

**NOTICE OF PRIVACY PRACTICES
FOR
Horizon Pediatric Consultants, LLC/Rocking Horse Rehab**

THIS NOTICE DESCRIBES HOW TREATMENT INFORMATION 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,
Sheri Marino at (973) 731-8588**

This Notice of Privacy Practices is effective August 1, 2004

Our Duty to Protect Your Health Information:

We are required by law to protect the privacy of your health information including the health information that can be used to individually identify you. This information is known as "Protected Health Information," or "PHI" and includes health information about your past, present or future health or condition. We use this PHI to create a record of the health care services we provide to you, to obtain payment for the health care services we provide to you and to perform other operational or administrative types of functions in connection with the health care services we provide for you.

We understand your health information is extremely personal and we understand we have a legal duty to protect your PHI. We are required to extend certain privacy protections to you and to give you this Notice of Privacy Practices so that you understand how, when and why we may use or disclose your PHI both with and without your authorization. We are required by law to abide by the terms of this Notice of Privacy Practices. We are also required to inform you of your rights to access and control your PHI. This Notice of Privacy Practices extends to all of the PHI we collect and maintain about you. Please note that we reserve the right to change the terms of this Notice of Privacy Practices. If we do make a change to this Notice of Privacy Practices, we will post the revised Notice of Privacy Practices in our office. Upon your request, we will also provide you with a copy of any revised Notice of Privacy Practices.

A. We may use and disclose PHI about you without your authorization to provide HEALTH CARE TREATMENT to you:

We may use and disclose PHI about you without your authorization to provide health care treatment to you. This may include communicating with our staff members or other health care providers regarding the treatment and health care services we provide to you. For example, we may use and disclose PHI about you when you need a prescription, an x-ray, laboratory work or other types of health care services. Also, we may use and disclose PHI about you when we refer you to another health care provider. For example, if we refer you to a doctor, this doctor will need to know the results of previous laboratory work or medical tests so this doctor will have complete information about your medical condition and treatment.

B. We may use and disclose PHI about you without your authorization to obtain PAYMENT for the services we provide to you:

We may use and disclose PHI about you without your authorization to obtain payment for the services we provide to you. When we bill and collect payment for the services we provide to you, PHI needs to be shared with those responsible for paying for your services. This includes sharing PHI about you to your health insurance companies, Medicare, Medicaid and any other third party payor involved in the payment of your health care. Many times, to bill and collect for the services we provide to you, we need to share your PHI with health plan billing departments, collection departments and agencies and consumer reporting agencies (for example, credit bureaus). For example, after a treatment session, we may need to share information with your health plan about the nature of your visit, a diagnosis and the services we provided to you so that we can be paid or you can be reimbursed for these services. Other times, we may need to tell your health plan about a treatment you are going to receive to obtain prior approval for the treatment or to determine whether your health plan will pay for this treatment.

C. We may use and disclose PHI about you without your authorization for HEALTH CARE OPERATIONS in connection with the services we provide to you:

We may use and disclose PHI about you without your authorization for health care operations in connection with the services we provide to you. Operating a therapy office involves many business type activities and at times, it is necessary to use and disclose your PHI for these "health care operations" to help improve the quality of the care we provide to you, to increase the efficiency of our office and to reduce health care costs. Some examples of the ways we might use and disclose PHI about you for these health care operations include using PHI about you to help us develop ways to assist our office and staff in deciding what treatments should be provided to others, cooperating with outside organizations including government agencies and accrediting bodies that assess the quality of the care we provide, cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities, assisting various people such as accountants and lawyers who review our activities and help us comply with the law, conducting business management and general administrative activities related to our office and resolving grievances with our office.

D. We may contact you to provide you with appointment reminders:

We may use and disclose PHI about you to contact you and provide you with a reminder about an appointment you have with our office.

E. We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you:

From time to time, we may use and disclose PHI about you to tell you about possible treatment alternatives or options that may be of interest to you. We may also, from time to time, use and disclose PHI about you to tell you about various health-related benefits or services that may be of interest to you. For example, if you are diagnosed with a particular condition, we may tell you about other therapy services that may be of interest to you.

F. You have the right to object to certain uses and disclosures:

Unless you notify our Privacy Officer listed on the cover page of this Notice of your objection to or restrictions on these uses and disclosures, we may use and disclose PHI about you in the following circumstances:

- **Others directly involved in your healthcare:** We may share PHI about you to a family member, a relative, a friend or any other person identified by you if this person is directly involved in your care, including payment for your care. If you are incapable or unavailable to object to this sharing of PHI about you, then we may use and disclose PHI about you to this person if, in our professional judgment, this use and disclosure is in your best interest.

- **Disaster relief purposes:** We may use and disclose PHI about you to an authorized public or private disaster relief agency (for example, the American Red Cross) to assist in disaster relief efforts so that your family can be notified about your condition, status and location.

G. We are required and/or permitted to use and disclose PHI about you without your authorization under certain circumstances:

The law provides that under certain circumstances, we are either required or permitted to use and disclose PHI about you without your authorization and without an opportunity for you to object. These circumstances include the following:

- **As required by law:** We may use and disclose PHI about you when a Federal, state or local law requires us to do so. This use and disclosure will be in compliance with the relevant law. For example, we must disclose PHI about you to government authorities that monitor compliance with these privacy requirements.

- **For public health activities:** We may use and disclose PHI about you to assist in public health activities. For example, we may use and disclose PHI we collect about you if you have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition. This PHI will be disclosed to a public health agency responsible for collecting this type of information.

- **For cases of abuse, neglect or domestic violence:** We may use and disclose PHI about you that relates to cases of abuse, neglect or domestic violence. This PHI about you can be used and disclosed to a law enforcement agency or other government authority.

- **For health oversight activities:** We may use and disclose PHI about you to health oversight agencies that are authorized to conduct audits, investigations and inspections of health care programs and other activities. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws. For example, we may use and disclose PHI about you to Medicaid programs to conduct audits of our billing practices.

- **For judicial and administrative proceedings:** We may use and disclose PHI about you for use in any judicial or administrative proceedings. For example, if you are involved in a lawsuit, we may disclose PHI about you in response to a court order such as a subpoena, but only if reasonable efforts have been made to tell you about this request or to obtain an order protecting the information requested.

- **For law enforcement purposes:** We may use and disclose PHI about you for certain law enforcement purposes. For example, we may use and disclose PHI about you in response to a court order, a subpoena, a warrant or a summons. Additionally, we may use and disclose PHI about you to identify or locate

a suspect or fugitive, to identify a victim of a crime in limited circumstances, to provide information about a death that may be the result of criminal conduct, to provide information about criminal conduct at this office and to provide information in emergency circumstances to report a crime, the location of a crime or the identity, description or location of the person who committed the crime.

- **For coroners, medical examiners and funeral directors:** We may use and disclose information about you to a coroner or medical examiner. For example, this may be necessary to identify you upon your death or to determine the cause of your death. We may also use and disclose information about you to funeral directors as necessary to carry out their duties.

- **For organ, eye or tissue donations or transplants:** We may use and disclose PHI about you to organizations that handle organ procurement and eye and tissue banks if you are an organ donor. This is to help these organizations and banks locate and assist in the organ or tissue donation and transplant process.

- **For research purposes:** We may use and disclose PHI about you for medical research purposes. For example, a research project may involve comparing the results of all patients who used one type of to the results of all patients who used another medication for the same condition.

- **To avert a serious threat to health or safety:** We may use and disclose PHI about you to prevent a serious threat to your health and safety or the health and safety of the public. However any use and disclosure for this purpose would only be to someone who is able to help prevent the threat.

- **For specific government functions:** We may use and disclose PHI about you as this relates to specialized government functions. For example, we may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President and medical suitability or other determinations to be made by the Department of State.

- **For correctional institutions:** We may use and disclose PHI about you if you are an inmate of a correctional institution or under the custody of a law enforcement official. For example, we may use and disclose PHI about you if this is necessary for the institution to provide you with health care services, to protect your health and safety or the health and safety of other inmates or to protect the health and safety of employees at the institution.

- **For workers' compensation:** We may use and disclose PHI about you for workers' compensation or other similar programs. For example, if necessary to comply with programs that provide benefits for work-related injuries or illness, we may use and disclose PHI about you.

***** ANY OTHER USES OR DISCLOSURES OF PHI ABOUT YOU REQUIRES YOUR SPECIFIC WRITTEN AUTHORIZATION *****

Except for the circumstances listed above, any other uses or discloses of PHI about you requires that we obtain from you a specific written authorization to release PHI about you. If you sign a written authorization allowing us to use or disclose PHI about you for a specific purpose, you have the right to cancel this authorization at a later time. You must cancel your authorization by notifying our Privacy Officer in writing. If you cancel your authorization in writing, we will not use or disclose PHI about you after we receive this cancellation except for disclosures which were being processed before we received your cancellation.

***** YOU HAVE CERTAIN RIGHTS REGARDING THE USE AND DISCLOSURE OF PHI ABOUT YOU**

Under the law, you have certain rights regarding the use and disclosure of PHI about you. Your PHI privacy rights include the following:

H. You have the right to request restrictions on uses and disclosures of PHI about you:

You have the right to request restrictions on the uses and disclosures of PHI about you for treatment, payment or health care operations. We will consider your request, but please note that we are not legally required to agree with the restriction. To the extent that we do agree to any restrictions on our use and disclosure of PHI about you, we will put this agreement in writing. Please note, however, if necessary in an emergency treatment situation, we are permitted to use and disclosure PHI about you. Also, we cannot agree to limit our uses and disclosures of PHI about you that are required by law. If you want to request a restriction, you must notify our Privacy Officer, in writing and tell us what information you want to limit.

I. You have the right to request alternative methods to communicate with you:

You have the right to request an alternative method to communicate with you. This includes the right to request how and where we contact you about your PHI. For example, you may request that we contact you at your work address or phone number instead of your home address or phone number or that all communications be in writing rather than by telephone. We must accommodate all reasonable requests, but when appropriate, we may condition your request on you providing us with information regarding how payment, if any, will be handled. To request an alternative method of communication, you must notify our Privacy Officer, in writing. This written request must include that alternative address, telephone number or other method of contact you request. We will not ask you for the reason for your request.

J. You have the right to inspect and copy PHI about you:

You have the right to inspect and copy the records that contain PHI about you. If you would like to inspect and receive a copy of PHI about you, you must notify our Privacy Officer, in writing and tell us the information you would like to inspect and copy. We have the right to charge you reasonable fees related to the copying of records. Instead of providing you with a full copy of the PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to this format and to the costs for such a summary or explanation. We will respond to your request within thirty (30) days. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we cannot grant your request and we will describe any rights you may have to request a review of our denial. Please note that this request usually applies to treatment and billing records, but does not include psychotherapy notes.

K. You have the right to request an amendment of PHI about you.

You have the right to make amendments to treatment, billing and other records about you if you believe there is a mistake and the information in such records is incorrect or inaccurate. To request an amendment, you must notify our Privacy Officer, in writing. This written request must explain your reason for the requested

amendment(s). We may deny your request for an amendment if: (1) the information in the record was not created by us, unless the person or entity who created the information is no longer available to amend the record; (2) the information is not part of the record used to make decisions about you; (3) the information is not part of the information which you would be permitted to inspect and copy as provided for in Part J; and, (4) we believe the information is accurate and complete. We will respond to your request within sixty (60) days. If we deny your request to an amendment of PHI about you, we will tell you in writing the reasons for the denial and describe your right to give us a written statement disagreeing with the denial. If we accept your request to amend the PHI about you, we make the correction and will make reasonable efforts to inform others of the amendment.

L. You have the right to an accounting of the disclosures we have made of PHI about you:

You have a right to request a list of certain disclosure we have made of PHI about you. You may ask for disclosures made up to six (6) years before your request (not including disclosures made prior to April 14, 2003). If you would like a list of the disclosures we have made of PHI about you, please notify our Privacy Officer, in writing. We will respond to your written request within sixty (60) days. The first list of disclosures you request within a twelve (12) month period will be free. For additional requests within a twelve (12) month period, we will charge you for the costs of providing the lists. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred. Please note that we are not required to account for disclosures made under the following circumstances: (1) for your treatment; (2) for billing and collecting for your treatment; (3) for our health care operations; (4) for disclosures requested or authorized by you or disclosures made to individuals involved in your health care; (5) for facility directory information; (6) for disclosure permitted by law when the use and disclosure relates to certain specialized government functions or relates to correctional institutions or other law enforcement custodial situations; (7) for disclosures that are part of a limited data set that does not contain certain information that would identify you; and, (8) for disclosures that were made before April 14, 2003. If we provide you with a list of disclosures, it will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed and the purpose of the disclosure.

M. You have the right to receive a paper copy of this Notice of Privacy Practices:

You have the right to request a paper copy of this Notice of Privacy Practices at any time by requesting a copy form our Privacy Officer. We will provide you with a copy of this Notice no later than the date you first receive service from us.

***** YOU MAY FILE A COMPLAINT ABOUT OUR
PRIVACY PRACTICES *****

If you believe your privacy rights have been violated by us and you would like to file a complaint with us about our privacy practices, please contact in writing the person listed below:

Sheri Marino, Privacy Officer
Horizon Pediatric Consultants, LLC/Rocking Horse Rehab
12-22 Woodland Avenue
West Orange, NJ 07052

(973) 731-8588

You may also file a written complaint with the Secretary of the Department of Health and Human Services.

If you file a complaint, we will not take any action against you or change our treatment of you in any way.



Rocking Horse Rehab
Horizon Pediatric Consultants, LLC
12-22 Woodland Ave.
West Orange, NJ 07052

Phone: 973-731-8588
Fax: 973-731-8520
www.rockinghorserehab.com

Application and Health History

Background Information

Today's Date: ____/____/____

Client's Name: _____ DOB: ____/____/____ Gender: ___M___F

Age: ____years ____months Height: _____ Weight: _____ Hand Preference: ___L___R

Mother's Name: _____ Father's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Mother's Cell Phone: _____ Father's Cell Phone: _____

Email Address: _____

Mother's Occupation: _____ Work No.: _____

Father's Occupation: _____ Work No.: _____

Siblings: _____ Age: _____
_____ Age: _____
_____ Age: _____

Referral Source: _____ Language Spoken: _____

Primary Medical Diagnosis: _____

Secondary Medical Diagnosis: _____

Precautions: _____



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Insurance Information

Insurance Company: _____ Patient ID #: _____

Phone #: _____ Address: _____

Birth History

Prenatal care began: _____

Please describe any illness, accidents, or problems relating to the mother or child during and/or after pregnancy.

Medication's taken during pregnancy:

Tests during pregnancy:

Ultrasound: _____ Amniocentesis: _____ Stress tests: _____ Other: _____

Place of Birth: _____ Weeks Gestation: _____ Type of Delivery: _____ Length of Labor: _____

Neonatal Period

Birth Weight: _____ Apgar Score: _____

Special Treatment in the delivery room: Intubated () Oxygen () Resuscitated () IV placed ()

Length of Stay and treatments received for both mom and child:

Since birth, please give dates and description of any hospitalizations, accidents, illnesses or health concerns:

Please list any medications your child takes on a regular basis:

Medication	Purpose	Times	Amount
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Medical Practitioner's Information: Please include names and phone numbers.

Pediatrician: _____ Phone _____

Hearing: _____ Phone _____

Vision: _____ Phone _____

Neuro: _____ Phone _____

Ortho: _____ Phone _____

Gastro: _____ Phone: _____

Education

School Placement _____ Phone No.: _____

Teacher's Name _____ Phone No.: _____

School Schedule:

Therapy Services

PT _____ Facility: _____ Phone No.: _____

Frequency & Duration: _____

OT _____ Facility: _____ Phone No.: _____

Frequency & Duration: _____

SLP _____ Facility: _____ Phone No.: _____

Frequency & Duration: _____



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Home Program Information (if applicable):

Home Program Coordinator: _____ Phone No.: _____
Home Program Tutor: _____ Phone No.: _____
_____ Phone No.: _____
_____ Phone No.: _____
Total Hours Weekly: _____

Reason for Referral

Oral Motor _____	Language _____	Behavior _____	Vision _____	Sensory _____
Feeding _____	Apraxia _____	Cognitive _____	Gross Motor _____	Attention _____
Articulation _____	Hearing _____	Social _____	Fine Motor _____	Other: _____

Please describe the area of concern indicating when it was first noticed, and it's development.

Current Skills

Please describe your child's.....

Eye contact

Gestures

Speech Sounds

Words



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Sentences

Behaviors

Gross Motor Skills

Fine Motor Skills

Sensory Processing

Hearing

Vision

Feeding Skills

Respiration/Circulation

Psycho/Social Function and Mental Health

Allergies

Primary Concerns and Goals

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Weekdays and times available for treatment services

Name of person completing this form: _____
Relationship: _____
Signature: _____
Date: _____/_____/_____

*** Please provide copies of recent IEP, evaluations and/or progress reports.*

PHOTO RELEASE

I ___DO/___DO NOT consent to and authorize the use and reproduction by Horizon Pediatric Consultants, LLC, dba Rocking Horse Rehab of any and all photographs and any other audio/visual materials taken of my child for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____
Parent or Legal Guardian



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PHYSICIAN'S STATEMENT

Dear Doctor,

Your patient, _____ is interested in participating in equine assisted therapies and activities. In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree.

<p><u>Orthopedic</u> Atlantoaxial Instability-describe neurologic symptoms Coxa Arthrosis Cranial Deficits Heterotropic Ossification/Myositis Ossificans Joint Subluxation/dislocation Osteoporosis Pathologic Fractures Spinal Fusion/Fixation Spinal Instability/Abnormalities</p> <p><u>Neurologic</u> Hydrocephalus/Shunt Seizure Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromelia</p> <p><u>Other</u> Age-under 4 years Indwelling Catheters Medications Poor Endurance Skin Breakdown</p>	<p><u>Medical/Psychological</u> Allergies Animal Abuse Physical/Sexual/Emotional Abuse Blood Pressure Control Dangerous to self or others Exacerbations of medical conditions Fire Settings Heart Conditions Hemophilia Medical Instability Migraines PVD Respiratory Compromise Recent Surgeries Substance Abuse Thought Control Disorders Weight Control Disorders</p>
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Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted therapies and activities, please feel free to contact the center at the address or phone number indicated above.

Sincerely,

Sheri A. Marino, MA, CCC-SLP
 Executive Director



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PHYSICIAN'S STATEMENT

*****PLEASE INCLUDE A PRESCRIPTION FOR PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPY. PRESCRIPTION SHOULD READ, FOR EXAMPLE "PT/OT/SPEECH EVALUATION AND TREATMENT FOR UP TO 1 YEAR." PLEASE INCLUDE ICD 10 CODES FOR CONDITIONS TO BE TREATED. THANK YOU.**

Patient: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____
 Diagnosis: _____ Date of Onset: _____
 Past/Prospective Surgeries: _____
 Medications: _____
 Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____
 Shunt Present: Y N Date of Last Revision: _____
 Special Precautions/Needs: _____

Mobility: Independent Ambulation: Y N Assisted Ambulation Y N Wheelchair Y N
 Down Syndrome: Y N AtlantoDens Interval X-Rays, date: _____ Result: + --
 Neurologic symptoms of AtlantoAxial Instability: _____

Please indicate current past or special needs in the following systems/areas, including surgeries:

Auditory: _____
 Visual: _____
 Sensory Processing: _____
 Speech: _____
 Cardiac: _____
 Circulatory: _____
 Integumentary/Skin: _____
 Immunity: _____
 Pulmonary: _____
 Neurologic: _____
 Muscular: _____
 Balance: _____
 Orthopedic: _____
 Allergies: _____
 Learning Disability: _____
 Cognition: _____
 Emotional/Psychological: _____
 Pain: _____
 Other: _____

To my knowledge there is no medical reason why this patient cannot participate in equine assisted therapies and activities. However, I understand that Horizon Pediatric Consultants, LLC dba Rocking Horse Rehab will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this patient's abilities and/or limitations by a licensed/credentialed health professional (e.g. physical therapist, occupational therapist, speech-language pathologist, etc.) in the implementation of an effective equine activity program.

Name/Title: _____ MD DO NP PA Other: _____
 Signature: _____ License/UPINNumber: _____
 Address: _____ Phone: _____ Date: _____

PLEASE STAMP WITH THE PRACTICE ID

Rocking Horse Rehab

Client On-Boarding Report

Please fill out the following in order for us to best help you. **Please also include a copy of both sides of your insurance card.**

Patient Name: _____

Date of Birth: _____

Address: _____

Contact Tel #: _____

Contact Email: _____

Mother's Name: _____

Date of Birth: _____

Father's Name: _____

Date of Birth: _____

Primary Insurance Carrier Name: _____

Primary Insurance ID # and Group #: _____

Primary Insurance Member Tel # (found on back of ID Card): _____

Primary Insurance Provider Tel # (found on back of ID Card): _____

Claims Address (found on back of ID Card): _____

Website Address: _____

User Name : _____

Password: _____

(If applicable)

Secondary Insurance Carrier Name: _____

Secondary Insurance ID # and Group #: _____

Secondary Insurance Member Tel #: _____

Secondary Insurance Provider Tel #: _____

Claims Address: _____

Diagnosis Code(s): _____

AUTHORIZATION FOR RELEASE OF INFORMATION

This will authorize Rocking Horse Rehab to submit health insurance claim forms on my behalf.

The confidential information is specified below:

1. Contact information
2. Health Insurance Information
3. Claims and supporting documents ie notes/reports/evals etc.

The specific purpose for disclosure is as follows: Claims submission and insurance management

The following information is provided to locate the requested records:

PATIENT'S NAME:

PATIENT'S ADDRESS:

DATE OF BIRTH:

A reproduction of this authorization form shall be considered as the original. I understand that by law, I do not have to release this information. However, I choose to do so voluntarily for the purpose specified above. I further understand that I may cancel this authorization for release of information at any time unless the information has already been sent. Permission to release the above information will expire in one year.

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2); the federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature (age 14 or older)

Date

Parent/Legal Guardian/or Authorized Representative

Witness Signature



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**ACKNOWLEDGEMENT OF RECEIPT OF THE
NOTICE OF PRIVACY PRACTICES
OF
HORIZON PEDIATRIC CONSULTANTS, LLC/ROCKING HORSE REHAB**

Address: _____

Telephone No:_____

I hereby acknowledge that I have received from Horizon Pediatric Consultants, LLC/Rocking Horse Rehab a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how Horizon Pediatric Consultants, LLC/Rocking Horse Rehab can use and/or disclose my personal health information both with and without my authorization. I further understand that I may contact Sheri Haiken, Privacy Officer, if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices of Horizon Pediatric Consultants, LLC/Rocking Horse Rehab

Signature of Patient or Patient's Parent/Legal Guardian

Date

Print Name of Patient or Patient's Parent/Legal Guardian