

EVAL DATE:

PATIENT INFORMATION			
LAST NAME	FIRST	MI	
ADDRESS (STREET, CITY, STATE ZIP)		SSN	DOB
HOME PHONE	WORK PHONE EXT.	CELL PHONE	
IS INJURY RELATED TO: <input type="checkbox"/> WORK <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER IF WORK, COMPLETE WORK RELATED INJURY INFORMATION BELOW.			
IS A HOME HEALTH AGENCY CURRENTLY PROVIDING NURSING SERVICES IN YOUR HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO			
HAVE YOU HAD ANY THERAPY SERVICES IN THE LAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE NUMBER	
RESPONSIBLE PARTY (IF OTHER THAN PATIENT)			
NAME (PARENT/GUARDIAN/OTHER, WHO BROUGHT MINOR FOR THERAPY)			
RELATIONSHIP TO PATIENT		DATE OF BIRTH	SSN
ADDRESS (STREET, CITY, STATE ZIP)			
HOME PHONE	WORK PHONE EXT.	CELL PHONE	
WORK RELATED INJURY			
EMPLOYER NAME:		CASE MANAGER NAME:	CASE MANAGER PHONE:
EMPLOYER ADDRESS (STREET, CITY, STATE ZIP)		CASE MANAGER FAX:	
EMPLOYER LIABILITY CARRIER		LIABILITY CARRIER ADDRESS	
DATE OF INJURY	CLAIM #:	NUMBER OF VISITS APPROVED:	
TO BE COMPLETED BY OFFICE			
IS THE PATIENT THE SUBSCRIBER? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF NO, THEN: SUBSCRIBER/ POLICYHOLDER NAME:	DOB
SUBSCRIBER/POLICYHOLDER ADDRESS (IF OTHER THAN PATIENT):			
PRIMARY INSURANCE		ID #	GROUP #
INSURANCE EFFECTIVE DATE:		PRE-CERT REQUIRED: <input type="checkbox"/> YES <input type="checkbox"/> NO	
PERSON QUOTING BENEFITS:		PRE-CERT CONTACT:	
DEDUCTIBLE AMOUNT:	DEDUCTIBLE AMOUNT MET:	PRE-CERT INFORMATION:	
COPAY \$:	COINSURANCE %:		
OUT OF POCKET AMOUNT:	OUT OF POCKET AMOUNT MET:	DOES PRE-EXISTING APPLY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
LIMITATIONS/EXCLUSIONS:			
CLAIMS MAILING ADDRESS:			PHONE:

INFORMED CONSENT

I consent to treatment rendered by HighPointe Therapy Services at the Women's Hospital as ordered or approved by my physician. I agree to participate in the therapy program to the best of my ability to facilitate recovery.

AUTHORIZATION FOR DISCLOSURE

I, a patient of ProgressiveHealth of Indiana, give my expressed permission to discuss with the individual(s) I have listed:

Please check appropriate box(es): Any aspect of my health care Health information only Financial information only

Name: _____ Relationship: _____ Phone: (____) _____
 Name: _____ Relationship: _____ Phone: (____) _____
 Name: _____ Relationship: _____ Phone: (____) _____

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

A confidential message (i.e.: appointment reminders) may be left on your telephone answering machine or voicemail.
 If you would like to receive these calls at an alternate number, please list: (____) _____

PATIENT/GUARANTOR SIGNATURE

DATE

PATIENT NAME:

DATE OF BIRTH:

Month Day Year

SEX: Male Female

RACE

- Asian
- Native Hawaiian/
Pacific Islander
- Black
- White

ETHNICITY

- Hispanic or Latino
- Not Hispanic or Latino

LANGUAGE

- English understood?
- Interpreter needed?
- Language you speak most often: _____

EDUCATION:

Highest grade completed (Circle one): 1 2 3 4 5 6 7 8 9 10 11 12

- Some college / technical school
- College graduate
- Graduate school / advanced degree

SOCIAL HISTORY:

Cultural/Religious

Any customs or religious beliefs or wishes that might affect care?

With whom do you live?

- Alone
- Spouse and other(s)
- Other relative(s) (not spouse or children)
- Group setting
- Other: _____
- Spouse only
- Child (not spouse)
- Personal care attendant

Have you completed an advance directive?

- Yes
- No

Who referred you to the physical therapist?

Employment / Work (Job/School/Play)

- Working full-time outside home
- Working part-time outside home
- Working full-time from home
- Working part-time from home
- Homemaker
- Student
- Retired
- Unemployed

Occupation: _____

Employer: _____

LIVING ENVIRONMENT:

Does Your home have:

- Stairs, no railing
- Stairs, railing
- Ramps
- Elevator
- Uneven terrain
- Assistive devices (eg, bathroom): _____
- Any obstacles: _____

Do you use:

- Cane
- Walker or rollator
- Manual wheelchair
- Motorized wheelchair
- Glasses, hearing aids
- Other: _____

Where do you live?

- Private home
- Rented Room
- Homeless (with or without shelter)
- Long-term care facility (nursing home)
- Other: _____
- Private apartment
- Board & care/assisted living/group home
- Hospice

Do you have any sensitivity to latex that you are aware of?

- Yes
- No

TODAY'S DATE: _____

GENERAL HEALTH STATUS:

At the present time would you say your health is:

- Excellent
- Very Good
- Fair
- Poor

Have you had any major life changes during past year? (eg, new baby, job change, death of a family member?) Yes No

SOCIAL / HEALTH HABITS:

Smoking:

1. Currently smoke tobacco? Yes Cigarettes # packs per day _____
 Cigars/Pipes # per day _____
 No
2. Smoked in the past? Yes: **Year Quit:** _____ No

Alcohol:

1. How many days per week do you drink beer, wine, or other alcoholic beverages, on average? _____
2. If one beer, one glass of wine, or one cocktail equals one drink how many drinks do you have, on an average day? _____

Exercise:

- Do you exercise beyond normal daily activities and chores?
- Yes. Describe the exercise: _____
On average how many days per week do you exercise or do physical activity? _____
For how many minutes, on an average day? _____
 - No.

FAMILY HISTORY:

(Indicate whether mother, father, brother/sister, aunt/ uncle, or grandmother/grandfather, and age of onset if known):

- Heart disease _____
- Hypertension _____
- Stroke: _____
- Diabetes: _____
- Cancer: _____
- Psychological: _____
- Arthritis: _____
- Osteoporosis: _____
- Other: _____

MEDICAL / SURGICAL HISTORY:

Please check if you have ever had:

- Arthritis
- Broken bones / fractures
- Osteoporosis
- Blood disorders
- Circulation/vascular problems
- Heart problems
- High blood pressure
- Lung problems
- Stroke
- Diabetes / high blood sugar
- Low blood sugar/hypoglycemia
- Head injury
- Depression
- Other: _____
- Multiple sclerosis
- Muscular dystrophy
- Parkinson disease
- Seizures / epilepsy
- Allergies
- Developmental/growth problems
- Thyroid problems
- Cancer
- Infectious disease (e.g. hepatitis)
- Kidney problems
- Repeated infections
- Ulcers / stomach problems
- Skin diseases

Within the past year, have you had any of the following symptoms?

(Please check all that apply)

- Chest pain
- Heart palpitations
- Cough
- Hoarseness
- Shortness of breath
- Dizziness or blackouts
- Coordination problems
- Weakness in arms or legs
- Loss of balance
- Difficulty walking
- Joint pain or swelling
- Pain at night
- Difficulty sleeping
- Loss of appetite
- Nausea / vomiting
- Difficulty swallowing
- Bowel problems
- Weight loss / gain
- Urinary problems
- Fever / chills / sweats
- Headaches
- Hearing problems
- Vision problems
- Other: _____

Have you ever had surgery? Yes No
 If yes, please describe, and include dates: _____

For men only: Have you been diagnosed with prostate disease?
 Yes No

For women only: Have you been diagnosed with:
 Pelvic inflammatory disease Pregnant, or think you might be pregnant?
 Endometriosis Trouble with your period Other gynecological or obstetrical difficulties?
 Complicated pregnancies or deliveries

CURRENT CONDITION(S) / CHIEF COMPLAINT(S):
 Describe the problem(s) for which you seek physical therapy:

When did the problem(s) begin (date)? _____
 What happened? _____

Have you ever had the problem(s) before?
 Yes.
 What did you do for the problem(s)? _____
 Did the problem(s) get better? Yes No
 No.

How are you taking care of the problem(s) now? _____
 What makes the problem(s) better? _____
 What makes the problem(s) worse? _____
 What are your goals for physical therapy? _____

Are you seeing anyone else for the problem(s)? (Check all that apply)
 Acupuncturist Occupational therapist
 Cardiologist Orthopedist
 Chiropractor Osteopath
 Dentist Pediatrician
 Family practitioner Podiatrist
 Internist Primary care physician
 Massage therapist Rheumatologist
 Neurologist Other: _____
 Obstetrician/gynecologist

How has the injury affected you emotionally?
 Depression Withdrawal
 Anger Anxiety
 None Other _____

What is the severity of your emotional reaction?
 Scale of 1(low) – 10 (high) _____

FUNCTIONAL STATUS / ACTIVITY LEVEL:
 (Check all that apply)
 Difficulty with locomotion / movement:
 Bed mobility
 Transfers (such as moving from bed to chair, from bed to commode)
 Gait (walking)
 On level On ramps
 On stairs On uneven terrain
 Difficulty with self-care (such as bathing, dressing, eating, toileting)
 Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)
 Difficulty with community and work activities/integration
 Work / school
 Recreation or play activity

MEDICATIONS:
 Do you take any prescription medications? Yes No
 If yes, please list: _____

Do you take any non-prescription medications? (Check all that apply)
 Advil/Aleve Decongestants
 Antacids Herbal supplements
 Ibuprofen/Naproxen Tylenol
 Antihistamines Other: _____
 Aspirin

Have you taken any medications previously for the condition for which you are seeing the physical therapist? Yes No
 If yes, please list: _____

OTHER CLINICAL TESTS: (Please list)

ANY COMMUNICATION DIFFICULTIES:
 (Check all that apply)
 Speech Hearing
 Short term memory Long term memory

Assignment of Insurance Benefits: I hereby authorize my signature on all insurance claim forms at the offices of **High Pointe Rehab** for payment directly to them for services rendered to me/patient. I authorize this office to make and seal copies of medical records that may be needed to file my insurance claims. I understand that I/patient am responsible for charges incurred regardless of whether my insurance pays or not. I/patient also understand that I am responsible for any attorney fees and court costs incurred in collecting any unpaid balances for services I/patient received. I agree that this statement applies to all current and future claims.

* **Any DME or special supplies require payment at time of service; we will assist patient with filing insurance.**

I have reviewed the above information and agree with all statements.

CLIENT: _____ **DATE:** _____

Reviewed with patient: _____ **DATE:** _____
THERAPIST: _____

PELVIC FLOOR FUNCTIONAL QUESTIONNAIRE

The following questions may take some time to complete and are personal, however their completion before your evaluation will allow us to be very focused in our assessment and decrease the cost of your treatment. Please indicate which of the following answers best complete the question for your symptoms. If leakage of stool or urine is not one of your symptoms, skip to question #8 and proceed. Thank you.

Patient Name _____

Date _____

- 1. Leakage of:**
- No Leakage
 - Urine
 - Stool
 - Urine & Stool

- 9. Pain location:**
- Rectal
 - Vaginal
 - Abdominal
 - Low back
 - Gluteal

- 2. Frequency of leakage:**
- | | <u>Urine</u> | <u>Stool</u> |
|--------------------|--------------------------|--------------------------|
| Never | <input type="checkbox"/> | <input type="checkbox"/> |
| Less than 1x/month | <input type="checkbox"/> | <input type="checkbox"/> |
| More than 1x/month | <input type="checkbox"/> | <input type="checkbox"/> |
| Less than 1x/week | <input type="checkbox"/> | <input type="checkbox"/> |
| More than 1x/week | <input type="checkbox"/> | <input type="checkbox"/> |
| Almost every day | <input type="checkbox"/> | <input type="checkbox"/> |
| More than 1x/day | <input type="checkbox"/> | <input type="checkbox"/> |

- 10. Frequency of pain:**
- Never
 - More than 1x/month
 - More than 1x/week
 - Less than 1x/week
 - Almost every day
 - More than 1x/day
 - Constant

- 3. Number of pads used/day:**

- 11. Intensity of pain: 0 = no pain, 10 = severe pain**

- 4. Type of pads used:**
- None worn
 - Panty shields
 - Mini pads
 - Maxi pads
 - Serenity/Poise

- 0**
- 1-2**
- 3-5**
- 6-8**
- 9-10**

- 5. Severity/Incident:**
- | | <u>Urine</u> | | <u>Stool</u> |
|---------------|--------------------------|-------------|--------------------------|
| Few drops | <input type="checkbox"/> | Smear/stain | <input type="checkbox"/> |
| Wet underwear | <input type="checkbox"/> | Small amt. | <input type="checkbox"/> |
| Wet outerwear | <input type="checkbox"/> | Med/lg amt | <input type="checkbox"/> |

- 12. Prolapse (feeling of pressure or falling out):**
- Never
 - 1x/month with period
 - Pressure at end of day
 - Pressure with straining
 - Pressure with standing
 - Pressure all day

- 6. Position/activity which causes leakage:**
- Any position/no activity required
 - Lying to sitting to standing
 - Strong urge
 - Coughing, laughing, sneezing

- 13. Frequency of urination:**
- Day:**
- every 5 or more hours
 - every 3 – 4 hours
 - every 2 1/2 hours
 - every 2 hours
 - every 1 1/2 hours

- 7. Able to delay the need to urinate or have bowel movement:**
- | | <u>Urine</u> | <u>Stool</u> |
|------------------|--------------------------|--------------------------|
| Indefinitely | <input type="checkbox"/> | <input type="checkbox"/> |
| More than 1 hour | <input type="checkbox"/> | <input type="checkbox"/> |
| 1/2 hour | <input type="checkbox"/> | <input type="checkbox"/> |
| 15 minutes | <input type="checkbox"/> | <input type="checkbox"/> |
| 1 - 2 minutes | <input type="checkbox"/> | <input type="checkbox"/> |
| Not at all | <input type="checkbox"/> | <input type="checkbox"/> |

- Night:**
- 0 x/night
 - 1x/night
 - 2x/night
 - 3x/night
 - 4x/night

- 8. Fluid intake per day (8 oz. glasses):**
- 9+ drinks/day
 - 6 - 8
 - 3 - 5
 - 1 - 2
- Number of caffeinated drinks/day _____

- 14. Difficulty starting urination or having bowel movement:**
- | | <u>Urine</u> | <u>Stool</u> |
|--------------------|--------------------------|--------------------------|
| Never | <input type="checkbox"/> | <input type="checkbox"/> |
| More than 1x/month | <input type="checkbox"/> | <input type="checkbox"/> |
| More than 1x/week | <input type="checkbox"/> | <input type="checkbox"/> |
| Almost every day | <input type="checkbox"/> | <input type="checkbox"/> |

15. Frequency of bowel movements:

- 2x/day
- 1x/day
- Every other day
- Once every 4 - 7 days
- Other

17. How I feel about this problem:

- No problem
- Minor inconvenience
- Slight problem
- Moderate problem
- Major problem

16. Ability to stop flow of urine:

- Can stop immediately
- Can maintain a deflection in stream
- Can partially deflect stream
- Unable to deflect slow stream

18. Confidence in my ability to control this problem:

- Complete confidence
- Moderate confidence
- Little confidence
- No confidence

What do you consider your main problem?

Briefly describe how this problem has affected your life

Date of last pelvic exam _____ Date of last urinalysis _____

Are you sexually active? Yes No

History of / or present sexually transmitted diseases? Yes No

If yes, what type? _____

Pain or problems with intercourse, urination, bowel movements (please explain):

Have you ever been taught how to do pelvic floor or Kegel exercises? Yes No

If yes, by whom? _____

How often do you perform pelvic floor exercises? _____

Do you have any metal/plastic implants? Yes No

Do you have any comments or concerns not addressed in this questionnaire?

Patient Signature

Date

Acct# _____
Patient _____
Medical Record # _____

**Financial Responsibility/Assignment
The Women's Hospital
Newburgh, IN 47630**

AGREEMENT TO PAY SERVICES RENDERED

The Patient is responsible for paying the amount of all charges for medical services and products ("medical charges") in accordance with the regular rates. We accept cash, check, Visa, MasterCard, American Express and Discover. Patients or responsible parties should be proactive in arranging for payment of all medical charges. Please contact our Financial Counseling Services at 812-842-4240 if you have questions or need assistance.

In consideration of The Women's Hospital and all associated providers rendering medical services and products for the above named Patient, the undersigned agree to be jointly and severally responsible with the Patient for all medical charges. In the event the Patient is not insured, or insurance does not cover all medical charges, we agree to pay the uninsured portion of the medical charges, which amount is entirely due and payable at the time of the Patient's discharge. I/we understand that past due patient accounts that are not subject to financial agreements with The Women's Hospital and associated providers will be submitted to a collection agency. I/we agree that I/we will pay all attorney fees and court costs incurred by The Women's Hospital and associated providers, in the collection of all sums due The Women's Hospital and associated providers.

WORKER'S COMP/LIABILITY/AUTO ACCIDENT

If the reason for my visit is related to a workers comp claim, liability claim, or auto accident, I understand that I am responsible for providing The Women's Hospital and associated providers with complete billing information, including police report, claim number, etc. as appropriate, within seven (7) business days. I understand that if I do not provide this information or these claims are denied, the balances then become the patient's responsibility.

PHYSICIAN FINANCIAL INTEREST DISCLOSURE

Deaconess Women's Hospital of Southern Indiana is a limited liability company organized under the laws of the State of Indiana. The hospital is privately owned, and a portion of our ownership includes a group of physicians. If you would like to receive a list of the physicians who are hospital owners, please ask your admitting representative. This disclosure is provided in accordance with Centers for Medicare and Medicaid Services.

ASSIGNMENT OF INSURANCE AND/OR EMPLOYEE PLAN BENEFITS TO HOSPITAL AND DOCTORS

In consideration of services rendered from time to time by The Women's Hospital and associated providers, all attending and consulting physicians and any ancillary services or other similar services rendered to me or to a member of my family, I hereby assign all insurance and/or employee plan benefits which I have or to which I may have a right. This assignment is a relinquishment and assignment of all legal or equitable interest which I have in any insurance and/or employee plan benefits which exist by reason or contract or otherwise, including, but not limited to Major Medical and other special coverages; this assignment includes the right to pursue any and all claims procedures or other administrative remedies available to me under any insurance policy or employee benefit plan or under any state or federal law, including the right to appeal any adverse benefit determinations thereunder; this assignment includes the right to bring a civil action in state or federal court to recover benefits due me under the terms of any insurance policy or employee benefit plan; this assignment may not completely discharge my full indebtedness to The Women's Hospital and all associated providers; this assignment is irrevocable except upon full payment of all indebtedness, or by express written agreement between The Women's Hospital and associated providers, and the undersigned; this assignment does not constitute payment for indebtedness and does not relieve the undersigned from liability for unpaid indebtedness. In the event that insurance and/or employee plan benefits to which I am entitled are paid directly to me for indebtedness incurred by me or a member of my family, or a person for whom I am financially responsible, I agree that I will immediately deliver all such benefits received.

AUTHORIZATION FOR RELEASE OF INFORMATION BY HOSPITAL AND DOCTORS

The Women's Hospital and all associated providers, all attending and consulting physicians and any ancillary services or other similar services are hereby authorized to furnish such professional information, in accordance with the policy of said hospital and the physicians, as may be necessary for the completion of my claim from the medical records compiled from time to time during treatment. The Women's Hospital and all associated providers, and said physicians are hereby released from all legal liability that may arise from the release of the information requested.

I have read the above and foregoing assignment of insurance benefits, promise to pay, and authorization for release of information and fully understand the terms thereof.

_____ and/or _____
Patient Guarantor, Relative or Representative

_____ Date _____ SS# of Signer
Witness

DEACONESS HEALTH SYSTEM
JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU WILL BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice applies to all the health records that we maintain for you. We are required by law to maintain the confidentiality of your health information and to give you this Notice describing our practices and legal duties and your rights regarding your health information. We must follow the terms of the Notice that is in effect. The practices described in this Notice apply to all our employees, volunteers, students-in-training, contract staff, members of our medical staff and their employees who may perform tasks at any of our locations, and any other persons authorized to make entries into or obtain information from your medical record. The terms of this Notice apply to all inpatient and outpatient services of these Deaconess Health System (DHS) facilities: Deaconess Hospital, (including the Mary Street, Gateway and Cross Pointe campuses), The Heart Hospital, The Women's Hospital, Deaconess Clinic, Evansville Surgery Centers, the Breast Center and Progressive Health of Indiana. These services will be collectively referred to in this Notice as 'DHS'.

We Will Use and Disclose Information for Treatment, Payment, and Operational Purposes

When you seek medical treatment in DHS, your information may be used within DHS and disclosed outside of DHS for the purposes described below.

Treatment: Information gathered by the persons treating you is entered into your record and used to determine your course of treatment and response. This information may be shared with other parties involved in your care including consulting health care providers, your primary care physician, other facilities to which you may be transferred, and other health care providers treating you.

Payment: We may use your information to verify your insurance coverage. A bill will be sent to you and your insurer or some other third party identified as a payer for your claim. We may disclose billing information to other health care providers involved in your care so that they have correct billing information. If you are overdue in paying your bill, information about you may be shared with collections agencies.

Health Care Operations: We will use your health information for operational purposes including but not limited to staff assessment and training, education programs, and quality reviews of our treatment and business processes. Limited information about inpatients may be shared with Deaconess Administrators or the Deaconess Foundation so they are aware of the presence of persons in our hospitals. Your health information may be disclosed to students or visiting observers who observe treatment and other processes during supervised programs within our facilities such as the Health Science Institute. Your health information may be disclosed to other providers involved in your care for their own health care operations.

Contacting you: We may contact you via telephone or mail regarding your appointments or other matters. We may leave voice messages at the number you have provided us.

Health Care Coordination, Related Services and Products: We may use or disclose your information to coordinate your care, and to advise you of alternative therapies, settings of care, or providers. We may use or disclose your information so that someone may contact you about services available at or through Deaconess Health System. We may tell you about another company's products or services in face-to-face communications. We may use and disclose your health information to send you a promotional gift from us that is of minimal value.

Business Associates: We may disclose your health information to certain third parties known as Business Associates who contract with us to perform certain services on our behalf. These third parties are obligated by law and by their contract to take certain steps to protect your health information.

Limited Data Sets and De-Identified Information: We may disclose some of your information as a 'limited data set' for use in research, certain public health purposes or for our operational needs. Information that does not identify you in any way is considered to be 'de-identified' and can be used or disclosed for any purpose.

Marketing and Fundraising: Information about you may be shared among DHS entities for marketing of services of DHS entities. We may use limited non-medical information to contact you in order to raise money for the Deaconess Foundation.

Sharing Information With Family, Relatives, Friends and Others Involved in Your Care or Payment for Your Care

If you agree verbally or do not voice an objection we will use your information in the following circumstances.

Hospital Directory: Unless you object, we may include your name, location in the hospital, and religious affiliation in a hospital Directory. If anyone asks for you by name, we will give them your room and telephone number and may briefly state your general condition. We may also contact your church to advise your minister that you are here. If you do not wish others to know that you are here or if you specifically do not wish your church to be notified, please let the registration desk know as soon as possible on your admission. **We do not list mental health patients in Unit 4200 (Mary Street campus) or at Cross Pointe in our Directory.**

Emergency Notification: If you are treated in an emergency situation and do not object, we may notify members of your family or other persons you identify that you are here. If you are admitted during a disaster, we may notify the Red Cross or other agency responsible for family notification that you are here.

Communication with Family, Friends and Others: Unless you object, we may discuss your health care with members of your family, close friends or other individuals you identify who may be involved in your care or the payment for your care. If you are admitted to our mental health facilities, no information about you will be shared with your family, friends or others identified by you unless you give us written permission to do so. If we determine it is appropriate to do so, we may permit your family or friends to act on your behalf to pick up your prescriptions, supplies, x-rays or other items. We will share information about a minor child with a non-custodial parent unless we have received a court order or decree prohibiting such sharing.

When It Is Reasonable to Assume That You Do Not Object: If you request that a family member or friend be present during an examination or discussion or you do not request them to leave, we will assume that you do not object to information about you being discussed in the presence of that person.

If you are unable to tell us whether you agree or object to a disclosure for any of the reasons listed in this section, we may discuss your treatment or your bill with your family, relative, close friend or other persons involved in your care or payment for your care. In these cases, we would share only what is important for them to know if, based on our professional judgment, we decide that it is in your best interest for information to be shared.

Uses or Disclosures for Research or When Authorized by Law

We may use or disclose your health information without your permission in the following circumstances, subject to all applicable laws.

- For research activities under certain limited circumstances and subject to a special approval process.
- When required to do so by federal, state or local law.
- To prevent a serious threat to the health and safety of you, another person or the general public.
- To organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- If required by the appropriate military command authority (military patients only)
- To report findings and treatment of your workers' comp injury to your employer, case manager, other health care providers and insurer as permitted or required by state law.
- To local, state or federal public health authorities for various public health activities including: recording births and deaths; reporting certain illnesses, injuries or communicable diseases; reporting unanticipated medication reactions, problems with medical devices or other unanticipated problems with your care; tracking, recall and post market surveillance of FDA regulated products; notifying you that you may have been exposed to a disease or may be at risk for contracting or spreading a disease. Information relating to your emergency room visit is communicated to the Indiana State Department of Health for communicable disease and counterterrorism monitoring.
- To report known or suspected child or adult abuse, neglect or endangerment to the appropriate state agencies or law enforcement authorities.
- To health oversight agencies who monitor our compliance with the law. In addition, individual employees, volunteers, students-in-training or Business Associates may use or disclose information about you in a 'whistleblower' action.

- In response to a court or administrative order or other court action that compels release of the information.
- To local, state or federal law enforcement officials when required by law, to identify or locate persons in our facilities, to report known or suspected criminal activity or when necessary to provide for national or state security.
- To a coroner or medical examiner or funeral director as authorized by law.

Other Uses and Disclosures of Health Information

Records of Mental Health and Alcohol or Substance Abuse Patients: If you are receiving mental health, alcohol or substance abuse treatment, your records may be subject to additional protections under federal or state law. Please contact the facility Privacy Officer or Medical Records Manager with any questions you may have using the address or telephone number provided below.

Incidental Uses and Disclosures: Although we take safeguards to avoid this, it is possible that in the course of a lawful use or disclosure of your health information, information is overheard or seen by someone other than the intended recipient of the information.

Uses and Disclosures Not Covered By This Notice: Uses and disclosures not covered by this Notice or the laws that apply to us will be made only with your written permission. You may, in most cases, revoke that permission, in writing, at any time. Note that we are unable to recover information that was previously disclosed with your permission. We are required to retain our records of the care that we provide to you for a mandated length of time. We cannot accept a revocation of your written permission when it was given as a condition of obtaining insurance coverage since other laws give the insurer the right to contest a claim under the insurance policy.

If you refuse to give your written permission for release of information, we may not refuse to treat you unless 1) your written permission is required as a condition of participation in research related treatment, or 2) the only reason for the health care encounter is to create health information for release to a third party (ex. A pre-employment physical or OSHA mandated testing for your employer.)

Your Rights Regarding Your Health Information

You may exercise the following rights by contacting the facility where you received your services.

Right to Inspect and Copy: With some exceptions you have the right to inspect and obtain a copy (for a fee) of the information we maintain on you in your medical records, billing records and other records used to make decisions about your care. Your request must be in writing. You may request an electronic copy of your electronically maintained medical records. We may deny your request to inspect and copy your information in certain limited circumstances. You may request review of a denial.

Right to Correct or Update Your Information: If you believe that your health records are incorrect or incomplete, you may request that we amend the records. You have the right to request an amendment for as long as we keep your information. Your request must be in writing. We will deny your request 1) if you do not provide a reason for the requested changes, or 2) if the information was not created or maintained by us, or 3) if the information is not within the records you are permitted to inspect and copy, or 4) if the information in your records is accurate and complete.

Right to a List of Certain Disclosures: We are required to keep a list of certain (*but not all*) disclosures we make of your health information and you are entitled to a copy of that list. Your request must be in writing. You must state the time period for which you want the list of disclosures, but the time period can not be longer than the preceding six years, and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. However, if you request additional lists during this period, we will charge you for the costs of providing the list.

Right to Request Restrictions: You have the right to request that we limit the use or disclosure of your health information for treatment, payment or health care operations. You also have the right to request that we limit the information we disclose to your family, friends or others involved in your care or payment for care. Your request for restriction must be in writing. Provided you have paid out-of-pocket in full for the service received, we will honor any request you make to restrict information about those services from your health plan provided that such release is not necessary for your treatment. In all other circumstances, we are not required to agree to your request for restriction nor provide a reason for our denial. We will not accept restriction on information when release is required or permitted by law or when we do not have the technical means to enforce a restriction. We cannot restrict information disclosed prior to your request for restriction. If we accept your request for restriction, we will comply with the request except if the information is needed to provide you emergency treatment. If we later decide to reverse our decision to accept a restriction, you will be notified in writing.

Right to Request Alternative Delivery of Information: You have the right to request that we communicate with you about health matters via alternative means or at alternative locations. *For example,* you may request that we only telephone you at work or that we mail your records to you at a location other than your home. Any request for alternative delivery of information must be made in writing and must specify how or where you wish to be contacted. We will accommodate requests that we can reasonably meet. Provided that you give clear and conspicuous instruction to do so, we will send an electronic copy of your electronically maintained records to you or to other parties you have designated.

Right to a Paper Copy of this Notice: You may obtain a paper copy of this Notice from any registration desk in a DHS facility or from our website at www.deaconess.com.

Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in each DHS facility. The Notice will contain on the first page, in the top right-hand corner, the effective date of the Notice. You may obtain a revised notice at any registration desk.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with the facility or with the Secretary of the Department of Health and Human Services.

TO FILE A COMPLAINT, PLEASE CONTACT:

Facilities	Contact
Deaconess Hospital – all inpatient campuses and all outpatient services including COMP Center, Chancellor Center, Deaconess Urgent Care	Privacy Officer 812 450-7223
The Women’s Hospital	Compliance/Regulatory Officer 812 842-4332
The Heart Hospital	Quality and Regulatory Specialist 812 842-3228
Deaconess Clinic	Practice Administrator 812 426-9404
Evansville Surgery Centers	HIPAA/Compliance Coordinator 812 250-0124
The Breast Center	Privacy Officer 812 450-7223
Progressive Health of Indiana	Compliance Officer 417 353-1495
Not sure who?	Deaconess Health System Privacy Officer 812 450-7223

**Questions regarding this Notice may be directed to:
 Privacy Officer
 Deaconess Health System
 600 Mary Street, Evansville, IN 47747
 812 450-7223.**

YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES

I have received a Notice of Privacy Practices from The Women's Hospital.

Date: _____ Signature: _____
(May only be signed by patient, guardian, Power of Attorney or parent of minor child)

A Notice was provided but no acknowledgement received

Notice was provided but no acknowledgement of receipt was obtained due to:

- | | |
|---|---|
| <input type="checkbox"/> Patient refused | <input type="checkbox"/> Patient asleep/unconscious |
| <input type="checkbox"/> Patient too ill to sign | <input type="checkbox"/> Emergent condition |
| <input type="checkbox"/> Patient unlikely to comprehend | |

Witness: _____ Date: _____
May be signed by family or staff.

Affix patient label here or print

Patient name: _____

Patient DOB: _____