



11111 Houze Road, Suite 101
Roswell, GA 30076

Phone: (770) 998-9599
Fax: (770) 645-1313

Dear Parent/Guardian:

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was created to benefit the patient population. Included in the benefits of the plan is a federal mandate that requires the protection of personally identifiable patient health information.

In addition to quality speech and language intervention, physical therapy, and occupational therapy, Cobblestone Therapy Group is committed to keeping our patient's health information confidential. In accordance with federal law, this notice is to inform you of our company's policy of patient privacy. We encourage you to read this notice carefully and inform us of any questions that you may have.

We have included a table of contents that outlines the proceeding pages. Please note that in accordance with federal guidelines on patient privacy, we will need the following documents read, signed and returned:

- 1) Patient Privacy Notice (p. 3)
- 2) Assignments of Benefits/Release of Information (p. 10)
- 3) Financial Policy (p. 10)
- 4) Babies Can't Wait Financial Policy (p. 11)
- 4) Consent to Use or Disclose Information (p. 12)
- 5) Consent for Purposes of Treatment, Payment and Health Care Operations (p. 13)
- 6) * Where applicable, we will need to see and/or copy your Medicaid, and/or health insurance cards for our records.

If you have any questions concerning this matter, please do not hesitate to contact us at (770) 998-9599.

Sincerely,

Heather R. Taylor
Cobblestone Therapy Group
Privacy Officer

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Patient Privacy Notice

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.

Please note that the term “you” in the following document is means “you the patient, guardian, or parent of the patient.” The terms “we” and “us” shall refer to Cobblestone Pathways, LLC, DBA “Cobblestone Therapy Group”.

In accordance with federal law, the following Patient Privacy Notice is used to communicate the way in which medical information about you may be used and disclosed. Also included in this document is how you can access this information.

As the provider of medical services, we may require your written consent before we use or disclose medical information for purposes including but not limited to the following:

- Providing or arranging for healthcare services related to you
- Payment or reimbursement for the care provided to you
- Related administrative activities supporting your treatment.

There are cases in which we may be required or permitted by law to use and disclose your medical information without your consent or authorization.

Each patient of Cobblestone Therapy Group retains important rights regarding their medical information. The following list includes, but is not limited to the right retained by you:

- Inspect, copy, amend, or correct your medical information that we maintain
- Obtain an accounting of our disclosures of your medical information
- Request confidential communication with you
- Request restrictions on specific uses and disclosures of your health information
- File a complaint if you believe your rights have been violated

A detailed version of our Notice of Privacy Practices is included and available to fully explain your rights and our obligations under the law. The Notice may be revised periodically and is available on paper or electronically upon request. The most recent update to the Notice is located in the top right hand corner of this document.

Any questions, comments, suggestions, or complaints regarding the Notice of Privacy Practices and your medical information should be either directed to our Privacy Officer, Heather Taylor at (404) 625-1691, and/or to the Secretary of the Department of Health and Human Services (DHHS).

ACKNOWLEDGEMENT:

I acknowledge by signing below that I have received and read or had explained to me this Notice of Privacy Practices for Cobblestone Therapy Group

Child’s Name: _____

Parent/Legal Guardian: _____

Date: _____

HIPAA Compliant Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION HELD BY COBBLESTONE THERAPY GROUP ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our Privacy Officer, Heather Taylor at 404-625-1691 or 11111 Houze Road, Suite 101, Roswell, GA 30076.

I. Who Will Follow this Notice

This notice describes the medical information privacy practices of Cobblestone Therapy Group and that of any third party that assists in the administration of the Plan claims. The practices described in this notice will be followed by healthcare providers you consult with by telephone or in person.

II. Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. Cobblestone Therapy Group is committed to protecting medical information about you. We create a record of the health care options you have chosen. This notice applies to all the medical information we maintain. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

Cobblestone Therapy Group is required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

III. How We May Use and Disclose Health Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

A. For Treatment- We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to providers, including doctors, nurses, therapists, office staff or other personnel who are involved in taking care of you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as requesting prescriptions from your physician to enable us to treat. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

B. As Required By Law- Cobblestone Therapy Group will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding.

C. To Avert A Serious Threat to Health or Safety- Cobblestone Therapy Group may use and disclose medical information about you when necessary to prevent a serious threat to your health and the safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

D. For Payment- We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

E. For Health Care Operations- We may use and disclose health information about you in order to operate our office operations in an efficient and quality manner. For example, your health information may be used as an evaluation tool for our staff involved in your treatment. Our patients' health information may be used to assist us in determining the scope of services offered, the effectiveness of our operations and how we may become more efficient.

F. Appointment Reminders- We may contact you to remind you of appointments.

G. Treatment Alternatives- We may recommend various treatment options or alternatives.

H. Health-Related Products and Services- We may recommend health-related products or services that you may find beneficial.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time.

If you do revoke your Consent, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations. Please note that a revocation of Consent may result in the discontinuation of treatment and services.

IV. Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

A. Disclosure to Health Plan Sponsor- Information may be disclosed to another health plan maintained by Cobblestone Therapy Group for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to Cobblestone Therapy Group personnel solely for purposes of administering benefits under the plan.

B. Workers' Compensation- Cobblestone Therapy Group may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

C. Public Health Risks- Cobblestone Therapy Group may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- 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;
- 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.

D. Health Oversight Activities- Cobblestone Therapy Group may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

E. Lawsuits and Disputes- If you are involved in a lawsuit or a dispute, Cobblestone Therapy Group may disclose medical 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 by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

F. Law Enforcement- Cobblestone Therapy Group may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

G. Coroners, Medical Examiners and Funeral Directors- Cobblestone Therapy Group may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

H. National Security and Intelligence Activities- Cobblestone Therapy Group may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

I. Inmates- If you are an inmate of a correctional institution or under the custody of a law enforcement official, Cobblestone Therapy Group may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

J. Research- We may use and disclose health information about you for research projects, subject to a special approval process. We will require your permission if the researcher will have access to your name, address or other information that reveals your identity.

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

L. Military, Veterans, National Security and Intelligence- If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

M. Information Not Personally Identifiable- We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

N. Family and Friends- We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection.

V. Other Uses and Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed Consent and a special written Authorization that complies with the law governing HIV or substance abuse records.

VI. Your Rights Regarding Medical Information About You

You have the following rights regarding health information we maintain about you:

A. Right to Inspect and Copy- You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Cobblestone Therapy Group may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

B. Right to Amend- If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request may be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

Cobblestone Therapy Group may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

C. Right to an Accounting of Disclosures- You have the right to request an “accounting of disclosures” where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list or accounting disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years and may not include dates before April, 2003. Your request should indicate what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions- You have the right to request a restriction or limitation the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Cobblestone Therapy Group is not required to agree to your request. To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).

E. Right to Request Confidential Communications- You have the right to request that we communicate with you about medical matters in a certain way or a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

F. Right to a Paper Copy of This Notice- You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by requesting a copy from your clinician, at our offices, or our website, www.cobblestonetherapygroup.com

VII. Changes to this Notice

Cobblestone Therapy Group reserves the right to change the notice. We reserve the right to make revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our offices and on the website when completed. The notice will contain the effective date in the footer.

VIII. Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with Cobblestone Therapy Group contact our Privacy Officer, Heather Taylor.

You will not be penalized for filing a complaint.

Assignment of Benefits/Release of Information

I hereby request that payment of authorized Medicaid, Peachcare for Kids and/or health insurance plan benefits be made on my behalf to Cobblestone Therapy Group for therapy services provided. I authorize Cobblestone Therapy Group to release to my third party payer / insurer and/or to the Health Care Financing Administration and its agents, if necessary, any medical information needed to determine the benefits payable for related services. I understand that I will be personally responsible for any amount denied, or any remaining amount owed for services partially covered by my third party payer / insurer.

Patient/Guardian _____ Date _____

No, I wish to file insurance on my own behalf.

Patient/Guardian _____ Date _____

FINANCIAL POLICY FOR COBBLESTONE THERAPY GROUP, LLC

Cobblestone Therapy Group, LLC (hereafter referred to as "Cobblestone") shall provide speech and language, or occupational therapy services, and in return for those services, the Financially Responsible Person (as indicated by signature below) shall pay: an hourly rate of (\$180.00 per hour for speech language services and \$180.00 for occupational and physical therapy services) (the "hourly rate"). The hourly rate may be changed subject to at least thirty (30) days prior written notice of such change.

Cobblestone will bill the insurance carrier of the Financially Responsible Person as part of its services. However, the Financially Responsible Person (as indicated by signature below) acknowledges that the financial obligation described herein is unconditional, and if the insurance company does not remit payment to Cobblestone within sixty (60) days of the date the request for payment was submitted, the full balance will be due from the Financially Responsible Person. In the event that the insurance company requests a refund of payments made after they have been paid to Cobblestone, the Financially Responsible Person will be responsible for the amount of money refunded to the insurance company. In the event the insurance company establishes an internal usual and customary fee schedule, the Financially Responsible Person will be responsible for any shortfalls.

If payment is made directly to the patient, or the Financially Responsible Person for services billed by Cobblestone, the Financially Responsible Person shall either: (1) promptly remit such payment for services to Cobblestone with an explanation of benefits (EOB) with endorsement made and reassigned to provider; or (2) remit payment to Cobblestone in the full amount received by the insurance company along with any explanation of benefits (EOB) provided to patient or Financially Responsible Person.

A charge of \$25.00 per visit will be billed for all cancellations and/or "no-shows" occurring without a 24-hour notification. If the patient is sick and needs to cancel, a letter from the child's physician will be required in order to waive the fee.

Payments are due each month on or before the 22nd. Payments not received by the 22nd will be subject to a late charge of one and one-half percent (1.5%) per month (or portion thereof) compounded monthly until paid.

If Cobblestone takes any legal action to collect any amounts due from Financially Responsible Person for services provided, all legal fees, court costs, and other related expenses in their entirety which are incurred by Cobblestone will also be due upon submission of appropriate documentation, notwithstanding the lack of prior notice to the undersigned as to the amount of fees, court costs, and related expenses.

By my signature below I hereby agree to be financially responsible for all of the Child's financial obligations hereunder.

FINANCIALLY RESPONSIBLE PERSON

Date: _____

Name: _____

Babies Can't Wait (BCW) Financial Policy

I authorize Cobblestone Therapy to bill BCW for services as outlined in the IFSP.

I decline the BCW services and billing effective today's date going forward.

This is not applicable as we are not part of Babies Can't Wait.

Although we bill BCW (if authorized) and/or your insurance carrier as part of our services, you remain responsible for the entire bill when services are rendered. We require that arrangements for payment or your estimated share be made upon receipt of your bill. If BCW and/or your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same amount to us by forwarding the actual payment with explanation of benefits to our office, with endorsement made and reassigned to provider.

By coming to our office for treatment, I understand and agree that I am declining services from Babies Can't Wait and accept financial responsibility of services rendered by Cobblestone Therapy Group.

A charge of \$25 per ½ hour visit will be billed for all cancellations and/or "no-shows" occurring without a 24-hour notification. If you or your child are sick and need to cancel, a letter from your or your child's physician will be required in order to waive this fee.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I have read the above information and understand my responsibility for the payment of my account.

Any changes to this agreement must be requested in writing and changes will not be retroactive.

Patient/Guardian _____ Date: _____

Consent to Use or Disclose Health Information

I authorize Cobblestone Therapy Group to use and disclose my medical information for the purposes of Treatment, Payment and Health Care Operations.*

*Treatment includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

*Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

*Health Care Operations includes the necessary administrative and business functions of our office.

I further authorize Cobblestone Therapy Group to use and disclose the following specific health and medical information for the below listed purpose(s):
Specific medical information consisting of: therapy evaluation, assessment, progress notes and transition/home plans.

For the specific purposes of: collaboration of services with: Speech and Language pathologists, Physical Therapists, Occupational Therapists, BCW Service Coordinators & Staff, Psychologists, and/or Physicians, and authorized business office personnel.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Cobblestone Therapy Group has already used or disclosed the information in reliance on this Consent.

Patient/Guardian _____ Date: _____

If Cobblestone Therapy Group is requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 7 years from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You may review Cobblestone Therapy Group's "Notice Of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

Consent for Purposes of Treatment, Payment, and Health Care Operations

I consent to the use or disclosure of my protected health information by **Cobblestone Therapy Group** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Cobblestone Therapy Group**. I understand that diagnosis or treatment of me by **Cobblestone Therapy Group** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Cobblestone Therapy Group** is not required to agree to the restrictions that I may request. If **Cobblestone Therapy Group** agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Cobblestone Therapy Group** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review **Cobblestone Therapy Group's** Notice of Privacy Practices prior to signing this document.

The Cobblestone Therapy Group's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Cobblestone Therapy Group.

The Notice of Privacy Practices for **Cobblestone Therapy Group** is also provided in the office and will be on the **Cobblestone Therapy Group** website www.cobblestonetherapygroup.com. This Notice of Privacy Practices also describes my rights and the duties of **Cobblestone Therapy Group** with respect to my protected health information.

Cobblestone Therapy Group reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the Cobblestone Therapy Group's office and requesting a revised copy be sent in the mail or brought to me at the time of my next appointment.

Printed Name of Patient or Personal Representative

Date

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority (i.e., mother, father, etc.)