GoodShepherd Penn Partners | Penn Therapy & Fitness

Official Therapy Provider for Penn Medicine

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

Would you like to provide information about your gender identity?: ❑ Yes ❑ No Sex assigned at birth: ❑ Male ❑ Female ❑ Not known ❑ Choose not to disclose

Gender Identity: ❑ Male ❑ Female ❑ Non-binary/Genderqueer ❑ Other _____ ❑ Decline to answer

Sexual Orientation: ❑ Bisexual ❑ Homosexual, lesbian or gay ❑Heterosexual, straight ❑ Other _____ ❑ Decline to answer

Preferred pronouns: ❑ He/Him/His ❑ She/Her/Hers ❑ They/Them/Theirs ❑ Other _____

Race: _____ Ethnicity:_____

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

Is there any chance that you could be pregnant? ❑ Yes ❑ No

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

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

Do you feel safe at home? ❑ Yes ❑ No If no, explain _____

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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Consent Form

CONSENT FOR MEDICAL TREATMENT:

I consent to routine diagnostic, medical and rehabilitation procedures and/or treatment provided by the Outpatient Hospital Based Facility. I understand that I will have the opportunity to discuss the risks and benefits of proposed procedures and treatment, together with any alternatives, with the physician or health professional to my satisfaction. I further understand that this consent does not include operations or any non-routine medical or rehabilitation procedures or treatment. The risks, benefits and alternatives to such non-routine procedures or treatment, will be explained to me by the physician or health professional. I have the right to consent or refuse any proposed procedure or treatment to the extent permitted by law. Subject to this Consent to Treatment, the Outpatient Hospital Based Facility may perform any procedures and administer any treatment deemed advisable in my care.

CONSENT TO USING AND PARTICIPATING IN TELEMEDICINE AND TELEHEALTH:

I agree that some of my medical care, including diagnosis, treatment and other related services, may be provided through the use of electronic communications and technologies, often referred to as "telemedicine" or "telehealth." Telemedicine includes but is not limited to audio-video conferencing, transmission of photographs or other images, patient portals, telephone, email and text-based consultations. and remote monitoring. I acknowledge that, as with any medical treatment, there are potential risks with telemedicine that may include, for example technical problems with the information transmission and equipment failures that could result in lost information or delays in treatment. The altematives to the use of telemedicine may include face-to-face encounters or receiving my care in another way. I understand that I have a right to refuse or withdraw my consent to participate in telemedicine in the course of my medical care at any time, without affecting my right to future medical care. Telemedicine services are generally billed in the same manner as regular provider services.

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS:

I authorize payment of insurance benefits (including Medicare/Medicaid benefits) to be made directly to Good Shepherd Penn Partners. I understand that I am financially responsible to Good Shepherd Penn Partners for services not covered by my insurance company. I understand that Good Shepherd Penn Partners is under no duty or obligation to seek payment from an insurance company until all required insurance information is provided to GSPP to process my bill. This authorization shall remain effective until revoked by me in writing. I intend that my consent shall apply to all outpatient services received by me from Good Shepherd Penn Partners.

ASSIGNMENTS OF BENEFITS:

I am receiving medical care and services from the Hospital and/or by the System Providers. In exchange for that care and treatment, I give and assign to the Hospital, and/or one or more of the System Providers, as appropriate, the right to receive payment directly for all insurance and other health benefits to which I am entitled, and/or which may be payable on my behalf I understand that this is called an "assignment of benefits" and that the Hospital and such System Providers may be called my "assignees". This assignment shall not be for more than the Hospital rate and the physicians' charges. I understand that I may be required to pay for charges that others do not pay on my behalf under this assignment. I agree that the Hospital and/or the System Providers can sue anyone in their own names as my assignee and get payment for the charges resulting from my medical care. This amount may include charges on the bill for my care and lawyers' fees resulting from collection efforts.

MEDICARE BENEFITS:

I request that payment of Medicare benefits be made on my behalf to the Hospital and/or one or more of the System Providers for any medical services, care or treatment any of them may provide to me. I authorize the Hospital and/or such System Providers and their agents to give to the Centers for Medicare & Medicaid Services and its agents any medical information about me (or the person I signed for) needed to determine these benefits or the benefits payable for related services. I have provided accurate information about Medicare secondary payers.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize Good Shepherd Penn Partners to release information contained in my medical records to the party responsible for payment for my care, including but not limited to the Medicare/Medicaid programs, my insurance carrier, my employer's insurance carrier, and/or any other party whom I have indicated will be responsible for payment for my care. I intend that this consent shall extend to any information concerning HIV infection, AIDS or AIDS Related Complex. This authorization is effective for as long as necessary to obtain payment. It will end when Good Shepherd Penn Partners obtains full payment from all sources or when revoked by me in writing.

☐ Yes ☐ No I understand that Good Shepherd Penn Partners has a teaching program and consent to the participation of those involved in the teaching program in my care.

☐ Yes ☐ No I understand that during the course of my treatment, Good Shepherd Penn Partners will create a medical chart for me and consent to the use of photographs and/or recorded images for treatment purposes.

NOTICE OF PRIVACY PRACTICE:

I understand that Good Shepherd Penn Partners; Penn Therapy & Fitness is part of The Good Shepherd Penn Partners Specialty Hospital. I also understand that this provider may share my health information for treatment, payment, and healthcare operations. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Good Shepherd Penn Partners has the right to change this notice at any rime. I may obtain a current copy by contacting the Compliance, Privacy Officer at 215.893.2548.

My signature constitutes my acknowledgment that I have been provided with a copy of the Notice of Privacy Practices and/or a Statement of the Patient's Rights and Responsibilities/Admission Notice Packet.

If any person is physically unable to provide a signature OR signs with a mark, print his/her name on the appropriate line below and record the signatures of two responsible persons who witness that such person understands the nature of this acknowledgment.

If patient is not capable of acknowledging the notice because of age or medical condition, complete the following:
Patient is a minor (_____ years of age) OR patient is unable to give acknowledgment because _____

REQUEST FOR RESTRICTION OF HEALTH INFORMATION:

Good Shepherd Penn Partners is committed to protecting your health information. We will not release confidential medical information regarding your care to any unauthorized person. You have the right to request us to restrict use of disclosure or your health information, including information for treatment, payment or health care operations. Good Shepherd Penn Partners has no obligation to agree to the request, but will review each request carefully. ***Date of Request:*** _____

1. ☐ Yes ☐ No Good Shepherd Penn Partners may call my home or other alternative location (i.e. cell phone/voice mail, pager) and leave a message on voice mail or in person in reference to any items that assist Good Shepherd Penn Partners in carrying out treatment, payment, and health care operations, including appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others. ***If an alternative location/number is requested, please list:***_____

2. ☐ Yes ☐ No Good Shepherd Penn Partners may mail to my home or other alternative location any items that assist Good Shepherd Penn Partners in carrying out treatment, payment, and health care operations, such as appointment reminder cards and patient statements.
If an alternative location is requested, please list: _____

3. ☐ Yes ☐ No ☐ N/A Good Shepherd Penn Partners may send a fax to my home or other alternative location in reference to any items that assist Good Shepherd Penn Partners in carrying out treatment, payment, and health care operations, including appointment reminders, insurance items, and any items pertaining to my clinical care, including laboratory results among others.

4. ☐ Yes ☐ No ☐ N/A Good Shepherd Penn Partners may email to my home or other alternative location any items that assist Good Shepherd Penn Partners in carrying out treatment, payment, and health care operations, such as appointment reminders and patient statements. ***My email address is:*** _____

5. Good Shepherd Penn Partners may communicate with the following people about my medical condition:

_____

USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist the patient in completing this form as follows:

☐ Foreign Language (specify) _____ ☐ Sign Language
☐ Patient is blind, form read to patient ☐ Other, (specify) _____
Interpretation provided by _____

{NAME OF INTERPRETER AND TITLE OR RELATIONSHIP TO PATIENT)

I have read and understood each paragraph above, and by signing give consent voluntarily.
If signing electronically: I accept and I intend the signature(s) below to be legally binding and the equivalent of my handwritten signature.
Patient Signing:

_____	_____	_____	_____
Patient Printed Name	Patient Signature	Date	Time

If any person (the patient or their legally authorized representative) who is physically unable to provide a signature wishes to consent to this and provides verbal consent whether in person or via telephone or signs with a mark, print their name on the appropriate line below and record the signature of two responsible persons who witness that such a person understands the nature of this release and freely give their consent.

Legally Authorized Representative Signing:

_____	_____	_____	_____
Print Name	Signature	Date	Time

Good Shepherd Penn Partners Representatives Signatures:

_____	_____	_____	_____
Print Name	Signature	Date	Time
_____	_____	_____	_____
Print Name	Signature	Date	Time

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HIPAA: Notice of Privacy Practices – July 2021

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

WE ARE COMMITTED TO YOUR PRIVACY

We understand that information about you and your health is very personal. We strive to protect our patients' privacy. We are required by law to maintain the privacy of our patients' protected health information ("PHI"). We are also required to provide notice of our legal duties and privacy practices with respect to PHI and to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of this Notice and to make a new Notice effective for all PHI we maintain. You can obtain a copy of a new notice at pennrehab.org/patients-and-visitors/patientresources/ or by contacting the GSPP Privacy Office as described below.

WHO THIS NOTICE APPLIES TO

The terms of this Notice apply to Good Shepherd Penn Partners (GSPP), including but not limited to The Specialty Hospital at Rittenhouse, and Penn Therapy & Fitness and the licensed professionals, employees, volunteers, and trainees seeing and treating patients at each of these care settings. This Notice also applies to the physicians, licensed professionals, employees, volunteers, and trainees seeing and treating patients at GSPP-owned and operated care settings. We are committed to excellence in providing state-of-the-art health care services through the practice of patient care, education, and research. Below is a description of how your health information will be used and disclosed to advance this mission.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION THAT DO NOT REQUIRE AN AUTHORIZATION

Treatment. For example, doctors, nurses, and other staff members involved in your care will use and disclose your PHI to coordinate your care or to plan a course of treatment for you.

Payment. For example, we may disclose information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you.

Health Care Operations. For example, we may disclose your PHI for billing or interpreter support. We may use your PHI to conduct an evaluation of the treatment and services provided or to review staff performance. We may disclose your PHI for education and training purposes to doctors, nurses, technicians, medical students, residents, fellows and others.

Health Information Exchanges. We participate in initiatives to facilitate electronic sharing of patient information, including but not limited to Health Information Exchanges (HIEs). HIEs involve coordinated information sharing among HIE members for purposes of treatment, payment, and health care operations. You may opt out of GSPP's information sharing through its HIE activities. If you wish to opt out, please speak with your patient/customer services associate or contact the GSPP Privacy Office as described below. More information about HIEs can be found on the GSPP website: pennrehab.org/patientsand-visitors/patient-resources/

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 (except for 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 do not ask for you by name. If you wish to have your information excluded from this directory, please contact your patient/customer services associate.

To Persons Involved in Your Care. As long as you do not object, we may, based on our professional judgment, disclose your PHI to a family member or other person if they are involved in your care or paying for your care. Similarly, we may also disclose limited PHI to an entity authorized to assist in disaster relief efforts for the purpose of coordinating notification to someone responsible for your care of your general condition or location.

Fundraising. We may contact you at times 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.
GSPP-010-1

Communicating with You.
We will use your PHI to communicate with you about a number of important topics, including information about appointments, your care, treatment options and other health-related services, payment for your care, and opportunities to participate in research, provided this research outreach is approved by the Institutional Review Board (IRB) and/or the IRB of Record, see Research section below.

We urge our inpatients to sign up for the Penn Medicine patient portal to send and receive communications conveniently and securely and to share your preferences for how we contact you. The patient portal is www.MyPennMedicine.org.

We may also contact you at the email, phone number or address that you provide, including via text messages, for these communications. If your contact information changes, it is important that you let us know. Texting and email are not 100% secure. Regarding text messages, please note that message and data rates may apply and you will have an opportunity to opt out.

Research. We may use and disclose your PHI as permitted by applicable law for research. This is subject to your authorization and/or oversight by the Institutional Review Boards (IRBs), committees charged with protecting the privacy rights and safety of human subject research.

Good Shepherd Penn Partners 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 tell your patient/customer services associate. In such case, we will use reasonable efforts to prevent research-related outreach. Note that GSPP may continue to use your PHI for research purposes as described above and your care providers may discuss research with you.

Business Associates. At times, we need to disclose your PHI to persons or organizations outside GSPP who assist us with our payment/billing activities and health care operations. We require these business associates and their subcontractors to appropriately safeguard your PHI.

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

- for any purpose required by law
- for public health activities, including required reporting of disease, injury, birth and death, for required public health investigations, and to report adverse events or enable product recalls
- to government agencies if we suspect child/elder adult abuse or neglect. We may also release your PHI to government agencies if we believe you are a victim of abuse, neglect or domestic violence
- to your employer when we have provided screenings and health care at their request for occupational health and safety
- to a government oversight agency conducting audits, investigations, inspections and related oversight functions
- in emergencies, such as to prevent a serious and imminent threat to a person or the public
- if required by a court or administrative order, subpoena or discovery request
- for law enforcement purposes, including to law enforcement officials to identify or locate suspects, fugitives or witnesses, or victims of crime
- to coroners, medical examiners and funeral directors
- if necessary to arrange organ or tissue donation or transplant
- for national security, intelligence, or protective services activities
- for purposes related to your workers' compensation benefits

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION BASED ON A SIGNED AUTHORIZATION

Except as outlined above, we will not use or disclose your PHI for any other purpose unless you have signed a form authorizing the use or disclosure. You may revoke an authorization in writing, except to the extent we have already relied upon it.

In some situations, a signed authorization form is required for uses and disclosures of your PHI, including:

- most uses and disclosures of psychotherapy notes
- uses and disclosures for marketing purposes
- disclosures that constitute the sale of PHI
- uses and disclosures for certain research protocols
- as required by privacy law. The confidentiality of substance use disorder and mental health treatment records as well as HIV-related information 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 other limited, regulated circumstances.

YOUR RIGHTS

Access to Your PHI. Generally, you can access and inspect paper or electronic copies of certain PHI that we maintain about you. You may readily access much of your health information without charge using the patient portal for inpatients of the Specialty Hospital and /or requesting access from a local staff representative. You may also access your information through the Health Information Management department, which you can contact at himsroi@gsrh.org. In line with set fees under federal and state law; we may charge you for a copy of your medical records.

Amendments to Your PHI. You can request amendments, or changes, to certain PHI that we maintain about you that you think may be incorrect or incomplete. All requests for changes must be in writing, signed by you or your representative, and state the reasons for the request. If we decide to make an amendment, we may also notify others who have copies of the information about the change. Note that even if we accept your request, we may not delete any information already documented in your medical record.

Accounting for Disclosures of Your PHI. In accordance with applicable law, you can ask for an accounting of certain disclosures made by us of your PHI. This request must be in writing and signed by you or your representative. This does not include disclosures made for purposes of treatment, payment, or health care operations or other limited exceptions. An accounting will include disclosures made in the six years prior to the date of a request.

Restrictions on Use and Disclosure of Your PHI. You can request restrictions on certain of our uses and disclosures of your PHI for treatment, payment, or health care operations. We are not required to agree but will attempt to accommodate reasonable requests when appropriate.

Restrictions on Disclosures to Health Plans. You can request a restriction on certain disclosures of your PHI to your health plan. We are only required to honor such requests when services subject to the request are paid in full. Such requests must be made in writing and identify the services to which the restriction will apply.

Confidential Communications. You can request that we communicate with you through alternative means or at alternative locations, and we will accommodate reasonable requests. You must request such confidential communication in writing to each department you would like to accommodate the request.

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

Paper Copy of Notice. You can obtain a paper copy of this Notice, even if you agreed to receive an electronic copy. This Notice is available on our website in several different languages at: pennrehab.org/patients-and-visitors/patient-resources/

ADDITIONAL INFORMATION

Complaints. If you believe your privacy rights have been violated, you can file a complaint in with the GSPP Privacy Officer, Office of Health Information Services Dept., 850 South 5th Street, Allentown, PA 18103. You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C.

A complaint must be made in writing and will not in any way affect the quality of care we provide you.

For further information. If you have questions about this Notice, or requests regarding privacy, please contact the GSPP Privacy Office at (484) 866-7949 or by e-mail at privacy@gsrh.org.

Effective Date. This Notice of Privacy Practices is effective July 1, 2021.

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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. If 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 thirdparty 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 as defined by applicable law prior to the start of any procedure or treatment, or both.

You have the right to not be involved in any medical care 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, gender 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 to collaboration with your physician or health care provider, to make decisions involving your health care. This right applies to the legally authorized representative, parent, 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 that is free from abuse, harassment, neglect, exploitation and verbal, mental, physical, and sexual abuse.

You have the right to be free from restraint and seclusion that is not medically necessary or that is 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 across Good Shepherd Penn Partners entities and outside of Good Shepherd Penn Partners. You or your designated/legally authorized representative, may, upon request, have access to information contained in your medical record, unless access is specifically restricted by your practitioner as permitted by law.

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 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, without recrimination, to voice complaints or grievances regarding your care, to have those complaints or grievances reviewed, and, when possible, resolved.

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 needs 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 to without recrimination, to voice complaints or grievances regarding your care, to have those complaints or grievances 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
(215) 893-6533

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 without worry of retaliation

The Pennsylvania Department of Health Division of Acute and Ambulatory Care
Room 532 Health & Welfare Building 625 Forster Street
Harrisburg, PA 17120-0701
(800) 254-5164
Website:http://apps.health.pa.gov/dohforms/FacilityComplaint.aspx

The Centers for Medicare and Medicaid Services (CMS)
Quality and Appeals (866)815-5440
You may complete a Medicare Quality Complaint Form found at:
www.bfccqioarea1.com/states/pa.html

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

The Joint Commission
By website: https://www.jointcommission.org/contact-us/
(click on Patient Safety Complaint)
By mail:
The Office of Quality and Patient Safety (OQPS) The Joint Commission,
One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181
The Joint Commission Patient Information Line on how to report a complaint, 1-800-994-6610

For complaints/grievances related to civil rights concerns:
The United States Department of Justice
950 Pennsylvania Avenue, NW
Civil Rights Division, Disability Rights Section – 1425
NYAV Washington, D.C., 20530
Online complaint forms are available at:
www.ada.gov/complaint/ Information Line: 1-800-514-0301
Facsimile: 202-307-1197

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:
Centralized Case Management Operations Toll Free Call Center: 1-800-368-1019 TTD Number: 1-800-537-7697
Centralized Case Management Operations

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F HHH Building Washington, D.C. 20201
Telephone: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html Email complaints: OCRComplaint@hhs.gov

STATEMENT OF PATIENT'S RESPONSIBILITIES

To foster our ability to provide safe, quality care you should act in accordance with Good Shepherd Penn Partners and the health care facility's 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 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 nonsmoking policy of this institution. You are also expected to be respectful of the property of other persons and the property of 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.

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 that have not been prescribed by your practitioner 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