High-Quality Therapy Services

ACCESS began as a small speech therapy clinic, founded in 1994. The therapy program has expanded to offer speech, physical and occupational therapy, as well as feeding therapy, sensory integration therapy and more. Clients include individuals ages birth to 17 who have developmental delays and disabilities. ACCESS Therapy is a family-centered approach: Therapists regularly model activities for parents, sharing activity ideas and creating custom therapy materials for use at home.

The ACCESS Therapy program is under the direction of Melissa Thomas, M.S., CCC-SLP. Clients are seen in one-on-one treatment areas and the 6,700-square-foot, state-of-the-art therapy gym, which includes equipment such as an in-ground trampoline, suspension equipment and more. We accept Medicaid, ARKids A, ARKids B (applies to speech therapy only) and TEFRA funding for individuals who qualify for this program. Honors: Favorite Childcare Facility, 2013 Little Rock Family Favorites; Best Pediatric Therapy Service, 2012 Savvy Kids Awards.
ACCESS® Therapy Fees

ACCESS Therapy fees cover the costs of treating clients. These costs may be supplemented by insurance coverage, and, when applicable, state and federal funding.

**Insurance:** ACCESS accepts private insurance with out-of-network benefits.

**Other Funding Sources:** Many children qualify for disability-based and/or income-based funding to offset the cost of therapy.

Most ACCESS families participate in TEFRA – or Tax Equity and Fiscal Responsibility Act – funding. TEFRA is a secondary insurance program that requires a modest premium for qualifying clients yet **fully funds** the cost of therapy services.

ACCESS also accepts ARKids First A, ARKids First B (applies to speech therapy only) and Medicaid funding for therapy services.

**Optional Developmental/Therapy Evaluation Fee:** All ACCESS Therapy clients must have comprehensive evaluations before enrollment. If evaluations from other providers meet our admissions application criteria, we may accept them, or you may choose to schedule an evaluation at ACCESS. ACCESS developmental and therapy evaluation fees cover the one-time costs of evaluating clients for either developmental evaluations for younger clients or speech-language, occupational or physical development for clients up to age 17, plus written reports. These costs may be supplemented by insurance coverage.
ACCESS® Therapy Application Package Checklist

Download an ACCESS Therapy application package at AccessGroupInc.org.

Candidates for ACCESS Therapy must demonstrate the appropriate therapeutic needs and behavioral skills to participate in therapy activities. We use information provided by parents and medical professionals, along with chart review by our team of therapists, to determine whether a child is eligible for therapy placement. Placement is also influenced by available staffing.

A completed ACCESS Therapy application package contains:

- ACCESS General Information and Insurance Form
- Copy of Insurance Cards
- Developmental History
- Receipt of Notice of Privacy Practices Written Acknowledgement Form
- Copy of Therapy Evaluations and Goals (If Previous Services Were Received)
- Copy of Intellectual or Academic Testing Results, If Applicable

Please return your completed package to:

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

Once your completed package has been received, we can consider your child for ACCESS Therapy placement. If a placement is not available, we will refer you to another service provider and place your child on our contact list, if desired. Please don’t hesitate to contact our Admissions Department with any questions at 501-217-8600 or Admissions@AccessGroupInc.org.
Today’s Date: __________________________ Admission Date: ________________________

Child’s Name: __________________________ Date of Birth: ________________________

Gender: _____ Race: ______________ Home Phone: ____________________________

Home Address: ________________________________________________________________

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: ___________________________________________________________________

Race:       [ ] I-American Indian/Native Alaskan [ ]  H-Hispanic or Latino
            [ ] A-Asian [ ] N-Not Hispanic or Latino
            [ ] B-Black or African American [ ] 7-Declined
            [ ] P-Native Hawaiian or Other Pacific Islander
            [ ] W-White/Caucasian
            [ ] E-Other

Ethnicity:  [ ] 7-Declined

Language: [ ]  Arabic [ ] Persian
            [ ]  Cantonese [ ] Polish
            [ ]  English [ ] Portuguese
            [ ]  French [ ] Russian
            [ ]  German [ ] Spanish
            [ ]  Hindi [ ] Tagalog
            [ ] Japanese [ ] Ukrainian
            [ ]  Korean [ ] Urdu
            [ ] Mandarin [ ] Vietnamese
            [ ] 7-Declined [ ]  Italian [ ]  French
            [ ]  Romanian [ ]  Russian
            [ ]  Spanish [ ]  Ukrainian

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  
Birth Date:  
Occupation:  
Employer:  
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>
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<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

Have illnesses or medical problems? YES NO

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? ______

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

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

Were there other complications with the baby? _____________________________

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

Is your child: Bottle weaned? ________

Pacifier weaned? ________
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°? ______ 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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Run</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Jump</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Hop</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Catch a ball</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Climb Stairs</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Skip</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Ride a tricycle/bicycle</td>
<td>___</td>
<td>___</td>
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</tbody>
</table>

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Hit a ball with a bat</td>
<td>___ Is your child clumsy? ___</td>
</tr>
</tbody>
</table>
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  
   - Excessive Responses  
   - Mood Swings  
   - Poor Consolability  
   - Outbursts without Obvious Reason  
   - Recurrent Nightmares  
   - Negative Self-Statements  
   - Inhibited Responses  
   - Flat/Bland Expression  
   - Sadness  
   - Tearfulness  
   - Fearfulness/Phobias  
   - Lack of Fear Response  
   - Excessive Worrying  
   - Anxiety  
   - Physical complaints without cause  
   - History of Abuse/Trauma  
   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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</table>

B. Previous grade retention(s)?__________ (please specify) ________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

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>Condition</th>
<th>Relationship to child</th>
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<tbody>
<tr>
<td>Attention problems</td>
<td>Behavioral problems</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>Convulsions/Seizures</td>
</tr>
<tr>
<td>Speech problems</td>
<td>Mental retardation</td>
</tr>
<tr>
<td>Language problems</td>
<td>Motor or Vocal Tics</td>
</tr>
<tr>
<td>Learning problems</td>
<td>Mental illness</td>
</tr>
<tr>
<td></td>
<td>(depression; bipolar; anxiety; schizophrenia)</td>
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<tr>
<td></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>
</thead>
<tbody>
<tr>
<td>Pediatrician</td>
<td></td>
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<tr>
<td>Family Doctor</td>
<td></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>
<td></td>
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<tr>
<td>Psychologist</td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td></td>
</tr>
<tr>
<td>Counselor</td>
<td></td>
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<tr>
<td>Others (please specify)</td>
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</tbody>
</table>

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

DOCUMENETATION OF “GOOD FAITH” EFFORTS TO OBTAIN WRITTEN ACKNOWLEDGEMENT

A written acknowledgment was not obtained from this client because

____  Client refused to sign.

____  Other – Briefly Explain:

____________________________________________________   ______________________
Signature of Employee Completing      Date
Documentation of “Good Faith” Efforts Form
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)

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.

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.

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.