The Therapy SPOT, PLLC
NOTICE OF PRIVACY PRACTICES

The Therapy SPOT LEGAL DUTY

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.

This notice of privacy practices describes how e may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO), and for other purposes that are permitted by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

The Therapy SPOT, PLLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

The Therapy SPOT, PLLC uses your personal health information which may be disclosed by your therapist or our office staff that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the Practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide treatment; coordinate or manage your health care and related services. This includes the coordination or management with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to endure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for health care services the Practice recommends for you.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of the practice. These activities include, but may not be limited to, quality assessment activities, contractor/employee review activities, training therapy students, licensing, and conducting or arranging other business activities. For example, we may disclose your protected health information to therapy students that see patients in our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to you're your name. We may also call you by name in the waiting room when your therapist is ready to see you. We may disclose your protected health information, as necessary to contact you to change or remind you of your appointment. We may need to leave phone messages with respect to appointments or schedules.

We may use your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, auditing purposes, research studies and for emergencies. Law Enforcement, Research, Criminal Activity, Military Activity and National Security. Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services, to investigate or determine compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: In any other situations, The Therapy SPOT's policy is to obtain your written authorization before disclosing your personal health information unless required by law.

You may revoke this authorization at any time, in writing, to the extent that the Practice has taken an action in reliance on the use or disclosure indicated in the authorization.

The Therapy SPOT may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

YOUR RIGHTS

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. Under federal law, however, you may not inspect or copy the following records: psycho therapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means that you may ask the practice not to use or disclose any part of protected health information for the purpose of treatment, payment or healthcare operations. You m ay also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request should be written and state the specific restriction requested and to whom you want the restriction to apply. The Practice is not required to agree to a restriction that you may request. If the Practice believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

You have the right to receive confidential communications from us by alternate means or at alternate locations. You have the right to obtain a paper copy of this notice from us.

You have the right to have your therapist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

We reserve the right to change the terms of this notice. When changes are made, a new Notice of Privacy Practices will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of our Policy at any time.

CONCERNS AND COMPLAINTS

If you are concerned that The Therapy SPOT, PLLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties. Parent/Guardians are required to sign this notice for their minor children as it applies to them. For further information on The Therapy SPOT's health information practices or if you have a complaint, please contact the following person:

The Therapy SPOT
Phyllis Lepre Reischmann
Telephone: (631) 582-0088 Fax: (631) 582-0405
1770 Motor Parkway, * Suite 202 * Islandia, NY, 11749

I have read, fully understand and accept The Therapy SPOT's notice of information practices.

_____
Patient Name (please print)

_____ _____
Patient Signature Date

We occasionally have professional students (OT, PT, ST) attending our facility. Please sign below to give your permission for these students to observe and participate in your treatment

_____ _____
Print Name Date

_____
Signature