HIPAA Notice of Privacy Practices

Blossom Craniosacral - Peoria, IL

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information – Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice, and any other use required by law.

Other Permitted and Requested Uses and Disclosures: will be made only with your consent. Authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

- You have the right to inspect and copy your protected health information
- You have the right to request a restriction of your protected health information
- You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.
- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you, at your request, of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Your signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name _____ Signature _____

Relationship to patient (if applicable) _____ Date _____

Craniosacral Therapy Informed Consent

I hereby request and consent to the performance of craniosacral therapy (CST), visceral manipulation (VM), and neural manipulation (NM) treatments and other procedures within the scope of the practice of craniosacral therapy on me - or on the patient named below for whom I am legally responsible - by the therapist named below.

I understand that methods of treatment may include, but are not limited to craniosacral therapy, therapeutic listening, somato-emotional release, visceral manipulation, and neural manipulation. I will immediately inform a member of the staff if I or the patient experience(s) any unpleasant or painful effects from the treatments received. I have been informed that CST, VM, and NM are generally safe methods of treatment.

I understand that the treating therapist may review my patient records, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I acknowledge that I have read and understand the above consent to treatment, and have had the opportunity to ask questions about any risks related to CST, VM, or NM treatment. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment from the person named below.

_____
Patient Name

_____ Date: _____
Responsible Party Signature

_____ Date: _____
Office Signature

Craniosacral Therapy Child Health Questionnaire

Welcome to Blossom Craniosacral! In order to plan the best course of treatment for your child, it is important for me to obtain information about his or her dental and medical history. Please answer each question below and feel free to write as much as you need to - you can use the back of the page if you need more space.

Name_____ DOB_____

Address _____

Phone (____) _____ e-mail _____

Is your child in good health? ☐ Yes ☐ No

Is your child under the care of a physician? ☐ Yes ☐ No

Has your child ever had a serious illness, injury, or mental health issue? ☐ Yes ☐ No

If yes, please give date and explain: _____

_____

_____

Is there anything else about your child's health that you would like to share? Please include any pertinent information regarding the pregnancy, birth, and postnatal period.

_____

_____

_____

Please give a reason for your child's visit today: _____

_____

_____

Has your child had craniosacral therapy in the past? ☐ Yes ☐ No

Would you like to receive Blossom updates / announcements via email? ☐ Yes ☐ No

Please note that you are responsible for giving me any medical or surgical updates at the start of the visit.
Please note that less than 24 hours cancellation notice is subject to payment in full.

Parent signature_____ Date _____