and begin treatments. Our treatments will help your child to make changes and increase the success your child has in everyday life. Don't worry about the payment; we have several convenient payment options to make your child's care more affordable.

What should I expect during therapy sessions?
At the first therapy session after the evaluation is completed, the therapist will pick up your child in the lobby and our staff will bring you the evaluation to review. The therapist will leave the gym early to answer any questions you might have and confirm that the specified goals address your concerns before we deliver it to your doctor. They will show you a treatment plan based on these findings. To help reach these goals and improve interactions at home, therapists may provide verbal instruction, written home programs, and/or physical adaptations to assist in building your child's skills and mastery of their goals. When these suggestions are carried out throughout the week at home your child has more opportunities for developmental progression. If you ever have questions regarding these suggestions, please ask your therapist at the next visit.

Sometimes the therapist that completed the evaluation will not provide the treatment sessions or it may be necessary for another staff member to fill in. Don't worry if this happens, ALL the staff at FUNctionabilities are

[1] FUNctionabilities was a DBA of Absolute Kare Therapy, Inc., a Utah corporation but is now a Utah corporation of its own.

trained and highly qualified. Therapy begins at the front door and continues through clean up and transitioning back to the lobby.

Most of the time getting the kids to leave the fun therapy activities is the hardest part; but it's a necessary part of what we do. Parents or guardians are required to be on the premises during therapy, you can enjoy a movie or magazine while you wait. We need the parent around so we can discuss: home programming, your child's successes, and/or to help you know how to assist your child until the next visit.

How long does a therapy session last?

- Speech therapy = 30-minute sessions: 23 minutes with your child; 7 minutes of preparation, clean up, and consultation.
- Occupational therapy = 45-minute sessions: 38 minutes with your child; 7 minutes of preparation, clean up, and consultation.

Don't worry if it appears all your child is doing is playing. That's the secret ingredient to your child's success in therapy and daily life. When your child is motivated and having fun, he/she is more able to learn, grow, and reach his/her goals. We assure you our staff is choosing the perfect activities to best assist your child in reaching his/her goals. Our therapists use experience and training to make changes to activities during treatment sessions to improve your child's success.

We run on time so please arrive a few minutes early to avoid a $25 appointment late fee. We are required to report the exact time we are with you and your child and are reimbursed accordingly. This means when you are late it affects both your child and our clinic. Let us know at least 48 hours in advance if you need to cancel or change an appointment to avoid a $40 cancellation fee. Remember cancellations delay the work we do with your child and extend the time it takes to get results. NO SHOWS ARE BAD. Because it is important to provide treatment to every child that needs our services, we charge a $50 fee per no-show. A no-show could mean we will no longer provide services to your child or will only offer you last minute, first-come, first-serve appointments. We are required to document all cancellations and missed visits in your medical record and report it to your physician and insurance company/third party payer. If you accumulate three cancelled or missed visits, your therapist may have to refer you back to your physician before scheduling another appointment. We do NOT like to charge fees so please be on time and schedule appointments you know you can make. We have many children waiting to be seen so it is critical that you remember your appointment and arrive on time. Our priority is to help children progress quickly, so they can be discharged and live a successful life.

How long will my child need therapy?

Each child varies depending upon the complexity of their condition and the goals that you wish to achieve with your child. Most children need 6-12 months of therapy; while other children require multiple years due to significant developmental delays. The therapist will show you our program pathway and how your child's journey will move along in this pathway. When your child has met his/her goals at 80% we will re-evaluate to either: 1) update the plan of care with new goals and continue therapy or 2) prepare for discharge. Discharge is an exciting and special occasion that we love to celebrate with you and your child. It gives the child a sense of accomplishment and allows the team to provide your child with a gift to celebrate his/her hard work and success.

Referral Appreciation:

We are a small business and recognize we need your support to continue to grow. We appreciate you writing reviews and telling your friends and family about us. You will receive a gift card when we evaluate someone that you referred to us.

One last thing:

Look us up on social media. We frequently post helpful resources that will further enhance your child's progress. Tell people about your child's success and celebrate with us on social media. You can visit our website: www.makingtherapyfun.com for more information about what we do and for more resources.

Thank you for being an important part of your child's team!

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Today's Date:

1. Personal Info

Please fill out entire form completely and legibly. ALL INFO REQUIRED in order to bill insurance

Child's Full Name: _____ Date of Birth: _____ Age: _____ Sex: M / F Diagnosis:_____

Primary Physician: _____ Location:_____ Dr. Phone #:_____

Names of professionals working with my child: _____

Mother's / Guardian Name: _____ Date of Birth: _____ Cell Phone:_____

Father's / Guardian Name: _____ Date of Birth: _____ Cell Phone: _____

Address: _____ City/State/Zip:_____

Who does the child live with most of the time?_____ Home Phone:_____ E-Mail: _____

Emergency Contact Name & Phone:_____

If applicable, Foster/Adopt Info: ❒Placed in our home for foster care at the age of _____ on ____mo/____yr Number of previous placements _____
❒Formally adopted by us at the age of _____ Date:___/____/____
Previous names child has had prior to adoption: _____

2. Child Info

Are there any precautions the therapist should be aware of when working with your child? ❒No ❒Yes If yes, when and what:

What are your primary concerns regarding your child's development?

In one year it would be amazing if my child could……

What do you see as your child's strengths?

In one sentence, how would you describe your child?

School/Grade/Teacher/Services at school:

Assistive Devices:_____

3. Payment Info

(Check only one box)

I am paying TODAY by….

❒ **INSURANCE** and would like to…

___ Have you deal directly with them. I will assign my benefits to you by completing the "**Assignment of Benefits Form**" (see p.6) Fees may apply in some cases if not filled out completely and correctly.

___ Get a 15% discount by paying the entire bill at the time of service. I'll get reimbursement on my own.

❒ **CASH or CREDIT** and would like a …

___ 15% discount for paying the entire bill at the time of service.

___ Discount of up to 40% for a package (Ask the receptionist for details)

___ Payment plan or apply for "Financial Hardship"
(Ask the receptionist for details)

4. Parent Permission

(Please initial each item and sign below)

1. **AUTHORIZATION OF SERVICES**: I give my consent for my child to receive services provided by FUNctionabilities in the clinic, my home, and in the community with parent / guardian present. _____ **(initial)**
2. **RELEASE OF INFORMATION:** I authorize the exchange of information between FUNctionabilities, physician's offices, therapy providers, insurances, and school records as they apply to the provision of therapies. _____ **(initial)**
3. **PHOTO CONSENT**: I hereby authorize FUNctionabilities to photograph/ videotape my child for the purpose of:
   a. Documenting my child's OT _____ **(initial)**
   b. Publications or educational programs __Yes __ No _____ **(initial)**
   c. Promotional ads for FUNctionabilities __ Yes __ No _____**(initial)**
4. **OBSERVATION CONSENT**: I understand that FUNctionabilities is a teaching facility and I hereby give permission for students to participate in and observe my child's therapy. _____ **(initial)**
5. **PARENT PROXY:** I understand that if another adult accompanies my child to therapy I am authorizing information to be released to that adult. _____ **(initial)**

Authorized Signature: _____**Date:**_____

5. Referral Info

How did you hear about us?

❒ Brochure ❒ Friend or Family
❒ Internet ❒Physician/Dentist/Chiropractor/Nurse
❒ Advertisement Name_____
❒ Insurance/Directory Phone _____
❒ Other _____

I have read and agree to all the policies on page 4 of this form. Signature _____

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Important Company Policies for a Successful Relationship

We strive to provide your child the best personalized care available. To make this possible, we adhere to very important policies. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom of page 3.

Initial All Boxes

☐ **Late Policy**: We have a strict late policy because we try so hard to run on time; if you arrive after the appointment time you will be charged a **$25 late appointment fee**. Remember, insurances only reimburse us for face-to-face time with your child so if you are not here on time both your child and our clinic lose out. We reserve the right if you are more than 10 minutes late, to require you to reschedule or wait for the next opening and charge a cancellation fee. There are no guarantees since cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient so please be early for your appointment.

☐ **48-Hour Advance Notice Policy:** If you wish to change or cancel an appointment we require a minimum ***48-hour advance notice*****.** Anything less will result in a **$40 cancellation fee** charged to your account. Whether you attend or not it costs us money to make appointments available to you (for staff wages, rent, etc.). We do not make money with this charge; the fee is to act as a deterrent from making last minute changes. Advance notice allows another child in need time to reserve an appointment in place of your child's. Please be courteous and responsible. Thank you.

☐ **No-Shows:** **No-shows are bad.** If you fail to show for an appointment without notice, all future appointments will be cancelled, and a **$50 fee** will be assessed to your account. **If there are 2 no shows within 90 days, we will no longer provide services to your child** allowing us to provide services to another child who needs therapy. We reserve the right to discontinue services under any circumstance as we may elect at our sole discretion.

☐ **Child-Centered Policy:** We believe firmly in a child-centered model of treatment and contribute our results to this focus. This model allows us to focus on the child and grants you a break while waiting in the lobby from the difficult job you have as parent.

☐ **Minors and Parents:** If a patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on the premises or not, and it is the responsibility of the parent or guardian to supervise the minor before and after treatments. You should be available during the session if needed. Should any of your children be left unattended before, during, or after a session you will incur at least a **$15 fee** since this requires a member of our team to sit with your child at the expense of leaving their regular duties.

☐ **Patient Declaration:** The therapist explained to me the type of treatments ideal for my child's condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form. I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my informed consent for the therapist to render treatments to my child.

☐ **Treatment Time:** Please be cognizant of the time you spend with our therapists and if you require more time please set up an appointment so that we don't take away time set aside for your child or someone else's child. Consultation can include preparation for IEPs, 504s, or other in-depth questions. Remember therapy sessions are 45 minutes and 30 minutes as laid out in the Welcome Letter. When you respect our time by setting up an appointment to further discuss your child's needs we will give you a 50% discount off our consultation fee.

☐ **Consultation Policy**: We want to spend every moment possible with your child. And while we do believe that your involvement and education is critical to your child's success; insurances do not pay for us to consult with you. We have set aside a few minutes to discuss your child's care with you and we will continue to provide homework to facilitate your child's care. Parent Consultation Fee: starts at $50 for 15 minutes.

☐ **Results:** The purpose of occupational / speech / physical therapy is to maximize your child's body's own healing potential through natural means and to promote their ability to perform daily, play, leisure, social, and sports activities through increased self-regulation, motor planning, strength, and movement strategies. It is not possible to predict the results or outcomes of treatment. Typically, benefits are realized gradually over time. Each case is unique and FUNctionabilities makes no representations or warranties regarding results of therapy provided.

☐ **Informed Consent:** By signing page 3, the parent or guardian represents and warrants that they are authorized to sign and hereby gives the therapist permission for the evaluation and treatment of the child. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your child's care, be sure to ask the therapist. It is up to the parent/guardian to inform the therapist/staff about any health problems or allergies the child may have. The parent/ guardian must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or previous or planned surgeries. Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

☐ **Important Notice from the Federal Government: "**It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments… even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan, even if your doctor allows it. You may both be charged with breaking the law. This includes services deemed as "professional courtesy" and TWIP's – take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A (a)(5) of the Health Insurance Portability and Accountability Act of 1996 (section 231(h) of HIPAA). Exceptional cases do apply. Please see contact info for more information: Office of Inspector General, Department of Health and Human Services. Contact by phone: 202-619-1343, by fax 202-260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Dept. of Health and Human Services, Room 5541 Cohen Building 333 Independence Ave, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202-619-0089."

We look forward to building a relationship with you that will last a lifetime!

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Payment Agreement

Thank you for choosing FUNctionabilities for your Pediatric Therapy needs. This financial agreement describes both patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have and sign in the space provided.

I have received this financial policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection agency. If it becomes necessary to send my account to a collection service, I agree to reimburse FUNctionabilities the fees of any collection agency, which may be based on a percentage of the debt, and all costs, and expenses, including reasonable attorneys' fees, you incur in such collection efforts.

_____ _____ _____

Parent/Guardian Signature | Printed Name | Date

Initial All Boxes

☐ **Patient Responsibility & Payments**: We will collect your portion upfront so when you arrive at each appointment please have cash or credit card available so that you can pay your portion of the services we provide your child. You are ultimately responsible if your insurance denies a claim for any reason. If you do not have insurance, payment in full will be due at time of service. If you take responsibility for your visits, we offer you a discounted price; however, we DO NOT bill your insurance. We can provide you with a detailed invoice that you can turn in to your insurance company. The amount of your bill is expected to be paid in full by the date on the statement, unless payment arrangements have been made with the Office Manager. Anything over 30 days is considered past due.

☐ **Costs:** There are extra charges for progress reports, re-assessments, and discharges. These extensive reports are NOT included in the discounted package prices nor are they always covered by insurance. All charges for these services are to be paid at the time of service.

☐ **Non-Payment:** Any unpaid balances that have not been paid within 30 days of the date of the invoice shall incur a 10% late fee. Failure to pay will result in your account being referred to a collection agency, which will affect your credit. You may also be responsible for reasonable attorney fees and other collection costs regardless of whether any legal action is filed.

☐ **Insurance**: Your insurance coverage is a contract between you and the insurance company and we are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. It is your responsibility to know your benefits and insurance coverage for therapy services, if any, including any referrals, authorizations, maximums, or exclusions. All patients are responsible for all charges whether paid by insurance or not. As a courtesy we will submit your claims to your primary and secondary insurance companies however we do expect payment for all services within 30 days. It may become necessary for you to pay your account in full if your insurance fails to do so within 30 days. If we are given incorrect or incomplete insurance information you will be billed, and payment will be expected within 30 days.

Our cash package discounts are to help you if you have no out-of-network benefits, large deductibles, or poor coverage for therapy. The parent listed above agrees to this payment method for the patient's outstanding account balance in place of insurance. Should the parent deviate from the prescribed payment plan at any time (including but not limited to: missed payments, late payments, declined payments, or payments not made in full) FUNctionabilities reserves the right to charge interest, penalties, or consider delinquency at any time.

❑ Basic $499 ❑ Intermediate $899 ❑ Advanced $1699

We also offer payment plans as outlined below. Finance charges will accrue from the original charge date. Remember, if you receive a cash discount we DO NOT bill your insurance, but we will provide you with an invoice that you can submit to your insurance company, if you so desire. Progress reports, re-assessments, and discharges are not included in the discount package pricing.

❑ Intermediate OT Treatment Package for 8 45-minute sessions at $899 to be broken down as follows:

Visit	Amount	Date Paid
1	$305.00	
3	$305.00	
6	$305.00	

❑ Advanced OT Treatment Package for 16 45-minute sessions at $1699 to be broken down as follows:

Visit	Amount	Date Paid
1	$430.00	
5	$430.00	
9	$430.00	
13	$430.00	

❑ Intermediate SLP Treatment Package for 12 30-minute sessions at $899 to be broken down as follows:

Visit	Amount	Date Paid
1	$305.00	
5	$305.00	
9	$305.00	

❑ Advanced SLP Treatment Package for 24 30-minute sessions at $1699 to be broken down as follows:

Visit	Amount	Date Paid
1	$430.00	
7	$430.00	
13	$430.00	
19	$430.00	

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Credit Card on File Authorization Form

Nothing will be charged unless a balance is due. Your payment will be automatically charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Credit Card on File Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

Here's How Credit Card on File Works:

You authorize regularly scheduled charges to your credit card for any patient responsibility, including standard co-pays, remaining balance, payment plans, appointment fees, and no-show fees. Nothing will be charged unless a balance is due. A receipt for each payment will be emailed to you. You agree that no prior-notification will be provided. You understand that FUNctionabilities is utilizing the latest standards in card data security and HIPAA compliance. Card data being stored is encrypted and tokenized and stored off-site in a secure vault trusted by many fortune 500 companies. If your card on file declines and we have to bill you there will be a $25 fee.

Please complete the information below:

I _____ authorize FUNctionabilities to charge my credit card to satisfy my financial obligations as defined by FUNctionabilities Payment Agreement.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Debit / Credit Card

☐ Visa ☐ MasterCard * Swipe or key card into merchant card services to save

☐ Amex ☐ Discover

Cardholder Name _____

Last 4 digits _____ Exp. Date _____

I understand that I can update my card information on file at any time by contacting our office directly. In fact, it is my responsibility to notify FUNctionabilities of any updates or changes to the credit card on file associated with this agreement as soon as possible. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I certify that I am an authorized user of this debit / credit card and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____

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Assignment of My Benefits

IMPORTANT: All information must be **completed,** or we will NOT be able to deal directly with your insurance.

BENEFIT INFO: ***Call the "800" number on your insurance card and ask the following questions:***
What is your deductible amount? $_____ and Copay $_____or Coinsurance %_____ for occupational therapy/speech therapy/physical therapy. Are there any exclusions on your plan concerning these services? _____
How many visits are you allowed for these services? _____ Is this per calendar year or from what date? _____
Do your benefits require preauthorization or clinical submission? Y / N Ask for a call reference number: _____

PATIENT INFO: Patient Name: _____ ID #_____ DOB_____

Insurance Policy: _____ Group # (if applicable) _____

*****IS PATIENT INSURED THROUGH SOMEONE ELSE'S POLICY?*** Relationship to Patient: Parent/Guardian, Other: _____

- Policyholder Name_____ Date of Birth_____ SSN_____
- Address (if different than Patient) _____

Insurance Policy #2: Name/Number/Group # (if applicable) _____

- Policyholder Name_____ Date of Birth_____ SSN_____
- Address (if different than Patient) _____
- Relationship to Patient: _____ Parent/Guardian _____ Other: _____

I hereby instruct and direct my insurance company to **pay by check made out to the "Healthcare Provider" to the right and mailed to** the address on the right (not mine). If my current policy prohibits direct payment to doctor/ therapist, I hereby also instruct and direct you to make the check payable to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. I will promptly upon receipt sign over all checks pertaining to services here.

Healthcare Provider Info:
FUNctionabilities
PO Box 363
Riverton, UT 84065

Medical Necessity
All treatments must be justified and medically necessary for us to treat and bill your insurance. Some factors that determine if treatment is medically necessary are:

1. Does your child's condition interfere with the quality of his/her life?
2. Does your child's condition interfere with his/her ability to perform typical tasks or daily activities?
3. Are you motivated and able to help your child participate in our treatment program and follow home and self-care instruction?
4. Is there potential for your child's condition to improve and/or resolve? If not, is there potential for your child's function or ability to perform daily activities to improve through modified movement, assistive devices, etc.? If not, is there potential for your child's condition to cause him/her to regress without intervention?
5. Are there specific goals set that are measurable and trackable?

This is a direct assignment of my rights and benefits under this policy.
This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. **(Check each box and sign at the bottom)**

- ❑ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ❑ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ❑ I authorize the use of this signature on all insurance submissions.
- ❑ I authorize the "Healthcare Provider" named above to deposit checks made in my name.
- ❑ I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner or file an appeal for any reason on my behalf.
- ❑ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____

_____	_____	_____
Signature of Policyholder	Witness	Signature of Claimant, if other than Policyholder

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NOTICE OF PRIVACY POLICIES

Effective June 1, 2015

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

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners. We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us at **(801) 443-7775 extension 3**. Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer. If our Privacy Officer is not available, you may make an appointment for a conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.
By way of my signature, I provide FUNctionabilities with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Parent's Name (print)

_____ _____
Parent's Signature Date

_____ _____
Authorized Facility Signature Date