POTOMAC RIVER CLINIC

Dear Parents,

Thank you for your interest in Potomac River Clinic. Information regarding our program is enclosed along with forms that should be completed and returned prior to your first appointment.

Please include any medical, psychological, therapy, and/or educational reports that may assist us in better understanding your child.

All correspondence should be addressed to:

Will Mellon
Potomac River Clinic
4880 MacArthur Boulevard, NW
Washington, DC 20007

If you have any questions, please do not hesitate to contact us at 202-333-1403, or by email at wmellon@potomacriverclinic.org

Sincerely yours,

Meredith Ouellette M.S., CCC-SLP
Director of Clinical Services
Potomac River Clinic

POTOMAC RIVER CLINIC

Pediatric Intake

Child's Name: _____

Enclosed is the intake packet for all new clients. Please contact us at 202-333-1403 should you have any questions. Check that all forms are completed, and documents are attached. You may return the forms by mail, fax, or email at your earliest convenience.

_____ Contact Information

_____ Pediatric Case History

_____ Credit Card Payment Information

_____ Medical Record(s) Release

_____ Insurance Information

_____ Client Information Letter and Fee Schedule

_____ Advanced Beneficiary Notice regarding Durable Medical Equipment (DME)

_____ *Obtaining Health Insurance Coverage for DME

_____ *Policy on Accounts Receivable

_____ *Notice of Privacy Practices

_____ Notice of Privacy Practices Signature Page

_____ Outside Reports and Test Results
- Audiological Information (e.g., audiogram, ABR/OAE test results, imaging, etc.)
- Speech/language and/or developmental evaluation
- Occupational, psychological, educational

**Keep for your records*

POTOMAC RIVER CLINIC

Contact Information

Date: _____

Child's information
Name:
Mailing address:
Home phone number:
Parent/Caregiver's contact information
Name:
Address (if different from above):
Employed by:
Home phone number:
Work phone number:
Cell phone number:
Email address:
Parent/Caregiver's contact information
Name:
Address (if different from above):
Employed by:
Home phone number:
Work phone number:
Cell phone number:
Email address:

POTOMAC RIVER CLINIC

PEDIATRIC CASE HISTORY

1. General Information

Client Name: _____ Age: _____

Date of Birth: _____ Gender: _____

What is a convenient time to reach you by telephone? _____

Preferred email address: _____

Pediatrician: _____ Otolaryngologist (ENT): _____

List five words that describe your child:

_____

_____

How did you hear about Potomac River Clinic? _____

How do you think Potomac River Clinic might benefit your child?

_____

_____

2. Family Information

Language(s) spoken at home: _____

Child Lives with: Parents: ___ Mother: ___ Father: ___ Other: ___

Siblings: Name Age Remarks

1. _____
2. _____
3. _____
4. _____

Caregivers/extended family (babysitter, nanny, daycare, grandparents):

1. _____
2. _____
3. _____

3. Pregnancy and Birth History

At what hospital was your child born? _____

Was the pregnancy abnormal in any way? *Yes / No*

If yes, briefly explain: _____

_____

_____

POTOMAC RIVER CLINIC

PEDIATRIC CASE HISTORY CONTINUED

Was the delivery abnormal in any way? *Yes / No*

If yes, briefly explain: _____

Was the delivery premature? *Yes / No*

If yes, at how many weeks was your child born? _____

Did your child stay in the Neonatal Intensive Care Unit (NICU) for any period of time after birth? *Yes / No*

If yes, why and how long was the stay? _____

Did your child undergo any medical or surgical treatment upon birth? *Yes / No*

If yes, please list treatment received. _____

Did the mother have any illness during the pregnancy? *Yes / No*

If yes, briefly explain: _____

After birth did your child have difficulties? *Yes / No (check all that apply)*

Breathing ___ Surgery? ___

Require incubator ___ Any infections requiring medication? ___

Any head, neck or ear abnormalities ___ Treatment for jaundice (yellow coloration of the skin) ___

Feeding problems ___

If yes, to any of the above, briefly explain:

_____
_____
_____
_____

4. Child's Medical History

Do you have medical concerns about your child?

If yes, explain:_____
_____
_____
_____
_____

POTOMAC RIVER CLINIC

PEDIATRIC CASE HISTORY CONTINUED

Please check if your child has had any of the following:

Ear infections ___
Ear surgery ___
Hospitalization ___
Head trauma/injury ___
Meningitis ___
Measles ___
Mumps ___
Chicken pox ___
Seizures ___
Kidney problems ___
Vision problems ___
Allergies ___
Asthma ___
Noise exposure ___
(e.g., farm equipment, loud music, etc.)

Please list any prescription or over-the-counter medications your child is taking and for what reason(s):
_____
_____
_____

Any other significant medical concerns:
_____
_____
_____

Milestones: (fill in the approximate age at which the following occurred)

Sat up: _____ First Word: _____
Walked: _____ Two-word combined: _____

Please indicate how your child communicates with you, and how you communicate with your child:
_____
_____

5. Hearing History

Do you have any concerns about your child's hearing? *Yes / No*

If yes, explain: _____
_____
_____
_____

Does anyone in your family have hearing loss (immediate and extended family) that began before the age of 30?

Yes / No If yes, please list:_____

POTOMAC RIVER CLINIC

PEDIATRIC CASE HISTORY CONTINUED

Does anyone in your family have night blindness? *Yes / No*

Does your child have a history of ear infections? *Yes / No*

Does your child consistently respond to your voice? *Yes / No*

Does your child respond to loud noises? *Yes / No*

When sound is present or someone is speaking, does your child search for the source? *Yes / No*

Does your child respond to sounds from other rooms? *Yes / No*

Does your child enjoy listening to music? *Yes / No*

Has your child's hearing ever been tested? *Yes / No*

If yes, please list by whom, when and results:_____

6. Audiological Information

Did your child pass the newborn hearing screening? *Yes / No*

If ***No***, please circle which ear referred (or both): *Right / Left / Both*

Cause of Hearing Loss:_____

Age at which Hearing loss was first diagnosed:_____

Name of the Audiologist: _____ Center testing was completed _____

Telephone#: _____ E-mail: _____

Date of Last Audiogram: _____
(please include copies of most recent audiogram, ABR and/or OAE test results)

Hearing Aids

When was your child fit with hearing aids? Date:_____

Where was your child fit with his/her hearing aids? Clinic: _____

What is the name of the audiologist that fit/programmed your child's hearing aids?

Audiologist: _____

What make and model of hearing aid(s) does your child have?

RIGHT _____ LEFT _____

POTOMAC RIVER CLINIC

PEDIATRIC CASE HISTORY CONTINUED

Cochlear Implants

When did your child receive their implant?

Surgery Date:_____ Activation Date:_____

Which ear? (please circle) RIGHT / LEFT

If your child is bilaterally implanted when did they receive their second implant?

Surgery Date:_____ Activation Date:_____

Which ear? (please circle) RIGHT / LEFT

What center was your child implanted?

City, State: _____ Implant Center(s):_____

What is the name of your child's surgeon? _____

What is the name of audiologist who performed the cochlear implant activation? _____

What implant manufacturer does your child use? *(i.e., Advanced Bionics, Cochlear, MED-EL)*

RIGHT _____ LEFT _____

What model of implant (internal device) does your child have? *(e.g., Nucleus Slim, HiRes Ultra, Synchrony, etc.)*

RIGHT _____ LEFT _____

What model of external processor does your child currently use? *(e.g., Naida, N7, Rondo, etc.)*

RIGHT _____ LEFT _____

What model of back-up external processor does your child use? *(e.g., Neptune, N6, SONNET, etc.)*

RIGHT _____ LEFT _____

What is the date your child's device(s) were last programmed/mapped?

RIGHT _____ LEFT _____

Does your child:

Turn to loud sounds? _____

Respond to: Music: ____ Door knock: ____ Telephone: ____ Name: ____

POTOMAC RIVER CLINIC

PEDIATRIC CASE HISTORY CONTINUED

7. Speech and Language History

Do you have any concerns about your child's speech and language? *Yes / No*

If yes, briefly explain:_____
_____
_____

About what age did your child:

Follow simple directions: _____
Say his/her first word: _____
Put two words together: _____

Did your child continue adding words after the first word? _____

If your child is 2 years old or younger, how many words does he/she use? _____

Does your child often use gestures when communicating? *Yes / No*

Is your child's speech understood by:

Parents *Yes / No*
Siblings *Yes / No*
Adults *Yes / No*

Has your child's speech ever been evaluated? *Yes / No*

If yes, please list by whom, when and results: _____

Is your child currently receiving speech therapy? *Yes / No*

8. School Settings and Schedule

Does your child attend nursery school/preschool/school? *Yes / No*

Name of School or Program: _____
Grade: _____
Teacher: _____
Telephone Number: _____
Fax Number: _____
E-mail address: _____

Does your child participate in any extracurricular activities?

Please List: _____
_____

POTOMAC RIVER CLINIC

PEDIATRIC CASE HISTORY CONTINUED

9. Additional History

Do you have any other concerns about your child? *Yes / No*

If yes, briefly explain: _____
_____
_____
_____

Does your child:

Play/interact well with other children? *Yes / No*
Have attention/concentration difficulties? *Yes / No*
Receive any special education services? *Yes / No*

If yes to any of the above, briefly explain: _____
_____
_____

Do you feel your child is having difficulty at school? *Yes / No*

If yes, please explain: _____

10. Statement of Nondiscriminatory Policy

Potomac River Clinic admits children of any race, color and national or ethnic origin to all the rights, privileges, programs, and activities it provides. The following information is optional and is used to collect statistical data.

Applicant's (child's) race: _____ (optional)

POTOMAC RIVER CLINIC

PEDIATRIC CASE HISTORY CONTINUED

11. Other Evaluations (Please include copies of any relevant evaluations or reports (e.g., IFSP/IEP, OT, Psychology, Educational, etc.)

Agency	Date

Does your child receive any other services? (e.g. speech therapy, occupational therapy, physical therapy, psychosocial, etc.) during the week? *Yes / No*

If yes, please list what type, frequency, duration, clinician, and center/school providing service:

Example: Speech therapy twice per week for 30 minutes with John Doe through Lincoln Elementary school

Service	Frequency	Duration	Clinician	Center/School

POTOMAC RIVER CLINIC

CREDIT CARD PAYMENT INFORMATION

I hereby authorize Potomac River Clinic to charge my credit card for the purpose of all services rendered and equipment on behalf of myself or my child, _____.

I understand that the charges to the below referenced credit card account will be based on charges that are due and payable at the time of the credit card transaction.

I understand that this agreement is between myself and Potomac River Clinic.

Name as it appears on card: _____

Type of Card: (circle one) VISA MASTER CARD

Account Number: _____

CVT CODE (3-digit security code/back of the card): _____

Expiration Date: _____

Cardholder Signature: _____

Credit Card billing address: _____

_____

Telephone number: _____

Today's Date: _____

POTOMAC RIVER CLINIC

MEDICAL RECORD(S) RELEASE

To/From: Potomac River Clinic

To/From: _____

_____

_____

The medical records for the following individual(s):

Name: _____

DOB: ____/____/____ **Phone:** _____

Address: _____

_____

☐ All Records ☐ Audiology Records ☐ Surgical Notes Only ☐ Other: _____

Reason for Transfer of Records:

☐ Collaboration of Care

☐ Change of Insurance to: _____

☐ Relocation [if yes new address]: _____

_____

☐ Other: _____

I hereby authorize you to release any information including the diagnosis and records of any treatment or examination rendered for the above specified patient.

Signed: _____ Date: ____/____/____

As pursuant to Virginia Law (VA Code 8.01-413) charges will be as follows: A fee of $15.00 for handling and a fee of $ 0.50 per page up to 50 pages, plus $ 0.25 per page for each page over 50 shall be posted to the patient account as one-line item and the payment posted against it.

Example: A 62-page chart; $25.00 (50 pages x $0.50) + $3.00 (12 pages x $0.25) = $28.00

Mailed on _____/_____/_____ Picked Up on _____/_____/_____

POTOMAC RIVER CLINIC

MEDICAL CLEARANCE FOR HEARING AID FITTING

Patient's name _____ Date of Birth _____

Address _____

City _____State_____ Zip _____

I have provided a medical examination of the ☐ right, ☐ left, ☐ both ear(s) for *(name of patient)* _____ on *(date of service)* _____ and certify that he/she may be considered a candidate for a hearing aid. I am therefore referring this patient for further audiological evaluation and testing.

Signature of physician _____

**Prospective hearing aid users under the age of 18 years of age must obtain a medical clearance from a physician (preferably one who specializes in diseases of the ear) prior to being fit with amplification. The medical clearance must have occurred in the last six months. Neither the child or their parent or guardian may waive this medical clearance requirement.

POTOMAC RIVER CLINIC

INSURANCE INFORMATION

Client's Name: _____ Date of Birth: _____ Gender: _____

INSURANCE	PRIMARY	SECONDARY
Company Name:		
Subscriber's Name:		
Subscriber's Date of Birth:		
Insurance Mailing Address:		
Member ID #:		
Group #:		
Provider's Phone #:		

****** PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD**

Please read carefully and sign below.

I authorize Potomac River Clinic to bill directly my/our insurance for services and/or durable medical equipment (DME) rendered. I understand that if an insurance payment is not received within 90 days of billing, Potomac River Clinic will bill me for the amount, which will become due immediately. If after I pay the charges and an insurance payment is received at a later date, Potomac River Clinc will credit my account and issue a refund. I understand that, under certain circumstances, therapy may be suspended until an overdue account is settled.

Signature of Client or Parent/Guardian: _____

Name (print): _____

Date: _____

Office Use Only:
Rep: _____
Comments: _____
_____
_____
_____
Initials: _____

POTOMAC RIVER CLINIC

CLIENT INFORMATION LETTER AND FEE SCHEDULE

Effective July 1, 2021

EVALUATION FEES

Psycho-educational Testing	$2,000 - $3,500
Occupational Therapy Evaluation	$700
Speech-Language Evaluation	$450
Audiological Evaluations	$200 - $400
Central Auditory Processing Evaluation	$350 - $500

TREATMENT FEES	**Individual**	**Group**
Occupational Therapy	$150	$100 per child
Speech-Language Therapy	$150	$100 per child
Psychological Testing	$150	

Treatment fees are based on individual, 60-minute appointments. The therapist/tutor will use 5-10 minutes of each individual appointment to provide the parent with written and verbal feedback about that day's session.

BILLING

Services are billed monthly and can be paid by cash, check, or credit card. A $25 service charge will be added for any returned checks. Potomac River Clinic will bill insurance companies on your behalf. Potomac River Clinic reserves the right to terminate a contract due to non-payment or repeated late payment.

CANCELLATION POLICY

If you fail to cancel an appointment 24 hours in advance, you will be billed the full amount of the visit. If your child becomes ill unexpectedly (e.g., during the school day), please notify us immediately for the absence to be considered excused. Our cancellation policy enables us to provide quality care, keep our charges reasonable, and retain our excellent staff.

SNOW AND EMERGENCY CLOSING POLICY

Potomac River Clinic will only be closed when DC Public Schools are closed for snow or an emergency.

SUSPENSION AND TERMINATION POLICY

Potomac River Clinic reserves the right to suspend services at any time and at its discretion.

Please read carefully and sign below. I authorize Potomac River Clinic to bill directly my/our insurance for services and/or durable medical equipment (DME) rendered. I understand that if an insurance payment is not received within 90 days of billing, Potomac River Clinic will bill me for the amount, which will become due immediately. If after I pay the charges and an insurance payment is received at a later date, Potomac River Clinic will credit my account and issue a refund. I understand that, under certain circumstances, therapy may be suspended until an overdue account is settled.

Signature of Client or Parent/Guardian: _____

Name (print): _____

Date: _____

Office Use Only:
Rep: _____
Comments: _____
_____
_____
_____
Initials: _____

POTOMAC RIVER CLINIC

ADVANCE BENEFICIARY NOTICE (ABN)

DURABLE MEDICAL EQUIPMENT

Effective July 1, 2021

Potomac River Clinic requires payment in advance for Durable Medical Equipment (DME). These include hearing aids, FM/DM systems, cochlear implant equipment, and any accessories/parts.

Potomac River Clinic will obtain authorization from your health insurance to reimburse you for items covered by your plan. However, there is no guarantee that your insurance plan will cover the cost of the items received. The patient or the patient's legal guardian remains liable for payment of any DME received. Therefore, you are accepting personal financial responsibility.

Payment is due in full at the time the DME is dispensed with either a personal check, money order, cash, or Visa/Master Card. Potomac River Clinic will then submit a courtesy bill to your health plan. If a partial payment is received by your health insurance, Potomac River Clinic will reimburse you the amount that was collected. It typically takes a minimum of 30 to 45 days to receive reimbursement.

Please contact your health plan directly for details regarding coverage of DME. Use the telephone number listed on your insurance card and give the insurance representative your policy number and the date of service indicated on your invoice. The representative should be able to provide you with the coverage amount for DME and status of the claim.

CODE	DESCRIPTION
V5257	Hearing Aid, digital, monaural, BTE
V5261	Hearing Aid, digital, binaural, BTE
V5264	Custom Earmold/ear piece (Not disposable)
V5265	Disposable ear mold, dome inserts, complied mold
V5266	Battery for use in hearing device (HA, FM/DM)
V5267	Hearing Aid or ALD supplies/accessories
V5014	Repair/Modification of hearing aid
V5281	ALD, Personal FM/DM system, monaural
V5282	ALD, Personal FM/DM system, binaural
V5283	ALD, Personal FM/DM system, neckloop
V5290	ALD, Personal FM/DM system, microphone

CODE	DESCRIPTION
L8619	CI External Processor replacement
L8621	Zinc air battery for CI
L8622	Alkaline battery for CI
L8623	Lithium Ion battery for CI, body worn
L8624	Lithium Ion battery for CI/BAHA, ear level
L8691	Auditory Osseointegrated device processor, replacement
L8692	Auditory Osseointegrated device processor, new
L9900	CI/Bone anchored, supplies and accessories
V5273	ALD for use with CI
V5286	ALD, Bluetooth FM/DM receiver

You will be responsible for any unpaid balance of DME regardless of what the insurance covers.

I have received and read Potomac River Clinic's *Policy on Durable Medical Equipment* and agree adhere to its terms.

_____ _____

Signature Date

_____

Name (print)

POTOMAC RIVER CLINIC

Obtaining Health Insurance Coverage for DME

Depending on your health care provider coverage, DME may be covered either as new equipment or as a "replacement."

Contact your health care provider by calling the member services phone number on the back of your insurance card and find out what is the specific coverage for DME under your plan

Below are examples of different codes you may need to provide depending on the equipment being purchased.

Hearing Aids	**HCPCS or CPT Code**
hearing aid monaural	V5261
hearing aids bilateral	V5257
Sound Processors	
cochlear implant processor	L8619
bone anchored hearing aid for use with softband	L8691
FM/DM Systems	
personal FM/DM system, monaural receiver	V5281
personal FM/DM system, binaural receivers	V5282

Typically, replacement of processors and/or hearing aids are covered under the DME benefits section of your health plan. If you do not have DME benefits, ask your insurance provider if they will consider covering the billing code under your major medical benefits.

Ask your health insurance representative:

1. If a prior authorization is needed. If NOT, ask if they will allow you to submit a "Predetermination of Benefits". Prior authorization and predetermination are not guarantees of payment.

2. If they will process your claim at the in-network benefit level for processors since Advanced Bionics and Cochlear Corporation are the sole providers of cochlear implant products.

3. What are your out-of-pocket expenses, for example, co-insurance, deductibles, reimbursement rate of the hearing aid or processor, and if your policy has a DME maximum limit. If your plan does have a DME maximum limit, you will be responsible for any amount over that limit.

4. If a Letter of Medical Necessity is needed. If yes, request one from your healthcare provider.

As a courtesy we will submit the claim for reimbursement. However, if you want to submit charges you will need to ask your health insurance representative how to submit a claim for reimbursement.

(keep for your records)

POTOMAC RIVER CLINIC

POLICY ON ACCOUNTS RECEIVABLES

Effective July 1, 2021

1. **Please open and review your monthly statement as soon as you receive it.** It clearly states, monthwise, services rendered, charges, any payment we have received (from insurance, other third party, or from you, the client), how these payments have been applied to outstanding charges, the balance payment due from each month of services, and how old these unpaid charges are. If you dispute the numbers, have a question or simply need a clarification, call us immediately. This will help us keep your account up to date and accurate.

2. **The last line on the statement reads 'Total Amount Due from Client as of this statement'. Please note that you are expected to pay the amount that is due, not just the amount that is past due.** To allow for insurance processing time, we allow 90 days before an amount becomes past due. This is more than most clinics allow (at most other places, it is only 30 days). Please pay your outstanding balance as soon as you can, but in any case before it becomes past due (i.e., if you have an outstanding balance that is 60 days old in this copayment statement, pay it within this month; if unpaid, it will become 90 days old, or past due, on the last day of this month).

3. **If your insurance does not settle within 90 days or if they make a partial payment and you are expecting them to make an additional payment in the future, the charges are still considered past due if they are 90 days or over.** Please go ahead and clear them, and if your insurance settles (or makes an additional payment) at a future date, your account will be credited and, if your account shows a net credit, you will receive a prompt refund from us. {The previous paragraph does not apply to Aetna, Anthem, CareFirst, Sentara, Medicaid or Tricare subscribers who are only responsible for the amount their insurance company directs them to pay, for example, deductibles, copays per session and/or coinsurance. All other clients, please note that we are not participating providers with your insurance and, while we file the insurance claim for you as a service, you are ultimately responsible for all the charges.}

4. **We strongly encourage you to give us your credit card number and authorization to charge your credit card for any past-due amounts on the day they become past due.** We will try to give you a call a week before the past-due date and alert you to the upcoming charge. To avoid your credit card being charged, please pay the amounts on your statement that are 60 days or over within the following month.

5. **Under our new policy, any unpaid past-due amount will be charged an interest of $1.50 per $100 per month.** Outstanding balance that is past due is shown in bold lettering in your statement. Past dues are unacceptable. If they are not immediately cleared, your account will be deemed delinquent. Under our policy, further therapy may be suspended until your account is cleared of past-due charges.

6. **If a client consistently ignores past-due balances, the account will be turned over to our lawyer or a professional collection agency (this could affect the client's credit rating).** No one from Potomac River Clinic will call the client prior to taking this step.

7. **Co-pays are billed to clients after payment is received from your insurance company**.

(keep for your records)

POTOMAC RIVER CLINIC

NOTICE OF PRIVACY PRACTICES

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We, Potomac River Clinic, are required by applicable federal and state laws to maintain the privacy of your child's protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your child's protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect July 1, 2021, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us by using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your child's protected health information about your child for treatment, payment, and health care operations. The following are examples of the types of uses and disclosures of your child's protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your child's protected health information to provide, coordinate or manage your child's health care and any related services. This includes the coordination or management of your child's health care with a third party. For example, we would disclose your child's protected health information, as necessary, to a home health agency that provides care to your child. We will also disclose your child's protected health information to other physicians who may be treating your child. For example, your child's protected health information may be provided to a physician to whom you and your child have been referred, to ensure that the physician has the necessary information to diagnose or treat your child.

In addition, we may disclose your child's protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your child's care by providing assistance with your child's health care diagnosis or treatment to your physician.

Payment: Your child's protected health information will be used, as needed, to obtain payment for your child's health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for your child, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to your child for protected health necessity, and undertaking utilization review activities.

Health Care Operations: We may use or disclose, as needed, your child's protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name as the parent or guardian of your child. We may also call you and/or your child by name in the waiting room when your child's doctor is ready to see you and your child. We may use or disclose your child's protected health information, as necessary, to contact you by telephone or mail a reminder to you regarding your child's appointment.

We will share your child's protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your child's protected health information, we will have a written contract that contains terms that will protect the privacy of your child's protected health information.

We may use or disclose your child's protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you and your child's health and/or treatment. We may also use and disclose your

POTOMAC RIVER CLINIC

NOTICE OF PRIVACY PRACTICES

child's protected health information for other marketing activities. For example, your child's name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to your child. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your child's protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your child's protected 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. Without your written authorization, we will not disclose your child's health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your child's protected health information that directly relates to that person's involvement in your child's health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your child's best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your child's care of your location, general condition or death.

Marketing: We may use your child's protected health information to contact you with information about treatment alternatives that may be of interest to you and your child. We may disclose your child's protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by contacting us by using the information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your child's protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your child's protected health information to the extent necessary to avert a serious and imminent threat to your child's health or safety, or the health or safety of others. We may disclose your child's protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose your child's protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your child's protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your child's protected health information if we believe that your child has been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your child's protected health information to a person or company required by the Food and Drug Administration to report adverse events; product defects or problems or biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your child's protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your child's protected health information when we are required to do so by law. For example, we must disclose your child's protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your child's protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your child's protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your child's protected health information to law enforcement officials.

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Law Enforcement: We may disclose limited information to law enforcement officials concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your child's protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your child's protected health information. You may also request access by sending us a letter to the address listed at the end of this notice. If you request copies, we will charge you $25.00 for each page or $10.00 per hour to locate and copy your child's protected health information, and postage if you want the copies mailed to you. If you would prefer, we will prepare a summary or an explanation of your child's protected health information for a fee. Please contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which The River School or our business associates disclosed your child's protected health information for purposes other than for treatment, payment, health care operations, and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided to you for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your child's protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Please contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your child's protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your child's protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your child's protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your child's protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Meredith S. Ouellette
Privacy Officer, Potomac River Clinic
4880 MacArthur Blvd., NW, Washington, DC 20007
(202) 337-3554

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NOTICE OF PRIVACY PRACTICES

SIGNATURE PAGE

I, (Print Name) _____, have received the Notice of Privacy Practices on (Date) _____, given to me by Potomac River Clinic. If I have any questions, or concerns, I realize that I can contact Meredith Ouellette, Potomac River Clinic's Privacy Officer, at 202-337-3554.

_____ _____

Signature Date