WELCOME TO

# Penn Therapy & Fitness

# University City

3737 MARKET STREET ◆ SUITE 200 ◆ PHILADELPHIA, PA 19104

☎ 215.349.5585 ◆ FAX: 215.222.8647

MONDAY – THURSDAY: 7:00 A.M. – 7:00 P.M.

FRIDAY: 7:00 A.M. – 6:00 P.M.

*Parking is available in two options:*
*Curb side valet and self-parking around the corner on Filbert Street.*

pennpartners.org/universitycity

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.***

- Each form must be completely filled out with appropriate boxes checked.
- **Forms should not be signed prior to 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 60 minute one-on-one evaluation with your therapist.***

***Please arrive 30 minutes prior to 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*

GOODSHEPHERD PENN PARTNERS | PENN THERAPY & FITNESS

*Official Therapy Provider for* Penn Medicine

# *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 about 90 minutes from registration to completion of the evaluation. Please arrive 30 minutes before your scheduled evaluation time to complete the registration process. The evaluation will take approximately 60 minutes.

### 2) The Initial Evaluation:

Allow approximately 60 minutes for your first visit. Your therapist will ask you questions regarding your condition, perform a physical exam, and then develop an individualized program to help facilitate your recovery. Your recovery depends on you being an active participant, and your program will most likely include a home exercise program.

### 3) What should I wear?

Please wear something that you can move in comfortably. Wear, or bring, sneakers or rubber soled shoes without a heel. You may want to wear, or bring, shorts. If you forget, examination gowns are available.

### 4) Do I really need to do my Home Exercise Program?

Performing 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 program. If an exercise causes discomfort or if you are unsure about an exercise, stop. Your therapist will review with you at your next session.

### 5) When should I return/ How to schedule appointments?

After the examination, your therapist will coordinate with you and determine the appropriate duration and frequency of visits for your course of care. Appointments may be scheduled up to 2 weeks in advance, and we strongly encourage you to do that.

### 6) Canceling and Rescheduling:

In order to achieve the best outcome, it is important that you **attend all scheduled appointments**. If you cannot keep your appointment, please call our office to reschedule. We request **24 hours advance notice**. Patients who miss 2-3 appointments without notifying us may be discharged from our care.

### 7) What if I'm late for an appointment?

In order to give you the best care and the attention that you deserve, please arrive on time for all appointments. If you will be late, please call the office to make us aware. We will do our best to accommodate you. It is possible that you may need to see another therapist, or we may need to reschedule your appointment.

### 8) Will my doctor get a letter?

Yes. Your referring physician will receive a summary of the therapist's initial evaluation, progress notes, and discharge summary.

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.**

| Condition | | Condition | | Condition | |
|---|---|---|---|---|---|
| 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? ______________

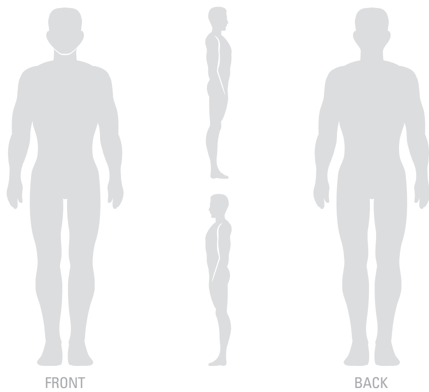
Do you drink alcohol? ❑ Yes ❑ No If yes, how much/often? ______________

**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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# *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.

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 payors

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 time. I may obtain a current copy by contacting the Compliance, Privacy Officer at 215.893.2548.

My signature constitutes my acknowledgement 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 above and record the signatures of two responsible persons who witness that such person understands the nature of this acknowledgement.

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 acknowledgement 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 and with full understanding of its nature.***

### Patient Signing

✕ ____________________ ____________________ __________ __________
PATIENT PRINTED NAME | PATIENT SIGNATURE | DATE | TIME

### Legally Authorized Representative Signing

____________________ ____________________ __________ __________
LEGALLY AUTHORIZED REPRESENTATIVE PRINTED NAME | LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE | DATE | TIME

____________________
RELATIONSHIP TO PATIENT

____________________ ____________________ __________ __________
WITNESS PRINTED NAME | WITNESS SIGNATURE | DATE | TIME

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# *Medicare Secondary Payer Questionnaire*

**ONLY COMPLETE THIS FORM IF YOU HAVE MEDICARE INSURANCE.**

*As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.*

1. Is the illness/injury due to an automobile accident, liability accident or Workman's Compensation? ❑ Yes ❑ No
2. Is illness covered by the Black Lung Program, Veterans Administration or research program? ❑ Yes ❑ No
3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? ❑ Yes ❑ No
4. Is patient covered by a large group health plan through either the patient's employer or spouse's current employer and the plan is primary over Medicare? ❑ Yes ❑ No
5. Medicare Beneficiary's (Patient) Retirement Date ______________________
6. Is the patient entitled to Medicare based on Disability? ❑ Yes ❑ No

## Registrar Notes:

A. If patient responds "no" to question 1-4, Medicare is primary.
B. If patient responds "yes" to any of the first 4 questions, Medicare is secondary and primary insurance information must be obtained.

Name of Insurance Company ______________________

Address of Insurance Company ______________________

Name of Policy Holder ______________________

Policy Number ______________________

Policy Holder's Employee Name ______________________

Policy Holder's Employer Address ______________________

Date of Accident (if applicable) ______________________

## Patient Signing

✗

PATIENT PRINTED NAME | PATIENT SIGNATURE | DATE | TIME

## Legally Authorized Representative Signing

LEGALLY AUTHORIZED REPRESENTATIVE PRINTED NAME | LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE | DATE | TIME

RELATIONSHIP TO PATIENT

WITNESS | DATE | TIME

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# *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.*