



Deborah A. Kimmet, M.S. LMT CNMT BCTMB CPT CES

PO Box 1252 · 913 SW Higgins, Suite 205 · Missoula, MT 59806

(406) 544-4704 · toll free outside Missoula: (888) 544-4704

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Provider Disclosures:

Deborah Kimmet holds state-issued massage therapy licenses in Montana, New Mexico, and Idaho. However, the work that is provided may also include non-massage therapy based bodywork and exercise. To ensure that you are informed as to Deborah's legal status:

1. The practitioner, Deborah A. Kimmet, M.S., LMT, CNMT, BCTMB, CPT, CES (Masters of Science degree in Human Movement Science, Licensed Massage Therapist, Certified Neuromuscular Therapist, Board Certified in Therapeutic Massage and Bodywork, Certified Personal Trainer, and Corrective Exercise Specialist), is not a licensed physician nor is she a licensed physical therapist.
2. Some of the treatment that you will receive from the practitioner is alternative or complementary to health services that are licensed by the State of Montana (massage therapy). Personal training and corrective exercise are services not currently licensed by the State of Montana.
3. Some of the services to be provided by the practitioner are not licensed by the State of Montana. The nature all of the services provided (including massage therapy):
 - Neuromuscular Therapy and Practical Movement Therapy include
Massage therapy / myofascial release, neuromuscular re-education, hydrotherapy (hot & cold packs), postural assessment, postural re-training, gait assessment, and movement therapy. Instruction for development of a home program may be developed for the patient which may include: neuromuscular re-education and movement therapy, contrast baths, postural retraining, and a limited amount of ergonomic strategies for self care. The goal is to normalize the posture and increase flexibility and circulation, which may reduce hypertonicity, reduce pain, and increase the range of motion to the affected areas.
 - Corrective Exercise and Personal Training include
Postural and movement assessment, postural re-training, movement therapy, stretching, foam rolling, exercise, and the development of home exercise and movement programs.
4. The theory of the treatment upon which the services are based:
National Academy of Sports Medicine (NASM) Corrective Exercise Specialist and Personal Training principles.
St. John Method of Neuromuscular Therapy, CranioSacral Therapy theory, Russian massage techniques, Biokinetics/Hanna Somatic movement therapies, Standard Swedish massage training, and sports massage theory.
The practitioner is the founder of PMT seminars and Practical Movement™ which combines many of the aforementioned therapies along with other research into a cohesive therapy.
5. The education, training, experience and qualifications of the practitioner, regarding the services:
Master of Science degree in Human Movement Science, Concordia University Chicago (August 2016)
Massage Technician Training, IPSB (May 1987)
Board Certified by the NCTMB (an industry-wide massage therapy certifying organization) since May 1993
Montana State Licensed in Massage Therapy (License # 1) since July 2010
New Mexico State Licensed in Massage Therapy (License # 300) since April 1992
Idaho State Licensed in Massage Therapy (License # MAS-2188) since July 2014

St. John Neuromuscular Therapist (NMT) since 1989
Certified St. John NMT since May 1998
On Training Staff August 1994 - 2006
St. John NMT Seminars instructor January 1999 – August 2006
Biokinetics/Hanna Somatics Certification (October 1993) – a movement based therapy.
Biokinetics Seminar Assistant (1994)
NASM Corrective Exercise Specialist certification (2016)
NASM Certified Personal Trainer (2016)
Courses and Seminars total over 625 hours. Listing is available upon request.
Maintained a private practice since 1987, which included contracting with Hand Therapy of San Francisco to provide services there for three years (February 1999 – January 2002).
Private research to round out the development of PMT seminars and Practical Movement™.

I have been provided with a copy of this document or have access to the information on-line at debkimmet.com/newclient.html

Signature: _____ Date: _____

Print Name: _____

If you are a Minor or are being represented by another party:

Personal Representative: (Print) _____ Relationship to Client: _____

Signature: _____ Date: _____



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e-mail: deb@debkimmet.com

FEDERALLY REQUIRED DISCLOSURES:

HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Federal law requires that we maintain the privacy of your health information and that we provide you with this notice of the legal duties and privacy practices with respect to your health information. Other than the uses and disclosures we described below, your health information will not be sold or provided to any outside marketing organization.

We must abide by the terms of this notice while it is in effect and we reserve the right to change the terms of this privacy notice. If a change is made, it will apply for all of your health information in our files, and you will be notified in writing. Please review it carefully.

USES AND DISCLOSURES

In the course of your care as a client of Deborah A. Kimmet Massage Therapy & Movement Education, LLC, your personal and health related information may be disclosed. Here are examples of use and disclosure of your health care information:

- Your personal health information, including your clinical records, may have to be disclosed to another health care provider or hospital if it is necessary to refer you for diagnosis or for further assessment or treatment.
- Your health care records as well as your billing records may have to be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Any information in your file may be used for quality control purposes or any other administrative purposes to run this practice.
- Your name, address, phone number, and your health records may be used to contact you regarding appointments, miscellaneous correspondence, information about alternatives to your present care, or other health related information that may be of interest to you. **If you are not available to receive phone messages regarding your appointment, a message may be left with the person answering the phone at the number on file in our records, or on your answering machine, voice mail, or email. If this is an issue, please specify in writing the where/how and under what limitations you wish us to contact you** (indicate contact preferences at the end of this document).

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have a right to inspect or obtain a copy of the information used for the purposes above. You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are also permitted or required to use or disclose your information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we are providing health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

REVOKING YOUR AUTHORIZATION

You may revoke your authorization to us at any time in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If your information has been released prior to your request to revoke your authorization. 165.508(b)(5)(I)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your information if they decide to contest any of your claims.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written

authorization.

CONFIDENTIAL COMMUNICATION

We will attempt to accommodate any reasonable written request regarding your contact information that has been provided by you.

INSPECTING/COPYING YOUR HEALTH INFORMATION

We normally provide information about your health to you in person at the time you receive care. You also have the right to inspect your files while in our office and/or have a copy made for you. The information is available up to seven years from the date that the record was created or as long as the information remains on file.

Your request to inspect or obtain a copy of the file must be in writing. There will be a charge of \$.20 per page copied.

Information regarding your health care or about the status of your account may also be mailed to you. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please submit written notification as to how you would like that information provided.

AMENDING YOUR HEALTH INFORMATION

In addition, you have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require a written request to amend your records that includes a valid reason to support the change. We have the right to refuse your request.

ACCOUNTING OF DISCLOSURES OF YOUR RECORDS

You have the right to request an accounting of any disclosures (not listed below) made of your information for six years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

- Required for your session, to obtain payment for services, to run our practice, and/or made to you.
- Necessary to maintain a directory of the individuals in our facility or to individuals involved in your care.
- For national security, intelligence purposes, or law enforcement officers.
- That were made prior to the effective date of the HIPAA privacy law (April 14, 2003).

We will provide the first accounting within a 12-month period without any charge, but any additional requests will be charged a fee. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

RE-DISCLOSURE

Information that is used or disclosed based on this privacy notice may be subject to re-disclosure by the individuals/facilities to whom we provide the information, and may no longer be protected by the federal privacy rules. We cannot control the actions of others to whom we have released this information.

COMPLAINTS

If you have a complaint regarding this privacy notice, or privacy policy or any aspect of the privacy practices, please discuss it with us so that the situation may be remedied. You may also complain to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Written comments should be addressed to our office address or Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201.

This notice is effective as of July 30, 2003. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created (the signature date below).

My signature acknowledges that I have received a copy of this notice.

Signature: _____ Date: _____

Print Name: _____

If you are a Minor or are being represented by another party:

Personal Representative: (Print) _____ Relationship to Client: _____

Signature: _____ Date: _____