Shenandoah SOUNDstart, LLC
Pediatric Therapy Center

Additional Documents

Patient Rights

The following is a statement of your rights with respect to your protected health information.

Restrictions: You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations.

Confidential Communications: You have the right to request that any part of your protected health information not be disclosed to family members or friends who may be involved in your child's care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Inspect and Copy your Health Information: You have the right to inspect and copy your protected health information, including your chart and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate/print your copy. All clients have access to their medical information through our on-line portal.

Amend your Health Information: You have the right to ask me to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize the process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information records in question were not created by our office, are not part of our records, or if the records containing your health information are determined to be accurate and complete.

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Documentation of Health Information: You have the right to ask for a description of how and where your health information was used by the office for any reason other than for treatment, payment, or health operations. Documentation procedures will enable me to provide information on health information usage from your initial visit and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years prior. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice: You have the right to obtain a copy of this ***Notice of Privacy Practices*** directly from the office at any time and we will mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this notice. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. If we change the privacy practices, we will be sure that all patients receive a copy of the revised notice.

Complaints: You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you have regarding the privacy of your information. Please let us know of your concerns in writing.

Patient Rights and Responsibilities

Summary of Patient's Rights:

• The right to considerate, confidential, private, and respectful care.

• The right to understandable information about your diagnosis and possible treatments.

• The right to know the name, role, and credentials of the people treating you.

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• The right to privacy of treatment records unless you have given permission to release information.

• The right to review your treatment records and to have the information explained.

• The right to know if Shenandoah SOUNDstart, LLC has relationships with outside parties that may influence your care.

• The right to give consent or decline any part of treatment. If you choose not to take part, you will receive the most effective care Shenandoah SOUNDstart, LLC otherwise provides.

• The right to know about any office policy that affects you and your treatment.

• The right to an itemized bill of charges and payments.

• The right to a quick response regarding any comments, questions, or complaints.

Summary of Patient's Responsibilities:

• The responsibility to be prompt for all scheduled appointments.

• The responsibility of notifying Shenandoah SOUNDstart, LLC a minimum of 24 hours in advance of cancellation.

• The responsibility of providing any information regarding previous evaluations, or health issues such as allergies or special diets.

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• The responsibility of providing Shenandoah SOUNDstart, LLC with correct and updated information regarding address, telephone, change of custody status.

• The responsibility of asking questions when you do not understand instructions or information.

• The responsibility to notify your therapist if you are unable or unwilling to follow therapy recommendations.

• The responsibility of being considerate of the needs of other patients.

• The responsibility to assure appropriate behavior of all non-patient visitors brought to the office.

• The responsibility to pay fees for services received at the time of treatment.

• The responsibility to remain in your child's session and actively participate throughout.

By signing the patient right's agreement, I understand and agree with both my rights as well as my responsibilities as detailed above.

Child's Name: ________________________ ***Date Of Birth:*** __________

Guardian Signature: ________________________ ***Date:*** ___________