EARLY CHILDHOOD

ACCESS® Early Childhood offers comprehensive early education services, including early intervention strategies critical to improving developmental outcomes, within a team approach.

Using our original, language- and literacy-based curriculum, our team members are building the foundation for our students’ future academic success.

who we serve

- Children ages 6 weeks through kindergarten transition
- Children with developmental delays including:
  - Autism spectrum disorder
  - Childhood apraxia of speech
  - Articulation disorder
  - Central auditory processing disorder
  - Sensory integration disorder
  - Down Syndrome
  - Cerebral Palsy
  - ADHD
  - Other learning disorders
  - Typically-developing children

Call 501.217.8600
or unlock more information at accessgroupinc.org
The early childhood years are a critical part of a child’s development and lay the foundation for future academic success. ACCESS is a quality early childhood program offering individualized education focused on developing a child’s cognition and language, fine and gross motor skills and social-emotional development. Literature is the cornerstone of the curriculum, setting the stage for the study of math, science, social studies and history. These learning experiences are enriched with music, art, drama and technology. By using multi-sensory elements that involve touching, seeing and hearing, ACCESS instructs for all learning styles.

**TEAM APPROACH**

Each classroom has a low student-to-teacher ratio allowing staff to give each child the instruction required to meet their individual needs with a team of professionals including a highly qualified teacher and teaching assistant, along with a speech therapist, occupational therapist and physical therapist. Therapy sessions allow for frequent one-on-one interaction within and outside the classroom setting.

**UNIQUE CIRRICULUM**

The ACCESS Early Childhood curriculum literacy-based and uniquely designed to promote language, early literacy, and phonological development. Every activity is based on children’s literature to assist children with developing vocabulary to discuss and participate in activities. Whether they are participating in music or art, children are learning about math, science or social studies across the curriculum.

**SPECIALY-ENGINEERED CLASSROOMS**

Classrooms are designed with an intensive focus on reading and development of written expression, as well as vital social skills training. Creative, multi-sensory materials engage auditory, tactile and visual learners.

**RESEARCH-BASED PRACTICES**

Research has proven that vocabulary at age 3 is an indicator of the reading comprehension of a 9- or 10-year-old student. ACCESS places a heavy emphasis on vocabulary development for oral communication and comprehension, both of which have a direct impact on reading.

**IMPORTANCE OF PLAY**

Play is critical to the development of social, emotional, language, and motor skills. Play is a child’s work and provides the perfect setting to develop specific language, social, cognitive and motor skills.

become a part of our story...@accessgroupinc
Candidates for ACCESS Early Childhood must demonstrate the appropriate cognitive, language and behavioral skills to participate in classroom activities. We use information provided by parents, educators and medical professionals, along with observation by our team of special educators and therapists, to determine whether a child is eligible for classroom placement. Placement is also influenced by available staffing and the desire to maintain balanced-for-abilities classrooms for optimal learning environments.

A completed ACCESS Early Childhood application package contains:
Please note some of these documents are only needed for families seeking placement for atypically developing children; typically developing children need only complete the General Information Form and Receipt of Notice of Privacy Practices Written Acknowledgement Form and then contact Beth Rice to inquire about available placement.

- ACCESS General Information and Insurance Form
- Copy of Insurance Card
- Developmental History
- Receipt of Notice of Privacy Practices Written Acknowledgement Form
- Copy of Evaluations and Goals (If Previous Services Were Received)

Please return your completed package to:

Admissions Coordinator
ACCESS
10618 Breckenridge Dr.
Little Rock, AR 72211
admissions@acessgroupinc.org
501-217-8600 Phone
501-217-8636 Fax

Once your completed package has been received, we can consider your child for ACCESS Early Childhood placement. If a classroom placement is not available, we may refer you to another service provider and/or place your child on our contact list. In some cases, parents may opt to enroll their children in our outpatient therapy program while waiting for Early Childhood placement. Please don’t hesitate to contact our admission department at 501-217-8600 or submit an online inquiry at https://acessgroupinc.org/applications/
Today’s Date:_______________________  Admission Date:_____________________

Child’s Name:_________________________________  Date of Birth: ______________________

Gender: _____       Race:______________         Home Phone:_____________________________

Home Address:__________________________________________________________________

   Street                                       City                       State                         Zip

Gestational Age:  ________________________________________________________________

Child’s Diagnosis:  _______________________________________________________________

Child’s Primary Care Physician:_____________________________________________________

Child’s Social Security Number:_____________________________________________________

Child’s Medicaid or Tefra Number:___________________________________________________

Father’s Name:__________________________________Date of Birth ______________________

Father’s Address:______________________________

Occupation & Employer:______________________________

Father’s Work Number:___________________________________________________________

Father’s Cell Number _____________________________________________________________

Email address:___________________________________________________________________

Mother’s Name:_________________________________ Date of Birth ______________________

Mother’s Address:______________________________

Occupation & Employer:______________________________

Mother’s Work Number:___________________________________________________________

Mother’s Cell Number _____________________________________________________________

Email address:___________________________________________________________________

**Emergency contact name & number:**_____________________________________________

Child lives with: ____Father  ____ Mother    ____Both parents     ____ Guardian

This information is current as of the above date.  I will notify the office if any changes occur.  This information will be updated annually.

_________________________________________       ____________________
Parent/Guardian Signature                        date

_________________________________________       ____________________
Program Coordinator                              date
MEDICAL INSURANCE INFORMATION

Please complete this form in its entirety and provide copies (front and back) of your insurance cards.

Child receives therapy services: Y_____ N_____

Student’s Full Name _____________________________________________________________________
(As shown on Insurance Card)

Student’s SSN: ____________________   Student’s Date of Birth: ____________________

Parent’s Names __________________________________________________________________________

Address: ____________________________________________________________________________

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<thead>
<tr>
<th>Race:</th>
<th>Ethnicity:</th>
<th>Language:</th>
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<tr>
<td>[ ] 1-American Indian/Native Alaskan</td>
<td>[ ] H-Hispanic or Latino</td>
<td>[ ] Persian</td>
</tr>
<tr>
<td>[ ] A-Asian</td>
<td>[ ] N-Not Hispanic or Latino</td>
<td>[ ] Polish</td>
</tr>
<tr>
<td>[ ] B-Black or African American</td>
<td>[ ] 7-Declined</td>
<td>[ ] Portuguese</td>
</tr>
<tr>
<td>[ ] P-Native Hawaiian or Other Pacific Islander</td>
<td>[ ] 7-Declined</td>
<td>[ ] Russian</td>
</tr>
<tr>
<td>[ ] W-White/Caucasian</td>
<td>[ ] 7-Declined</td>
<td>[ ] Spanish</td>
</tr>
<tr>
<td>[ ] E-Other</td>
<td>[ ] 7-Declined</td>
<td>[ ] Arabic</td>
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<tr>
<td>[ ] Other</td>
<td>[ ] 7-Declined</td>
<td>[ ] Persian</td>
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</tbody>
</table>

Primary Insurance Company: ___________________________________________________________

Address ___________________________________________________________________________

Policy Holder ________________________________________________________________
(As shown on Insurance Card)

Policy Holders SSN: ____________________   Date of Birth: ____________________

Policy Number: _____________________________ Group Number _____________________

Secondary Insurance Company: ______________________________________________________

Address ___________________________________________________________________________

Policy Holder ________________________________________________________________
(As shown on Insurance Card)

Policy Holders SSN: ____________________   Date of Birth: ____________________

Policy Number __________________________ Group Number ________________________

Name on Medicaid Card: _________________________________________________________

Medicaid Type: __________________________ Effective Date: _______________________

ACCESS Group Inc. will file your insurance for you. However, this does not guarantee that your insurance company will pay for the services.

I hereby authorize ACCESS Group Inc. to furnish information to my insurance company concerning the care of my child. I assign all payments for services rendered to my child to the above. I understand that I am ultimately responsible for the payments due on all services.

If your child is relying on Medicaid Funding, it is your responsibility to ensure the status remains active. Medicaid/TEFRA paperwork not returned in a timely manner, may result in your child being referred to another provider.

Parent/Guardian/Member Signature __________________________ Date __________

(Version 04-7-2017)
Developmental History

I. IDENTIFYING INFORMATION

Child’s name: _______________________________  Birth Date: __________________________

Address: ___________________________________  *Gender ____________________________
          Street
          City  State  Zip Code  County

Parent(s) or Guardian(s): _______________________________

Home Telephone # ___________________  E-Mail ____________________________

Other Telephone #'s (work, cell, etc.)  (Mother) ___________________ (Father) ______________

School/Preschool (daycare) _______________________________  Grade _______________________

Who referred you to Access? _______________________________

Person completing this form: ________________________  Date: _________________________

II. FAMILY INFORMATION

Father’s Name: ___________________ First Last  Mother’s Name: ___________________ First Last

Birth Date: ________________________  Occupation: ________________________________

Employer: _________________________  Employer: _________________________________

Highest school grade completed: ______  Highest school grade completed: ______

Current marital status of parents: ______  Marriage date: _________________________

Date divorced, if applicable: __________  Date of parent death, if applicable: __________

List all persons living in the child’s home:

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>RELATIONSHIP TO CHILD</th>
</tr>
</thead>
<tbody>
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</table>
III. PARENTAL CONCERNS

A. What do you think the issues are with your child?

B. What concerns about your child have been expressed by doctors, teachers, others?

C. What results would you like to see from your child’s evaluation, therapy, and/or school?

IV. PREGNANCY HISTORY

This child’s birth order: __________________________

The number of mother’s other children: ______________

During this pregnancy, did the mother

YES  NO

Have illnesses or medical problems?  ______  ______

Complications and/or Medications

V. BIRTH INFORMATION

Length of pregnancy: __

Age of Mother at Delivery: __________

Length of labor: __________

Was labor induced? ______

Labor complications: ________________________________

Birth was: Normal ______ Cesarean ______

Breech ______ Twins or More ______

Did Mother experience complications? ______

_______________________________

Is your child: Bottle weaned? ______

Pacifier weaned? ______

_______________________________

Birth weight: ______

Did the baby need medical assistance in starting to breathe? __________________________

Were there other complications with the baby? __________________________

How long did the baby stay in the hospital after birth? ______

Did the baby have health problems in the first six months after birth? ______ If yes, please describe:

_______________________________
VI. MEDICAL HISTORY

A. List any serious illnesses, injuries or hospitalizations your child has had (with dates):

B. Has your child had any fevers above 104°? Yes ____________ If so, when? ________________

C. Has your child ever had a seizure? ________________

D. List any medications the child is now taking, how often, dosage, for what, and how long taking:

E. Any concerns about hearing or vision? ________________ Last hearing and vision exams and results: ________________

F. Does child wear glasses? ________________

G. Is child frequently sick? (explain): ________________

VII. CHILD’S GROWTH AND DEVELOPMENT

When did your child develop the following skills?

Make sounds ________ Sat alone ________
Say single words ________ Crawled ________
Say simple phrases ________ Walked alone ________
Toilet trained: Daytime ________
Nighttime ________

Is your child understood by the family ________, by others ________?

Can your child

Run ____________ Yes ______ No ______
Jump ____________ Yes ______ No ______
Hop ____________ Yes ______ No ______
Catch a ball ____________ Yes ______ No ______
Climb Stairs ____________ Yes ______ No ______
Skip ____________ Yes ______ No ______
Ride a tricycle/bicycle ____________
Hit a ball with a bat ________ Is your child clumsy? ________
Does your child lean excessively on surface when sitting or standing? Yes___ No___

Does your child attend & stay focused through: Dinner? Yes___ No___
Grocery Store? Yes___ No___
Restaurant? Yes___ No___

Is your child overly sensitive to certain stimuli such as bright lights, crowds, noises, tags in clothes, movement, hair washing, nail cutting, etc? Please describe: _____________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Does your child crave wrestling activities, firm hugs, swinging, spinning, etc? Please describe: _________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Do you have any concerns about your child’s height, weight, eating habits, or sleeping habits? (explain) _____________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Has your child lost any previously acquired skills? (what; when) ________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

VIII. CHILD’S MOOD, TEMPERAMENT, & BEHAVIOR

A. Which of these describes your child now:
   (Check all that apply):
   _____ Tantrums  _____ Inhibited Responses  _____ Fearfulness/Phobias
   _____ Excessive Responses  _____ Flat/Bland Expression  _____ Lack of Fear Response
   _____ Mood Swings  _____ Sadness  _____ Excessive Worrying
   _____ Poor Consolability  _____ Tearfulness  _____ Anxiety
   _____ Outbursts without Obvious Reason  _____ Physical complaints without cause
   _____ Recurrent Nightmares  _____ History of Abuse/Trauma
   _____ Negative Self-Statements  Elaborate as necessary: ____________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

B. Behavior

Are you having any problems with your child’s behavior? _____________________________

(If yes, please describe): _________________________________________________________

__________________________________________________________________________
Is anyone else (e.g., school, sitter) having problems with your child’s behavior?  

(If yes, please describe):

Does your child have any difficulties getting along with other children?  

(If yes, please describe):

What does our child like to do with their free play?

---

IX.  SCHOOL HISTORY

A. Please list all schools your child has attended, beginning with any nursery or daycare before kindergarten, and ending with your child’s current school.

<table>
<thead>
<tr>
<th>SCHOOL</th>
<th>ADDRESS</th>
<th>GRADE OR CLASS</th>
<th>PLACEMENT(S)</th>
<th>DATES OF ATTENDANCE</th>
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<tbody>
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</table>

B. Previous grade retention(s)?  

(please specify)

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C. Has your child ever been evaluated before? Such as by the school, a clinic, or a speech-pathologist?  

If yes, where and when?

---

*** Please attach copies of any previous test results, if available. ***

D. Has your child ever received specialized services such as speech-language therapy, occupational therapy, physical therapy, or academic services?  

If yes, please specify:
X. **FAMILY HISTORY**

A. Please note below if any of the **child’s relatives** have had any of the following conditions (For example, brother, aunt, cousin, etc.):

<table>
<thead>
<tr>
<th>Relationship to child</th>
<th>Relationship to child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention problems</td>
<td>Mental retardation</td>
</tr>
<tr>
<td>Behavior</td>
<td>Motor or Vocal Tics</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>Convulsions/Seizures</td>
</tr>
<tr>
<td>Speech problems</td>
<td>Mental illness</td>
</tr>
<tr>
<td>Language problems</td>
<td>(depression; bipolar; anxiety; schizophrenia)</td>
</tr>
<tr>
<td>Learning problems</td>
<td>Alcoholism/Drug abuse</td>
</tr>
</tbody>
</table>

B. Do any relatives have other conditions?
If yes, please describe:  

C. Has your family recently experienced any stressful events (for example, deaths, financial worries, marital conflicts)?
If yes, please describe:  

XI. **OTHER HISTORY**

A. Please list the names and addresses of other professionals who have worked with you and your family.

<table>
<thead>
<tr>
<th>NAME</th>
<th>COMPLETE ADDRESS Or Telephone Number</th>
</tr>
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<tbody>
<tr>
<td>Pediatrician</td>
<td>(PCP)</td>
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<tr>
<td>Family Doctor</td>
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<tr>
<td>Occupational Therapist</td>
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<tr>
<td>Speech Pathologist</td>
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<tr>
<td>Physical Therapist</td>
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<tr>
<td>Psychologist</td>
<td></td>
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<tr>
<td>Psychiatrist</td>
<td></td>
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<tr>
<td>Counselor</td>
<td></td>
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<tr>
<td>Others (please specify)</td>
<td></td>
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</table>

***Please use the backside of this page for providing any other information you feel will be helpful.***
ACCESS Group, Inc.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, ______________________________, have received a copy of ACCESS Group, Inc.’s Notice of Privacy Practices.

____________________________________   _________________
Signature of Client       Date

____________________________________   _________________
Witness, if needed       Date

_________________________     _________________
Signature of Parent/Guardian, if applicable    Date

DOCUMENTATION OF “GOOD FAITH” EFFORTS TO OBTAIN WRITTEN ACKNOWLEDGMENT

A written acknowledgment was not obtained from this client because

_____ Client refused to sign.

_____ Other – Briefly Explain:

____________________________________   ______________________
Signature of Employee Completing Documentation of “Good Faith” Efforts Form       Date
ACCESS GROUP, INC.

NOTICE OF PRIVACY PRACTICES
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A CLIENT OF ACCESS GROUP, INC.) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

ACCESS Group, Inc. is dedicated to maintaining the privacy of your individually identifiable health information as protected by law, including the Health Information Portability and Accountability Act (HIPAA). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain at ACCESS Group, Inc. concerning your protected health information (PHI). By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

• How we may use and disclose your PHI
• Your privacy rights in your PHI
• Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by ACCESS Group, Inc.. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that ACCESS Group, Inc. has created or maintained in the past, and for any of your records that we may create or maintain in the future. ACCESS Group, Inc. will post a copy of our current Notice at each facility in a visible location at all times, and you may request a copy of our most current Notice at any time.
B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer
ACCESS GROUP, INC.
10618 Breckenridge Drive
Little Rock, AR  72211
501-217-8600

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. ACCESS Group, Inc. may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for ACCESS Group, Inc. – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. ACCESS Group, Inc. may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. ACCESS Group, Inc. may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, ACCESS Group, Inc. may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for ACCESS Group, Inc. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

OPTIONAL:

4. Appointment Reminders. ACCESS Group, Inc. may use and disclose your PHI to contact you and remind you of an appointment.
OPTIONAL:
5. **Treatment Options.** ACCESS Group, Inc. may use and disclose your PHI to inform you of potential treatment options or alternatives.

OPTIONAL:
6. **Health-Related Benefits and Services.** ACCESS Group, Inc. may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:
7. **Fundraising.** We may contact you to raise funds for ACCESS Group, Inc..

OPTIONAL:
8. **Release of Information to Family/Friends.** ACCESS Group, Inc. may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician’s office for treatment of a cold. In this example, the babysitter may have access to this child’s medical information.

9. **Disclosures Required By Law.** ACCESS Group, Inc. will use and disclose your PHI when we are required to do so by federal, state or local law.

D. **USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** ACCESS Group, Inc. may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
   - maintaining vital records, such as births and deaths
   - reporting child abuse or neglect
   - preventing or controlling disease, injury or disability
   - notifying a person regarding potential exposure to a communicable disease
   - notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - reporting reactions to drugs or problems with products or devices
   - notifying individuals if a product or device they may be using has been recalled
   - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight Activities.** ACCESS Group, Inc. may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** ACCESS Group, Inc. may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person’s agreement
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

**OPTIONAL:**

5. **Deceased Patients.** ACCESS Group, Inc. may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

**OPTIONAL:**

6. **Organ and Tissue Donation.** ACCESS Group, Inc. may release your PHI to ACCESS Group, Inc.s that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

**OPTIONAL:**

7. **Research.** ACCESS Group, Inc. may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the
use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. **Serious Threats to Health or Safety.** ACCESS Group, Inc. may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or ACCESS Group, Inc. able to help prevent the threat.

9. **Military.** ACCESS Group, Inc. may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security.** ACCESS Group, Inc. may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates.** ACCESS Group, Inc. may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers’ Compensation.** ACCESS Group, Inc. may release your PHI for workers’ compensation and similar programs.

**E. YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that ACCESS Group, Inc. communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. ACCESS Group, Inc. will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit ACCESS Group, Inc.’ use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer in order to inspect and/or obtain a copy of your PHI. ACCESS Group, Inc. may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. ACCESS Group, Inc. may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for ACCESS Group, Inc.. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. ACCESS Group, Inc. will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by ACCESS Group, Inc., unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures ACCESS Group, Inc. has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in ACCESS Group, Inc. is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests
for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but ACCESS Group, Inc. may charge you for additional lists within the same 12-month period. ACCESS Group, Inc. will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with ACCESS Group, Inc. or with the Secretary of the Department of Health and Human Services. To file a complaint with ACCESS Group, Inc., contact the Privacy Officer. We urge you to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures.** ACCESS Group, Inc. will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer.