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Children's Evaluation & Therapy Center
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NOTICE OF PRIVATE PRACTICE

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. The Notice takes effect November 18, 2008 and will remain in effect until we replace it.

The Health Insurance Portability & Accountability Act (**HIPAA**) describes how we may use or disclose your protected health information, with whom that information may be shared and the safeguards we have in place to protect it. This Notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our Practice except when the release is required or authorized by law or regulation.

**THE PRIVACY OF YOUR HEALTH INFORMATION IS VERY IMPORTANT TO US.
PLEASE REVIEW THIS NOTICE CAREFULLY!**

Use and Disclosures of Health Information



We use and disclose health information about you for treatment, payment, and healthcare operation. For example:

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you. In emergencies, we will use and disclose your protected information to provide the treatment you require.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, billing, evaluating practitioners and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient's Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up related health information.

Marketing Health-Related Services: We will not use your information or media for marketing communication without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law. We may also disclose health information during any judicial or administrative proceedings, in response to a court order or administrative tribunal, and in certain conditions in response to a subpoena, discovery request, or other lawful purposes. We may disclose protected health information for law enforcement purposes, including responses to legal proceedings, information requests for identifications and location, and circumstances pertaining to victims of a crime.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you or your child are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others involved.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody or protected information of inmates or patients under certain circumstances.

Communicable Diseases: We may disclose your protected health information if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

Public Health: We may disclose your protected information to a public health authority who is permitted by law to collect or receive the information in regard to some of the following: preventing or controlling diseases, injury or disability, reported births and deaths, or problems with adaptive products.

Research: We may disclose protected health information to researchers when authorized by law, as approved by institutional review boards that have reviewed the information for research proposals to ensure the privacy of your health information.

Parental Access: State laws concerning minors permit or require certain disclosure of protected information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State (or if you are treated in another state, the laws of that State) and will make disclosures following such laws.

Appointment Reminders: We may use or disclose health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

Patient's Rights

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the beginning of this Notice. We will charge you a reasonable cost-based fee for providing the health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the beginning of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 2 years, but not before May 12, 2017. If you request this account more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except for in emergencies).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to an alternative location. (You must make this request in writing.) Your request must specify the alternative means or location and provide

satisfactory explanation of how payments will be handled under the alternative means or location you requested.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your access to your health information or in response to a request you made to amend or restrict the use or disclose of your health information or to have us communicate with you by an alternative location, you may complain to us by using the contact information listed at the beginning of this Notice.

You may also submit a written complaint to the U.S. Department of Health and Human Services. You can 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/. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the U.S. Department of Health and Human Services or us.

Notice of Private Practice

Health Insurance Portability and Accountability Act

(HIPAA)

I have reviewed the Notice of Private Practice under the Health Insurance Portability and Accountability Act (HIPAA) and have accepted the privacy practices, legal duties, and rights concerning my health information. I also understand that the information supplied is required by applicable federal and state law to maintain the privacy of my health information.

Parent Signature (E signature)

Date (E signature)

Thank you for your interest in receiving services from **Children's Evaluation & Therapy Center**. We hope that your child's/family's experience with us will be positive and successful. Enrolling your child at our Center is as simple as 1, 2, 3! Please carefully read and follow these three (3) basic steps.