Cornerstone Therapy Services

Speech/Language Pathology Occupational and Physical Therapy
1333 Gateway Drive, Suite 1014
Melbourne, Florida 32901
Office 321-432-2572 Fax 321-768-2489

What to Expect From Cornerstone

Cornerstone Therapy Services is a small individually owned pediatric therapy practice. Cindy Peters-Pontones, owner and speech/language pathologist, has been a practicing therapist since 1984 and established in Brevard County since 1986.

Success is Teamwork:
At Cornerstone we believe that each child can make progress to achieve their maximum potential through teamwork that involves first and foremost, the parent/caregiver and the child, and then the team of professionals who are involved with the child and family. The parents are the "cornerstone" of what happens in the treatment process. They know their child the best and are the best educators of their children's habits. Thus, it is imperative that parents are intimately involved in their child's treatment process. We encourage involvement through teaching/training parents on how to work on certain skills in the home environment.

Parents are Trainers of Their Children:
Parents are the real teachers and trainers of their children. Therapists understand the developmental processes and are professional facilitators of those skills. At times, expect the therapist to spend entire sessions with you, the parent, training you on how to teach your child at home. Counseling and training regarding your child's special circumstances are as important as hands on work with your special little one. Particularly with children who are between the ages of birth and three years of age, the emphasis of treatment should primarily be with the parent.

Consistency of Attendance:
It is quite important that you and your child attend appointments on a regular basis. This is a major part of achieving success. Pleases refer to our attendance/cancellation policy and commitment to treatment for further clarification.

We enjoy working with your children and feel it is a privilege to serve you and your family to achieve optimal progress. The ultimate goal is discharge into the world to be a child free to learn, play and grow to their fullest potential.

Cindy Peters-Pontones

*"**Hope exists here at Cornerstone Therapy Services.** We build a foundation for your child so they can learn to live, cope with their challenges, reach their fullest potential and ultimately be happy and succeed. We help change a parent's fear to hope through scientifically based methods, education, evidence-based practice and interventions."*

CONSENT/AUTHORIZATION FORM

Date _____

CONSENT FOR TREATMENT I authorize Cornerstone Therapy Services to perform the therapy(s) described below. I have been informed of the reason(s) for therapy(s), along with the expected benefits.
Please check all that apply below:

□ Speech Therapy □ Occupational Therapy □ Physical Therapy

Telehealth - □ Speech Therapy □ Occupational Therapy □ Physical Therapy

The therapy(s) was explained to me in detail and all my questions were fully answered. Understanding this, I authorize Cornerstone Therapy Services consent to treat _____.
(Name of patient if minor)

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

RELEASE OF MEDICAL RECORD
In order to ensure proper follow-up and continuity of care, I agree that a copy of the medical record may be released to my physician, and designated referral physician and/or the provider who referred me. I authorize Cornerstone Therapy Services to release the medical records of

_____as explained above.

INSURANCE AUTHORIZATION
I request that payment of authorized benefits be made to Cornerstone Therapy Services on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicaid and its agents, any insurance company, any other third-party payer, state medical assistance agency or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits of benefits for related services. I agree to pay all charges not covered by a third - party payer. I authorize a copy of this authorization to be used in place of the original. I understand that filing insurance is a courtesy and not an obligation. I also understand that the contract is between myself and the insurance carrier, not the practice and the insurance carrier.

_____ _____
Parent or person authorized to consent for patient Date

PATIENT FINANCIAL AGREEMENT

Thank you for choosing us as your provider. We are committed to being a partner in providing your child with quality care. **Payment of the bill is considered an important part of the partnership. Please let us know if you have any questions.**

The following is a statement of our Financial Policy, which we require you to read and sign:

We wanted to take this opportunity to thank you for allowing us to provide care for your child. We understand that therapy can be a significant expense and having medical insurance can help to alleviate some of that cost. Please be aware that **no** insurance covers 100% of your therapy care. Once insurance has been verified & the evaluation has been billed to insurance, we will do our best to provide you with an estimated co-payment/co-insurance cost based on the information available to us. Payment of your estimated portion is expected at the time of service. For your convenience, we accept cash, check, or pay using the Venmo app. Which we can provide you with that information.

Our goal is to provide quality care to all our patient. Treatment recommendations are based on what is best for your child, not what is best for the insurance company. Please understand that your insurance policy is an agreement between you and your employer; we cannot guarantee any estimated coverage. Any questions or disputes involving insurance should remain between you, the subscriber, and your insurance company.

As a courtesy, we will promptly file the necessary forms to your insurance provider to ensure that you will receive the full benefits of your policy. It is important that you familiarize yourself with your medical benefits and keep a record of your treatment expenditures. This will keep you from exceeding an annual allowance your insurance may impose. Payment to our office remains your responsibility, regardless of how much your insurance does or does not pay.

We are unable to file secondary insurance except for Medicaid but will gladly provide you with the proper forms to assist you in filing your own claims.

If you have questions regarding your treatment, please feel free to ask our staff to assist you in scheduling a consultation appointment. We hope that this information will help us to effectively meet your needs.

Please indicate that you have read and understand the office policies regarding treatment insurance coverage.

- I have read and understand this Financial Agreement
- I authorize and consent to the release of medical information necessary to bill and process insurance claims
- I authorize the payment of benefits directly to Cornerstone Therapy Services
- I agree to pay all charges not covered or paid by my insurance company

_____ _____

Name of Patient (Please Print) Date of Birth

_____ _____

Signature of responsible Party Date

ATTENDANCE AND CANCELLATION POLICY

Cornerstone is committed to the best treatment possible for your child. Due to an increasing problem with "No Shows" for scheduled appointments, even with a **text** confirmation the Friday before, I regretfully must institute a "No Show Policy" ….

"No Shows" drive up the cost of patient appointments for everyone. "No Shows" also prevent us from taking a patient who could have been seen that day but were not because someone was scheduled for that time slot. For this reason, a **$50.00** fee will be charged to you for the failure to show for a scheduled appointment or for legitimate cancellations not made within **24 hours** of that appointment. This charge is **NOT** covered by your insurance. If you are unable to keep your appointment, please give **24 hours**' notice to your therapist to avoid this charge.

Also, the "reminding" text is **ONLY** a courtesy… not receiving that text does not relieve you of your responsibility to arrive for your appointment or cancel appropriately.

Childhood Disease:

Please note if your child contracts lice, ringworm, pink eye, strep throat, chickenpox or any other typical childhood communicable disease, you need to contact our office immediately. The child will be placed on hold until the contagious period is over, and your doctor gives Cornerstone authorization to resume treatment. **_____ Initial**

Holiday and School Vacations:

Cornerstone Therapy Services does not follow the school calendar. We are open 12 months a year and closed only for the following holidays: New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day. Unless otherwise explicitly stated, we are open our regular hours on the days immediately before and after these holidays. If your child has a special school event or vacation, please inform your therapist 30 days in advance in order to rearrange the schedule. **_____ Initial**

Attendance:

Therapy will not be effective unless it is consistent and regular. Therefore, regular attendance to all appointments are important. If two or more appointments within a four-week period are missed due to reasons other than illness, and not rescheduled, we will not be able to hold the appointment time and it will be given to another person. In that case, we will place you on our waiting list for therapy. If the regular appointment time is difficult to maintain, please discuss the possibility of a different time or day with your therapist. We cannot guarantee an appointment be held for an extended vacation greater than 30 days.
_____ Initial

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THE ABOVE POLICY AND UNDERSTAND AND ACCEPT THE TERMS AND CONDITIONS.

_____ _____

Please print name of patient **Date**

_____ _____

Signature of patient/responsible person (if patient is a minor) **Relationship to patient**

_____ _____

Speech Therapist Name **Speech Therapist Cell Phone Number**

_____ _____

Occupational Therapist Name **Occupational Therapist Cell Phone Number**

_____ _____

Physical Therapist Name **Physical Therapist Cell Phone Number**

CASE HISTORY FORM

Identifying Information:

Child's Name: _____ Date of Birth:_____

Parent's Name(s): _____ Home Phone: _____

Home Address: _____ Cell Phone: _____

_____ Work Phone: _____

Parent's Occupation(s): _____ _____

Email Address: _____ _____

Child's School: _____ Grade: _____ Teacher: _____

Referred By: _____

Doctor's Name: _____Doctor's Phone: _____

Child lives with (check one):

_____ Birth Parent _____ Foster Parents

_____ Adoptive Parents _____ One Parent

_____ Parent & Step-Parent _____ Other: _____

Family History:

Siblings: _____ Age: _____

_____ _____

_____ _____

Is there a family history of: Yes/No

Speech/Language Difficulties _____

Hearing Impairment/Deafness _____

Learning Difficulties _____

Developmental Difficulties _____

If you responded "yes" to any of the above, please describe:

_____
_____
_____
_____

Statement of the Problem:

Describe in your own words what problem your child is having:

_____
_____
_____

List any other concerns you have regarding your child's development:

_____
_____
_____

Does your child have a formal diagnosis: Yes_____ No_____ If yes, what is it? _____
_____

When was it made?_____ By whom? _____

Pregnancy/Birth History:

Prenatal Care Provided: Yes _____ No _____

Pregnancy was: Normal Complicated (please circle one)

If complicated, please elaborate below:

Spotting High Blood Pressure Diabetes Smoking Pre-Existing Condition

Fever RH Incompatibility Medications Alcohol/Drug Other_____

Birth:

Term of Pregnancy: Full _____weeks Premature: _____weeks

Delivery: Vaginal Cesarean

Presentation: Breech Head Down

Labor: Induced Natural Length of Labor_____

Child's Birth Weight: _____

Special Considerations:

Cord around neck Meconium Birth Jaundiced Twin (first or second)

Incubation Time _____ Medication _____

Length of Child's Hospital Stay _____

Complications at Birth?_____

Medical Information:

Illnesses, Chronic Medical Conditions and Diagnoses Include:

_____

_____

Hospitalizations or Surgeries:

Date Reason Location

_____

_____

_____

_____

_____

Has your child had any of the following? List approximate dates of when?

Adenoidectomy: _____

Allergies: _____

Breathing Difficulties: _____

Chicken Pox: _____

Frequent Colds: _____

Frequent Ear Infections: _____

Ear (PE) Tubes: _____

High Fever: _____

Head Injury: _____

Sleeping Difficulties : _____

Thumb/Finger Sucking: _____

Tonsillectomy: _____

Tonsillitis: _____

Vision Problems: _____

If you check any, please provide additional details:

_____

_____

_____

_____

Immunizations: _____Current _____Not Current

Specialists Seen (Neurology, ENT, Orthopedic, GI, etc.):

_____

_____

Allergies:

_____

_____

Current Medications and Dosage:

_____

_____

_____

Vision: (note if formal screening done, surgery, corrective lenses used)

_____

_____

Dental: (note if teeth are present, any abnormalities or overbites)

_____

_____

Hearing: (note if ear infections are frequent, tube placement or hearing tests performed)

_____

_____

Please check the appropriate column:

	Y	**N**
My child has 3 or more ear infections between birth and 12 months of age.		
My child has had at least one ear infection which lasted more than three months.		
My child has been evaluated by an audiologist who determined that his/her hearing is within normal limits. Date of screening:		
I suspect my child has a hearing problem.		
My child prefers one ear over the other. If yes, which ear? (Circle) **Right or Left**		
My child has had tubes in his/her ears. If yes, when?		
My child wears hearing aids. If yes, what type and for how long?		

<u>Oral Motor & Feeding History:</u>

Has your child experienced feeding/eating difficulties (e.g. biting, swallowing, and chewing)? Yes/No _____
If yes, please explain:_____
Was your child breast-fed or bottle-fed? _____
Does your child eat by one's self using utensils? Yes/No _____ Drool? _____
Does your child put toys in their mouth? Yes/No _____

If yes, please explain: _____
Does your child have food allergies? Yes/No _____
If yes, please explain: _____
Does your child have food preferences/aversions? Yes/No _____
If yes, please explain: _____

Does your child have a history of feeding problems? If yes, check all that apply:

_____Choking _____Difficulty Biting _____Overstuffing Mouth

_____Poor Nursing _____Difficulty Chewing _____Difficulty Swallowing

Is your child a messy or picky eater? Yes/No _____
Please list favorite foods:
_____
_____

Speech, Language and Hearing Development:

Did your child make babbling or cooing sounds during the first 6 months of life? _____
At what age did the child say his or her first word? _____
What were your child's first words? _____
Did your child keep adding words once he/she started to talk? Yes/No _____
If no, explain: _____
At what age did the child begin using 2 and 3 word sentences? _____
Did speech learning ever seem to stop for a period of time? Yes/No _____
If yes, explain _____
Does your child talk a lot _____ occasionally _____ never _____
Does your child prefer to talk _____ gesture _____ talk and gesture_____
Does the child most frequently use sounds _____ single words _____ 2-word sentences _____
3-word sentences _____ more than 3-word sentences_____
List examples: _____
_____
_____
Does your child make sounds incorrectly? Yes/No _____ If yes, which ones? _____
_____
Does your child hesitate, "get stuck", repeat or stutter on sounds or words? Yes/No _____ If yes, describe:_____
Describe any recent changes in the child's speech: _____
_____
Can the child tell a simple story? Yes/No _____

How well can he/she be understood by the following individuals? (indicate "A" for all the time; "M" for most of the time; "S" for some of the time; or "R" for rarely)
Parents _____ Siblings _____ Teacher(s) _____ Friends _____ Strangers _____
Comments _____

Does the child seem to understand what you say to him or her? Yes/No _____
If no, explain _____
Does your child consistently answer to his/her name? Yes/No _____
Does your child make appropriate eye contact with adults? Yes/No _____ Other children? Yes/No _____
Does your child identify simple objects? Yes/No _____
Does your child follow simple commands? Yes/No _____
Please describe/give examples: _____
Does your child ever have trouble remembering what you have told him or her? Yes/No _____
If yes, explain? _____
Does your child enjoy looking at books? Yes/No _____ How often do you read to your child? _____

Sensory and Motor Development:

Does your child have any difficulty walking, running, sitting or other large motor skills? Yes/No _____
If yes, please describe _____
_____
_____
Does your child tippy-toe walk? Yes/No _____
Is your child clumsy or does he/she fall easily? Yes/No _____
Does your child have low body tone? Yes/No _____
Does your child have difficulty with fine motor skills such as stacking, cutting and handwriting? Yes/No ____

If yes, please describe: _____
_____
_____

Motor milestone development ages obtained:
Crawled _____ Sat _____ Stood _____ Walked _____ Fed Self _____ Dressed Self _____ Toileted _____ 1st Words _____

Is your child sensitive to certain textures of food or clothing? Yes/No _____
If yes, please describe: _____
_____
_____
Does your child dislike having substances on his/her hands such as glue or dirt? Yes/No _____
Is your child oversensitive to being touched or dislike being touched? Yes/No _____
If yes, please describe: _____
_____
_____

Does your child have any known gastrointestinal issues? Yes/No _____
If yes, explain _____
_____
Check all that apply: Child finger feeds_____uses a fork_____a spoon_____on open cup_____ a straw _____
Is adult assistance needed with feeding? Yes/No _____
If yes, explain _____
_____
Has he/she ever choked on solid foods? Yes/No _____ Does your child cough on liquids? Yes/No _____
Can your child chew well? Yes/No _____ Does he/she drool? Yes/No _____ If yes, when? _____
Did your child us a pacifier? Yes/No _____ If yes, age weaned from pacifier _____
Does your child continue to mouth objects? Yes/No _____
Did your child suck his/her thumb/fingers? Yes/No _____ If yes, until when? _____
Does your child suck on his/her hair/clothing/blanket/etc? Yes/No _____ If yes, what? _____
Does your child resist tooth brushing? Yes/No _____ Does he/she like taking a bath? Yes/No _____
Swings? Yes/No _____ Parties? Yes/No _____ Rough housing? Yes/No _____
Child prefers to primarily play: alone _____ with other children _____ with older children _____
with younger children _____ with adults _____
Is your child overly sensitive to loud sounds? Yes/No _____ Bright lights? Yes/No _____
Tags on clothing? Yes/No _____
Give ages at which the following first occurred:
Sat up _____ Crawled _____ Stood _____ Walked _____ Ran _____
Bladder trained _____ Bowel trained _____ Night trained _____
Which hands does the child use more frequently? Right _____ Left _____No preference _____

Behavior:

Does your child typically display any of the following behaviors? (check all that apply.)

☐reduced or lack of interaction with others
☐tantrums
☐passive in interactions
☐very active
☐underactive
☐inattentive
☐refuses to perform tasks
☐difficulty staying on task
☐difficulty finishing tasks
☐sensitive
☐angry/acting out behavior
☐frustrated
☐shy

Educational History:

Does your child attend? Daycare _____ Preschool _____ Kindergarten _____ Grade School _____
Name of School _____ Grade/Level _____
In school, does he/she do: average _____ below average _____ above average _____ work?
What are the child's best subjects? _____
Has he or she repeated a grade? Yes/No _____ If yes, which one(s)? _____
What is your impression of your child's learning abilities? _____
_____

What is your impression of your child's social skills? _____
_____
_____

Does your child display any behavioral or attentional issues at school? _____
_____
_____
_____

Describe any speech, language, hearing, OT, PT, psychological, special education services, tutoring that the child is receiving/has received.

Type of Therapy	Therapist	Frequency	Place (Private/School)	Group or Individual?	Duration (e.g., age 3-5)

Favorite Activities:

Please list some of your child's favorite toys, games, hobbies, etc.

_____
_____
_____
_____

What do you consider to be your child's greatest strengths?

_____
_____
_____

What other concerns do you have about your child?

_____
_____
_____

Signed: _____ Date: _____

CORNERSTONE THERAPY SERIVCES

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM
EFFECTIVE DATE OF THIS NOTICE: APRIL 14, 2003

I, _____, have received a copy of CORNERSTONE THERAPY SERVICES'S Notice of Privacy Practices.

_____
Patient's Name

_____ _____
Signature of Parent/Patient Date

_____
Printed Name of Parent/Patient

NOTICE OF PRIVACY PRACTICES

New federal laws require us to give you this Notice about our privacy practices regarding your protected health information. This is effective as of April 14, 2003, and will remain in effect until we replace it.

PLEASE REVIEW NOTICE CAREFULLY.

HOW DO WE PROTECT YOUR INFORMATION?

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). We maintain physical and procedural safeguards to protect your personal information. We establish confidentiality agreements with contracted parties that receive non-public personal, financial and health information about you. Our office will make reasonable efforts to disclose only the minimum necessary protected information to accomplish the intended purpose. The terms of this notice apply to all records containing your PHI that are created or retained by this practice. We reserve the right to change our privacy practices and terms of this notice at any time, provided such changes are permitted by law. Before we make a significant change to our privacy procedures, we will change this Notice and make the new Notice available upon request.

HOW DO WE USE YOUR PROTECTED HEALTH INFORMATION (PHI)?

1. **Treatment.** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Many of the people who work for our practice, including but not limited to, our therapists may use or disclose your PHI in order to treat you or to assist others in your treatment. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. We may disclose our PHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. **Persons Involved In Care.** If you are available and do not object, we may disclose your PHI to your family, friends, and others involved in your care or payment of a claim. If you are unable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgement to share PHI with your spouse concerning the processing of a claim. Your authorization may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time.

Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose our protected health information:

1. **Disclosure Required by Law.** We may disclose your health information when we are required to do so by law. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release PHI if asked to do so by a law enforcement official. We will require adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law).
2. **Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
3. **National Security and Military.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to a correctional institution or law enforcement official having lawful custody of protected health information of a patient under certain circumstances.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:
1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Cornerstone Therapy Services specifying the requested method on contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of you PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of you PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing. Your request must describe in a clear and concise fashion:
    (a) the information you wish restricted.

(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Cornerstone Therapy Services in order to inspect and/or obtain a copy of you PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with you request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information. To request an amendment, you request must be made in writing and explain why the information should be amended. We may deny you request under certain circumstances.

5. **Accounting of Disclosures.** You have the right to request an accounting of certain disclosures made by us of your PHI. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing, and may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reason described in the authorization. Please note, we are required to retain records of your care.

8. **Right to a Copy of This Notice.** You have the right to a paper copy of this Notice upon request by contacting Cornerstone Therapy Services.