COMPREHENSIVE
Speech & Therapy Center

1001 Laurence Ave., Suite E
Jackson, MI 49202
(517) 750-4777

Client Information (Child)

Client Full Name:_____ Date:_____

Client's Preferred Name:_____Sex Assigned at Birth:_____

Gender:_____Client's pronouns: she/her, he/him, they/them, prefer not to answer

Date of Birth: _____/_____/_____ Age:_____ Email: _____

Race/Ethnicity: _____

Contact 1 #: (____)_____-_____Contact 1 Name:_____

Contact 1 Pronouns:_____

Contact 2 #: (____)_____-_____ Contact 2 Name:_____

Contact 2 Pronouns_____

Address:_____ City/Zip: _____

_____

Do you need assistance with housing? ⬜yes ⬜ no Does client or family currently or have they in the past received any community based resources? ⬜no ⬜yes-please list:_____

_____

Would you be interested in receiving information regarding additional resources?⬜no ⬜yes-please list:_____

Mother's/Guardian's Name:_____Age:_____Occupation:_____
Father's/Guardian's Name:_____Age:_____Occupation: _____

Siblings/Ages:_____

Others Living in the Home:_____

Others who may be involved in the client's care:_____

Languages Spoken in the Home:_____

What is your preferred language for written communication? *¿Cuál es su idioma preferida para comunicación en escrito?* _____

What is your preferred language for oral communication? *¿Cual es su idioma preferida para comunicación verbal?* _____

Any cultural or religious considerations that may impact their therapy:

_____

_____

Any legal or custody situations which impact therapy: ⬜no ⬜yes-please list:_____

_____

Any medical or mental health diagnosis in immediate family members that would impact therapy?
⬜no ⬜yes-please list:

_____

Does the client have a crisis/safety plan in place?⬜no ⬜yes (If yes please provide a copy)

Whom may we contact in the event of an emergency (other than parent/guardian)?

Name:_____ Telephone #: (____)_____-_____.

Primary Care Physician:_____Phone #:(___)_____-_____

Has the client been seen by their Primary Care Physician within the last year? ⬜yes ⬜ no

Has your child had any change in health status, medical diagnosis in the last year (i.e., infection/contagious disease/ change in weight/eating/appetite, diagnosis etc.)⬜yes ⬜ no

_____

Is the client current on their immunizations? ⬜yes ⬜ no ⬜other*

*_____

Is your child presently under the care of any doctor other than your pediatrician? ⬜yes ⬜ no
Name of Doctor: _____ Phone #: (____)_____-_____
Name of Dentist:_____Phone #: (____)_____-_____
Reason:_____

Who is responsible for this client's bills:

Name:_____Relationship to client:_____

Address: _____ City: _____ _____State: _____

Zip Code: _____ Phone #: _____ Date of Birth: _____

Employer: _____ Phone #: _____

Address of Employer: _____

Would you like assistance in obtaining insurance reimbursement: Yes No

Would you like additional information on financial assistance: Yes No

_____

Who may we thank for referring you:_____

BIRTH HISTORY

Pregnancy:

Age of mother: _____Length of pregnancy:_____

General Health of Mother:_____

Complications:_____

Medications taken during pregnancy:_____

Delivery:

Duration of Labor:_____ Type of Delivery:_____

Difficulties during delivery: _____

_____

Birth Weight:_____ Birth Length:_____ Apgar score:_____

Intensive care (NICU) needed? Yes No Length of stay:_____

Any health problems the first 2 weeks of life?_____

_____

MEDICAL HISTORY

Hospitalizations: Yes No Describe:_____

High Fevers: Yes No Describe:_____

Ear Infections: Yes No Describe:_____

Hearing Problems: Yes No Describe:_____

Vision Problems: Yes No Describe:_____

Surgeries: Yes No Describe:_____

Seizure Disorder: Yes No Describe:_____

Colic: Yes No Describe:_____

Constipation/Diarrhea: Yes No Describe:_____

Allergies: Yes No Describe:_____

Significant weight gain/loss: Yes No Describe:_____
(5% in 6 mos, or 10 lbs in 3 mos)

Disordered eating: Yes No Describe:_____
(binge eating, vomiting after eating)

Other: Yes No Describe:_____

_____

Has the client been exposed to any of the following that may affect their therapy:

Trauma:	yes	no	n/a
Abuse:	yes	no	n/a
Neglect:	yes	no	n/a
Exploitation:	yes	no	n/a
Substance abuse (self/others):	yes	no	n/a
If yes, are additional resources needed?	yes	no	n/a

Medications (Current/Previous): _____

MEDICAL PRECAUTIONS: Are there any precautions the therapist should be aware of when working with your child? _____

_____

Does your child engage in any dangerous, or unsafe behaviors (hurting self, hurting others, eloping, suicidal tendencies etc): Yes* No

*If yes: how often?_____

What is the severity?_____

What settings does this behavior occur in?_____

Who does the behavior occur around?_____

What are some triggers or things to avoid?_____

When does the behavior never occur/when will it always occur?_____

Do you have any additional safety concerns (elopement, weapons, suicidal tendencies) or precautions?

Yes* No

Does your child engage in any less/severe but still challenging behaviors? (for example, yells and throws a temper tantrum if he can't have what he wants)

Yes* No * Please describe when this occurs, what it looks like, etc.

_____

_____

_____

If your child becomes upset, are there any ways we can help them to calm?_____

_____

_____

Does your child interact with other children (either at home, or in the community)? Yes* No

*If yes, how (sharing, watching, conversing, avoiding, etc)_____

_____

_____

_____

Developmental History

Motor milestones: At what age did your child:

Roll:_____ Sit:_____ Crawl:_____ Pull to stand: _____ Stands up independently: _____

Cruise furniture: _____ Walk independently: _____ Ride a tricycle: _____

Jumps in place: _____ Skipping: _____ Swings independently: _____

Ride a bike: _____ Use a writing utensil: _____ Cut with scissors: _____Feed self: _____

Reach for objects: _____ Drink from a cup: _____ Use a straw: _____ Toilet training: _____

Speech/Language milestones: At what age did your child:

Babble: _____ First word: _____Combine two words: _____ Use sentences: _____

Does your child speak clearly? Yes No Do others understand your child? Yes No

Is your child's voice hoarse or husky? Yes No Describe_____
_____

Does your child stutter? Yes No Describe _____
_____

Is your child self conscious about his/her speech? Yes No

Self Care Skills:

Please describe your child's current level of function with the following activities:

Dressing: _____
Toileting: _____
Bathing: _____
Hygiene: _____
Oral Hygiene:_____
Sleeping: _____
Feeding: _____

Social History:

How does your child play with other children (cooperative, leader, lone, aggressive, picked on, etc.):
_____

Does your child make friends easily? Yes No

Does your child need to be in control? Yes No

List any concerns you may have about your child's social skills:
_____

Favorite Toys/Activities:_____.

Behavior:

____No Specific Problems _____Short Attention Span _____Self Injurious Behavior

____Easily Frustrated _____Plays Well With Others _____Redirects with the following

____Difficult to Discipline _____Easily Distracted

Supporting detail:

_____

_____

_____

EDUCATIONAL HISTORY:

Schools attended (please include day-care and preschools): Current grade: _____

Dates Attended:	Name/Location/District

Is your child in a special education classroom and/or receiving special education services? Yes No

Primary special education eligibility: _____

Describe services: _____

_____

Does your child have a current IEP? No * Yes *pre provide a copy of most current IEP

THERAPY HISTORY:

List any therapy your child has received (when, where, and duration of treatment):_____

_____

Is there any other important information that you feel may be helpful to your child's treatment? _____

_____

What goals would you like your child to achieve through therapy? _____

_____

Has your child had a hearing test/had their hearing screened? _____

Does your child have any medical diagnoses? (e.g. ASD, ADHD, CP, Down Syndrome, Seizure Disorder, Other?)

_____

Do you have any concerns with the following:

_____what your child understands?

_____ how your child can express him/herself?

_____ speech sounds/pronunciation of words?

_____ feeding/swallowing?

Please explain

_____

_____

This information will be kept confidential and used solely for providing the appropriate care to the client. Thank you.

CONSENT FOR SERVICES & PAYMENT POLICY GUIDELINES

I/ We, _____ give permission to Comprehensive Speech and
(Parent or Guardian)

Therapy Center (CSTC), Inc. to render services to _____.
(Name of Client)

I/We agree to the following:

NO SHOW/LATE/CANCELLATION POLICY: Appointment cancellation requires **a prompt** notification. If an appointment is missed without appropriate notification a **$25.00 "no show" fee** with be assessed. These charges will be due at the time the appointment is being rescheduled. It must be paid in full before the client can be seen again. There will be phone call attempts to reschedule each missed appointment. The third no show could result in a change of scheduled therapy times or even dismissal from service.

AUTHORIZATION: I/We grant permission to COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. to interview, videotape, photograph, or record the client for the purposes of data collection, creation of therapy materials, and/or to ensure continuity of services across treatment team members.

RELEASE: I/We request habilitation/rehabilitation and/or behavioral health services from CSTC and consent to the treatment ordered by my physician who monitors, approves and certifies the need for my care. I consent to the release of information and a copy of my medical records to CSTC by any health care provider where I received treatment.

CONFIDENTIALITY: I/We have received COMPREHENSIVE SPEECH AND THERAPY CENTER, INC.'s Notice of Privacy Practices and HIPAA Guidelines. I/We acknowledge that patients that participate in group therapy, ABA therapy, and/or family education includes risk of incidental disclosure of PHI. I/We agree to help protect the privacy of other patients/families by keeping information that I/we may hear or see regarding others' treatment confidential.

SERVICES AND PAYMENT: Following the initial evaluation, CSTC will recommend the necessary frequency and duration of treatment. A written report will be provided by CSTC inclusive of a treatment plan and goals. CSTC will provide verbal and/or written update of progress and goals at no additional charge every 90 days. All fees are to be paid at the time of each visit unless prior payment arrangements have been made. Accounts which become 30 days overdue will be assessed a 1.5% fee on the outstanding balance each month.

Insurance/Secondary Payer

- As a courtesy to you and your family, we will bill your insurance company for the services rendered at our facility, if appropriate.
- To the extent necessary to determine liability for payment and to obtain reimbursement, COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. may disclose portions of the client's record including his/her clinical records to any person or corporation which is or may be liable for all or any portion of COMPREHENSIVE SPEECH AND THERAPY CENTER, INC.
- **You are responsible for any co-pay or deductible you have at the time of service.**
- The undersigned agrees, whether he/she signs as the agent or the client, that in consideration of the services to be provided, he/she hereby individually obligates himself/herself to pay the account of COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. in accordance with its regular charges and/or as set forth by the terms of a managed care contract entered into by COMPREHENSIVE SPEECH AND THERAPY CENTER, INC.
- The undersigned authorizes whether he/she signs as agent or client, direct payment to COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. of any insurance benefits otherwise payable to the undersigned. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment. Should your insurance company fail to compensate COMPREHENSIVE SPEECH AND

THERAPY CENTER, INC. within 60 days for services and/or reimbursements at a lower rate than ours, **you will be responsible, in full, for all fees and services which have been rendered.**

- The undersigned, if a Medicare client, certifies, whether he/she signs as agent or the client, that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

- Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney's fees and collection expense. All delinquent accounts shall bear interest at the legal rate.

The undersigned certifies that he/she has read the foregoing and is the client or is duly authorized by the client to execute the above and accept its terms.

Client's Name (print) _____

Signature_____ Date_____

Witness_____ Date_____

If the client did not sign this form, what is the relationship of the signer to the client?_____

_____ **I acknowledge that I received the Client Rights.**
(initial)

_____ **I acknowledge and received the NOTICE OF PRIVACY PRACTICES.**
(initial)

NOTICE OF PRIVACY PRACTICES AVAILABILITY

Please sign below to acknowledge your review and understanding. This notice is posted in the office where registration occurs. A copy will be provided at your request and can also be downloaded from our website at www.therapyjackson.com.

_____ _____
Signature of Patient or Legal Representative **Date**

_____
Printed Name of Patient or Legal Representative

Relationship to Patient (*if applicable*)
☐ Parent or guardian
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

COMPREHENSIVE
Speech & Therapy Center

RELEASE OF INFORMATION

_____

Client Name Date of Birth

I/We, _____, authorize Comprehensive Speech and Therapy Center to release information or secure information to/from the following:

- ☐ Pediatrician/Physician_____
- ☐ Jackson County Intermediate School District
- ☐ Lyle Torrant Center
- ☐ Lifeways
- ☐ Early On
- ☐ Henry Ford Allegiance Health
- ☐ University of Michigan Health System
- ☐ Center For Family Health
- ☐ SSI/Disability
- ☐ Audiologist
- ☐ AAEC Evaluation_____
- ☐ Psychological/Cognitive Testing_____
- ☐ School_____
- ☐ Other_____

Regarding: ☐ my son/daughter ☐ myself ☐ my parent/spouse

_____

Signature of patient, spouse, parent, legal guardian Date

1001 Laurence Ave. • Suite E
Jackson, MI 49202

Phone: (517) 750-4777
Fax: (517) 782-4717

Authorized Pick Up form

We have implemented security measures to ensure the safety of your children. We respectfully request your assistance in these measures by providing a list of names and phone numbers of relatives or other adults who will be authorized to pick up your child. Thank you for your cooperation.

Name of Client Signature of Parent/Guardian

Printed Name of Authorized Adult Phone Number

Printed Name of Authorized Adult Phone Number

Printed Name of Authorized Adult Phone Number

Photo Release

This photo release is to be updated annually or at the expiration date (one year following initial signature), whichever comes first. It can be revoked/rescinded at any time and without penalty by notifying administration.

I hereby give my consent for Comprehensive Speech & Therapy Center, Inc. (CSTC) to use my/my child's photo/video content or likeness to be used in its publications, including:

- **Website**
- **Marketing Material**
- **Social Media**

I release CSTC from any expectation of confidentiality for the undersigned minor children and myself and attest that I am the parent or legal guardian of the child listed below

Childs name:_____ Age:_____

Parent/Legal Guardian Signature:_____ Date:_____

---------OR---------

I do not give consent:

Please initial here if you DO NOT give your consent: _____ (initials) Date:_____

Clinical Studies at CSTC

Thank you for allowing Comprehensive Speech and Therapy Center (CSTC) the opportunity to serve you and your family. Our primary goal is always to provide the highest quality clinical services to the communities that we serve. A secondary goal is to partner with universities to participate in clinical studies that will help to inform and guide future practitioners and clinical practices. We have listed ways that you can become involved as a client at CSTC. **Please know that these opportunities will not affect your treatment or welfare, and your health information will continue to be protected. You may consent to one, both, or neither of the listed opportunities.**

Please complete the back of this form if you chose to participate OR if you do not give consent

Opportunity #1

Our team members use the best available evidence and clinical expertise to design individualized treatments. In order to make informed decisions to best serve you, clinicians regularly record data during sessions to monitor progress and update treatment goals. In some cases, these clinical data would make meaningful contributions to improve future practices. It is required that clinical data that are used for publication remove specific identifiers (e.g., name, address, etc.) so that you could not be identified by the health information provided in the publication. We respectfully request the privilege to use information from CSTC clinical records in future clinical studies.

Your privacy and health information will continue to be protected as specified in "Notice of Privacy Practices and HIPAA Guidelines." You may ask questions about or request a copy of these documents. Additionally, you may revoke your permission at any time, in writing, by contacting our Administrative Operations Manager.

By signing, I agree that CSTC may use my clinical data that were collected through the provision of clinical services for future research purposes. I understand that treatment services will continue as usual. I understand that I am consenting for researchers to use deidentified data collected during my treatment to study and potentially publish.

Client's Name: _____ Minor Age: _____

Parent/Legal Guardian Signature: _____ Date: _____

I do not give my consent_____(Initials)

Opportunity #2

CSTC is proud to partner with local universities that conduct research in the areas of speech-language pathology, occupational therapy, physical therapy, psychology, and medicine. All research projects are approved through a special approval process through the affiliated university's Human Subjects Internal Review Board (HSIRB) which protects the participants of research.

By consenting to this document, you are stating that you are willing to be contacted by a CSTC staff member or research representative for potential research involvement. You will be invited to participate in studies that you are found to be eligible and would be invited to meet with a researcher to participate in an informed consent process at that time. Your privacy and health information will continue to be protected as specified in "Notice of Privacy Practices and HIPAA Guidelines." You may ask questions about or request a copy of these documents. Additionally, you may revoke your permission at any time, in writing, by contacting our Administrative Operations Manager.

By signing, I agree that a CSTC staff member or research representative may contact me to notify me of upcoming research studies for which I qualify for participation. I understand I may be contacted for any new research opportunities that apply to me.

Client's Name: _____ Minor Age: _____

Parent/Legal Guardian Signature: _____ Date: _____

I do not give my consent_____(Initials)

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A written request must be made to the Privacy Officer and a reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law;
   - for national security or intelligence purposes;;
   - incidental to other permissible uses or disclosures;
   - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
   - made to patient or their personal representatives;
   - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI**

(Rev 10/23/20)

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Teaching Students: To help train the next generation of helping professionals, we are proud to be the training site for high school upperclassman as well as undergraduate and graduate students to neighboring universities. Student involvement may be as limited as a single observation to months of internship. Consequently, a student may be involved in assisting with your clinical care under the supervision of a licensed and/or certified clinical professional as a part of their training program.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fundraising: Unless you notify us you object, we may contact you as part of a fundraising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fundraising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, 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.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research: Research is conducted under strict supervision of affiliated Human Subjects Institutional Review Boards (IRBs) with guidelines to protect the participants of research. Health information about you may be disclosed to affiliated researchers preparing to conduct a research project or retrospective study. For example, it may be necessary for researchers to look for patients with specific medical characteristics or treatments to prepare a research protocol. For actual research studies or for use of existing clinical data, we will obtain your specific authorization.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information during your lifetime and for 50 years following your death.. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our office at 517-750-4777 or speak with our Privacy Officer. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Comprehensive Speech and Therapy Center, Inc or with the Secretary of the Department of Health and Human Services. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for the Department of Health and Human Services:

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257

Toll Free: 1-877-696-6775 http://www.hhs.gov/contacts
(Rev 10/23/20)

Client Rights

The following is our policy regarding the rights of clients receiving services. Any complaints regarding denial of client's rights may be registered in confidence with the Michigan Department of Community Health, U.S. Department of Health and Human Services, Lifeways, CSTC administration, The Joint Commission, Recipient Rights, or OSHA. Upon request, the staff will assist the client to contact the appropriate office of the state agency. Each client has the right to:

A. Be fully informed of agency policies that apply.
B. Be fully informed at the time of admission of services available and related charges not covered under Title XVIII of the Social Security Act.
C. Be fully informed by a physician of his/her medical condition unless medically contraindicated, and to be afforded the opportunity to participate in the planning of his/her medical treatment. This right may be denied for good cause only by the attending physician and documented in the client's clinical record.
D. Refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
E. Be assured of confidential treatment of clinical records and to approve or refuse their release to any individual, except in the case of a transfer to another healthcare facility, or as required by law or third party payment contracts.
F. Be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and care of personal needs.
G. Be assured that personnel who provide care are qualified through education and experience.
H. Receive services and treatment without discrimination on the basis of race, color, national origin, disability or age.
I. Review the Notice of Privacy Practices that describes how medical information may be used and disclosed and how to access the information.

Comprehensive Speech and Therapy Center (CSTC) is a community mental health provider, that educates its staff through orientation and training that concerns about the safety or quality of care provided in the organization may be reported to the Michigan Department of Community Health, U.S. Department of Health and Human Services, Lifeways, CSTC administration, The Joint Commission, Recipient Rights, or OSHA. Staff will assist clients in filing a complaint when asked and may also file a complaint of client right violations themselves. Staff are protected by the Whistleblower Protection Act of 1989 and no disciplinary or punitive action will be taken, or threatened, because an employee or other person who provides care, treatment, or services reports safety or quality-of-care concerns to above listed agencies. In order to ensure all staff are appropriately trained to assist in protecting client rights designated clinical staff must participate in annual recipient rights training through Lifeways. Staff are signed up and informed of when and where this training takes place each year. Similarly, staff will participate in QBS training to support successfully maintaining client rights while dealing with unsafe situations. Staff are trained to recognize signs of abuse/neglect and are mandatory reporters for any concern of safety to the client. Staff are responsible for knowing the following:

The address and phone number of CSTC, this is printed staff name tags and posted next to each phone in the building.

1001 Laurence Ave., Suite E, Jackson, MI 49202
(517) 750-4777

How to make a recipient rights report:

Send or drop off Recipient Rights Complaint form to address below. This form is available for consumers at the front desk and a copy is included in this orientation manual for your convenience. 1200 N. West Ave., Jackson, MI 49202	Call a recipient rights representative listed below: Recipient Rights Officer: (517) 796-4516 Recipient Rights Specialist (517) 780- 3325 Recipient Rights Administrative Assistant (517) 789-1237
How to make a report to The Joint Commission: Submit a complaint to The Joint Commission via The Joint Commission's website: www.jointcommission.org. Scroll down to "Report a Client Safety Event." Fax: 630-792-5636 Mail: Office of Quality and Client Safety	The Joint Commission One Renaissance Boulevard Oakbrook Terrace, Illinois 60181

How to make a report to BHCOE: Go to BHCOE website www.BHCOE.org Select “Compliance” > “Report a Compliance Concern” Or submit a complaint via the link below: https://www.bhcoe.org/become-a-bhcoe/report-a-compliance-concern/	How to make a report to BACB: Go to BACB website www.bacb.com Select “Ethics” > “Reporting to the BACB” Or submit a complaint via the link below: https://www.bacb.com/ethics-information/reporting-to-ethics-department/
U.S. Department of Health and Human Services Office of the Secretary 200 Independence Avenue, S. W. Washington, D.C. 20201 Tel: (202) 619-0257 Toll Free: 1-877-696-6775 http://www.hhs.gov/contacts	Submit an Ethical Concern Form to CSTC’s Ethic’s Officer. This form is available for consumers in the front lobby and on our website. www.therapyjackson.com