

Dear Parents,

Thank you for your interest in our center-based Autism services at Partners in Excellence. Our mission is to positively impact the life of each child through our unparalleled commitment and desire to see our clients reach their greatest potential.

Treatment services are aimed at developing and improving your child's communications, interaction with others, expressing emotions and coping strategies. The Assessment of Basic Language and Learning Skills-Revised (ABLLS-R) and Hawaii Early Learning Profile (HELP) curriculums enable our staff to assess and assign measurable objectives in developing the Individual Treatment Plan for the child. In addition to these curriculums, we use a variety of supplemental programs to meet each child's individual needs. Through data collection, we actively track your child's progress through our program.

To ensure that your child receives the most fitting treatment, the initial evaluation of your child is critical. This should include a comprehensive assessment of your child's physical, developmental, and mental health needs as well as a copy of your child's Education Plan. This evaluation guides the direction of treatment and ensures that the treatment goals are appropriate for your child's optimal growth and development. This is important baseline information for you to have so that you can have an accurate understanding of your child's current abilities as well as a basis for comparison to measure progress in treatment over time. These evaluations are also a requirement of most insurance companies.

The following areas of your child's overall health will need to be assessed prior to beginning treatment at Partners In Excellence. These evaluations do not have to be completed with one particular health care provider but must meet the outlined requirements. All evaluations must be completed within 12 months of the anticipated start date. Once Partners In Excellence receives records of each of these evaluations and we receive insurance approval, your child's treatment start date can be determined.

(✓)	Evaluations / Assessments
	1) Medical Evaluation - this is an examination by a <i>licensed physician</i> . It is important that your child's physical health be assessed, in addition to any family history or other medical issues. This can be records from your child's most recent well child check up, but must confirm the diagnosis of autism spectrum disorder.
	2) Audiology Evaluation – this is an evaluation of your child's hearing by a <i>licensed physician</i> or <i>specific audiologist</i> . It is important to assess whether your child's hearing is adequately intact and to rule out that the problem symptoms of the autism spectrum disorder are not due to or worsened by a hearing deficit.
	3) Comprehensive Speech/Language Assessment – this is an evaluation by a <i>licensed Speech/Language Pathologist</i> . Since speech and language deficits are a primary component of autism spectrum disorders, it is important these areas specifically be evaluated.
	4) Comprehensive Psychological Evaluation – this is an evaluation by a <i>Ph.D level licensed psychologist</i> . This evaluation must include an IQ test to assess your child's cognitive (mental) capabilities.
	5) Autism-specific Diagnostic Assessment – this evaluation can be completed within either the Psychological Evaluation or the Speech/Language Assessment. This includes the use of any of a variety of diagnostic tools (CARS, ADOS, etc), which are designed to evaluate specifically for the symptoms of autism spectrum disorders.
	6) Copy of Education Plan – most recent Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)

It may be helpful to bring this letter to your chosen providers to explain the particular kind of assessments that your insurance provider requires before treatment can begin. To locate providers in your area who can complete these evaluations, please request referral names from Partners In Excellence or phone your insurance plan's Customer Service Center. If you have questions regarding the enrollment process or need referrals, please contact Keri Lewis, Intake Manager, for assistance.

Keri Lewis: 952-818-2876 or intake@partnersmn.com

Thank you, and we look forward to working with you.

EMERGENCY PLAN Date Filled Out: ___/___/___

IMPORTANT! USE ONLY BLACK INK WHEN FILLING OUT THIS FORM

Child's Name _____ Date of Birth _____ Sex _____

Address _____ City, State, ZIP _____

(Mother/Guardian) _____ Phone Number(s) _____

(Father/Guardian) _____ Phone Number(s) _____

Emergency Contact #1 _____ Relationship _____ Phone Number(s) _____

Emergency Contact #2 _____ Relationship _____ Phone Number(s) _____

Child's Physician _____ Clinic Name & Address _____ Clinic Phone Number _____

Dentist _____ Clinic Name & Address _____ Clinic Phone Number _____

Transport to which Hospital? _____ City _____ Registered There? _____ Hospital Phone Number _____

Allergies	Description	Remarks
Type (Food, Medicine, Other)	Description	Remarks

What is the first thing you notice when your child is having an allergic reaction?

Medications	Used for	Administered by Partners?
Name	Used for	Administered by Partners?

(Continue medication and allergies lists on separate sheet if necessary)

Emergency Action Plan for Seizures & Allergies

Child has a seizure history: No

Emergency Plan: 911 will be called if:

- Seizure lasts longer than _____ minutes
- Your child is having difficulty breathing
- Vomitus is aspirated
- A significant injury occurs during the seizure
- Status epilepticus occurs (continuous seizure)

Describe your child's typical seizure. What do you want Partners In Excellence staff to do (other than routine First Aid) if your child has a seizure while at the center? (List out step-by-step instructions)

Call parent when:

Call physician when:

The following people are authorized to pick up

Name	Relation to child	Phone number

The following people are restricted from contact with your child

Name	Relation to child	

I give permission to Partners In Excellence to take whatever emergency (e.g. first aid, disaster evacuation, etc) measures are judged necessary for the care and protection of my child while at Partners In Excellence. Yes No

I give permission for my child to be transported to the appropriate medical facility by the local emergency unit for treatment. Yes No

I give permission for a copy of this form to be sent with emergency transport personnel. Yes No

I understand that in some medical situations, the staff will need to contact local emergency resources before the parent/guardian, child's physician and or other adult acting on the parent/guardian's behalf.

Parent/Guardian Signature _____ Date _____

REGISTRATION FORM
Please Print Legibly in Black Ink

Client Information

Name: _____
Last Name First Name Initial
Street Address: _____
City: _____ State: _____ Zip Code: _____
Sex: M F Age: _____ Date of Birth ____/____/____ Diagnosis: _____

Primary Insurance

Name of Primary Insurance Company: _____
Contract #: _____ Group #: _____ ID # _____
Insurance Policy Holder: _____ Relationship to Client: _____
Date of Birth ____/____/____ Employed by _____ Occupation _____
Business Address: _____ Business Phone: _____

Secondary Insurance

Name of Secondary Insurance Company: _____
Contract #: _____ Group #: _____ ID # _____
Insurance Policy Holder: _____ Relationship to Client: _____
Date of Birth ____/____/____ Employed by _____ Occupation _____
Business Address: _____ Business Phone: _____

Medical Assistance (Tefra)

(Write "N/A" if your child does not have Medical Assistance)

Your child's MA number: _____

Assignment & Release

I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Partners In Excellence all medical benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all the charges whether or not paid by insurance. I hereby authorize Partners In Excellence to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Parent/Guardian/Responsible Party _____ Date _____

Client Name: _____

AUTHORIZATION FOR TREATMENT:

By signing this form, I consent to and authorize Partners In Excellence to evaluate and provide treatment to my child, the above named patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR MEDICAL CARE:

I authorize release of pertinent medical information to other treating healthcare providers, for purposes of my child's treatments at Partners In Excellence, and for business operations.

Initial: Yes _____ No _____

CLIENT'S RIGHT TO PRIVACY:

I acknowledge that I have been given a copy of the Partners In Excellence Privacy Notice (HIPAA).

Initial: Yes _____ No _____

CLIENT'S BILL OF RIGHTS:

I acknowledge that I have been given a copy of the Partners In Excellence Client's Bill of Rights.

Initial: Yes _____ No _____

AUTHORIZATION FOR COMMUNICATION VIA EMAIL:

I authorize Partners in Excellence and its authorized personnel to use email as need to communicate with me and internally for purposes of my child's treatments at Partners In Excellence, and for business operations.

Initial: Yes _____ No _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES:

I authorize release of pertinent medical information to third party payers / insurance companies to determine payments related to treatment received.

Initial: Yes _____ No _____ **If NO, you are assuming all financial responsibility for your services.*

ASSIGNMENT OF BENEFITS:

I authorize payment of benefits be made directly to Partners In Excellence for services provided to my child, the above named patient, by Partners In Excellence. I understand and agree that I am financially responsible to Partners In Excellence for charges not covered by insurance. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

Initial: Yes _____ No _____ **If NO, you are assuming all financial responsibility for your services.*

The above information is warranted to be true. I agree to pay all bills within 10 days after receiving an invoice or as otherwise expressly agreed in writing. I hereby authorize Partners In Excellence to investigate any information obtained from me pertaining to my financial responsibility.

Parent/Legal Guardian's printed name	Signature	Date

Financial Agreement

This financial agreement sets Partners In Excellence's expectations regarding payment. Partners In Excellence (Partners) believes that financial arrangements should be discussed and understood prior to the onset of services and before any problems or concerns develop.

Prior to receiving services, Partners In Excellence will work with you to ensure that the funding source you are planning to use will pay for services. It is the parents' responsibility to monitor the funding source they are utilizing and to immediately notify Partners In Excellence of any changes to insurance or other coverage's.

When discussing payment for services with insurance companies; it is important that the insurance company clearly understands the type of services Partners In Excellence provides. Partners In Excellence provides Intensive Behavioral Therapy in a center-based program delivered by unlicensed mental health practitioners.

It is essential that Partners In Excellence is involved in the prior authorization process. To do this, it is necessary for you to provide our Intake and Billing staff with the required information that enables us to bill your insurance company. In some circumstances even participating insurance plans require you to pay a balance not covered. It is your responsibility to know what limitations, exclusions, deductibles or co-pays your plan has. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract and our financial relationship is with you, not your insurance company.

At this time, Partners In Excellence is not a medical assistance (TEFRA) provider in Minnesota and therefore cannot bill medical assistance for services or deductibles/co-payments.

Private Pay

Partners in Excellence will enter into a Private Pay Agreement with private parties. Partners sends invoices on a weekly basis and expects that payment will be received weekly.

Payment in Full

In some cases a funding source may pay for only a portion of the charges. Unless specifically contracted; co-pays, discounted charges, and deductibles are the responsibility of the insured. Partners In Excellence will prepare a statement with outstanding charges due on a monthly basis and payment is due from this statement upon receipt of the statement. Insurance companies often discount rates to a "usual and customary" price. Unless contracted, Partners In Excellence does not accept discounted rates.

Partners In Excellence accepts checks, money orders, ACH, and Credit/Debit Cards (Visa, MasterCard, and Discover) for payments. Returned checks will incur an additional fee of \$25.00 that will be added to your bill. Prior to your child's first day at Partners, our billing coordinator will contact you to complete and authorize the necessary paperwork for the payment of out of pocket amounts and services not covered by your insurance plans. Payments for out of pocket expenses and services must be made prior to your child's first day of therapy at Partners.

Payment Plans are available to clients who are unable to pay their bill on time. Please contact our billing department to arrange a payment plan.

Delinquent Accounts

An account is considered past due when payment is not received 30 days from the statement date. If other written arrangements have been agreed to, the arrangements need to follow the written agreement. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency. Legal costs incurred in collecting delinquent accounts will be the responsibility of the person responsible for the account.

If the insurance company does not pay your balance in full within 30 days, we will ask that you contact your insurance company to help facilitate the processing of this payment.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to contact us so we can assist you in the management of your account.

Secondary Insurance

Partners In Excellence will invoice a secondary insurance in the same manner as a primary insurance source. In all cases, Partners In Excellence will bill the primary insurance first and the secondary insurance once Partners In Excellence has obtained the Explanation of Benefits (EOB) from the primary insurance.

Insurance Disputes

Despite everyone's best efforts, at times a dispute will occur over payment from an insurance company. It is our policy to assist you in obtaining payment from an insurance company. However, if the account is delinquent; Partners In Excellence will request payment from you as a private individual and reimburse you when and if the insurance company decides to pay for the services in dispute.

Missed and Late Therapy Appointments

We would appreciate the courtesy of a call if you are unable to keep an appointment. Please notify our office at least twenty four (24) hours prior to the appointment time. We reserve the right to charge a missed appointment fee for each appointment that is not canceled in a timely manner.

Chronic absenteeism and tardiness will have a negative effect on your child's therapeutic progress and may result in termination of services.

Divorce Decrees

Partners In Excellence will not enter into any disputes between parents who have separated or divorced. One parent must agree to be the person responsible for the child's account.

Interest and Late Charges

Partners In Excellence reserves the right to charge interest up to the amount allowed by law (currently 18%) for late payments.

Consequences for Non Payment

Partners In Excellence reserves the right to discharge your child from therapy or suspend therapy for unpaid services or accounts that are delinquent. If services are terminated or suspended; your child is placed on the waiting list and may begin services after the account is paid in full and payment for future services is established.

My signature indicates that I have received a copy of Partners In Excellence's Financial Agreement and I have read and understand that I am responsible for my child's account and agree to pay for services as indicated in this agreement.

(Parent/Guardian/Legal Representative Signature) Date

Printed Name

(Parent/Guardian/Legal Representative Signature) Date

Printed Name

Picture/Video Release

Client Name _____

Date of Birth: _____

Partners in Excellence uses photographs and/or videos of children receiving services in our center based program for the purposes of instructional analysis, training, reporting, and selected marketing pieces for program awareness.

I have indicated below that photographs/digital images, video clips, and/or quoted remarks may be used as follows:

(Check all that you authorize)

<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Staff/Client Photo Board
<input type="checkbox"/>	<input type="checkbox"/>	Pictures used internally for individual programming (ex. PECS books, Visual Schedules, Social Stories)
<input type="checkbox"/>	<input type="checkbox"/>	Video used to document programming
<input type="checkbox"/>	<input type="checkbox"/>	Scrapbooks
<input type="checkbox"/>	<input type="checkbox"/>	Printed publications or materials (such as magazines, newspapers, brochures or flyers)
<input type="checkbox"/>	<input type="checkbox"/>	Electronic publications or presentations (TV or other broadcast media)
<input type="checkbox"/>	<input type="checkbox"/>	Websites (Partners website, Facebook)

I agree that my child's name and identity may be revealed **OR** may not be revealed in descriptive text or commentary in connections with the image(s).

I agree that the media may **OR** may not contact my family to speak with my child regarding his/her involvement with Partners In Excellence.

I authorize the use of these materials (as indicated above) indefinitely without compensation to me. All negatives, positives, prints, digital reproductions and video or audio recordings shall be the property of Partners In Excellence.

Parent/Legal Guardian Signature

Date

Occupational Therapy/Speech Therapy Interest Form

Date _____

Client Name _____

Parent(s) _____

Phone Number _____

Occupational Therapy

Yes, I would like my child to receive Occupational Therapy services at Partners in Excellence.

Currently receiving services at: _____

Previously received services at: _____

Has not previously received Occupational Therapy

No, I do not want to enroll my child in Occupational Therapy services at Partners in Excellence.

Currently receiving services at: _____

Previously received services at: _____

Has not previously received Occupational Therapy

Speech Therapy

Yes, I would like my child to receive Speech Therapy services at Partners in Excellence.

Currently receiving services at: _____

Previously received services at: _____

Has not previously received Speech Therapy

No, I do not want to enroll my child in Speech Therapy services at Partners in Excellence.

Currently receiving services at: _____

Previously received services at: _____

Has not previously received Speech Therapy

SUNSCREEN PERMISSION

Children are often given the opportunity to go outside to play on playground equipment or go on short walks. Children will be dressed appropriately for the weather. In cold weather, children will be required to wear hats, mittens, and boots if appropriate. In warmer weather, staff will apply sunscreen to clients going outdoors for more than 15 minutes. Children with a history of bolting may not be permitted to go outside due to safety concerns.

Name of Child: _____

- ___ As the parent/guardian of the below mentioned child, I recognize that too much exposure to UV rays may increase my child's risk of getting skin cancer someday. Therefore, I **give permission** for the staff at Partners In Excellence to apply sunscreen (provided by Partners in Excellence).
- ___ Partners staff have permission to **ONLY** use the brand/type of sunscreen that I have provided.
Note: If your child does not have his/her own sunscreen, he/she will not be allowed to go outside.
- ___ My child does not need to wear sunscreen.

Parent/Guardian's Name: _____ Date: _____

Parent/Guardian's Signature: _____

NOTE: DO NOT RELY ON SUNSCREEN ALONE TO PROTECT CHILDREN FROM SKIN CANCER!
You may also send in hats and sunglasses to help protect your child.

Parent Handbook Acknowledgement Form

By signing the Parent Handbook Acknowledgement Form, you are indicating that you have read, understand and agree to follow the Policies and Procedures relating to parents. The Parent Handbook consists of a basic outline of Partners In Excellence Autism Therapy services and expectations. Please keep this handbook in a safe place to use it in the future for reference and information.

The Parent Handbook is subject to change without notice. Parents will receive notification of these changes.

Thank you,

Deb Thomas, Chief Executive Officer

Child's Name _____ Date of Birth _____

My signature indicated that I have received a copy of the Parent Handbook. I understand that it is my responsibility to read, understand and follow the Policies and Procedures outlined in this handbook and any future revisions.

Parent Signature _____ Date _____

Client Bill of Rights *(Parent copy)*

Partners In Excellence believes in treating children and their families with respect and dignity. We are also committed to abiding by the laws and public policies, which govern relationships between consumers and agencies providing health services.

Partners In Excellence acknowledges that the clients and their families have the following rights:

- You and your child have the right to receive courteous treatment and appropriate care based on your needs.
- You have the right to know the qualifications/credentials of the staff.
- You have the right to receive information about your child's treatment in language you can understand. This includes being informed of the therapy program and the nature and purpose of the treatment as it relates to your child.
- You have the right to know the estimated length of the therapy, costs, goals and all the information related to the progress of your child.
- You have the right to make decisions about your treatment plan prior to and during the course of treatment.
- You have the right to refuse to provide information at any time. However, lack of information may affect our ability to help your child and reduce the possibility of receiving outside funding for the services provided.
- You have the right to refuse treatment or request alternate staffing.
- You have the right to review your child's internal therapy records – Records Partners In Excellence may have received from outside sources cannot be released to you.
- You have the right to every consideration of privacy of information.
- You have the right to request the release of information to any person or organization you choose.
- You have the right to receive complete information about our services.
- You and your child have the right to receive services free from sexual harassment (both physical and verbal).
- You have the right to receive services and be free from any form of exploitation.
- You have the right to be informed of the policies and procedures of Partners In Excellence
- You have the right to not be terminated from our program without explanation and/or notice.
- You have the right to express dissatisfaction or request a change in the treatment plan without restraint, interference, coercion, discrimination or reprisal.

- You have the right to not be discriminated against on the basis of race, religion, age, gender, ethnic origin, creed, sex, sexual orientation, arrest or conviction record, or status with regard to public assistance.
- You have the right to file a complaint or grievance.

Client Responsibilities

As a client of Partners In Excellence, you have responsibilities as well as rights.

- You are responsible to be clear and direct about your child and his/her disability or developmental delays. It is important for you to provide complete and accurate information about your child's medical history, medications and any other matters relating to your child.
- You are responsible to understand your child's treatment plan. Your willingness to follow home program requests bears directly on the success of your child's treatment.
- You are responsible for arranging payment for the services you receive.
- You are responsible for keeping your scheduled appointments. If your child cannot keep an appointment, please advise us as soon as you can. We recognize that children get sick unexpectedly and miss scheduled appointments. Partners In Excellence does reserve the right to discharge your child when three out of four consecutive appointments are missed without advance notice. Therefore, you must advise scheduling as soon as possible whenever your child is unavailable for a scheduled appointment.
- You are responsible for respecting the right of privacy and confidentiality of other clients in our center. This is especially true of other clients you meeting when participating in group situations meeting in settings outside of the center.
- You are responsible to help us assure that our therapy center feels safe and all are protected. Partners In Excellence reserves the right to terminate contact with individuals who engage in abusive language or behavior, any form of harassment or who are perceived to be under the influence of alcohol or drugs.

Health Insurance Portability and Accountability Act Privacy Notice (HIPAA)
(Parent Copy)

This notice describes how Partners In Excellence (Partners) uses and discloses your medical and other identifying Protected Health Information (PHI). In addition, this notice describes your legal rights in regards to your records, and the process for accessing your records. Please review this notice carefully.

As part of providing services, Partners In Excellence will collect PHI about your child's health care and your family. Partners In Excellence needs this PHI to provide quality services and to comply with certain legal requirements. This notice applies to all records generated by Partners In Excellence. This law requires us to:

- Make sure that records with identifying PHI are kept private;
- Give you this notice of our legal duties and privacy practices with respect to PHI; and
- Follow the terms of the Privacy Notice that is currently in effect.

How Partners May Use and Disclose PHI

Listed below are a number of reasons or ways in which Partners In Excellence may disclose PHI. In each category, there is an explanation of the reason and usually an example. This notice does NOT LIST EVERY USE OR DISCLOSURE IN A CATEGORY. The reasons Partners In Excellence might disclose PHI includes:

- **For Treatment:** Partners In Excellence may disclose PHI to Partners In Excellence personnel or outside of Partners In Excellence to others who are involved in providing care to you or your child. For example, Partners In Excellence Senior Therapists meet weekly to discuss challenging behaviors and programming and may share PHI at that time. In addition, with written consent, Partners In Excellence may communicate with your child's County Case Manager.
- **For Payment:** Partners In Excellence may use and disclose PHI so that services may be billed and payment may be collected from an insurance company or a government health program. Partners In Excellence may also tell your health plan about a service your child may receive to obtain prior approval or to determine whether your health plan will cover the treatment. As legal guardians, you must provide informed consent for Partners In Excellence to release this PHI.
- **For Health Care Operations:** Partners in Excellence may use Partners In Excellence to run our program and to make sure Partners In Excellence is providing quality services or to decide if services should be changed or modified.
- **As Required by Law:** Partners In Excellence will disclose PHI when required by federal, state, or local law. For example, state law requires Partners to report suspected abuse or neglect to the proper authorities, which will require the release of PHI. This use of PHI does not require consent.
- **To Avoid a Serious Threat to Health or Safety:** Partners In Excellence may use or disclose PHI when necessary to prevent a serious threat to your child's health and safety or the health and safety of the public or another person. As legal guardians, you will have the opportunity to provide written consent for this use of PHI.
- **Military and Veterans:** If you are a member of the armed forces, Partners In Excellence may release PHI about you as required by military command authorities without additional consent.
- **Workers' Compensation:** Partners In Excellence may release PHI for workers' compensation or similar programs when required by law to do so. For example, if you are involved in a claim for

workers' compensation benefits, Partners In Excellence may release PHI requested about your child's health.

- **Health Oversight Activities:** Partners In Excellence may disclose PHI to a health oversight agency for activities authorized by law. Examples are government audits, investigations, inspections and licensure.
- **Lawsuits and Disputes:** If you are involved in a lawsuit or dispute, or if there is a lawsuit or dispute concerning our services or someone who provided services to you, Partners In Excellence may disclose PHI in response to a court or administrative order. Partners In Excellence may also disclose PHI in response to a subpoena, discovery request, or other lawful process from someone else involved in the dispute, but only if efforts have been made to inform you about the request prior to providing the PHI to allow you to obtain an order protecting the PHI requested.
- **Law Enforcement:** In certain situations, Partners In Excellence may release PHI to law enforcement officials. For example, Partners In Excellence might release PHI about you to identify or locate a missing person; about a death at Partners In Excellence that may be the result of criminal conduct; or in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description of location of the person believed to have committed the crime.
- **Coroners, Medical Examiners and Funeral Directors:** Partners In Excellence may release PHI to a coroner or medical examiner to identify a deceased person or determine a cause of death. Partners In Excellence may release PHI to funeral directors as necessary to help them carry out their duties.
- **National Security and Intelligence, Protective Services for the President and Others:** Partners In Excellence may release PHI to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
- **Correctional Programs:** If you are an inmate or in the custody of a law enforcement officer, Partners In Excellence may release PHI to the correctional institution or law enforcement official, to protect your health and safety or the health and safety of others.

Your Rights and Your Child's Rights Regarding Your Protected Health Information

As legal guardians for your child, you have the following rights:

1. To Inspect and Copy Partners In Excellence Service Records: Usually this includes medical and billing records but may exclude psychotherapy notes. To inspect and copy PHI in your record you must submit a request in writing to the Chief Executive Officer or HIPAA Compliance Officer. Partners In Excellence is allowed to charge a reasonable fee for the costs of copying, mailing or other costs related to your request.

In very limited circumstances Partners In Excellence may deny your request. If Partners In Excellence denies your request you may ask that the denial be reviewed. Another licensed health care professional of Partners In Excellence will then review your request and either uphold the original decision or reverse it.

2. To Amend Your Records. If you believe that the PHI Partners In Excellence has about you and/or your child is incorrect or incomplete; you may make a written request to the HIPAA Compliance Officer to amend the PHI. You must include a reason that supports your request.

Partners In Excellence may deny the request if it is not in writing or does not include reasons to support the request. Partners In Excellence may also deny your request if you ask us to amend PHI that:

- was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;

- is not part of the PHI kept in our file;
- is not part of the PHI you would be permitted to inspect and copy or
- Partners In Excellence believes the PHI is accurate and complete.

If you disagree with the denial, you may submit a statement of disagreement. If you request an amendment to your record Partners In Excellence will include your request in the record, whether the amendment is accepted or not.

3. To Receive an Accounting of Disclosures: Partners In Excellence will keep a log of disclosures made on or after April 13, 2003, other than disclosures for treatment, billing or health care operations. You have the right to request the list of disclosures. You must submit a written request to the HIPAA Compliance Officer. The request may not cover more than a six-year period.

4. To Request Restrictions: You may request a restriction on the disclosure of PHI for treatment, payment or health care operations. Your request must be in writing to the HIPAA Compliance Officer. Your request must clearly state 1) what PHI is to be limited 2) whether you want to limit our use, our disclosure or both; and 3) to whom you want the limit to apply. For example, you could ask that Partners In Excellence not use or disclose PHI to a certain person about services your child has received.

Partners In Excellence does not have to agree to your request to restrict access to PHI. If Partners In Excellence does agree, Partners In Excellence will comply with your request unless the PHI is needed to provide emergency treatment or to comply with a lawful and legal request or investigation.

5. To Request Alternative Ways to Communicate: You may request that Partners In Excellence communicate with you about services in a certain way or at a certain location. For example, you can ask that Partners In Excellence contact you only at work, or only by mail. Your request must be in writing, must tell us how you would like us to communicate with you, and must be sent to the HIPAA Compliance Officer. Partners In Excellence will accommodate all reasonable requests.

6. To Receive a Paper Copy or Electronic Copy of this Notice: You have the right to receive a paper or an electronic copy of this notice from the HIPAA Compliance Officer.

Additional Rights Under State Law: State privacy laws may provide additional privacy protections. Any such protections will be attached in a separate State addendum to this Notice.

Changes to this Notice: Partners In Excellence may change this notice in the future. Partners In Excellence can make the revised or changed notice effect for PHI Partners In Excellence already have about you as well as any PHI Partners may create or receive in the future.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the HIPAA Compliance Officer or with the Secretary of Health and Human Services. All complaints must be in writing. Partners In Excellence will not retaliate against you for filing a complaint.

GET CONNECTED



Visit www.partnersmn.com to sign up for our NEWSLETTER



Find us on FACEBOOK

Partners In Excellence has a Facebook Page!

It's a fun, informative, and interactive place to get updated on news and events involving Partners, the autism community, and beyond! The wall is updated regularly with events, quotes/stories from the kids, and photos from various activities at Partners.

Don't forget to tell friends and family to follow us too!

