maple valley pediatric therapy

Notice of Privacy Practices and Signature of Acceptance/Agreement

Privacy Practice Agreement:

This notice is effective as of January 1, 2019 and we are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this Notice of Privacy Practices and to make new notice provisions for all health care information that we maintain. You may request a copy of the revised Notice from us.

You have the right to file a formal, written complaint with us at the address below or with the Department of Health and Human Services, Office of Civil Rights, in the event that you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

Maple Valley Pediatric Therapy
A Division of Relaxing Resources, PLLC
Security Officer: Christie Armitage, OTR/L
22443 SE 240th Street Suite 206
Maple Valley, WA 98038
425-358-3070

Office of Civil Rights
U.S Department of Health and Human Services
2201 Sixth Avenue – Mail Stop RX - 11
Seattle, WA 98121
206-615-2290; 206-615-2296 (TDD)

(Please print) I, _____ the parent/legal guardian of *(child's name)* _____, have read and agree with this Notice of Privacy Practices.

Parent/Guardian Signature: _____ **Date:** _____

Consent to Contact:

I understand that contact by phone and/or e-mail messages (including any attachments transmitted), may contain legally privileged and confidential information intended solely for the use of the addressee. If you have chosen to communicate *Patient Identifiable Information* by e-mail, or allowing communication to any persons other than yourself, you are consenting to associated risks. Please note that communication by e-mail is not secure and WE cannot guarantee that information transmitted will remain confidential. *You may rescind this permission at any time.*

(Please Print) I, _____ hereby authorize Maple Valley Pediatric Therapy to communicate with the following person/s listed below about my child regarding the specified topics/information in which I have indicated by marking the adjacent box below:

Primary contact: _____ Relationship to child: _____
Home phone: _____ Mobile phone: _____ Work Phone: _____
Email: _____

Check all that apply: ☐Billing/Financial ☐Report Results ☐Appointments/scheduling ☐Informational handouts ☐ General communications

Secondary contact: _____ Relationship to child: _____
Home phone: _____ Mobile phone: _____ Work Phone: _____
Email: _____

Check all that apply: ☐Billing/Financial ☐Report Results ☐Appointments/scheduling ☐Informational handouts ☐ General communications

Other contact: _____ Relationship to child: _____
Home phone: _____ Mobile phone: _____ Work Phone: _____
Email: _____

Check all that apply: ☐Billing/Financial ☐Report Results ☐Appointments/scheduling ☐Informational handouts ☐ General communications

Parent/Guardian Signature: _____ **Date:** _____

Authorization to Photograph/Video Record

Our therapists frequently employ photos and/or video recordings during evaluations and review privately as a tool to accurately evaluate our clients. We may also use photography/video recording during regular treatment sessions as a tool to motivate and/or educate. If, for any reason, the staff or myself wishes to use or share video recordings in any form outside of the clinical setting, I will be provided with a form pertaining to such use in which to record my written consent. **This authorization is strictly for professional in clinic use only.**

Please Print: I, _____ hereby authorize the taking of photos and/or video recording of my child to be viewed by the staff at Maple Valley Pediatric Therapy. I understand that photos and/or video recordings cannot be released without my specific written consent. I understand that this consent can be revoked at any time.

Parent/Guardian Signature: _____ **Date:** _____