Outpatient Therapy Patient Paperwork Guide – Checklist

Forms to be completed by patient or patient's responsible party

1. OTC Patient Information Form (Mandatory for all payers)
2. OTC Patient H and P form (Mandatory for all payers)
3. OTC Patient Acknowledgement and Signature form (Mandatory for all payers)
4. OTC Medicare Secondary Payer Questionnaire – (Mandatory for Medicare B Only)

Optional forms if patient is private pay or has a co-pay/co-insurance

1. OTC Credit Card Bank Account Authorization – Optional

Provide the following paperwork to the patient or patient's responsible party

1. OTC Financial Agreement – Patient Copy
2. OTC Patient Rights – Patient Copy
3. OTC Notice of Privacy – Patient Copy

Outpatient Patient Information

Patient Name: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

DOB: _____ Social Security #: _____

Insurance Information

Primary Insurance: _____ Insurance Phone #: _____

Medicare #/ID #: _____ Group #_____

Subscriber Name (if different from self): _____

Subscriber DOB: _____

Secondary Insurance: _____ Insurance Phone #: _____

ID#: _____ Group #: _____

Subscriber name (if different from self): _____

Subscriber DOB: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____

Physician Information

Referring Physician: _____ Physician Phone #: _____

OUTPATIENT REHABILITATION

PATIENT INFORMATION AND BRIEF MEDICAL HISTORY

Federal and State Regulations require a medical history must be included in the patient's medical record.

Patient Name:_____ Date:_____

DOB:_____ Reason For Therapy Referral:_____

Date of Onset of Injury/Condition:_____ Have you had previous therapy for this injury/condition?_____ Is this injury/condition work related? _____ If so, has it been reported to your employer? _____

Medical History:

Do you have currently or have you had in the past any of the following:

Diabetes	Yes	No	Sensitivity to heat	Yes	No
High Blood Pressure	Yes	No	Sensitivity to cold	Yes	No
Circulatory Disorders	Yes	No	Dizziness	Yes	No
Heart Disease	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Headaches	Yes	No
Stroke/TIA	Yes	No	Cancer	Yes	No
Pacemaker	Yes	No	Visual Problems	Yes	No
Metal Implants	Yes	No	Allergies	Yes	No
Kidney Problems	Yes	No	Previous Surgeries	Yes	No
Hernia	Yes	No	Back Injuries	Yes	No
Nervous Disorders	Yes	No	Other injuries	Yes	No
Are you Pregnant?	Yes	No	Other Illnesses	Yes	No
Breathing Difficulties	Yes	No	Difficulty Sleeping	Yes	No
Osteoporosis	Yes	No	Neurological Problems	Yes	No
Weight Loss	Yes	No	DVT/Pulmonary Embolism	Yes	No
COVID-19	Yes	No	COVID-19 Vaccine	Yes	No

If you answered **YES** to any of the above, please explain and give appropriate dates:

_____

_____

_____

Medications:

Are you currently taking any medications? _____If **YES**, please let the medications, dosage and for what condition.

Medication Name *Dosage* *Condition*


GREATER SOUTHSIDE
HEALTH AND REHABILITATION

Patient Acknowledgements Signature Form

Please **initial** each section below:

Financial Responsibility: I do hereby guarantee payment of therapy services to Greater Southside Health and Rehabilitation. I understand that I am responsible for payment of my account and the facility does not accept responsibility for negotiating a settlement on a disputed claim. As a courtesy, the facility will bill my insurance. I understand that co-payments are due when services are rendered. Any balances, after initial insurance payment has been received, is due and payable upon receipt.
Interest of 1.5% monthly (18% per annum) will be added to all accounts 30 days past due. In the event this account is placed with an attorney or collection agency for collection, the undersigned agrees to pay reasonable attorney's fees, legal expenses and lawful collection costs in addition to all other sums due hereunder.

_____

Financial Agreement Acknowledgement: I have received a copy of the financial agreement. Patient and responsible party hereby certify that each has read this agreement in its entirety, understand and agree to its terms and conditions. Responsible party, or other person who signs this agreement on behalf of and in the place of the patient represents that he/she is authorized by patient to do so, and the above-named patient and each responsible party signing this agreement agrees by so signing accepting all of the terms hereof and to perform all obligations hereunder. There are no representations made by facility or any of its employees or agents other than are set forth in this agreement.

_____

Treatment Consent: I hereby consent to the evaluation(s) and treatments ordered or recommended by my physician or designated alternate.

_____

Cancellation Policy: 24-hour notice is required to cancel a therapy appointment. A cancellation fee of $__25___ may be charged to the responsible party if sufficient notice is not provided.

_____

Authorization for Release of Information: The institution rendering services is hereby authorized to furnish and release, in accordance with the facility's policy, such professional and clinical information as may be necessary for the completion of my medical claims by valid third-party agents or agencies from the medical records compiled during

treatment. The facility is hereby released from all legal liability that may arise from the release of said information.

_____

Assignments and Authorization to Pay Insurance Benefits: I hereby assign and authorize payment directly to the facility, herein specified and otherwise payable directly to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am responsible to the facility for charges not covered or paid by my insurance.

_____

Assignments and Authorization to Bill Medicare: I hereby assign and authorize payment directly to this facility, herein specified and otherwise payable to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am financially responsible for 20% of the Medicare Part B services.

_____

Telehealth Acknowledgement: I understand and give approval for the use of telehealth services for evaluations and/or treatments as determined by my clinician. I understand that services rendered using telehealth are billed following the insurance providers requirements.

_____

Co-pays and Authorization to charge credit card or bank account on file: Before evaluations and/or treatments are rendered all co-pay balances need to be paid. I hereby authorize the institution rendering treatment to charge my credit card or process a withdrawal from my bank account for co-pay balances on the day of treatment unless otherwise paid by other means. *Bank account/credit card authorization form must be completed in order to utilize this form of payment.*

_____

Acknowledgement of Receipt of Notice of Privacy Practices: My signature below acknowledges that I received a copy of the Facility/Agency's Notice of Privacy Practices (with a revision date of March 1, 2016). Refusing to sign does not prevent the facility/agency from using or disclosing health information as permitted by law.

_____

Acknowledgement of Patient Rights: My initials below acknowledge that I have been informed of the OTC policy on patient rights, received a copy of my patient rights and have been informed of the complaint process.

_____

Acknowledgement of Advanced Directives: My initials below acknowledge that I have been made aware and have been offered a copy of the facilities policy on advanced directives.

_____

***If a copy of your advanced directives is provided, both patient and OTC representative initial below.

_____ _____

Home Health Service Agreement: I am currently not receiving Home Health Services. I understand that I cannot participate in outpatient therapy at while I am receiving Home Health Services and will be accountable for payment if both are being received at the same time.

_____

PATIENT AND/OR RESPONSIBLE PARTY BY SIGNING BELOW IS AGREEING TO ALL OF THE ABOVEAND IS ACKNOWLEDGING THAT HAVE RECEIVED COPIES OF THE ABOVE DOCUMENTS

These copies were received by: Email Paper

Patient or Responsible Parties** Name (Printed):

**If form is completed by responsible party/POA, a copy of POA paperwork is given to the OTC.

_____ _____ YES _____OTC employee initials

Patient or Responsible Parties** Signature:

_____

Date: _____

OTC Representative (if not signed electronically) and verification that all pages of this form have been completed:

_____

Date: _____

FOR OFFICE USE ONLY

If any of the above agreements and acknowledgements are not obtained, please complete the following:

Patient's Name: _____

Acknowledgments not obtained: _____

Date of attempt to gain acknowledgement: _____

Reason Acknowledgement was not signed:

_____ Patient/Responsible Party received all of the above-mentioned notices but refused to sign

_____ Emergency treatment situation

_____ Patient was incapacitated and there was no Responsible Party present

_____ Unable to communicate secondary to language barrier

_____ Other: (Please describe) _____

Authorization for Auto Draft

I understand that Auto Draft is an automatic bank account or credit card withdrawal system for paying my co-payments on the days that outpatient therapy is provided. I further understand that the decision of whether to participate in the Auto Draft program is **voluntary**, and I am under no obligation whatsoever to do so, as co-payments can be taken care of manually prior to each session.

(Please initial your choice(s) from the options listed below)

_____ I authorize *Greater Southside Health and Rehabilitation* and my financial institution to deduct from my bank account the co-payment amount that is determined by my insurance provider for according to my rehabilitation benefits on the day that rehabilitation services are rendered.

_____ I authorize *Greater Southside Health and Rehabilitation* and my financial institution to deduct from my credit card the co-payment amount that is determined by my insurance provider for according to my rehabilitation benefits on the day that rehabilitation services are rendered.

_____I authorize *Greater Southside Health and Rehabilitation* and my financial institution to deduct from my bank account or my credit card any private balance due which is greater than 60 days in arrears.

_____I authorize *Greater Southside Health and Rehabilitation* to process this payment for Dates of Service _____ and going forward Month/Year_____

First Name: _____Last Name: _____

Phone Number: (H): _____ (C): _____ (W): _____

Mailing Address:_____

Financial Institution: _____

Financial Institution Address: _____

Please Check One: _____ Checking Account _____ Savings Account _____ Credit Card

Routing Number: _____ Account Number _____

Credit Card Number: _____ Exp. Date: _____

Credit Card Type: _____ Three Digit Security Code: _____

I may revoke this Authorization at any time, by providing notice to the Facility (Attention: Outpatient Administrator), in writing, thirty (30) days before I intend the revocation to be effective.

Today's Date: _____

Print Name: _____ Signature: _____

Therapy Communication Preferences

Patient Name _____ Date _____

SHARING YOUR INFORMATION WITH CAREGIVERS, FAMILY AND OTHER VISITORS: It is our policy not to release confidential medical information regarding your treatment to caregivers, family members (other than the authorized representative), or other visitors unless we can reasonably infer from the circumstances that you do not object to sharing your information (for example, if a family member or other visitor is present while we are providing care, we will assume, unless you object, that the person is entitled to receive information regarding your treatment).

List which caregivers, family members, or other visitors may have limited verbal updates regarding your treatment when you are not present:

_____

_____

Patient Signature _____ Date _____

Therapy Representative _____ Date _____

MEDICARE SECONARDY PAYER QUESTIONAIRE

Patient Name: _____ **Medicare ID:** _____

INSTRUCTIONS:
Ask the following questions to Medicare beneficiaries upon **each inpatient** and **outpatient admission**. Answer the questions in sequence. The instructions will direct you to the next appropriate question to determine MSP situations.

PART I

1. Are you receiving Black Lung (BL) Benefits?
   - ☐ Yes. Date began: MM/DD/CCYY _____ **BL IS PRIMARY** ONLY FOR CLAIMS RELATED TO BL
   - ☐ No.

2. Are the services to be paid by a government research program?
   - ☐ Yes. **GOVERNMENT RESEARCH PROGRAM IS PRIMARY**
   - ☐ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?
   - ☐ Yes. **DVA IS PRIMARY**
   - ☐ No.

4. Was the illness/injury due to a work-related accident/condition?
   - ☐ Yes. Date of injury/illness: MM/DD/CCYY _____ GO **to PART III**

If YES, OBTAIN NAME & ADDRESS OF WC PLAN, POLICY NUMBER, AND NAME & ADDRESS OF YOUR EMPLOYER

WORKERS' COMPENSATION(WC) IS PRIMARY ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS

- ☐ No. GO **to PART II**

PART II

1. Was illness/injury due to a non-work-related accident?
   - ☐ Yes. Date of accident: MM/DD/CCYY _____
   - ☐ No. GO **to PART III**

2. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident) NO-FAULT INSURER IS PRIMARY for services related to accident.
   - ☐ Yes.
     Name & address of no-fault insurer(s) and no-fault insurance policy owner: _____
     _____
     Insurance claim number(s): _____
   - ☐ No.

3. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property) LIABILITY INSURANCE IS PRIMARY for services related to settlement.
   - ☐ Yes.
     Name & address of liability insurer(s) and responsible party: _____
     _____
     Insurance claim number(s): _____
   - ☐ No.

GO **to PART III**

PART III

Are you entitled to Medicare based on:

- ☐ Age. GO **to PART IV**
- ☐ Disability. GO **to PART V**
- ☐ End-Stage Renal Disease (ESRD). GO **to PART VI**

Note that both **Age** and **ESRD** – OR - **Disability** and **ESRD** may be selected simultaneously. An individual **CANNOT** be entitled to Medicare based on **Age** and **Disability** simultaneously

PART IV – AGE

Are you currently employed?

☐ Yes.

Name & address of your employer: _____

☐ No. If applicable, date of retirement: MM/DD/CCYY _____

☐ No. Never Employed.

2. Do you have a spouse who is currently employed?

☐ Yes.

Name & address of your spouse's employer: _____

☐ No. If applicable, date of retirement: MM/DD/CCYY _____

☐ No. Never Employed.

IF NO TO BOTH 1 AND 2, MEDICARE IS PRIMARY STOP **DO NOT PROCEED FURTHER**

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

☐ Yes, both.

☐ Yes, self.

☐ Yes, spouse.

☐ No. STOP **MEDICARE IS PRIMARY**

4. If the GHP coverage is based on **your own** current employment, **your spouse's** current employment - Does the employer that sponsors or contributes to the GHP **employ 20 or more employees**?

☐ Yes. **GHP IS PRIMARY**

If YES, OBTAIN NAME & ADDRESS OF GHP, POLICY NUMBER, NAME OF POLICY HOLDER/NAMED INSURED, AND RELATIONSHIP TO PATIENT

☐ No. STOP **MEDICARE IS PRIMARY**

PART V – DISABILITY

1. Are you currently employed?

☐ Yes.

Name & address of your employer: _____

☐ No. If applicable, retirement date: MM/DD/CCYY _____ STOP **MEDICARE IS PRIMARY**

☐ No. Never Employed. STOP **MEDICARE IS PRIMARY**

2. Do you have a spouse who is currently employed?

☐ Yes.

Name & address of your spouse's employer: _____

☐ No. If applicable, retirement date: MM/DD/CCYY _____ STOP **MEDICARE IS PRIMARY**

☐ No. Never Employed. STOP **MEDICARE IS PRIMARY**

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

☐ Yes, both.

☐ Yes, self.

☐ Yes, spouse.

☐ No. STOP **MEDICARE IS PRIMARY**

4. Are you covered under the GHP of a family member other than your spouse?

☐ Yes.

Name & address of your family member's employer: _____

☐ No. STOP **MEDICARE IS PRIMARY**

5. If you have GHP coverage based on **your own** current employment, **your spouse's** current employment, or **family member's** current employment - Does the employer that sponsors or contributes to the **GHP employ 100 or more employees**?

☐ Yes. **GHP IS PRIMARY**

If YES, OBTAIN NAME & ADDRESS OF GHP, POLICY NUMBER, GROUP NUMBER, MEMBER NAME, NAME OF POLICY HOLDER/NAMED INSURED, AND RELATIONSHIP TO PATIENT

☐ No. STOP **MEDICARE IS PRIMARY**

PART VI – ESRD

1. Do you or your spouse have group health plan (GHP) coverage?

☐ Yes.

If YES, OBTAIN NAME & ADDRESS OF GHP, POLICY NUMBER, GROUP NUMBER, MEMBER NAME, NAME OF POLICY HOLDER/NAMED INSURED, RELATIONSHIP TO PATIENT, AND EMPLOYER NAME & ADDRESS (if GHP through spouse)

☐ No. STOP **MEDICARE IS PRIMARY**

2. Have you received a kidney transplant?

☐ Yes. Date of transplant: MM/DD/CCYY _____

☐ No.

3. Have you received maintenance dialysis treatments?

☐ Yes. Date dialysis began: MM/DD/CCYY _____

If you participated in self-dialysis training program, date training started: MM/DD/CCYY _____

☐ No.

4. Are you within the 30-month coordination period that starts MM/DD/CCYY?

☐ Yes.

☐ No. STOP **MEDICARE IS PRIMARY**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

☐ Yes.

☐ No.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

☐ Yes. STOP **GHP CONTINUES TO PAY PRIMARY** DURING THE 30- MONTH COORDINATION PERIOD

☐ No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY**

7. Does the working aged or disability MSP provision apply (is the GHP already primary based on age or disability entitlement)?

☑ Yes. **GHP CONTINUES TO PAY PRIMARY** DURING THE 30-MONTH COORDINATION PERIOD

☐ No. **MEDICARE CONTINUES TO PAY PRIMARY**

Beneficiary/Responsible Party Signature _____

Facility Witness Signature _____

Date: _____

THIS NOTICE DESCRIBES THE RIGHTS YOU HAVE AS A PATIENT IN OUR PRACTICE.
PLEASE REVIEW THEM CAREFULLY.

Patients Have a Right to:

- Be treated with dignity, respect, and consideration
- Not be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse or assault, restraint or
- seclusion (subject to R9-10-1012(B)), retaliation for submitting a complaint to the Department or another entity, or misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student
- Not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis
- Receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities
- Receive privacy in treatment and care for personal needs
- Review, upon written request, the patient's own medical record
- Receive a referral if the outpatient treatment center is not authorized or able to provide certain health services needed by the patient
- Participate or have the patient's representative participate in the decisions concerning treatment
- Refuse treatment to the extent allowed by law
- Receive assistance by the patient's representative or other individual in understanding, protecting, or exercising the patient's rights

Administrators Shall Ensure that:

- A patient or the patient's representative either consents to or refuses treatment, except in an emergency
- A patient or the patient's representative may refuse or withdraw consent before treatment is initiated
- A patient is informed of alternatives to a proposed psychotropic medication or surgical procedure and
- associated risks and possible complications of a proposed psychotropic medication or surgical procedure, except in emergencies
- A patient or the patient's representative is informed of the outpatient treatment center's policy on health care directives and the patient complaint process
- A patient consents to a photograph before taken, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes
- A patient provides written consent to release information in the patient's medical record or financial records, except as otherwise permitted by law

Patient Responsibilities:

- Providing us with honest, complete information about matters that relate to your care
- Showing respect and consideration for the rights of fellow patients, our staff and our property
- Complying with the rules of our facility, including our visitor and smoke-free environment policies
- Patient Comment or Complaint Process:
- Ask to speak with the center's Site Manager
- Any patient or patient's representative has to right to report any concerns to:

OTC Financial Agreement

FACILITY RESPONSIBILITIES

1. The facility shall provide services and materials as described in Section 2 below, in compliance with the orders of the Patient's physician. Administration of treatments shall be ordered by the Patient's physician.
2. Facility shall provide the following prescribed services to Patient (circle all that apply): Occupational Therapy, Physical Therapy, Speech Therapy)
3. Additional services may be provided by Facility upon receipt of subsequent orders from the Patient's physician. Any such services provided by Facility shall be subject to all the terms of conditions and obligations of this Agreement. Facility welcomes all persons without regard to race, color. national origin. religion sex or qualified handicaps.

PATIENT/RESPONSIBLE PARTY RESPONSIBILITIES

1. Patient and Responsible Party agree jointly and severally to assume and be liable for all charges of whatever nature incurred by or on behalf of Patient for the services described herein and to pay such charges as they become due.
2. Patient and Responsible Party further agree that, if any of the services rendered by Facility to Patient, are covered by insurance, or benefits under either Title XVIII or Tile XIX of the Social Security Act (Medicare/Medicaid), is nevertheless the joint and several obligation of Patient and Responsible Party to pay all charges incurred by or on behalf of Patient. Patient and Responsible Party further agree that any co-insurance or deductible obligation under Medicare, Medicaid or private insurance must be paid directly to Facility by Patient and Responsible Party.
3. Patient and Responsible Party further agree that any charges which are not made IN FULL when due or no later than 30 days shall be subject to a late charge of 1.5% monthly, (18%) percent per annum until paid. Should it become necessary for the Facility to refer Patient's delinquent account to an attorney for collection, Patient and Responsible Party agree to pay in addition to all sums due all reasonable attorney's fees, court costs and all other reasonable costs of collection.

PATIENT'S CERTIFICATION

1. Patient certifies and warrants that all information submitted on behalf of Patient for purposes of applying for or receiving benefits under Title XVIII or XIX of the Social Security Act (Medicare/Medicaid) is true and correct. Patient and Responsible Party warrants that all information they have supplied to facility is correct and true and further agree to hold harmless and indemnify Facility from and against any and all loss, damage, cost. expenses, or liability resulting from Patient's or Responsible Party's submission of false or incorrect information to Facility.
2. Patient authorizes any health care facility or doctor to furnish the facility and/or or the Social Security Administration. its fiscal intermediary or carrier all requested information from Patient's medical or financial records. Patient further authorizes Facility to disclose all or any part to Patient's medical or financial records to any person or entity which is or may be liable under contract to Facility, to Patient or to a family member or to the employer of Patient to pay all or a portion of the costs or care provided to Patient including, but not limited to, hospital or medical service companies, insurance companies, worker's compensation carrier, welfare fare of Patient's

employer. Patient further authorizes Facility to disclose all or any part of Patient's medical or financial records to any independent auditor of Facility.

3. Patient requests and hereby authorizes that payment for any authorized benefits be made directly to Facility on Patients behalf Facility does not make any assurance of any kind whatsoever that Patient's care will or can be covered by Medicare/Medicaid or any private insurance, and the Patient and Responsible Party hereby release Facility, its agents, servants, and employees from any liability or responsibility in connection with the Patient's and/or Responsible Party's potential claim of coverage under Medicare/Medicaid and/or private insurance program.

RESTRICTIONS AND LIABILITIES

1. Patient and Responsible Party hereby release Facility from any and all harm, liability. injury or loss suffered by Patent while outside the physical confines of the Facility and/or the supervision and contract of Facility's staff.
2. Facility shall have no liability for injuries of any kind suffered by Patient while under its care. except where the injury is caused by the negligence of Facility or its regular staff or as required by law. If Patient discontinues or suspends treatment before the attending physician has so ordered, or if Patient fails to follow a prescribed regimen of activity, treatment or therapy, Patient and Responsible Party agree to assume all responsibility for any result which may follow Patient's action.
3. Facility is not responsible or liable for any injury to Patient caused by Facility visitors attempting to assist to treat Patient in anyway. For the safety of Patient and others, only the Patient and Patient's guardian, if a minor, are permitted into patient treatment areas of the Facility.
4. The Facility is not liable or responsible for any personal belongings brought into and left in Facility by Patient. except as required by law.

MISCELLANEOUS

1. Where Patient is eligible for Medicaid benefits and/or where Facility is precluded under state or federal law in requiring that a Responsible Party act as guarantor for Patient. the term "Responsible Party", as used herein. shalt be deemed to mean "Patient Agent". The Patient Agent is responsible for assuring that any of Patient's own funds, over which such Patient Agent exercises any management or control, and which constitutes the Patient's share of costs or liability to Facility, shall be paid to Facility as such liability is incurred.

Notice of Privacy Practices

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

YOUR RIGHTS

When it comes to your health information, you have certain rights. You have the right to:

- **Get an electronic or paper copy of your medical records**
  - You may ask to see or obtain an electronic or paper copy of your medical records and other health information we have about you. Ask us how to do this
  - We will provide a copy or a summary of your health information and may charge a reasonable, cost-based fee for doing so

- **Ask us to correct your medical records**
  - You may ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this
  - We may deny your request and will provide you a reason in writing

- **Request confidential communications**
  - You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address
  - We will comply with all reasonable requests

- **Ask us to limit what we use or share**
  - You may ask us **not** to use or share certain health information for treatment, payment or our operations. We may deny your request if we believe it may affect your care
  - If you pay for a service or health care item out of pocket in full, you may ask us not to share that information for the purpose of payment or our operations with your health insurer. We will comply with your request unless a law requires us to share that information

- **Get a list of those with whom we have shared your information**
  - You may request a list (accounting) of the times and to whom we have shared your health information for six (6) years prior to the date you ask.
  - We will include all the disclosures except for those about treatment, payment and healthcare operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free and may charge a reasonable, cost-based fee if you request additional lists within twelve (12) months.

- **Get a copy of this privacy notice**
  - You may ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly

- **Choose someone to act for you**
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person may exercise your rights and make choices about your health information
  - We will verify the person has this authority and may act for you before we take any action

- **File a complaint if you feel your rights have been violated**
  - You may complain if you feel we have violated your right by contacting us using the information below. We will not retaliate against you for filing a complaint.
    - *Our Compliance Hotline at **1-866-256-0955** which is available 24 hours per day, 7 days per week.*
  - You may file a complaint with the U.S Department of Health and Human Services Office for Civil Rights by sending a letter to: **200 Independence Avenue, S.W. Washington, D.C 20201, calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.**

YOUR CHOICES

For certain health information, you may tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- **In these cases, you have both the right and choice to tell us to:**
  - Share information with your family, close friends, or others involved in your care
  - Share information in a disaster relief situation
  - Include your information in a directory
- **In these cases we may not share your information unless you give us written permission:**
  - Marketing purposes
  - Sale of your information
  - Most psychotherapy notes
- **In the case of fundraising**
  - We may contact you for fundraising efforts, but you may tell us not to contact you again

Notice of Privacy Practices/ Original Effective Date: 4/13/2003; Revised Date: 3/1/2016

OUR USES AND DISCLOSURES OF YOUR INFORMATION

We may use or share your health information for treatment, to obtain payment, and/or to operate our business.

- **Treat you**
  - We may use your health information and share it with other professionals who are treating you
    - *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

- **Run our organization**
  - We may use and share your health information to run our practice, improve your care, and contact you when necessary
    - *Example: we use health information about you to manage your treatment and services.*

- **Bill for your services**
  - We may use and share your health information to bill and receive payment for health plans or other entities
    - *Example: We give information about you to your health insurance plan to obtain payment for your services.*

We are allowed or required to share your information in other ways – usually in ways that contribute to public good, such as public health, safety, and research. We must meet many conditions in the law before we may share your information for these purposes. For more information visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

- **Help with public health and safety issues**
  - We may share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to a person's health or safety

- **Do research**
  - We may use or share your information for health research with your written permission

- **Comply with the law**
  - We may share information about you if state or federal laws require it, including with the Department of Health and Human Services (DHHS)

- **Respond to organ and tissue donation requests**
  - We may share health information about you with organ procurement organizations or other entities engaged in the procurement, banking, or transplantation for the purpose of facilitating organ and/or tissue donation

- **Work with a medical examiner or funeral director**
  - We may share health information with coroners, medical examiners, or funeral directors as necessary to carry out their duties

- **Address workers' compensation law enforcement and other government requests**
  - We may use or share health information about you:
    - For Workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services.

- **Respond to lawsuits and legal actions**
  - We may share health information about you in response to a court or administrative orders, or in response to a subpoena

OUR RESPONSIBILITIES

- We are required to maintain the privacy and security of your protected health information
- We are required to notify you promptly in the event your information is compromised
- We must follow the duties and privacy practices described in this notice and give you a copy of it on request
- We will not use or share your information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
- For more information visit:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Changes to the Terms of This Notice

We may change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our website.

Notice of Privacy Practices/ Original Effective Date: 4/13/2003; Revised Date: 3/1/2016