Canyon Kids
Pediatric Occupational Therapy Services

Welcome to Canyon Kids!

Canyon Kids is pleased to have you as a valued family in this practice. Our private practice offers a full range of Pediatric Occupational Therapy Services, as well as any support services you might need in relation to the integration of OT into your child's other therapeutic and academic programming.

The information in this packet will give you details about our clinic and therapy sessions. Also, new patient forms are included. Please complete all the information requested on the forms in the right side of the folder. **The forms request: general contact information and your signature to confirm your agreement with the clinic's policies. Please mail or drop off the completed forms, or fax them, for receipt at our clinic at least 48 hours prior to your child's first session.**

The Canyon Kids clinic is conveniently located in downtown Bethesda. If driving, there is meter parking on Rugby Avenue and the surrounding streets (quarters accepted). There is a metered, public parking garage to the right of the building when facing our building. Do not park in the garage attached to the left of our building's front door.

The Metro's red line has two stops near our clinic: Bethesda and Medical Center. Also, the Bethesda Circulator is a free bus with a convenient route through Bethesda. Please consult our website for more details at www.canyonkids.com.

Our clinic has a waiting area where your therapist will meet you, or an approved caregiver, at the beginning and end of your child's therapy session. We welcome you to watch your child during a session and to take part within the session. We ask that you keep conversations to a minimum and hold them at the end of the session to benefit your child and the therapeutic process.

An individual, co-treat, or group treatment session is 60 minutes and consists of 50 minutes of direct time with your child's therapist and 5 minutes for your child to help clean up and have free play in the gym while your therapist generates a daily note for you to take home. The last 5 minutes of the session will be a brief consultation with you, or the caregiver, in the waiting room, to discuss the session and any suggested at-home methods.

Also, Canyon Kids partners with a billing company to submit your insurance claims to your insurance company on your behalf. Statements are mailed to you every 4 weeks detailing any balance due to Canyon Kids, after the insurance claims process is complete and any insurance payments are applied to your account.

Thank you again for choosing Canyon Kids and Welcome! We are looking forward to working with your child, family, and therapeutic or educational team to help your child develop independence and reach his or her goals.

Sincerely,

Christine T. Sproat MA, OTR/L; Director

4833 Rugby Avenue ❖ Suite 101 ❖ Bethesda, Maryland 20814
Phone: 301-523-0902 ❖ Fax: 301-913-2939 ❖ www.canyonkids.com

Canyon Kids
Pediatric Occupational Therapy Services

CHECKLIST OF ITEMS TO COMPLETE AND RETURN TO CANYON KIDS

Please complete the following forms included in this packet and return them to Canyon Kids. Forms need to be received at Canyon Kids prior to 48 hours in advance of your child's first session date. Also, please forward any prior evaluations or medical history.

Please mail or drop off completed forms to:
Canyon Kids
c/o Christine Sproat
4833 Rugby Avenue
Suite 101
Bethesda, MD 20814

Or fax them to:
301-913-2939

- ☐ **GENERAL INFORMATION FORM**
- ☐ **FINANCIAL AGREEMENT AND POLICY – 2 PAGES**
- ☐ **NOTICE OF PATIENT PRIVACY PRACTICES**
- ☐ **PATIENT INFORMATION CONSENT FORM**
- ☐ **AGREEMENT AND WAIVER FOR PARTICIPATION IN ONSITE THERAPY**
- ☐ **PROFESSIONAL RELEASE FORM**
- ☐ **CANCELLATION AND DISCONTINUANCE FROM SERVICES POLICY**
- ☐ **SICK POLICY**
- ☐ **PERMISSION SLIP FOR CAREGIVERS**
- ☐ **COMPLETED CREDIT CARD AUTHORIZATION FORM**

Canyon Kids
Pediatric Occupational Therapy Services

GENERAL INFORMATION FORM

Today's Date _____

Patient's Information	
Name of Patient	
Date of Birth	Gender Male / Female (circle one)
Patient's Home Telephone	
Patient's Home Address	

Patient's Medical Information
Referred By
Diagnosis
Reason for seeking OT services? Please provide some specific instances that have been of concern to you
Pediatrician's Name
Pediatrician's Address
Pediatrician's Phone
Precautions/Medications

Parents' Information				
Parents' Names	Home Phone	Cell Phone	Work Phone	Email

Emergency Contact Information				
Emergency Contact	Home Phone	Cell Phone	Work Phone	Email

4833 Rugby Avenue ❖ Suite 101 ❖ Bethesda, Maryland 20814
Phone: 301-523-0902 ❖ Fax: 301-913-2939 ❖ www.canyonkids.com

Canyon Kids
Pediatric Occupational Therapy Services

FINANCIAL AGREEMENT AND POLICY

Welcome to Canyon Kids Pediatric Occupational Therapy Services. We are pleased that you have chosen us for your child's therapeutic needs. Our mission is to provide you with the highest level of professional therapeutic care and patient satisfaction. In order to provide this level of care, we have created an agreement for financial responsibility to avoid any misunderstandings and to ensure timely payment for therapeutic services.

Canyon Kids requires that all clients sign the Financial Agreement and Policy, Agreement and Waiver for Participation in Onsite Therapy Form and Patient Information Consent Form (HIPAA) prior to receiving therapeutic services.

Billing Services

1. Canyon Kids provides direct billing to your insurance carrier through our billing department. We will verify your insurance benefits first and submit insurance claims for OT services on your behalf. _____Parent Initial

2. Canyon Kids is **out of network for all insurance plans**. If your insurance does not provide out-of-network benefits or if your out-of-network benefits create a financial burden, the Practice will help you with financial concessions. Please contact the billing department for more information at: 1-240-415-9877. _____Parent Initial

3. Canyon Kids is able to bill your insurance for Evaluations and OT Sessions. OT Sessions are typically billed to insurance in 15 minute increments. Please contact our billing department with any questions regarding insurance or claims submission at 1-240-415-9877. _____Parent Initial

4. Patients are responsible for updating new insurance information with our billing department. Any delay in updating information may result in lack of coverage for services provided prior to new insurance being put on file. Full payment is still due to Canyon Kids for services provided in the interim. _____Parent Initial

5. Canyon Kids is <u>unable</u> to submit to insurance the following list of services. Our fee for these services is $140.00 per hour and is billed in 15 minute increments:
   - School Observation
   - School Meeting
   - **Consultation in the office or by phone**
   - **Additional written reports or letters requested by the parent/guardian or insurance (amount of time agreed upon with parent/guardian prior to delivery)**
   - Fabrication of therapeutic materials or programs (amount of time agreed upon with parent or guardian prior to delivery) _____Parent Initial

6. Canyon Kids' billing department will send an invoice in the mail to you every 28 days based on when you commence services. Payment is due upon receipt of any monthly balance due invoice. We accept Visa, Master Card, Discover, AMEX, personal check and ACH payments. The patient's parent or guardian is responsible for payment of all balance due invoices. _____Parent Initial

Pediatric Occupational Therapy Services

Evaluation Fees

7. The fee for a Full OT Evaluation is $650.00 and includes: test administration, scoring, written analysis and a 1 hour consultation to discuss results. Payment of $325.00 is due by check or credit card 48 hours before testing. The balance is due after insurance has processed. An invoice will be generated showing charges, payments and balance due.

_____Parent Initial

Out of Office Fee

8. An "Out of Office Fee" will be added to sessions outside of Canyon Kids Therapy Offices at $30.00 per session.

_____Parent Initial

Cancellations and No-Shows

9. If your child is sick or unable to attend therapy, please respect your therapist's time and call your therapist immediately to cancel and reschedule your session. Please do not bring your child to the office if they are sick. Your child must be free from fever, stomach virus/vomiting, and on antibiotics as needed for 24 hours prior to coming for their session. This policy is to protect your child and the other children and staff at our practice. _____Parent Initial

10. **Please cancel 24 hours prior to your scheduled session or a "No Show Fee" of $140.00 will be applied to your balance due.** We understand that your child may become ill the day of your session. If this is the case we will waive the "No Show Fee" if the session can be made up within 4 weeks of the missed session at a mutually agreed upon time between you and your therapist. If you feel your child may be getting sick please call 24 hours prior and discuss this with your therapist. This fee cannot be submitted to insurance. _____Parent Initial

11. Excessive cancellations will result in the loss of your reserved appointment time. _____Parent Initial

Overdue Outstanding Balances and NSF Fees

12. In the case of an outstanding balance, Canyon Kids' billing department will attempt to contact you via phone and mail. Uncollected, delinquent balances will be sent to an outside agency and collection fees will be assessed._____Parent Initial

13. Canyon Kids will assess a "Non-Sufficient Funds Fee" to all returned checks or ACH transactions. A charge from Canyon Kids of $35.00 will be added to your balance due statement. _____Parent Initial

Acknowledgement of Canyon Kids Financial Agreement and Policy

14. Fees are reviewed on a periodic basis and Canyon Kids reserves the right to adjust the fees when necessary. Thirty day advance written notification will be provided if any fee increase is instituted. _____Parent Initial

15. I have read and understand Canyon Kids Financial Agreement and Policy and I agree to be bound by its terms. I also understand that such terms may be amended by The Practice for time to time and notice will be provided in advance.

Name of Parent or Legal Guardian _____

Signature _____ **Date** _____

4833 Rugby Avenue ❖ Suite 101 ❖ Bethesda, Maryland 20814
Phone: 301-523-0902 ❖ Fax: 301-913-2939 ❖ www.canyonkids.com

Canyon Kids
Pediatric Occupational Therapy Services

NOTICE OF PATIENT PRIVACY PRACTICES

According to the Health Insurance Portability and Accountability Act, known as HIPAA, physical, occupational and speech therapists in private practices must incorporate the federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Please note that your child's personal health information may be used by Canyon Kids Pediatric Occupational Therapy Services for treatment, obtaining payment, during an audit, in emergencies, or when required by law. The child's parent/guardian will be asked for written authorization to use the child's personal medical information for any other reason than those listed above. You have the right to review your child's personal health information at any time, to request that inaccurate information be corrected, or to request a list of instances when the information has been disclosed for reasons other than treatment, payment, or other administrative purposes. You have the right to restrict how the information is used and disclosed for treatment, payment, and administrative operations. The requests for restrictions will be considered on a case-by-case basis. You have the right to address concerns and complaints about a potential violation of your child's health privacy to the US Department of Health and Human Services.

For further questions, you may contact the Compliance Officer

Christine Sproat MA, OTR/L
4833 Rugby Avenue
Suite 101
Bethesda, MD 20814

PATIENT INFORMATION CONSENT FORM

I have read and understand this practice's **Notice of Patient Privacy Practices**. I understand that the company may use or disclose my child's personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my child's personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the Company. I also understand that the Company will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my child's personal health information for purposes as noted in the Company's **Notice of Patient Privacy Practices.** In doing so, I hereby release Canyon Kids from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying the Company in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given and no further confidential information will be released without the execution of an additional written authorization.

Patient's Name _____ Name of Parent/Legal Guardian _____

Signature _____ Date _____

Canyon Kids
Pediatric Occupational Therapy Services

AGREEMENT AND WAIVER FOR PARTICIPATION IN ONSITE THERAPY

I (print parent/guardian name) _____

the parent or guardian of (patient's name) _____
(thereafter referred to as "my child") give permission for my child to participate in therapy sessions at Canyon Kids Pediatric Occupational Therapy Services.

I hereby release Canyon Kids, its principal owners, therapists, employees and representatives and all other individuals or organizations acting on behalf of Canyon Kids in connection with this program from any and all claims which I or my child may have arising from, resulting from, or in connection with my child's participation therapy, including, but without limitation, any claim, demands or causes of action for injuries to my child, including but not limited to injuries resulting from the use of any play equipment during the program. This agreement is signed for the purpose of fully and completely releasing, discharging and indemnifying Canyon Kids, its principal owners, therapists, employees, representatives, and all other individuals or organizations acting on behalf of Canyon Kids, in connection with this program from all liability as herein described.

Signature _____ Date _____

4833 Rugby Avenue ❖ Suite 101 ❖ Bethesda, Maryland 20814
Phone: 301-523-0902 ❖ Fax: 301-913-2939 ❖ www.canyonkids.com

Canyon Kids
Pediatric Occupational Therapy Services

PROFESSIONAL RELEASE FORM

I hereby give permission to Canyon Kids to discuss, release, or obtain information relative to my child's therapy, from the following professionals:

PROFESSIONAL'S NAME	COMPANY NAME / TITLE	EMAIL ADDRESS	PHONE NUMBER

Patient's Name _____ Name of Parent/Legal Guardian _____

Signature _____ Date _____

4833 Rugby Avenue ❖ Suite 101 ❖ Bethesda, Maryland 20814
Phone: 301-523-0902 ❖ Fax: 301-913-2939 ❖ www.canyonkids.com

Canyon Kids
Pediatric Occupational Therapy Services

CANCELLATION AND DISCONTINUANCE FROM SERVICES POLICY

This office requires 24 hours' notice for cancellations. Otherwise, if cancelled fewer than 24 hours in advance of the session, you will be charged the full fee of the session. In addition, you will be charged the full fee for the session if you do not show for a confirmed appointment. Should your child miss three consecutive visits, it will be considered that you are not in adherence or compliance with your child's plan of care, and your child will be discharged from this clinic. Your primary physician will be notified and you will be given the names of three like professionals for your future use should you decide to begin therapy services again.

If there is a concern about weather effecting therapy sessions, you must contact your therapist directly the morning of the session to discuss these conditions. Canyon Kids DOES NOT follow Montgomery County Schools closing and delays. Of course, safety is our first concern.

I have read and agree to the above policies and procedures related to being billed in full for missed and cancelled sessions if I don't give more than 24 hours' notice.

Name of Parent/Legal Guardian _____

Signature _____ Date _____

4833 Rugby Avenue ❖ Suite 101 ❖ Bethesda, Maryland 20814
Phone: 301-523-0902 ❖ Fax: 301-913-2939 ❖ www.canyonkids.com

Canyon Kids
Pediatric Occupational Therapy Services

SICK POLICY

Canyon Kids' sick policy is designed to ensure your child's health and your child's therapist's health and keep those around us as well as possible so that we can all do our jobs.

Please note that it is ***not* beneficial for your child to participate in therapy while he/she is ill or contagious. For these reasons, your child must be fever-free for 24 hours and vomit-free for 24 hours before participating in therapy.
**If your child has a contagious illness (such as Strep, Pink Eye, green discharge from nose/eyes, chicken pox, lice, etc.), your child should be under the treatment of a physician when necessary and be receiving appropriate care for at least 24 hours prior to the session.
**If your child has had an illness for 4-7 days and is no longer contagious, but has residual side effects (such as runny nose or cough), please use your best judgment as to whether to bring your child for therapy.
**It is also imperative that parents, caregivers, and siblings of those attending therapy not attend a therapy session or stay in the waiting room if they are ill. Prior arrangements can be made with your therapist to prevent this situation. Please contact your child's therapist directly.
**All cancellations made less than 24 hours in advance are billed at the full hourly rate. However, your child's therapist is willing to schedule make-up sessions for missed appointments due to illness. Please be in touch with your child's therapist directly to schedule.
**We encourage that you help your child with hand washing prior to a therapy session.
**If your child's therapist happens to be ill, he/she will notify you as soon as possible. Your therapist will make every attempt to schedule a make-up session for the missed time.

Name of Parent/Legal Guardian _____

Signature _____ Date _____

PERMISSION SLIP FOR CAREGIVERS

I (print parent/guardian name) _____

the parent or guardian of (patient's name) _____

give permission for (print caregiver's name)

_____

to pick up my child from Canyon Kids when my child's therapy is finished. In the event that another person will pick up my child, I will notify Canyon Kids.

Signature _____ Date _____

4833 Rugby Avenue ❖ Suite 101 ❖ Bethesda, Maryland 20814
Phone: 301-523-0902 ❖ Fax: 301-913-2939 ❖ www.canyonkids.com

Canyon Kids
Pediatric Occupational Therapy Services

CREDIT CARD AUTHORIZATION

I direct Canyon Kids to use the following credit card to process payment

Patient's Name _____

Name on Credit Card _____

Credit Card Number _____

(We accept VISA, MasterCard and Discover)

Expiration Date Month and Year _____ / _____

Billing Address _____

Billing City, State,
Zip _____

This credit card is ☐ To use THIS TIME ONLY

☐ To KEEP ON FILE for future monthly charges going forward

Cardholder's Signature _____

Notes _____

4833 Rugby Avenue ❖ Suite 101 ❖ Bethesda, Maryland 20814
Phone: 301-523-0902 ❖ Fax: 301-913-2939 ❖ www.canyonkids.com

Canyon Kids
Pediatric Occupational Therapy Services

PLEASE KEEP THIS AGREEMENT FOR YOUR RECORDS

NOTICE OF PATIENT PRIVACY PRACTICES

According to the Health Insurance Portability and Accountability Act, known as HIPAA, physical, occupational and speech therapists in private practices must incorporate the federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Please note that your child's personal health information may be used by Canyon Kids Pediatric Occupational Therapy Services for treatment, obtaining payment, during an audit, in emergencies, or when required by law. The child's parent/guardian will be asked for written authorization to use the child's personal medical information for any other reason than those listed above. You have the right to review your child's personal health information at any time, to request that inaccurate information be corrected, or to request a list of instances when the information has been disclosed for reasons other than treatment, payment, or other administrative purposes. You have the right to restrict how the information is used and disclosed for treatment, payment, and administrative operations. The requests for restrictions will be considered on a case-by-case basis. You have the right to address concerns and complaints about a potential violation of your child's health privacy to the US Department of Health and Human Services.

For further questions, you may contact the Compliance Officer

Christine Sproat MA, OTR/L
4833 Rugby Avenue
Suite 101
Bethesda, MD 20814

Pediatric Occupational Therapy Services

PLEASE KEEP THIS AGREEMENT FOR YOUR RECORDS – 3 PAGES

HIPAA AGREEMENT FOR COVERED BUSINESS ENTITY

Name of Covered Entity	Canyon Kids Pediatric Occupational Therapy Services	
Names of Business Associates	Christine Sproat Director/OT	Shannon Elie OT
	Allison Martin OT	Katherine Compart OT
	Stacey Silver OT	Susan Barnett OT
	Kelsey Schwartz OT Intern	Candace Tucker OT Admin
	Michael Hiscock CoDirector/Admin	Lisa Abrams OT

A. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required by Law.

Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary, in a time and manner or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule

Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

1. Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(i)(B).

Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

B. OBLIGATIONS OF COVERED ENTITY

1. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

2. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity except if the Business Associate will use or disclose protected health information for, and the contract includes provisions for, data aggregation or management and administrative activities of Business Associate

3. Term and Termination

Term: The Term of this Agreement shall be effective as of January 1, 2013 and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible

to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

Termination for Cause: Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement

Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or

If neither termination nor cure are feasible, Covered Entity shall report the violation to the Secretary.

Effect of Termination: Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon [Insert negotiated terms] that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

C. MISCELLANEOUS

Regulatory References: A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

Amendment: The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

Survival: The respective rights and obligations of Business Associate under Section [Insert Section Number Related to "Effect of Termination"] of this Agreement shall survive the termination of this Agreement.

Interpretation: Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.