



EVAL DATE:

**PATIENT INFORMATION**

LAST NAME		FIRST	MI
ADDRESS (STREET, CITY, STATE ZIP)			
ADDRESS CON'T		SSN	DOB
HOME PHONE	WORK PHONE	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			

<b>EMERGENCY CONTACT NAME</b>	<b>RELATIONSHIP</b>	<b>PHONE NUMBER</b>
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**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	CELL PHONE
	EXT.	

**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):		
<b>PRIMARY INSURANCE</b>	<b>ID #</b>	<b>GROUP #</b>
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:

INITIALS	I confirm that my quote of benefits has been provided to me and I have been given the opportunity to address any questions with the front office staff regarding this quote.
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**INFORMED CONSENT**

I consent to treatment rendered by Deaconess Hospital's Physical Medicine Dept. as ordered or approved by my physician. I agree to participate in Deaconess Hospital's Physical Medicine Dept. program to the best of my ability to facilitate a rapid and full recovery.

I consent to having my picture taken for objective analysis of my condition. This information will be used solely for the purpose of education of myself for my condition and to compare pre and post treatment outcomes. Any other use of this information will require my written consent.

I understand that some increase in pain may be normal. I must determine how much pain increase is acceptable to me, and I may be asked to describe any pain using a Visual Analog Scale. I will not be asked to perform activities that increase my pain to a level that is unsafe or undesirable to me. I will be asked to perform activities, but will not be forced to perform any activity that I believe unsafe. I will be informed if I'm seen doing anything unsafe or that jeopardizes my recovery.

**CONSENT FOR RELEASE OF INFORMATION**

Insurers may release to Deaconess Hospital's Physical Medicine Dept. any information regarding the extent of my insurance coverage, information concerning the status of claims submitted by Deaconess Hospital's Physical Medicine Dept., and information regarding payments made directly to me on those claims. Deaconess Hospital's Physical Medicine Dept. may obtain any information and/or medical records pertinent to "treatment" provided from hospitals, physicians, nursing agencies, and other health care providers, Pursuant to the privacy rule 45CFR164.501 of HIPAA, "treatment" generally means the provision, coordination, or management of health care and related services among providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

I understand that Deaconess Hospital's Physical Medicine Dept. has provided me with a copy of their Notice of Privacy Practices, which states how my personal health information (PHI) may be used or disclosed and outlines my rights regarding this information. I understand that Deaconess Hospital's Physical Medicine Dept. has the right to change this notice at any time and that I must request in writing any objections to any of these "uses" or "disclosure". I may obtain an additional copy of this notice from this office per my request.

**Please check one of the following statements:**

- I received a copy of the Privacy Practices
- I declined a copy of the Privacy Practices

**AUTHORIZATION FOR DISCLOSURE**

I, a patient of Deaconess Hospital's Physical Medicine Dept., 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: (\_\_\_\_) \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

**I understand that I am ultimately responsible for the charges incurred for my services at Deaconess Hospital's Physical Medicine Dept., whether the Benefits are through Commercial Insurance, Workers' Compensation or a Third-Party Payor (i.e.: auto accident).**

I also understand that additional information may be required of me to assist Deaconess Hospital's Physical Medicine Dept. in filing such claims. I may have to provide information from the following list regardless of my insurance:

- Social Security Number
- Date of Birth
- Copy of Insurance Card (for commercial filing and/or workers' compensation)
- Name of employer, Employer address, phone number and contact person
- Auto Insurance

**Deaconess Hospital's Physical Medicine Dept. will file my insurance claims as a courtesy, and I understand that any quoted benefits given at the time of service are not a guarantee of payment. I assign all benefits paid by insurance to be paid directly to Deaconess Hospital's Physical Medicine Dept. By my signature below I acknowledge my responsibility and assign said benefits and verify that I have read and agree to the terms of Deaconess Hospital's Physical Medicine Dept. Payment Policy.**

\_\_\_\_\_  
**PATIENT NAME**

\_\_\_\_\_  
**SIGNATURE OF PATIENT/GUARDIAN**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**WITNESS**



MEDICAL HISTORY QUESTIONNAIRE (PLEASE PRINT)		
PATIENT LAST NAME	FIRST	MI
DATE OF ONSET OF INJURY/CONDITION:	FAMILY PHYSICIAN	REFERRING PHYSICIAN
HAVE YOU EVER HAD SURGERY FOR THIS INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, TYPE OF SURGERY:	DATE OF SURGERY:
HAVE YOU HAD PREVIOUS PHYSICAL THERAPY FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU BEEN ADMITTED OR DISCHARGED FROM A PART A STAY AT DEACONESS HOSPITAL WITHIN THE PAST 72 HOURS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU PREGNANT OR THINK YOU MIGHT BE PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOW HAS YOUR INJURY AFFECTED YOU EMOTIONALLY? <input type="checkbox"/> DEPRESSION <input type="checkbox"/> WITHDRAWAL <input type="checkbox"/> ANGER <input type="checkbox"/> ANXIETY <input type="checkbox"/> NONE <input type="checkbox"/> OTHER, PLEASE LIST:		
WHAT IS THE SEVERITY OF YOUR EMOTIONAL REACTION? SCALE OF 1(LOW) - 10(HIGH)	WHO IS YOUR FAMILY/COMMUNITY SUPPORT?	
LIST ALL MEDICATION (S) YOU ARE ALLERGIC TO:		
DO YOU HAVE ANY SENSITIVITY TO LATEX THAT YOU ARE AWARE OF? <input type="checkbox"/> YES <input type="checkbox"/> NO		
LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING, EITHER PRESCRIPTION OR NON-PRESCRIPTION:		
PLEASE LIST ANY OTHER HEALTH CARE PROFESSIONALS WHOSE CARE YOU ARE CURRENTLY UNDER FOR THIS CONDITION:		
IS THERE ANY OTHER INFORMATION THAT WOULD ASSIST US WITH YOUR CARE?		

<b>HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?</b>	
<p><b>YES NO</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest Pain or Shortness of Breath</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Diseases</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke or TIA</p> <p><input type="checkbox"/> <input type="checkbox"/> Congestive Heart Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Clots</p> <p><input type="checkbox"/> <input type="checkbox"/> Circulation Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizure Disorder or Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma, Emphysema or Bronchitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Chemical Dependency</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Arthritis Conditions</p> <p><input type="checkbox"/> <input type="checkbox"/> Fibromyalgia</p>	<p><b>YES NO</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Infectious Diseases</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Headaches Frequent/Severe</p> <p><input type="checkbox"/> <input type="checkbox"/> Hearing/Vision Difficulties</p> <p><input type="checkbox"/> <input type="checkbox"/> Numbness or Tingling</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Weakness</p> <p><b>Surgery or Injury of any of the following:</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Neck-Type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Back-Type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Shoulder-Type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Elbow-type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Hand-Type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Hip-Type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Knee-Type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Ankle or Foot-Type: _____</p>

\_\_\_\_\_  
**THERAPIST SIGNATURE**

\_\_\_\_\_  
**DATE**

Deaconess Health System  
Medicare Secondary Payer Questionnaire

Patient Account No: \_\_\_\_\_ Date of Service: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Medicare No: \_\_\_\_\_

Information Supplied By: \_\_\_\_\_ Relationship: \_\_\_\_\_

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1. What is the name of your spouse: \_\_\_\_\_
  
2. Is patient insured by a group health plan due to current employment of self?  Yes  No  
How many employees work for the sponsoring employer?  Yes  No  
 Don't know  1-19  20-99  100 or more Date coverage began: \_\_\_\_\_  
*(If yes, EGHP is primary. Collect appropriate insurance information.)*
  
3. Is patient insured by an employer group health plan due to current employment of spouse or other family member?  Yes  No  
  
How many employees work for the sponsoring employer?  Yes  No  
 Don't know  1-19  20-99  100 or more  
*(If yes, EGHP is primary. Collect appropriate insurance information.)*
  
4. Is patient entitled to Medicare due to End Stage Renal Disease (ESRD)?  Yes  No  
Is patient insured by an employer group health plan?  Yes  No  
Is patient within the 30-month coordination period?  Yes  No  
*(If yes to all questions, EGHP is primary. Collect appropriate insurance information.)*
  
5. Is patient under 65 and entitled to Medicare due to a disability?  Yes  No  
Is patient insured by an employer group health plan?  Yes  No  
*(If yes to both questions, EGHP is primary. Collect appropriate insurance information.)*
  
6. Is this illness/injury covered under the Federal Black Lung Program?  Yes  No  
*(If yes, Federal BL Program is primary for claims related to BL.)*  
Date benefits began: \_\_\_\_\_
  
7. Is this illness/injury covered under **no-fault** or **automobile** insurance?  Yes  No  
*(If yes, no-fault/auto ins is primary. Collect appropriate insurance information.)* :  
Date of illness/injury: \_\_\_\_\_
  
8. Is this an illness or injury for which another party could be held **liable**?  Yes  No  
*(If yes, liability ins is primary. Collect appropriate insurance information.)*
  
9. Are services covered by a Public Health Service or Research Program?  Yes  No
  
10. Is the patient enrolled in Hospice?  Yes  No

**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](http://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:**

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

**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.**