

# WELCOME TO

# *Penn Therapy & Fitness*

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# *Arcadia*



GPS ADDRESS ♦ 723 LIMEKILN PIKE, GLENSIDE, PA 19038

PHYSICAL ADDRESS ♦ 310 SOUTH EASTON ROAD, GLENSIDE, PA 19038

☎ 215.887.2648 ♦ FAX: 215.885.2950

*Please call for hours of operation.*



Official Therapy Provider for  Penn Medicine

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[Pennpartners.org/Arcadia](http://Pennpartners.org/Arcadia)



# Driving & Parking Directions to PENN THERAPY & FITNESS Arcadia

310 SOUTH EASTON ROAD ♦ GLENSIDE, PA 19038 ♦ 215.887.2648 ♦ FAX: 215.885.2950

## FROM PHILADELPHIA AND SOUTHERN POINTS:

### *Traveling I-76*

- ♦ Head north on I-476 N
- ♦ Use the 2nd from the left lane to keep left at the fork and stay on I-476 N
- ♦ Use the right 2 lanes to merge onto I-276 E toward New Jersey
- ♦ Use the right 2 lanes to take exit 339 to merge onto PA-309 S toward Philadelphia
- ♦ Take the Easton Rd exit toward PA-152/Glenside
- ♦ Turn left at 152N-destination will be on your right-driveway of the two-story parking garage

### *Traveling PA-611*

- ♦ Head southwest on PA-611 S toward Woodland Rd
- ♦ Turn right onto Canterbury Rd
- ♦ Turn left onto Highland Ave
- ♦ Continue onto Rices Mill Rd
- ♦ Slight left to stay on Rices Mill Rd
- ♦ Turn right onto PA-73 W
- ♦ Turn right onto PA-152 N and the destination will be on the right

## FROM FORT WASHINGTON (PA-309) AND POINTS NORTH:

- ♦ Head south on PA-309 S
- ♦ Take the Easton Road exit toward PA-152/Glenside
- ♦ Turn left onto PA-152N
- ♦ Destination will be at the right-driveway of the two story parking garage

## FROM PLYMOUTH MEETING AND WESTERN POINTS:

- ♦ Head southeast on E Germantown Pike toward Mayflower Rd
- ♦ Continue onto Germantown Ave
- ♦ Turn left onto E Hillcrest Ave
- ♦ Turn right onto Stenton Ave
- ♦ Keep left to stay on Stenton Ave
- ♦ Slight left onto Paper Mill Rd
- ♦ Use the right lane to take the ramp onto PA-309 S
- ♦ Take the Easton Rd exit toward PA-152/Glenside
- ♦ Turn left at 152N-destination will be on your right-driveway of the two-story parking garage

## PARKING

### *From the Easton Road main entrance:*

- ♦ Parking is available right outside our doors in the two-story parking garage.

# 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.*

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*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*

# 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.*

# 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

Frequent Cough  Yes  No

Pneumonia  Yes  No

Sinus Infections  Yes  No

Weight Changes: gain / loss  Yes  No

Frequent Laryngitis  Yes  No

Frequent Sore Throat  Yes  No

Difficulty Swallowing  Yes  No

GERD/Reflux  Yes  No

Poor Appetite  Yes  No

Frequent Nausea / Vomiting  Yes  No

Hearing Loss  Yes  No

Vertigo / Dizziness  Yes  No

TMJ  Yes  No

Cataracts  Yes  No

Glaucoma  Yes  No

Low Blood Pressure  Yes  No

High Blood Pressure  Yes  No

Congestive Heart Failure (CHF)  Yes  No

Heart Disease  Yes  No

Pacemaker  Yes  No

Arthritis  Yes  No

Osteoporosis / Osteopenia  Yes  No

Chronic Back Pain  Yes  No

Peripheral Neuropathy  Yes  No

Aneurysm  Yes  No

Seizure  Yes  No

Stroke / TIA  Yes  No

Circulatory Problems  Yes  No

Blood Clot  Yes  No

Leg Wounds  Yes  No

Diabetes  Yes  No

Kidney Disease / Renal Failure  Yes  No

Thyroid Disorder  Yes  No

Incontinence  Yes  No

Bowel Irregularity  Yes  No

Urinary Frequency / Urgency  Yes  No

Bladder Infections  Yes  No

Tuberculosis  Yes  No

Immune Deficiency  Yes  No

Anxiety  Yes  No

Depression  Yes  No

Panic Attacks  Yes  No

Diagnosis of Cancer  Yes  No

Date diagnosed: \_\_\_\_\_

If yes, state type of cancer \_\_\_\_\_

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: \_\_\_\_\_

# Patient Summary Form, continued

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? \_\_\_\_\_

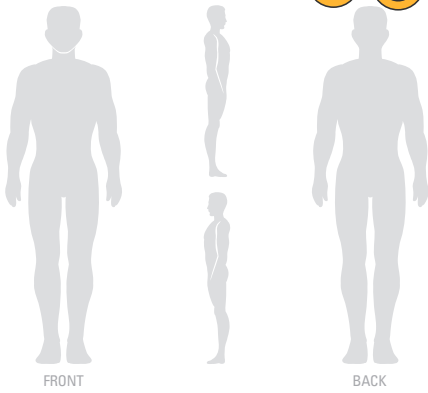
Do you use tobacco?  Yes  No If yes,  Smoke  Chew How much/often? \_\_\_\_\_

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: \_\_\_\_\_

**X** \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ : \_\_\_\_ 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

# 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.

Outpatient Consent & Authorization Form, continued

LABEL AREA

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

X 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



# 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

**X** \_\_\_\_\_  
 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

# HIPAA: Notice of Privacy Practices

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Changes on this notice will not be honored.***

We understand that information about you and your health is very personal and 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 applicable 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. 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 of Privacy Practices 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 a copy may be obtained by mailing a request to the Penn Medicine Privacy Office, Office of Audit, Compliance and Privacy, St. Leonard’s Court, Suite 214, 3819 Chestnut Street, Philadelphia, PA 19104.

The terms of this Notice of Privacy Practices apply to the following entities owned and operated by and/or affiliated with the Trustees of the University of Pennsylvania: the Perelman School of Medicine at the University of Pennsylvania; the University of Pennsylvania Health System and its subsidiaries and affiliates (“Penn Medicine”), including but not limited to the Hospital of the University of Pennsylvania, Pennsylvania Hospital, Penn Presbyterian Medical Center, the Clinical Practices of the University of Pennsylvania (CPUP), Clinical Care Associates (CCA), Clinical Health Care Associates of New Jersey, P.C. (CHCA), Surgery Center of Pennsylvania Hospital, Penn Medicine at Radnor, Penn Center for Rehabilitation and Care, Penn Home Infusion Therapy, Wissahickon Hospice, Penn Care at Home, the Perelman Center for Advanced Medicine, Presbyterian Anesthesiology Foundation, Presbyterian Multi-Specialty Group Practice Foundation, Penn Presbyterian Infusion Services, Endoscopy Center at Pennsylvania Hospital, Good Shepherd Penn Partners, Good Shepherd Penn Partners Specialty Hospital at Rittenhouse, Good Shepherd Penn Partners Penn Therapy & Fitness, and the physicians, licensed professionals, employees, volunteers, and trainees seeing and treating patients at each of these care settings. This Notice of Privacy Practices does not apply when visiting a non-CPUP or non-CCA physician in their private medical office.

## Uses and Disclosures of your PHI

The following categories detail the various ways in which we may use or disclose your PHI. For each category of uses or disclosures, we will give you illustrative examples. It should be noted that while not every use or disclosure will be listed, each of the ways we are permitted to use or disclose information will fall into one of the following categories.

**Your Authorization.** In specific situations, Penn Medicine will not use or disclose your PHI without you signing an authorization form. This form will describe what information will be disclosed, to whom, for what purpose, and when. You have the right to revoke this authorization in writing, except to the extent we have already relied upon it. These situations include:

- ♦ uses and disclosures of psychotherapy notes;
- ♦ uses and disclosures of PHI for marketing purposes, including marketing communications paid for by third parties; and
- ♦ disclosures that constitute a sale of PHI

Except as outlined below, we will not use or disclose your PHI for any other purpose unless you have signed a form authorizing the use or disclosure.

**Uses and Disclosures for Treatment.** We will use and disclose your PHI as necessary for your treatment. For instance, doctors, nurses, and other professionals involved in your care will use information in your medical record to plan a course of treatment for you that may include procedures, medications, tests, etc. We may also disclose your PHI to institutions and individuals outside of Penn Medicine that are or will be providing treatment to you.

**Uses and Disclosures for Payment.** We will make uses and disclosures of your PHI as necessary for payment purposes, subject to your right to Request Restrictions on Disclosures to your Health Plan as outlined below. 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 or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

**Uses and Disclosures for Health Care Operations.** We will use and disclose your PHI as necessary, and as permitted by law, for health care operations. This is necessary to run Penn Medicine and to ensure that our patients receive high quality care and that our health care professionals receive superior training. For example, we may use your PHI in order 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.

**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, will 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. Please let our staff know when you check in or register if you would like to have your information excluded from this directory.

**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 other person that is 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 in order for that entity to locate a family member or other persons that 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.

## HIPAA: Notice of Privacy Practices, continued

**Research.** We may use and disclose your PHI 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.

**Business Associates.** Certain aspects and components of our services are performed through contracts with outside persons or organizations, 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 who assist us with our payment/billing activities and health care operations. 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;
- We may release your PHI for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- We may release your PHI 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;
- We may release your PHI to entities regulated by the Food and Drug Administration, if necessary, to report adverse events, product defects, or to participate in product recalls;
- We may release your PHI 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;
- We may release your PHI if required by law to a government oversight agency conducting audits, investigations, inspections and related oversight functions;
- We may use or disclose your PHI in emergency circumstances, such as to prevent a serious and imminent threat to a person or the public;
- We may release your PHI 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;
- We may release your PHI to law enforcement officials to identify or location suspects, fugitives, witnesses, or victims of crime, or for other allowable law enforcement purposes;
- We may release your PHI to coroners, medical examiners, and/or funeral directors;
- We may release your PHI, if necessary, to arrange an organ or tissue donation from you or a transplant for you;
- We may release your PHI 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
- We may release your PHI if necessary for purposes related to your workers' compensation benefits.

**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. Unless you are currently a patient in our hospital, requests for access must be made in writing and be signed by you or your representative. We will charge you for a copy of your medical records in accordance with a schedule of fees established by applicable state law. You may obtain an access request form from the doctor's office or Medical Records department of the hospital you visited.

**Amendments to Your PHI.** You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. Please note that even if we accept your request, we may not delete any information already documented in your medical record. You may obtain an amendment request form from the doctor's office or hospital you visited.

**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 but, in no event will include disclosures made prior to April 13, 2003. Requests must be made in writing and signed by you or your 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.

**Restrictions on Use and Disclosure of Your PHI.** You have the right to request restrictions on certain of our uses and disclosures of your PHI for treatment, payment, or health care operations. A restriction request form can be obtained from the doctor's office or hospital you visited. 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 and 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.

**Restrictions on Disclosures to Health Plans.** You have the right to request a restriction on certain disclosures of your protected health information to your health plan. We are only required to honor such requests for restriction when you or someone on your behalf, other than your health plan, pay for the health care item(s) or service(s) in full. Such requests must be made in writing, and should identify the services that the restriction will apply to. You may obtain a restriction request form from the doctor's office or hospital you visited.

Please note that Penn Medicine is not required to inform any other providers of your request not to disclose your PHI to a health plan, but will attempt to do so where feasible.

**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 must request such confidential communication in writing to each department to which you would like the request to apply.

**Breach Notification.** We are required to notify you in writing of any breach of your unsecured PHI as soon as possible, but in any event, no later than 60 days after we discover the breach.

**Paper Copy of Notice.** As a patient, you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means. Our Notice may also be obtained 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 or Guest Services department of the hospital 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 of Privacy Practices, you may contact us in writing at: Penn Medicine Privacy Office, Office of Audit, Compliance and Privacy, St. Leonard's Court, Suite 214, 3819 Chestnut Street, Philadelphia, PA 19104 or by telephone at 215.898.7260, or by e-mail at [privacy@uphs.upenn.edu](mailto:privacy@uphs.upenn.edu).

**Effective Date.** This Notice of Privacy Practices is effective September 23, 2013.