

KIDS THRIVE THERAPY, LLC

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.

Uses and Disclosures

There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Certain uses and disclosures may be made without your written permission. Other uses and disclosures require that you consent in writing.

We may use and share your information as we:

- Treat you, including sharing information with other professionals who are treating you
- Run our organization, including improving your care and contacting you when necessary
- Bill for your services, including billing and getting payment from health plans, insurance companies, and other entities
- Help with public health and safety issues, including preventing disease, helping with product recalls, and reporting adverse reactions to medications
- Comply with the law, including reporting instances of suspected or documented abuse, neglect, or domestic violence and preventing or reducing a serious threat to someone's health
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions, including responses to court or administrative orders, or subpoenas.

Authorization for Use or Disclosure

Except as otherwise described in this Notice, your medical information will not be used or disclosed to any other person or entity without your written Authorization, which may be revoked at any time. If you revoke an authorization, however, it will not have any effect on any disclosures made before your revocation.

Additional Uses and Disclosures

Appointment Reminders and Treatment Alternatives. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits or services that may be of interest by phone, answering machine, text or by mail. SMS opt-in and phone numbers collected for SMS communication purposes will not be shared with any third party and affiliates for marketing purposes.

SMS Terms & Conditions

1- SMS Consent Communication:

The information (Phone Numbers) obtained as part of the SMS consent process will not be shared with third parties for marketing purposes.

2- Types of SMS Communications:

If you have consented to receive text messages from Kids Thrive Therapy, you may receive messages related to the following:

- Appointment reminders

“Hello, just a reminder about your child’s appointment on [Date] at [Time]. You can reply STOP to opt out of SMS messaging from Kids Thrive Therapy at any time.”

- Follow-up messages

“Hello, this is Kids Thrive Therapy. Just want to confirm that you received our call and/or email regarding your child’s appointment change. You can reply STOP to opt out of SMS messaging from Kids Thrive Therapy at any time.”

- Schedule Changes

“Hello, [therapist name] is out today, but we have another therapist to see your child at their regular time. Please let us know if this works for you. You can reply STOP to opt out of SMS messaging from Kids Thrive Therapy at any time.”

3- Message Frequency

Message frequency may vary depending on the type of communication. For example, you may receive up to [3] SMS messages per week related to your appointments, activities, etc..

"Message frequency may vary. You may receive up to 3 SMS messages per week regarding your appointments."

4- Potential Fees for SMS Messaging:

Please note that standard message and data rates may apply, depending on your carrier's pricing plan. These fees may vary if the message is sent domestically or internationally.

5- Opt-In Method:

You may opt-in to receive SMS messages from Kids Thrive Therapy in the following ways:

- By consenting when submitting the online submission form
- Signing the consent line below

6- Opt-Out Method:

You can opt out of receiving SMS messages at any time. To do so, simply reply "STOP" to any SMS message you receive. Alternatively, you can contact us directly to revoke your consent to receive SMS messages.

7- Help:

If you are experiencing any issues, you can reply with the keyword HELP. Or, you can get help directly from us at 443-836-5400.

Additional Options:

- If you do not wish to receive SMS messages, you can choose not to check the SMS consent box on our forms.

8- Standard Messaging Disclosures:

- Message and data rates may apply.
- You can opt-out at any time by texting "STOP."
- For assistance, text "HELP"
- Message frequency may vary

By checking this box, you agree to receive text messages from Kids Thrive Therapy related to conversational purposes at the phone number(s) you've provided. You may reply STOP to opt-out at any time. Reply HELP for assistance. Messages and data rates may apply. Message frequency will vary.

Marketing. We must obtain your written authorization prior to using your PHI to send you any marketing materials. (We can however, provide you with marketing material in a face-to-face encounter, without obtaining your marketing authorization. We are also permitted to give you a promotional gift of nominal value, if we choose, without obtaining your marketing authorization.)

Sale of Your Information. We will not sell your information unless you give us written permission.

Family and Friends. Under certain circumstances, we may disclose PHI to family members, other relatives, or close personal friends or others that you identify to the extent it is directly relevant to their involvement with your care or payment related to your care; or to notify them of your location, general condition, or death.

After Death. We may disclose PHI to coroners or medical examiners to identify a person who has died, determine the cause of death, or perform other functions authorized by law; and (before or after death) to funeral homes as necessary to carry out their duties. In addition, PHI of a person who has died may be used or disclosed in connection with research that does not involve any live subjects.

Individual Rights

You have certain rights with respect to your medical record information, as follows:

1. You may request that we restrict the uses and disclosures of your medical records. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with respect to emergencies or if we are otherwise required by law to make a full disclosure without restriction. Requests to restrict the use and/or disclosure of your medical record information (or later revoke the request) must be made in writing and be addressed to “Privacy Officer” at our address. If we do not agree to your request, we will tell you why in writing within 60 days.
2. You can ask us to contact you in a specific way (for example, home or office phone), or to send mail to a different address. We will agree to reasonable requests; however, you will be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
3. You have the right to inspect, copy, and request amendment to your medical records. Access to your medical records will not include psychotherapy notes contained in them, or information

compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding or for which your access is otherwise restricted by law. We will charge a reasonable fee for providing a copy of your medical records, or a summary of those records, at your request, which includes the cost of copying, postage, or preparation of an explanation or summary of the information.

4. All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to “Privacy Officer” at our address. We will respond to your request in a timely fashion.
5. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information, except for disclosures made for the purposes of treatment, payment, and/or health care operations; disclosures that require an Authorization; disclosures incidental to another permissible use or disclosure; and otherwise as allowed by law. We will not charge you for the first accounting in any 12-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12-month period.
6. You have the right to obtain a paper copy of this Notice and to take one home with you if you wish.
7. All requests related to your rights herein must be made in writing and addressed to “Privacy Officer” at the address noted below.

Our Duties

We have the following duties with respect to the maintenance, use and disclosure of your medical records:

1. We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this Notice of our legal duties and privacy practices.
2. We are required to notify you of a breach of privacy.
3. We are required to abide by the terms of this Notice currently in effect.

4. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information we have. All changes to this Notice will be prominently displayed and available at our office.

Complaints

You may file a written complaint with us or with the Secretary of Health and Human Services if you believe your privacy rights have been violated. If you wish to file a complaint with us, the complaint must be in writing and sent to:

Privacy Officer
Kids Thrive Therapy, LLC
22 West Road, Suite 101
Towson, MD 21204

We will not retaliate against you for filing a complaint.

Contact Person

All questions concerning this Notice or requests made pursuant to it should be addressed to:

Katy Burger, President
22 West Road, Suite 101
Towson, MD 21204
443-836-5400

Effective Date

This Notice is effective April 15, 2025 and applies to all protected health information contained in your medical records maintained by us.

I acknowledge that I have received Kids Thrive Therapy, LLC’s Notice of Privacy Practices for protected health information.

Date: _____

Name of Patient: _____

Print Name

Signature of Patient/Personal Representative