JoyRide Center, Inc.
29550 Tudor Way
Magnolia, TX 77355
281-356-5900
Fax 281-356-5901
www.JoyRideCenter.org

JOYRIDE CENTER PREPARATORY PROGRAM (JRC Prep)

APPLICATION PROCEDURE

Thank you for your interest in the JoyRide Center Preparatory Program! The mission of the JoyRide Center is to help people with different abilities find more joy in life through equine-assisted activities and therapies, along with functional/life skills education. Our program serves individuals with disabilities who are no longer eligible for public school services. In order to be considered for this program, applicants must be independent with eating, toileting, or have an aide in attendance, and have no history of behavioral problems.

JRC Prep is a Day Program that functions within the JoyRide Center Therapeutic Horsemanship Program. This relationship allows for a unique blend of functional/pre-vocational training integrated into a worksite. JRC Prep combines the following three distinct pillars of instruction into an integrated program:

1. **Worksite:** JoyRide Center serves as a worksite for all JRC Prep clients. In this portion of the program, clients become involved in all aspects of running a small horse farm.
2. **Production:** JRC Prep clients create numerous products that are used for fundraising events and activities. These products include horse treats, stationery, Christmas ornaments and many others. Clients are involved in every step of the process of making these products.
3. **Direct Instruction:** JRC Prep utilizes the transition band of the Unique Learning System curriculum, which works on employability skills, daily living skills, recreation and leisure skills and functional academics.

Each client has a program consisting of these three components tailored to meet their specific needs.

Our application process has four steps:

1. The family completes a tour of JoyRide Center and the JoyRide Center Preparatory Program.
2. At the conclusion of the tour the JRC Prep staff will complete a family interview to address the four domains of transition: employment, education/training, personal independence and community involvement.

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3. The attached application is completed, returned and reviewed by the JRC Prep staff. A thorough answer to all questions is essential. Please return the following to us:
    a. Completed Application for Admissions *with dates and signatures where indicated*
    b. Notice for Release/Consent to Request Confidential Information
    c. HIPAA Notice of Privacy Practices
    d. Copies of the most recent educational, psychological, and psychiatric evaluations (if available)

4. If the applicant is determined to be a good candidate for our program, an evaluation is conducted while the applicant spends a day at JRC Prep. The evaluation fee of $65 is due at this time.

Once these steps are completed, the staff will work with the family to schedule entry into JRC Prep. If you have any questions, please do not hesitate to contact the Prep Program Manager, Kristi Pierce, at prepmanager@joyridecenter.org.

Please read the following Client Guidelines. It contains important information about policies and procedures of the JoyRide Center. Please keep handy to refer to when needed.

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JOYRIDE CLIENT GUIDELINES

How We Are Organized: JoyRide is governed by a volunteer Board of Directors with a knowledgeable, dedicated staff of professionals. Some staff members are paid employees, while some are volunteers. JoyRide receives no funding from any state or federal sources. We rely on private and corporate donations, grants, proceeds from special events and client tuition.

Semesters: JRC Prep offers spring, summer and fall semesters which vary in length. Calendars are available at the center and on our website, www.JoyRideCenter.org.

Summer Semester Option: Active JRC Prep clients may choose to take the summer off without losing their place in the fall semester as long as:

a) all updated paperwork, including medical forms, is received in the JRC office by Paperwork Renewal Date
and
b) any outstanding tuition payment is paid in full by Paperwork Renewal Date

If active clients choose to take the summer off, these limited number of SUMMER ONLY spots are made available for new clients on the waiting list. A new client who gets into a summer only spot has no guarantee that they will be able to continue in the fall.

Sessions: JRC Prep is in session on Mondays, Tuesdays, Wednesdays, and Thursdays from 9:00 am to 3:00 pm. The ratio of staff to participant is kept very low, with a class size maximum of 7. The staff includes a certified teacher, job coach or instructional assistants and trained mentors. Available openings will be discussed with families upon inquiry.

Tuition/Fees:

- Tuition Rate: **$65** per day for a 6-hour day, **$50** per day for a 4-hour day
- Evaluation Fee – same as tuition rate … a one-time, non-refundable fee paid on evaluation day
- Administration Fee - $25… a yearly fee paid by all clients billed on your first month's invoice, then again every January.

JRC Prep does not accept HCS or CLASS funding.

Tuition Assistance: JoyRide Center has a tuition assistance program, funded by generous donors, which can provide a maximum of 50% of the tuition costs. Interested families may contact Peggy Wagner, Office Manager, at pwagner@joyridecenter.org for information and an application.

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Billing: JoyRide appreciates (and depends on!) tuition being paid in a timely manner, therefore we have the following payment policy:

- Clients are billed at the beginning of each month for JoyRide services rendered the previous month. Payment is due upon receipt and considered late if received after the 15th of the month.
- If a client becomes 2 months behind in payments, they have until the 15th of the next month to pay the total balance due or they will be withdrawn from the program and their place will be offered to someone on the waiting list.
- If at any time during that semester they are able to pay the total balance due AND their place has not been filled, they may re-enter the program.
- A client who is withdrawn from the program for financial reasons will be placed on the waiting list above clients who have not yet joined the program, but must pay total balance due before returning to the program.
- If a client is having difficulty staying current on payments, they are encouraged to apply for help from the Tuition Assistance Fund.

If you need to discuss billing issues, please contact Office Manager, Peggy Wagner, pwagner@joyridecenter.org.

Tuition/fees are payable to *JoyRide Center* by cash or check, or through the Quickbooks bank draft option. Payments can be placed in the "Pony Express" box at JoyRide or mailed to:

JoyRide Center
29550 Tudor Way
Magnolia, TX 77355

Absences: Please call the instructor or the JoyRide office (281-356-5900) if you must be absent for a JRC Prep session. You will not be charged for sessions **cancelled by JoyRide**; however, if **you** cancel or do not show up for a session, you will be charged a cancellation fee equal to your **regular class tuition rate**.

Excused Absences: During fall and spring semesters (summer not included), when the JoyRide financial situation allows, each rider may receive one absence per semester without being charged a cancellation fee (excused absence).

Illness: We want to keep everyone healthy; therefore, the client should not attend unless he/she has been fever- free with no vomiting or diarrhea for at least the past 24 hours.

Medical Leave: Medical leave may be applied to clients who are absent due to a hospital stay or a significant medical issue. The instructor will determine, on a case by case basis, if the absences are considered "Medical Leave". Common illnesses and doctor's appointments are not considered Medical Leave. Clients may have up to 4 consecutive absences for medical leave during a semester without losing their place in the riding schedule or being charged a class cancellation fee.

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Long Term Medical Leave: Long Term Medical Leave is when a client is on medical leave for ***more than*** 4 consecutive classes. After the 4th absence, the client is offered 2 options:

Option 1: The client may request "Medical Tuition Assistance" to hold their place in the program. This means that the client is responsible for paying half of the tuition amount for each class missed over 4, and the other half is paid from the JoyRide Tuition Assistance Fund**.

***This option is only available if the Tuition Assistance program has adequate funds available.*

Option 2: The client may choose to give up their place for the rest of the semester so it can be offered to someone on the waiting list. If they choose to give up their place but plan to return to the program in the next semester, they are placed at the top of the Returning Client Waiting List.

If a client has been on medical leave for more than 12 months, they are moved to the bottom of the Returning Client Waiting List and must be re-evaluated before returning to the program. Regular class fee will be charged for re-evaluations.

Parking: Clients may park on the concrete parking area opposite the covered arena.

Conduct at the Center: It is mandatory that everyone complies with all posted **safety rules** and abide by all posted **off-limit areas**. JoyRide is a **no smoking** facility and the use of **drugs or alcohol on the property is strictly forbidden**. Open carry of handguns is prohibited. Firearms or weapons must be secured and locked in your vehicle while on JoyRide property. No mistreatment, abuse or suggested abuse of any person or animal will be tolerated. We reserve the right to ask anyone to leave the premises.

JOYRIDE CENTER PREPARATORY PROGRAM (JRC Prep)

APPLICATION FOR ADMISSIONS

Applicant Information

Applicant's Full Name:

Date of Birth:_____ Gender: _____

Address: _____

City:_____ State:_____ Zip: _____

Height: _____ Weight: _____

Applicant Phone:_____ Applicant Email: _____

Documented Disability: _____

Parent/Guardian Information

Mother/Legal Guardian: _____

Home Address (if different than above): _____

City:_____ State:___ Zip: _____ Preferred

Email Address: _____

Cell Telephone #:_____ Home Telephone #:_____

Business Telephone #:_____ (Please put a * by preferred number)

Occupation/Name of Company: _____

Father/Legal Guardian: _____

Home Address (if different than above): _____

City:_____ State:___ Zip: _____ Preferred

Email Address: _____

Cell Telephone #:_____ Home Telephone #:_____

Business Telephone #:_____ (Please put a * by preferred number)

Occupation/Name of Company: _____

FOR OFFICE USE ONLY:

Date App Recv'd _____, Interview Date _____, Prep Eval Date _____

Accepted?_____, Start Date_____, Tuition Rate_____, Hrs/Day _____

Data Entry (initial & date): SF_____ File_____ Scanned_____ Attach to SF_____

8.19.2020

JOYRIDE CENTER PREPARATORY PROGRAM (JRC Prep)

APPLICATION FOR ADMISSIONS

Caregiver (if applicable):_____ **Phone:** _____

Who should we call to inform you of cancellations? _____ **In the event of an emergency and parent/guardian cannot be reached, contact:**

Name:_____ Relation:_____ Phone: _____

Name:_____ Relation:_____ Phone: _____

Preferred emergency medical facility or nearest: _____ **Names and ages of applicant's siblings:**

_____

_____

_____

Who referred you to JoyRide Center? _____

Have you attended a tour of JoyRide Center?_____ Yes _____ No

SCHOOLS OR PROGRAMS ATTENDED

CHECK ALL SITUATIONS IN WHICH THE APPLICANT HAS PARTICIPATED:

____ Day School

____ Sheltered Workshop

____ Group/Family Care Home

____ Public School

____ Home School

____ Competitive Employment

____ State School

____ Private School

____ Independent Living Situation

____ Other, (Explain) _____

PLEASE COMPLETE THE FOLLOWING INFORMATION ON EACH PROGRAM CHECKED ABOVE:
(Use additional pages if more space is needed)

1) _____
Name Dates

_____
Address City State Zip

_____
Type of Situation (Refer to list above)

8.19.2020

Reason for Leaving

Person to contact for More Information

2) Name Dates

Address City State Zip

Type of Situation (Refer to list above)

Reason for Leaving

Person to contact for More Information

3) Name Dates

Address City State Zip

Type of Situation (Refer to list above)

Reason for Leaving

Person to contact for More Information

4) Name Dates

Address City State Zip

Type of Situation (Refer to list above)

Reason for Leaving

Person to contact for More Information

5) Name Dates

Address City State Zip

Type of Situation (Refer to list above)

Reason for Leaving

Person to contact for More Information

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1) Please describe the applicant's general health, including special medical problems and/or physical disabilities:

2) Please describe the applicant's communication abilities:

3) Please describe the applicant's social/emotional state most of the time (for example: withdrawn, hyper-verbal, frustrated, sociable, even-tempered, etc.):

4) Does he/she prefer to be with peers, family, someone older, younger, or alone? Please explain:

5) Please describe the applicant's self-help skills (What does someone need to do daily to help the applicant?)

6) Please describe the applicant's daily routines and leisure (free time) activities:

7) What do you see to be the applicant's functional disabilities?

8) What do you think the applicant feels are his/her disabilities?

_____

_____

_____

9) What are the applicant's specific aptitudes, interests, and/or strengths?

_____

_____

_____

10) Has the applicant ever been involved with any of the following?

	YES	NO	EXPLAIN
Tobacco			
Drug Abuse			
Criminal Activity			
Sexual Misconduct			

11) Please describe activity areas and/or situations that the applicant strongly dislikes:

_____

_____

_____

12) Please describe activity areas and/or situations that the applicant enjoys:

_____

_____

_____

13) Please describe your goals and expectations for the applicant and what you hope JRC Prep can accomplish: _____

_____

_____

MEDICAL HISTORY

Applicant's Primary Physician: _____ Phone: _____

_____
Address City State Zip

Please list any other specialists who have treated or are treating the applicant:

_____

_____

Is the applicant on any regular medications? ____Yes _____No

If yes, please list below: (If more space is needed, use separate piece of paper and attach.)

Medication	Side Effects That May Impact Functioning in Class	Time Administered	Self-Administer (yes/no)

Note: JoyRide Center does not administer medications. Applicant must be able to self-administer medications that need to be taken during the day.

ALLERGIES/RESTRICTIONS

Is the applicant allergic to foods, pollens, insect bites, skin contacts, substances, etc? If yes, please describe reaction and what treatment is usually necessary: _____

_____

_____

_____

Does the applicant have any dietary restrictions? If so, please list: _____

_____

_____

_____

HISTORY OF ILLNESS/HOSPITALIZATION/SURGERY

Has the applicant had more that a brief illness during the past three years?_____Yes_____No

If yes, when? _____ Describe: _____

_____

_____

Has the applicant ever been hospitalized? _____Yes _____No

Describe: _____

_____

Has the applicant had any surgery? _____Yes _____No

If yes, when?_____ Describe: _____

_____

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APPLICATION FOR ADMISSIONS

SEIZURE ACTIVITY

Has the applicant ever had a seizure? _____Yes _____No

If yes, date of last seizure: _____

Type of seizure:_____What happens prior to the seizure? _____

During the seizure? _____

After the seizure? _____

HEALTH HISTORY

If the applicant is prone to (or has had) problems with any of the following, please indicate YES or NO. If YES, please explain.

	NO	YES	EXPLAIN
Headaches			
Asthma			
Heart Trouble			
Kidney Disease			
Stomach Trouble			
Diabetes			
Neurological Problems			
Emotional Problems			
Behavioral Problems			

IMPORTANT

If there is any further information you feel should be provided which is a factor and could influence the care, health, and well-being of this individual at Joyride Center, please explain:

_____

_____

_____

JOYRIDE CENTER PREPARATORY PROGRAM (JRC Prep)

APPLICATION FOR ADMISSIONS

The information in the above medical history is correct to the best of my knowledge.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Applicant (If appropriate) Date

LIABILITY RELEASE:

_____ (Client's Name) would like to participate in the JoyRide Center, Inc. program. I acknowledge the risks and potential risks of working around or near farm animals. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs, and assigns, executors or administrators, waive and release forever all claims for damages against JoyRide Center, Inc., its Board of Directors, Instructors, Therapists, Aides, Horse Owners, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in JoyRide programs. **WARNING** - Under Texas law (Chapter 87, Civil Practice and Remedies Code), a farm animal professional is not liable for an injury to or the death of a participant in farm animal activities resulting from the inherent risks of farm animal activities.

Signature:_____ Date: _____

Client, Parent, Legal Guardian

PHOTO RELEASE:

I hereby (Check one): ☐ **Consent** ☐ **Do NOT Consent**

to the use and reproduction by JoyRide Center of any and all photographs and any other audio/visual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program. JoyRide policy is that only first names will be used to identify people unless specific permission is given from the parent/client/caregiver.

Signature:_____ Date: _____

Client, Parent, Legal Guardian

The above releases apply to all family members & caregivers of this client. Contact your instructor if you have any questions about this policy.

JOYRIDE CENTER PREPARATORY PROGRAM (JRC Prep)

APPLICATION FOR ADMISSIONS

Virtual Lesson/Distance Learning Recording

If I/my child chooses to participate in Distance Learning video lessons, I understand that these lessons conducted through Google Meet, Zoom or other similar type applications will be recorded and distributed to other JRC Prep clients via email. If you do not wish your image to be included on the video lesson, it is your responsibility to disable the camera during video lessons.

Signature:_____ Date: _____

Client, Parent, Legal Guardian

The above releases apply to all family members & caregivers of this client. Contact your instructor if you have any questions about this policy.

BILLING INFORMATION

JoyRide invoices are normally emailed around the first of each month for services rendered in the previous month. Payment is due upon receipt and considered late if received after the 15th of the month.

☐ **Email** bills to:_____ Email Address: _____

☐ I do **not** have an email address. Please **mail** invoices to:

Address:_____

City:_____ Zip: _____

☐ I understand that I will be charged my regular daily tuition fee if I cancel or do not show up for a session. There will be no charge for classes cancelled by JoyRide.

☐ **I have read and agree to abide by all JoyRide guidelines and policies included in this packet.**

_____ _____

Client/parent/guardian Signature Date

8.19.2020

JoyRide Center, Inc.
NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: 8/28/18

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

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
    - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
    - is not part of your medical or billing records;
    - is not available for inspection as set forth above; or
    - is accurate and complete.

    In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
    - to carry out treatment, payment and health care operations as provided above;
    - to persons involved in your care or for other notification purposes as provided by law;
    - to correctional institutions or law enforcement officials as provided by law;
    - for national security or intelligence purposes;
    - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
    - incidental to other permissible uses or disclosures;
    - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
    - made to patient or their personal representatives;
    - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI**

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HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

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

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

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OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Peggy Wagner, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at JoyRide Center, Inc. or with the Secretary of the Department of Health and Human Services or Texas Attorney General's office. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services Office of the Secretary 200 Independence Avenue, S.W. Washington, D.C. 20201 Tel: (202) 619-0257 Toll Free: 1-877-696-6775 http://www.hhs.gov/contacts	**Office of the Texas Attorney General Consumer Protection Division** PO Box 12548 Austin, TX 78711-2548 Tel: (512) 463-2100 Toll Free: (800) 252-8011 https://www.oag.state.tx.us/forms/cpd/form.php	**JoyRide Center, Inc.** 29550 Tudor Way Magnolia, TX 77355 281-356-5900 Fax: 281-356-5901 contactus@joyridecenter.org www.joyridecenter.org

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site (if applicable Web site exists) for downloading.

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JoyRide Center, Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____

I hereby acknowledge that I have received a copy of JoyRide Center's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____

Signature of Patient or Legal Representative

____

Printed Name of Patient's Representative (*if applicable*)

____

Date

Relationship to Patient (*if applicable*)

☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

- -

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

______________________________but acknowledgment could not be obtained because:

☐ Patient/representative refused to sign
☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____

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☐ Other (Specify)

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