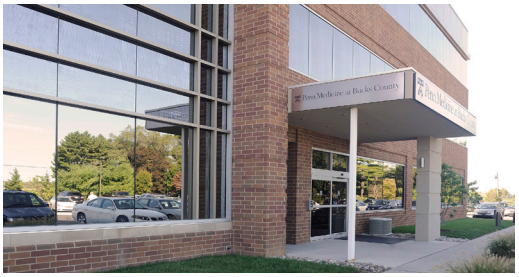
WELCOME TO
Penn Therapy & Fitness

Yardley


777 TOWNSHIP LINE ROAD ◆ SUITE 180 ◆ YARDLEY, PA 19067

☎ 215.968.0145 ◆ FAX: 215.968.2498

MONDAY – THURSDAY: 7 A.M. – 7 P.M.

FRIDAY: 7 A.M. – 5 P.M.

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pennpartners.org/yardley

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WELCOME TO
Penn Therapy & Fitness

This packet contains the documents necessary for your first visit.

Please bring these forms with you.

- Patient summary form (pages 3 & 4)
- **Form should be signed upon your arrival.** These forms must be signed with date and time in person and witnessed by our staff.

Other important documents to bring with you to your first visit include:

- ❑ Your prescription(s), which must be signed and dated within 90 days of your initial therapy appointment
- ❑ Photo ID and insurance card
- ❑ Insurance Referral *(if required by your insurance plan)*
- ❑ Insurance copayment *(if required by your insurance plan)* Copays are due each treatment day
- ❑ Complete list of medications
- ❑ Complete medical history list *(if not covered on patient summary form)*

Your first scheduled appointment is a one-on-one evaluation with your therapist. Your evaluation may take up to 60 minutes. We ask you arrive 30 minutes before your appointment to complete the check-in process and start on time.

If you have any questions, feel free to contact us.

Please provide 24-hour notice if you need to cancel.

Thank you,

The Staff at Penn Therapy & Fitness

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Frequently Asked Questions

AT PENN THERAPY & FITNESS,
our goal is to provide you with excellent care.

PLEASE SEE BELOW *to understand how you can prepare for and participate in your care.*

1) How long is the initial appointment?
Your initial appointment will take **up to 90 minutes** from registration to completion of the evaluation.

2) When should I arrive?
Arrive 30 minutes before your scheduled evaluation time to complete the registration process. A Patient Service Representative may contact you to modify this arrival time based on your diagnosis and prior completion of Intake documentation.

3) What is involved in the registration process?
The registration process may take up to 30 minutes. Patients will be asked to complete a medical history questionnaire, including their explanation of the issue for which they are being evaluated, their goals and report of pain, if any. Patients will also complete a baseline functional outcome measure. All patients will sign informed Consent and review Patient Privacy and Bill of Rights forms.

4) What will occur during the initial evaluation?
Your therapist will ask you questions regarding your condition, perform a physical exam and develop an individualized program to help facilitate your goals.

5) What should I do if I am running late for an appointment?
It is important that you arrive on-time for all appointments. Your individualized plan of care will be developed in collaboration with you based on an expected frequency and the duration of each appointment. **If you are running late, call the office to make us aware.** We will do our best to accommodate you. However, it is possible that you may need to see another therapist on your care team or reschedule.

6) What happens if I need to cancel and reschedule?
It is important that you consistently attend all scheduled appointments. The purpose of your rehabilitation program is to restore your maximal functional status as quickly and as safely as possible. In order to achieve the best therapeutic outcome, it is important that you meet your agreed-upon plan of care and consistently attend all scheduled appointments. **If you must cancel or reschedule, we require that you call at least 24 hours in advance of the scheduled appointment date and time.** In addition, if you fail to attend three scheduled appointments without proper notification, your care may be discharged and your referring provider may be notified.

7) What should I wear?
Wear comfortable clothing, including sneakers or rubber-soled shoes without a heel. If you are coming for issues related to your low back or legs, please bring or wear shorts.

8) Will I have follow-up appointments?
After the examination, you and your therapist will develop a plan of care, including your goals for therapy. Together, you and your therapist will determine the appropriate follow-up, including the duration and frequency of visits for your course of care.

9) Do I really need to do my home exercise program?
Yes. A home exercise program is an essential part of your recovery. You will be given pictures, as well as written instructions on how to perform your particular program.

10) What should I do if I experience pain or discomfort?
Stop. If an exercise caused unexpected discomfort or pain, or if you are unsure about an exercise, stop. **Contact our office with immediate questions or concerns.** Your therapist will review your exercises with you either during your call or at your next visit.

IF YOU HAVE ANY QUESTIONS OR CONCERNS *prior to your first appointment, please call our office and we will be happy to answer them.*

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LABEL AREA

Patient Summary Form

Name: _____ Date of Birth: ____/____/____ Age: _____

Home Phone #: _____ Cell Phone #: _____ E-mail: _____

Preferred means of contact:: ❑ Phone ❑ Email

EMERGENCY CONTACT: Name: _____ Phone #: _____

MEDICAL HISTORY: Are you currently receiving any Home Care Services? ❑ Yes ❑ No

Are you currently receiving any other Therapies? ❑ Physical ❑ Occupational ❑ Speech ❑ None

Current quality of life/health status: ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

Please check Yes or No as appropriate for the following conditions.

Asthma/Wheezing/Shortness of Breath	❑ Yes ❑ No	Cataracts	❑ Yes ❑ No	Circulatory Problems	❑ Yes ❑ No
Frequent Cough	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Blood Clot	❑ Yes ❑ No
Pneumonia	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Leg Wounds	❑ Yes ❑ No
Sinus Infections	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No
Weight Changes: gain / loss	❑ Yes ❑ No	Congestive Heart Failure (CHF)	❑ Yes ❑ No	Kidney Disease / Renal Failure	❑ Yes ❑ No
Frequent Laryngitis	❑ Yes ❑ No	Heart Disease	❑ Yes ❑ No	Thyroid Disorder	❑ Yes ❑ No
Frequent Sore Throat	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Incontinence	❑ Yes ❑ No
Difficulty Swallowing	❑ Yes ❑ No	Arthritis	❑ Yes ❑ No	Bowel Irregularity	❑ Yes ❑ No
GERD/Reflux	❑ Yes ❑ No	Osteoporosis / Osteopenia	❑ Yes ❑ No	Urinary Frequency / Urgency	❑ Yes ❑ No
Poor Appetite	❑ Yes ❑ No	Chronic Back Pain	❑ Yes ❑ No	Bladder Infections	❑ Yes ❑ No
Frequent Nausea / Vomiting	❑ Yes ❑ No	Peripheral Neuropathy	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Hearing Loss	❑ Yes ❑ No	Aneurysm	❑ Yes ❑ No	Immune Deficiency	❑ Yes ❑ No
Vertigo / Dizziness	❑ Yes ❑ No	Seizure	❑ Yes ❑ No	Anxiety	❑ Yes ❑ No
TMJ	❑ Yes ❑ No	Stroke / TIA	❑ Yes ❑ No	Depression	❑ Yes ❑ No
				Panic Attacks	❑ Yes ❑ No

Diagnosis of Cancer ❑ Yes ❑ No If yes, state type of cancer _____

Date diagnosed: _____ Radiation ❑ Yes ❑ No Chemotherapy ❑ Yes ❑ No

SURGICAL HISTORY: *List any surgical history. Please include dates or time frame:*

_____

_____

ADDITIONAL MEDICAL HISTORY:

_____

_____

MEDICATIONS: ❑ NONE

Please CLEARLY LIST any medications you are taking, including herbals and over the counter medications:

_____

_____

ALLERGIES: Latex: ❑ Yes ❑ No *Please list others:* _____

Date:

SOCIAL HISTORY: Occupation: _____ ❑ Retired With whom do you live? _____

Married: ❑ Yes ❑ No Children: ❑ Yes ❑ No If you have children, how many? _____

Where do you live? ❑ House ❑ Apartment How many stories? _____ How do you enter? ❑ Stairs ❑ Ramp

If you have stairs to enter home, how many? _____ Railing? ❑ Right ❑ Left ❑ Both sides ❑ None ❑ Other: _____

If you have stairs inside the home, how many? _____ Railing? ❑ Right ❑ Left ❑ Both sides ❑ None ❑ Other: _____

Do you exercise? ❑ Yes ❑ No What type and how often? _____

Do you use tobacco? ❑ Yes ❑ No If yes, ❑ Smoke ❑ Chew How much/often? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much/often? _____

FALLS: ❑ Not Applicable ❑ Yes, I have a fear of falling.

❑ I have fallen _____ times in the past **3 months**. ❑ I have fallen _____ times in the past **6 months**. ❑ I have fallen _____ times in the past **year**.

PAIN DIAGRAM

Please mark the area(s) of injury or discomfort by clicking and dragging each circle on the chart below.

Please click and drag the circle to the number that reflects your pain.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

What are you coming to therapy for today?

_____

When did your symptoms begin?

_____

Have you ever received Physical/Occupational/Speech Therapy for this condition? ❑ Yes ❑ No

If yes, explain:

_____

_____

Pain? ❑ Yes ❑ No How do you treat it?

_____

_____

If you have pain, what makes it worse? What makes it better?

_____

_____

What are your goals for therapy?

_____

_____

_____

How do you best learn (select all that apply)? ❑ Seeing ❑ Doing ❑ Hearing ❑ Reading ❑ Other: _____

✕ _____ ___ / ___ / ___ ___ : ___ AM/PM

Patient Signature or Person Authorized to Consent on Behalf of the Patient Date Time

FOR PENN THERAPY & FITNESS THERAPIST ONLY: I have read and reviewed this Patient Summary Form

Therapist Name/Signature: _____ / _____ Init _____ ___ / ___ / ___ ___ : ___ AM/PM

Date Time

Therapist Name/Signature: _____ / _____ Init _____ ___ / ___ / ___ ___ : ___ AM/PM

Date Time

❑ Attached medication list provided by patient

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LABEL AREA

HIPAA: Notice of Privacy Practices – June 2016

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. Changes on this notice will not be honored. *You will be asked to acknowledge that you have received our Notice of Privacy Practices.*

We understand that information about you and your health is very personal.

Therefore, we will strive to protect your privacy as required by law. We will only use and disclose your personal health information ("PHI"), as allowed by law.

We are committed to excellence in the provision of state-of-the-art health care services through the practice of patient care, education, and research. Therefore, as described below, your health information will be used to provide you care and may be used to educate health care professionals and for research purposes. We train our staff and workforce to be sensitive about privacy and to respect the confidentiality of your PHI.

We are required by law to maintain the privacy of our patients' PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice ("Notice") so long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new notice effective for all PHI maintained by us. You may receive a copy of any revised notice at any of our hospitals or doctors' offices, or ambulatory care facilities.

The terms of this Notice apply to Penn Medicine, consisting of the Perelman School of Medicine at the University of Pennsylvania and the University of Pennsylvania Health System and its subsidiaries and affiliates, including but not limited to the Hospital of the University of Pennsylvania, Pennsylvania Hospital, Penn Presbyterian Medical Center, Chester County Hospital, Lancaster General Hospital, the Clinical Practices of the University of Pennsylvania (CPUP), Clinical Care Associates (CCA), Penn Home Care and Hospice, Good Shepherd Penn Partners, Clinical Health Care Associates of New Jersey, and the physicians, licensed professionals, employees, volunteers, and trainees seeing and treating patients at each of these care settings. This Notice does not apply when visiting a non-CPUP or non-CCA physician in their private medical office.

If you have questions regarding the coverage of this Notice, or if you would like to obtain a copy of this Notice, please contact the Penn Medicine Privacy Office as described below.

Uses and Disclosures of your PHI

The following categories describe the ways we may use or disclose your PHI without your consent or authorization. For each category, we will give you illustrative examples.

Uses and Disclosures for Treatment, Payment, and Health Care Operations.

Treatment: We use and disclose your PHI as necessary for your treatment. For instance, doctors, nurses, and other professionals involved in your care — within and outside of Penn Medicine — may use information in your medical record that may include procedures, medications, tests, etc. to plan a course of treatment for you.

Payment: We use and disclose your PHI as necessary for payment purposes. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. Also, we may use your information to prepare a bill to send to you or to the person responsible for your payment.

Health Care Operations. We use and disclose your PHI for health care operations. This is necessary to operate Penn Medicine, including by ensuring that our patients receive high quality care and that our health care professionals receive superior training. For example, we may use your PHI to conduct an evaluation of the treatment and services we provide, or to review the performance of our staff. Your health information may also be disclosed to doctors, nurses, staff, medical students, residents, fellows, and others for education and training purposes.

The sharing of your PHI for treatment, payment, and health care operations may happy electronically. Electronic communications enable fast, secure access to your information for those participating in and coordinating your care to improve the overall quality of your health and prevent delays in treatment.

Health Information Exchanges: Penn Medicine participates in initiatives to facilitate this electronic sharing, including but not limited to Health Information Exchanges (HIEs) which involve coordinated information sharing among HIE members for purposes of treatment, payment, and health care operations. Patients may opt-out of some of these electronic sharing initiatives, such as HIEs. Penn Medicine will use reasonable efforts to limit the sharing of PHI in such electronic sharing initiatives for patients who have opted-out. If you wish to opt-out, please contact your patient services associate.

Our Facility Directory. We use information to maintain an inpatient directory listing your name, room number, general condition, and if you wish, your religious affiliation. Unless you choose to have your information excluded from this directory, the information, excluding your religious affiliation, may be disclosed to anyone who requests it by asking for you by name. This information, including your religious affiliation, may also be provided to members of the clergy, even if they don't ask for you by name. If you wish to have your information excluded from this director, please contact your patient services associate.

Persons Involved in Your Care. Unless you object, we may, in our professional judgment, disclose to a member of your family, a close friend, or any other person you identify, your PHI, to facilitate that person's involvement in caring for you or in payment for your care. We may use or disclose your PHI to assist in notifying a family member, personal representative or any person responsible for your care of your location and general condition. We may also disclose limited PHI to a public or private entity that is authorized to assist in disaster relief efforts to locate a family member or other persons who may be involved in some aspect of caring for you.

Fundraising. We may contact you, at times in coordination with your physician, to donate to a fundraising effort on our behalf. If we contact you for fundraising purposes, you have the right to opt-out of receiving any future solicitations.

Appointments and Services. We may use your PHI to remind you about appointments or to follow up on your visit.

Health Products and Services. We may, from time to time, use your PHI to communicate with you about treatment alternatives and other health-related benefits and services that may be of interest to you.

Research. We may use and disclose your PHI, including PHI generated for use in a research study, as permitted by law for research, subject to your explicit authorization and/or oversight by the University of Pennsylvania Institutional Review Boards (IRBs), committees charged with protecting the privacy rights and safety of human subject research, or similar committee. In all cases where your specific authorization has not been obtained, your privacy will be protected by confidentiality requirements evaluated by such committee. For example, the IRB may approve the use of your health information with only limited identifying information to conduct outcomes research to see if a particular procedure is effective.

Research (continued).

As an academic medical center, Penn Medicine supports research and may contact you to invite you to participate in certain research activities. If you do not wish to be contacted for research purposes, please inform your patient services associate. In such case, we will use reasonable efforts to prevent this research-related outreach. This will not apply to the use of your PHI for research purposes as described above and will not prevent your care providers from discussing research with you.

Business Associates. We may contract with certain outside persons or organizations to perform certain services on our behalf, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations. In such cases, we require these business associates, and any of their subcontractors, to appropriately safeguard the privacy of your information.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your PHI without your consent or authorization. Subject to conditions specified by law, we may release your PHI:

- for any purpose required by law;
- for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- to certain governmental agencies if we suspect child abuse or neglect; or if we believe you to be a victim of abuse, neglect, or domestic violence;
- to entities regulated by the Food and Drug Administration, if necessary, to report adverse events, product defects, or to participate in product recalls;
- to your employer when we have provided health care to you at the request of your employer for purposes related to occupational health and safety. In most cases you will receive notice that your PHI is being disclosed to your employer;
- if required by law to a government oversight agency conducting audits, investigations, inspections and related oversight functions;
- in emergency circumstances, such as to prevent a serious and imminent threat to a person or the public;
- if required to do so by a court of administrative order, subpoena or discovery request. In most cases you will have notice of such release;
- to law enforcement officials, including for purposes of identifying or locating suspects, fugitives, witnesses, or victims of crime, or for other allowable law enforcement purposes;
- to coroners, medical examiners, and/or funeral directors;
- if necessary, to arrange an organ or tissue donation from you or a transplant for you;
- if you are a member of the military for activities set out by certain military command authorities as required by armed forces services; we may also release your PHI, if necessary, for national security, intelligence, or protective services activities; and
- if necessary for purposes related to your workers' compensation benefits.

Your Authorization. Except as outlined above, we will not use or disclose your PHI for any other purposes unless you have signed a form authorizing the use or disclosure. The form will describe what information will be disclosed, to whom, for what purpose, and when. you have the right to revoke your authorization in writing, except to the extent we have already relied upon it. These situations can include:

- uses and disclosures of psychotherapy notes;
- uses and disclosures of PHI for marketing purposes, including marketing communications paid for by third parties;
- uses and disclosures of PHI specially protected by state and/or Federal law and regulations;
- uses and disclosures for certain research protocols;
- disclosures that constitute a sale of PHI.

Confidentiality of Alcohol and Drug Abuse Patient Records, HIV-Related Information, and Mental Health Records. The confidentiality of alcohol and drug abuse treatment records, HIV-related information, and mental health records maintained by us is specifically protected by state and/or Federal law and regulations. Generally, we may not disclose such information unless you consent in writing, the disclosure is allowed by a court order, or in limited and regulated other circumstances.

Rights That You Have

Access to your PHI. Generally, you have the right to access, inspect, and/or receive paper and/or electronic copies of the PHI that we maintain about you. Requests for access must be made in writing and be signed by you or, when applicable, your personal representative. We will charge you for a copy of your medical records in accordance with a schedule of fees under federal and state law. You may obtain the appropriate form from the doctor's office or any entity where you received services. You may also access much of your health information using the myPennMedicine.org patient portal.

Amendments to Your PHI. You have the right to request that PHI that we maintain about you be amended or corrected. Requests for amendment must be made in writing and signed by you or, when applicable, your personal representative and must state the reasons for the amendment/correction request. We are not obligated to make all requested amendments but will give each request careful consideration. If we grant your amendment request, we may also reach out to other prior recipients of your information to inform them of the change. Please note that even if we grant your request, we may not delete any information already documented in your medical record. You may obtain the appropriate form from the doctor's office or entity where you received services.

Accounting for Disclosures of Your PHI. You have the right to receive an accounting of certain disclosures made by us of your PHI, except for disclosures made for purposes of treatment, payment, and health care operations or for certain other limited exceptions. This accounting will include only those disclosures made in the six years prior to the date on which the accounting is requested. Requests must be made in writing and signed by you or, when applicable, your personal representative. The first accounting in any 12-month period is free; you will be charged a reasonable, cost-based fee for each subsequent accounting you request within a 12-month period. You may obtain the appropriate form from the doctor's office or entity where you received services.

Restrictions on Use and Disclosure of Your PHI. You have the right to request restrictions on certain uses and disclosures of your PHI for treatment, payment, or health care operations. We are not required to agree to your restriction request, unless otherwise described in this notice, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event we have terminated an agreed upon restriction, we will notify you of such termination. The appropriate form can be obtained from your doctor's office or entity where you received services and must be signed by you or, when applicable, your personal representative.

Restrictions on Disclosures to Health Plans. You have the right to request a restriction on certain disclosures of your PHI to your health plan. We are required to honor such requests for restrictions only when you or someone on your behalf, other than your health plan, pays for the health care item(s) or service(s) in full. Such requests must be made in writing and signed by you, and, when applicable, your personal representative. You may obtain the appropriate form from the doctor's office or entity where you received services.

Confidential Communications. You have the right to request communications regarding your PHI from us by alternative means or at alternative locations and we will accommodate reasonable requests by you. You, or when applicable, your personal representative must request such confidential communication in writing to each department to which you would like the request to apply. You may obtain the appropriate form from the doctor's office or entity where you received services.

Breach Notification. We are required to notify you in writing of any breach of your unsecured PHI without unreasonable delay, but in any event, no later than 60 days after we discover the breach.

Paper Copy of Notice. As a patient, you have the right to obtain a paper copy of this Notice. You can also find this Notice on our website at: http://www.pennmedicine.org/health-system/about/organization/policies/notice-of-privacy-practices.html.

Additional Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint in writing with the doctor's office, ambulatory care facility, or Guest Services department of the hospital/facility you visited. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. All complaints must be made in writing and in no way will affect the quality of care you receive from us.

For further information. If you have questions or need further assistance regarding this Notice, you may contact the Penn Medicine Privacy Office in the Office of Audit, Compliance and Privacy by telephone at 215.573.4492 or by e-mail at privacy@uphs.upenn.edu.

This Notice is effective June 27, 2016.

GoodShepherd Penn Partners | Penn Therapy & Fitness

Official Therapy Provider for Penn Medicine

Patient Bill of Rights & Responsibilities

As a health care facility within Good Shepherd Penn Partners, we are committed to delivering quality medical care to you, our patient, and to making your stay as pleasant as possible. The following, "Statement of Patient's Rights," endorsed by the administration and staff of this facility, applies to all patients. In the event that you are unable to exercise these rights on your own behalf, then these rights are applicable to your designated legally authorized representative. As it is our goal to provide medical care that is effective and considerate within our capacity, mission, and philosophy, applicable law and regulations, we submit these to you as a statement of our policy.

STATEMENT OF PATIENT'S RIGHTS

You have the right to respectful care given by competent personnel which reflects consideration of your cultural and personal values and belief systems and which optimizes your comfort and dignity.

You have the right, upon request, to be given the name of your attending physician, the names of all other physicians or practitioners directly participating in your care, and the names and roles of other health care personnel, having direct contact with you.

You have the right to every consideration of privacy concerning your medical care program. Case discussion, consultation, examination, and treatment are considered confidential and should be conducted discreetly, giving reasonable visual and auditory privacy when possible. This includes the right, if requested, to have someone present while physical examinations, treatments, or procedures are being performed, as long as they do not interfere with diagnostic procedures or treatments. This also includes the right to request a room transfer if another patient or a visitor in the room is unreasonably disturbing you and if another room equally suitable for your care needs is available.

You have the right to have all information, including records, pertaining to your medical care treated as confidential except as otherwise provided by law or third-party contractual arrangements.

You have the right to know what hospital policies, rules and regulations apply to your conduct as a patient.

You have the right to expect emergency procedures to be implemented without unnecessary delay.

You have the right to good quality care and high professional standards that are continually maintained and reviewed.

You have the right to full information in layperson's terms, concerning diagnosis, treatment, and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable that such information be given to you, the information shall be given on your behalf to your designated/legally authorized representative. Except for emergencies, the physician must obtain the necessary informed consent prior to the start of any procedure or treatment, or both.

You have the right to not be involved in any experimental, research, or donor program unless you have, or your designated/legally authorized representative has, given informed consent prior to the actual participation in such a program. You or your designated/legally authorized representative may, at any time, refuse to continue in any such program to which informed consent has previously been given.

You have the right to accept medical care or to refuse any drugs, treatment, or procedure offered by the institution, to the extent permitted by the law, and a physician shall inform you of the medical consequences of such refusal.

You have the right to assistance in obtaining consultation with another physician at your request and expense.

You have the right to expect good management techniques to be implemented within this health care facility considering effective use of your time and to avoid your personal discomfort.

You have the right to examine and receive a detailed explanation of your bill.

You have the right to full information and counseling on the availability of known financial resources for your health care.

You have the right to expect that the health care facility will provide a mechanism whereby you are informed upon discharge of continuing health care requirements following discharge and the means for meeting them.

You have the right to seek review of quality of care concerns, coverage decisions, and concerns about your discharge.

You cannot be denied the right of access to an individual or agency authorized to act on your behalf to assert or protect the rights set out in this section.

You have the right to have a family member or representative of your choice and your physician notified promptly of your admission to the hospital.

You have the right to medical and nursing services without discrimination based upon age, sex, race, color, ethnicity, religion, gender, disability, ancestry, national origin, marital status, familial status, genetic information, gender identity or expression, sexual orientation, culture, language, socioeconomic status, domestic or sexual violence victim status, source of income, or source of payment.

You have the right to appropriate assessment and management of pain.

You have the right, in collaboration with your physician or health care provider, to make decisions involving your health care. This right applies to the family and/or guardian of neonates, children, and adolescents. Decisions may include the right to refuse drugs, treatment, or procedure offered by the hospital, to the extent permitted by law. Your health care provider will inform you of the medical consequences of the refusal of such drugs, treatment, or procedure.

While this health care facility recognizes your right to participate in your care and treatment to the fullest extent possible, there are circumstances under which you may be unable to do so. In these situations (for example, if you have been adjudicated incompetent in accordance with the law, are found by your physician to be medically incapable of understanding the proposed treatment or procedure, are unable to communicate your wishes regarding treatment, or are an unemancipated minor) your rights are to be exercised to the extent permitted by law, by your designated representative or other legally authorized person.

You have the right to make decisions regarding the withholding of resuscitative services or the foregoing of or the withdrawal of life-sustaining treatment within the limits of the law and the policies of this institution.

You have the right to receive care in a safe setting, and be free from all forms of abuse and harassment.

You have the right to be free from restraint and seclusion not medically necessary or used as a means of coercion, discipline, convenience or retaliation by staff.

You have the right to have your medical record read only by individuals directly involved in your care, by individuals monitoring the quality of care, or by individuals authorized by law or regulation.

You have the right to receive written notice that explains how your personal health information will be used and shared with other health care professionals included in your care. You or your designated/legally authorized representative, may, upon request, have access to all information contained in your medical records, unless access is specifically restricted by the attending physician for medical reasons.

You have the right to be communicated with in a manner that is clear, concise and understandable. If you do not speak English, you should have access, where possible, free of charge, to an interpreter. This also includes providing you with help if you have vision, speech, hearing or cognitive impairments.

You have the right to access protective services.

You have the right to be free from neglect, exploitation, and verbal, mental, physical and sexual abuse.

You have the right to participate in the consideration of ethical issues surrounding your care, within the framework established by this organization to consider such issues.

You have the right to formulate an advance directive, including the right to appoint a health care agent to make health care decisions on your behalf. These decisions will be honored by this facility and its health care professionals within the limits of the law and this organization's mission, values and philosophy. If applicable, you are responsible for providing a copy of your advance directive to the facility or caregiver.

You are not required to have or complete an "advance directive" in order to receive care and treatment in this facility.

When this facility cannot meet the request or need for care because of a conflict with our mission or philosophy or incapacity to meet your needs or request, you may be transferred to another facility when medically permissible. Such a transfer should be made only after you or your designated/legally authorized representative have received complete information and explanation concerning the need for, and alternatives to, such a transfer. The transfer must be acceptable to the other institution.

You have the right to decide whether you want visitors or not during your stay here. You may designate those persons who can visit you during your stay. These individuals do not need to be legally related to you. They may include, for example, a spouse, domestic partner, including a same sex partner, another family member, or a friend. The hospital will not restrict, limit, or deny any approved visitor on the basis of race, color, national origin, religion, sex, gender identity or expression, sexual orientation or disability. The hospital may need to limit or restrict visitors to better care for you or other patients.

You have the right to be made aware of any such clinical restrictions or limitations.

You have the right to designate a family member, friend, or other individual as a support person during the course of your stay or during a visit to a physician or other ambulatory care treatment.

You have the right to give or withhold informed consent to produce or use recordings, films or other images of you for purposes other than your own care, treatment or patient identification.

You have the right, without recrimination, to voice complaints regarding your care, to have those complaints reviewed, and, when possible, resolved.

FOR FURTHER INFORMATION

If you have questions or problems concerning your healthcare please speak with your physician, nurse or other hospital or ambulatory practice representative before you leave the clinical site.

You may also direct questions, concerns regarding your healthcare or questions about the Patient Bill of Rights and Responsibilities to the appropriate Patient and Guest Relations office:

Good Shepherd Penn Partners
1800 Lombard Street
Philadelphia, PA 19146
(267) 414-3980

You may direct questions or concerns regarding the Health Insurance Portability and Accountability Act (HIPAA) / privacy related matters to:
Electronic Mail: privacy@gsrh.org
Telephone: (484) 866-7949

You may direct questions or concerns regarding accessibility or accommodations to the **Patient Safety Manager** at (267) 414-3980.

If you or a family member thinks that a complaint or grievance remains unresolved through the hospital resolution process, or regardless of whether you have used the hospital's grievance process, **you have the right** to contact the following organizations about your concerns:

The Pennsylvania Department of Health
Division of Acute and Ambulatory Care
P.O. Box 90
Harrisburg, PA 17120
(800) 254-5164

The Centers for Medicare and Medicaid Services
(800) 633-4227

For concerns related to quality and/or safety of care issues (including premature discharge) or safety of the environment, contact:

The Joint Commission
Office of Quality and Patient Safety
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181
Facsimile: (630) 792-5636
E-mail: patientsafetyreport@jointcommission.org

For concerns related to disability accessibility or accommodations, contact:

The United States Department of Justice
950 Pennsylvania Avenue, NW
Civil Rights Division, Disability Rights Section – 1425 NYAV
Washington, D.C. 20530
Facsimile: (202) 307-1197
E-mail: ADA.complaint@usdoj.gov

For concerns related to discrimination or any civil rights concerns, contact:

The U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
or by mail or phone at
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F,
HHH Building Washington, D.C. 20201
Telephone: 1-800-868-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

STATEMENT OF PATIENT'S RESPONSIBILITIES

To foster our ability to provide safe, quality care you should act in accordance with Good Shepherd Penn Partners policies, rules, and regulations and assume responsibility for the following:

This health care facility expects that you or your designated/legally authorized representative will provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, advance directives, and other matters relating to your health history or care in order for you to receive effective medical treatment.

In addition, you are responsible for reporting whether you clearly understand the planned course of action and what is expected of you.

It is expected that you will cooperate with all hospital personnel and ask questions if directions and/or procedures are not clearly understood.

You are expected to be considerate of other patients and health care personnel, to assist in the control of noise and visitors in your room, and to observe the non-smoking policy of this institution. You are also expected to be respectful of the property of other persons and the property of the Good Shepherd Penn Partners. Threats, violence, disruption of patient care or harassment of other patients, visitors or staff will not be tolerated. You are also expected to refrain from conducting any illegal activity on Good Shepherd Penn Partners property. If such activity occurs, Good Shepherd Penn Partners will report it to law enforcement.

In order to facilitate your care and the efforts of the health care personnel, you are expected to help the physicians, nurses, and other health care personnel in their efforts to care for you by following their instructions and medical orders.

Duly authorized members of your family or designated/legally authorized representative are expected to be available to Good Shepherd Penn Partners personnel for review of your treatment in the event you are unable to properly communicate with your health caregivers.

It is understood that you assume the financial responsibility of paying for all services rendered either through third-party payers (your insurance company) or being personally responsible for payment for any services which are not covered by your insurance policies.

It is expected that you will not take drugs which have not been prescribed by your attending physician and administered by appropriate staff and that you will not complicate or endanger the healing process by consuming alcoholic beverages or toxic substances during your hospital stay and/or visit.

Our entire Good Shepherd Penn Partners team thanks you for choosing to receive your care here. It is our pleasure to serve and care for you.

The Leadership Team at:
Good Shepherd Penn Partners