ADULT PHP PACKET

EXPLANATION OF VOLUNTARY ADMISSION RIGHTS

For adult patients, patients 14 years of age or over but less than 18 years of age, and for the parents or guardians of children under 14 years of age.

Before your or your child's voluntary admission to this hospital, you or your child have the right to:

1. An explanation of the type of treatment which may be involved.
2. An explanation of any restraints or restrictions which may be used.

Upon your or your child's admission, you or your child will have the following rights:

1. Within 72 hours after admission, an plan of treatment will be developed. You may participate in the development of this plan.
2. You may withdraw or you may withdraw your child from treatment at any time by giving written notice in advance to the Director of the facility; however,
3. You may be asked to agree to remain or allow your child to remain in the facility for a specified period of time up to 72 hours after you request discharge. If, when you request discharge, you are asked to remain or allow your child to remain for this period of time, someone will immediately explain why to you. The facility may institute involuntary commitment proceedings during this period.
4. You or your child may not be transferred from this facility to another facility without your consent.

In addition to the above rights, the Bill of Rights attached applies to you and your child upon admission. You will receive a longer, more detailed version of these rights within 72 hours of admission.

If you do not understand any of these rights, ______________________________ would be pleased to discuss them with you.
(NAME OF MENTAL HEALTH WORKER)

IMPORTANT NOTICES

<u>If you are 14 years of age or over but less than 18 years of age</u>: Treatment does not require your parents' consent; however, according to the Mental Health Procedures Act of 1976, the Director of this facility is required to inform your parent or guardian of your admission. Your parent or guardian has the right to object to your treatment and may ask the court for a hearing on their objections.

<u>If you are under 14 years of age</u>: If any responsible person believes that treatment in this facility is not in your best interest, that person may ask the court for a hearing on their objections.

YOU HAVE THE RIGHT TO BE TREATED WITH DIGNITY AND RESPECT

YOU SHALL RETAIN ALL CIVIL RIGHTS THAT HAVE NOT BEEN SPECIFICALLY CURTAILED BY ORDER OF COURT

1. You have the right to unrestricted and private communication inside and outside this facility including the following rights:

   A. You have the right to peaceful assembly and to join other patients. You have the right to participate in or organize a body of patient government when patient government has been deemed to be feasible by the facility.

   B. You have the right to be assisted by any advocate of your choice in the assert of your rights and to see a lawyer in private at any time.

   C. You have the right to make complaints and to have your complaints heard and decided promptly.

   D. You have the right to receive visitors of your own choice at reasonable hours unless your treatment team has determined in advance that a visitor or visitors would seriously interfere with you or others' treatment of welfare.

   E. You have the right to receive and send unopened letters and to have outgoing letters stamped and mailed. Incoming mail may be examined for good reason in your presence for contraband.

   F. You have the right to have access to a telephone designated for patient use.

2. You have the right to practice the religion of your choice or to abstain from religious practices.

3. You have the right to keep and to use personal possessions, unless it has been determined that specific personal property is contraband. The reasons for imposing any limitation and its scope must be clearly defined, recorded and explained to you. You have the right to sell any personal article you make and you may keep the proceeds from its sale.

4. You have the right to handle your personal affairs, including making contracts, holding a driver's license or professional license, marrying or obtaining a divorce and writing a will.

5. You have the right to participate in the development and review of your treatment plan.

6. You have the right to receive treatment in the least restrictive setting within the facility necessary to accomplish to treatment goals.

7. You have the right to be discharged from the facility as soon as you no longer need care and treatment.

8. You have the right not to be subjected to any harsh or unusual treatment and to have your boundaries respected. You have the right to approach the staff if someone touches you or speaks to you in a way that makes you feel uncomfortable.

9. If you have been involuntarily committed in accordance with civil court proceedings, and you are not dangerous to yourself or others, and you can survive safely in the community, you have the right to be discharged from the facility.

10. You have the right to be paid for any work you do which benefits the operation and maintenance of the facility in accordance with the existing Federal Wage and Hour Regulations.

11. You have a right to consent to receive the visitors whom you designate, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and you shall have the right to withdraw or deny such consent at any time. Before you are furnished patient care, if possible, you also have the right to designate a Support Person who can exercise your visitation rights in the event you are incapacitated or otherwise unable to do so. Patient Visitation Rights shall not be restricted, limited or otherwise denied by the hospital on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability. All visitors shall enjoy full and equal visitation privileges consistent with you preferences. The Hospital may impose clinically appropriate limitations on patient visitation when visitation would interfere with your care, whether the reason for limiting or restricting visitation is infection control, disruptive behavior of visitors, or your or your roommate's need for rest or privacy.

APPEAL PROCEDURE WHILE AT HORSHAM CLINIC

Should you have any objection to your treatment plan or treatment modalities, you should discuss this with your treatment team. If you are unable to resolve your differences, you should contact Director of Social Service, to make an independent assessment of your treatment plan. You have the right to request to review your medical record.

LEGAL ASSISTANCE

If you have questions regarding the legality of your admission, you may contact your lawyer or call The Office of Public Defender in Montgomery County at 278-3295 or The Office of Public Defender is Bucks County at 348-6473.

MEDICAL TREATMENT

Each patient has the right to informed consent, as the law requires, concerning restrictions and medications. Each patient has the right to request another professional opinion at his/her own expense.

Additional information regarding your rights is posted on your program.
For further explanation of your rights and the appeal procedure, you may contact any nurse on your unit.

Signature of Patient	Date	Witness	Date

Signature of Parent/Guardian (If applicable) Date

722 East Butler Pike
Ambler, PA 19002-2398
215-643-7800 FAX 215-643-5384

CIVIL RIGHTS COMPLIANCE PATIENT AWARENESS

In accordance with applicable Federal and State Civil Rights Laws, and Regulatory Requirements, you, as a patient of this facility, have the right:

> To be provided services at this facility and to be referred for services at other facilities without regard to your race, color, religious creed, handicap, ancestry, national origin, age or sex.
>
> To file a Complaint of Discrimination if you feel you have been discriminated against on the basis of your race, color, religious creed, handicap, ancestry, national origin, age or sex.

Complaints of Discrimination may be filed with any of the following:

The Horsham Clinic
Patient Advocate
722 E. Butler Pike
Ambler, PA 19002

Bureau of Equal Opportunity
Dept. of Public Welfare
Room 521 Health & Welfare Bldg.
P.O. Box 2675
Harris burg, PA 17105-2675
Tel. (717) 787-9695

Office of Civil Rights Region III
U.S. Dept. of Health and Human Services
Suite 372 Public Ledger Bldg.
150 S. Independence Mall West
Philadelphia, PA 19106-9111
Tel. (215) 861-4441 TDD (215) 861-4440
1-800-368-1019

Americans With Disabilities Coordinator
Governor's Office of Administration
Bertolino Bldg.
P.O. Box 2675
Harrisburg, PA 17105-2675
Tel. (717) 705-3912

Bureau of Equal Opportunity
Northeast Field Unit
331 Scranton State Office Bldg.
100 Lackawanna Ave.
Scranton, PA 18503-1923
Tel. (570) 963-4342

PA Human Relations Commission
1101-1125 S. Front St.
Fifth Floor Riverside Office Complex
Harrisburg, PA 17104
Tel. (215) 787-9780 TDD (717) 787-7279

____
Patient Signature   Date

____
Staff Signature   Date

722 East Butler Pike
Ambler, PA 19002-2398
215-643-7800 FAX 215-643-5384

PATIENT'S RESPONSIBILITIES REGARDING TREATMENT

A. PROVISION OF INFORMATION –

You have the responsibility to the best of your knowledge to give accurate and complete information about present complaints, past illnesses, hospitalizations and other matters relating to your mental health. You are responsible to report unexpected changes in your condition to the staff. You are responsible for making it known whether or not you clearly understand a proposed course of action and what is expected of you.

B. COMPLIANCE WITH INSTRUCTIONS –

You are responsible for following the treatment plan recommended by the attending staff. You are expected to facilitate your care by following the instructions and medical orders of the physicians, nurses and mental health staff.

C. REFUSAL OF TREATMENT –

You are responsible for the consequences of your actions if you refuse recommended treatment and do not follow the physician's orders. You will be informed of these consequences.

D. HOSPITAL CHARGES –

You are responsible for assuring that the financial obligations for your health care are fulfilled as soon as possible.

E. HOSPITAL RULES –

You are responsible for following hospital rules and regulations affecting your care and conduct.

F. RESPECT AND CONSIDERATION –

You are responsible for being considerate of the rights of other patients and hospital personnel and for assisting in the control of noise, smoking and number of visitors. You are also expected to be respectful of the property of other persons and the property of the hospital.

Patient Identification Label

PARTIAL PROGRAM RULES

SEARCH POLICY

To ensure everyone's safety and to respect the individual rights of all persons receiving treatment to have a safe and secure environment, I agree to adhere to the following:

1. Book bags, handbags, backpacks, cell phones and open containers such as water bottles, glass bottles, cans of soda and coffee purchased from outside the hospital may not be brought into the program.

2. Daily searches of all individuals and their belongings will be conducted with a magnetic wand.

________________________________ __________ __________

Person Attending Treatment/Parent or Guardian **Date** **Time**

(if person is under 14 years old)

________________________________ __________ __________

Staff **Date** **Time**

INDIVIDUAL HOSPITAL INSURANCE FORM

HOSPITAL COMPLETE FOLLOWING AND FURNISH COPY TO	TO		ADDRESS
NAME OF POLICYHOLDER		POLICY NUMBER(S)	
ADDRESS — STREET AND NUMBER	CITY	STATE	PHONE
NAME OF PATIENT (IF OTHER THAN POLICYHOLDER)		AGE	
DATE ADMITTED	TIME ADMITTED AM PM	DATE DISCHARGED	TIME DISCHARGED AM PM

OTHER INSURANCE INDICATED BY HOSPITAL RECORDS. IF YES NAME OF COMPANY.

☐ NO ☐ YES

COMPLAINT

DATE OF FIRST SYMPTOMS

DIAGNOSIS FROM RECORDS (If Injury, Give Date and Place of Accident)

OPERATIONS OR OBSTETRICAL PROCEDURES PERFORMED (Nature and Date)

HOSPITAL CHARGES (Complete This Section or Attach Copy of Itemized Bill Showing Information Below)

ROOM AND BOARD	☐ WARD	DAYS AT $	TOTAL	$
	☐ SEMI-PRIVATE	DAYS AT $	TOTAL	$
	☐ PRIVATE	DAYS AT $	TOTAL	$
	☐ OTHER			$
OTHER CHARGES				
			X-RAY	
			LABORATORY	
			AMBULANCE	
			MEDICAL AND SURGICAL SUPPLIES	
			PHARMACY (Except Take Home Drugs)	
			TOTAL CHARGES	$

TOTAL CHARGES	$
	$
	$
	$

THIS FORM APPROVED BY THE HEALTH INSURANCE COUNCIL AND ACCEPTED BY THE AMERICAN HOSPITAL ASSOCIATION FOR USE BY HOSPITALS.

IHF-1 (1961)

HOSPITAL	ADDRESS
TAKEN FROM RECORDS ON	SIGNED BY

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named hospital to release information requested on this form.

Date____________________, 20_____ Signed ______________________________

Patient (Parent if a Minor)

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize payment directly to the above named hospital of the Hospital Benefits otherwise payable to me but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the hospital for charges not covered by this authorization.

Date____________________, 20_____ Signed ______________________________

(Policyholder)

NUTRITION SCREEN - PARTIAL PROGRAMS

1. **HEIGHT** ______________ **WEIGHT** ______________ **AGE** ____________

   Recent weight loss / gain (explain) ____
   ____

2. Consumes: (check those that apply) — Describe

   - ☐ Regular Diet ____________________
   - ☐ Diabetic Diet ____________________
     - ☐ Insulin Dependent ____________________
   - ☐ Avoid foods due to allergies / intolerance's ____________________
   - ☐ Special diet for medical reasons ____________________
   - ☐ Special diet for religious reasons ____________________
   - ☐ Special diet for weight loss ____________________
   - ☐ Special diet for weight gain ____________________
   - ☐ Special diet - Other ____________________

3. Eating Habits (check those that apply)

   - ☐ Difficulty chewing ____________________
   - ☐ Difficulty swallowing ____________________
   - ☐ Binging ____________________
   - ☐ Purging ____________________
   - ☐ Altered meal schedule ____________________
   - ☐ Preferences / dislikes ____________________
   - ☐ Other ____________________

4. Summary of special dieting needs including physician / dietician commendations:
   ____
   ____

Completed by: ___________________________________ Date: ____________________

TO BE COMPLETED BY PHYSICIAN:

- ☐ Regular Diet
- ☐ Special Diet
- ☐ Referral to: ____
- ☐ Other: ____

______________________________________ ______________________
Physician Signature Date

HCHIMS 4/2015

Name ______________________

Date ______________________

Patient Identification

The Horsham Clinic Partial Hospital Programs
Pain Assessment / Reassessment

1. Do you have pain now? Yes _____ No _____
2. Have you had pain in the past several weeks or months? Yes _____ No _____
3. Location - Where on your body is your pain? *(See attached body map)*
   If answer to #1 and/or #2 is yes, refer to the Medical Physician

If answer to #1 or #2 is "Yes", complete the following questions:

a. Quality - How does your pain feel?
   1. Aching 2. Burning 3. Throbbing 4. Pulling 5. Sharp
   6. Dull 7. Pricking 8. Tingling 9. Numb 10. Pressing

b. Duration - Is pain always there? Does it come and go (breakthrough pain)? ______________________

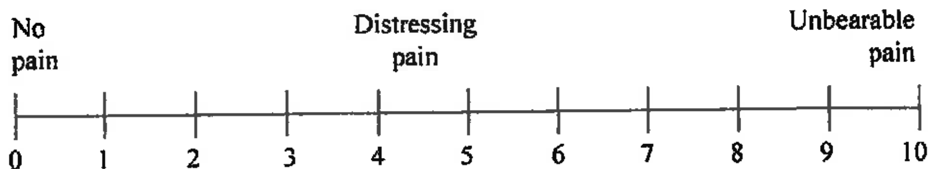
c. Triggers - What positions, activities, or situations:
   Make the pain worse? ______________________
   Make the pain better? ______________________

d. Effects - Is the pain affecting important parts of your life? (yes/no)
   1. Relationships ______________________
   2. Work ______________________
   3. Recreation ______________________
   4. Eating ______________________
   5. Sleeping ______________________
   6. Moods ______________________
   7. Energy ______________________

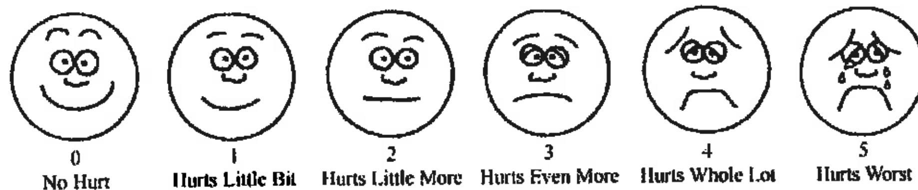
e. What has worked for you in the past to relieve this pain? ______________________

f. Intensity: Use the assessment scale to rate your pain. Circle the number/picture that best describes the pain

Adults



Child/Adolescents

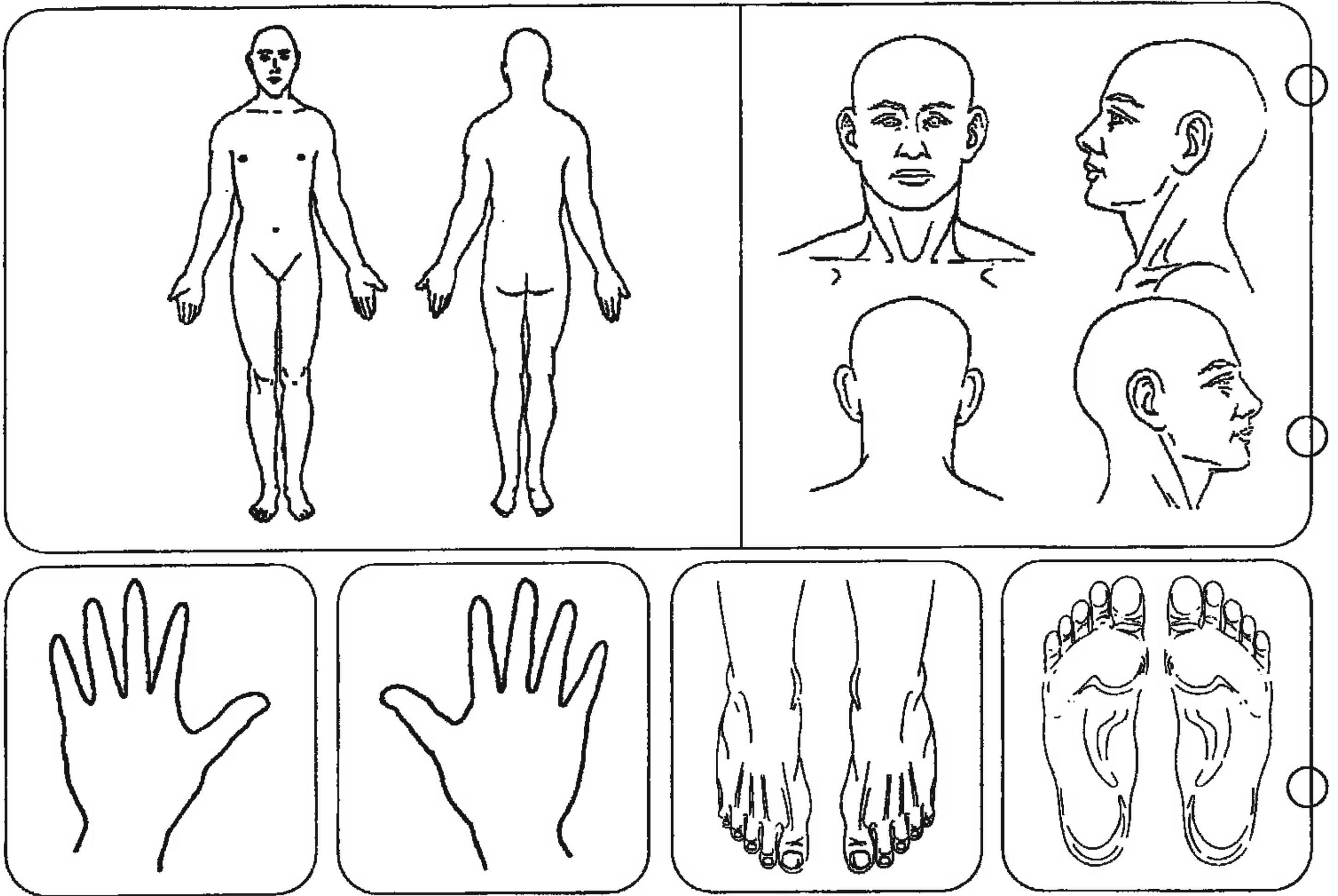


4. Do you have any symptoms in addition to pain? *(circle answer)* ______________________
   1. Nausea/vomiting
   2. Constipation
   3. Itching
   4. Weakness
   5. Sleepiness/confusion
   6. Problems with urination

Physician Signature ______________________ Date/Time ______________________

201PHP223 (9/06)

PAIN ASSESSMENT BODY MAP



Please note the exact location of the pain by placing a number on the model above. Use the lines below to describe the quality of the pain.

____

____

____

____

Physician Signature ______________________________

Date______________________________ Time ______________

THE HORSHAM CLINIC

PHYSICAL HEALTH SCREEN
PARTIAL HOSPITAL PROGRAM

Patient ID

Patient Name: ____________________

Date: ____________ Age: ____________ Sex: (circle) M F

A. Past and Current Medical History

Please check if you have problems with or are presently experiencing any of the following:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Asthma / Lung Disease
- ☐ Rheumatic Fever
- ☐ Head Injury
- ☐ Seizure
- ☐ Hepatitis / Liver Disease
- ☐ Gall Bladder Disease
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Other: ____________

Please explain any you have checked, or make comments: ____________________

____

____

B. **Allergies to medications or other substances:** (circle) Yes No

If yes, please list name and type of reaction: ____________________

____

C. **Please list and supply the dates of:**

Surgeries: ____________________

Medical Hospitalization: ____________________

____

Immunization up to date?: (circle) Yes No

Tetanus shot up to date?: (circle) Yes No

D. **Communicable Diseases** (i.e. TB Hepatitis B or C, HIV, etc.): (circle) Current Past

What: ____________________ When Treated: ____________

E. **Dental**

Recent dental checkup: (circle) Yes No

Comments: ____________________

F. **Speech or language delays:** (circle) Yes No

Comments: ____________________

(if available, please provide evaluations related to this for us to incorporate in our treatment effort)

G. **Functional Limitations:**

Vision as reported ____________ (circle) Glasses Contacts

Recent eye exam (circle) Yes No

Hearing impairment: (circle) Yes No

Hearing aids: (circle) Yes No

Please check any physical limitations to mobility: ☐ Paralysis ☐ Weakness ☐ Contracture ☐ Prostheses ☐ Fractures

Other:

Motor development delays: (circle) Yes No

Comments:

Sensorimotor functioning impairment (e.g. coordination difficulties, sensitivities): (circle) Yes No

Comments: ____________

Equipment needed: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Nebulizer ☐ Accucheck ☐ Brace

Other: ____________

Please indicate if the patient needs help with: ☐ Walking ☐ Dressing ☐ Toileting ☐ Feeding ☐ Bathing

Other ____________

Signature of person completing the form: ____________ Date: ______

If Other Than Parent - Relationship to Patient: ____________

Reviewed By Attending Physician: ____________ Date: ______

FOR DOCTORS USES ONLY:

If limitations, have you completed a FIMS? ☐ **Yes** ☐ **No**

Consult needed? ☐ **Yes** ☐ **No**

Physical Exam Required?

☐ **Immediately (Emergency)**

☐ **Urgent (within 72 hours)**

☐ **Within 30 days**

☐ **Within Year**

Comments:

THE HORSHAM CLINIC

ADULT PARTIAL PROGRAM

Identification Label

PROGRAM RULES

The following rules need to be followed in order to continue to attend the Horsham Adult Partial Program:

1. Book bags, handbags, backpacks, cell phones and open containers such as water bottles, glass bottles, cans of soda and coffee purchased from outside the hospital may not be brought into the program.

2. Daily searches of everyone and their belongings will be conducted with a magnetic wand.

3. Attendance is required for all scheduled days and groups, unless the staff approves the absence in advance. It is expected that you will notify staff when you will be absent and the reason for the absence. Failure to do so will result in staff taking necessary steps to confirm your safety. Attendees are expected to remain on grounds during program hours unless given permission to *leave* by staff.

4. The use of drugs or alcohol at the program or coming to the program intoxicated is strictly prohibited. (This does not apply to the use of medication, taken as prescribed by your medical doctor.)

5. Participants are requested to bring with them daily to the program only those prescribed medications that they need to take during program hours. Participants are also requested to refrain from giving any prescribed or non-prescribed medication to other attendees.

6. Fighting, destruction of property, stealing, physically hurting oneself or others,using abusive language, or bringing drugs/alcohol or weapons of any kinds onto the Horsham Clinic grounds is prohibited.

7. On a daily basis, staff will collect all attendees car keys which will be secured until the end of the program day.

8. Dating others in program attendance is prohibited for the duration of your participation in the program. Additionally, family members and significant others will not be treated concurrently in the program.

9. No soliciting money from other program participants.

10. Participants sharing the same living situation is prohibited.

I understand that violation of any of the *above* regulations will result in staff reviewing any eligibility to remain in the Horsham program and may result in my termination from the program.

I have read the client handbook and agree to abide by the policies and procedures of the program.

____
Person Attending Treatment Signature

____
Witness Signature

Date:____________________________

MEDICARE QUESTIONNAIRE

Date: ________________________ Provider No.: ______________________

Name: _______________________ Medicare No.: _____________________

Date of Admission/Registration: ________________________

1. Are you or your spouse employed and covered by a group health plan? Yes ☐ No ☐
   a. Does the employer employ 20 or more employees? Yes ☐ No ☐
      Give approximate number of employees ____________
   b. If no, list retirement date: Patient ____________ Spouse ___________

2. Is the patient under the age of 65? Yes ☐ No ☐
   a. Is the Medicare entitlement due to
      1. ESRD Yes ☐ No ☐
         If yes, 1st date of dialysis treatment ___________
         Date of kidney transplant ___________
      2. Disability Yes ☐ No ☐
         If yes, are you considered an active employee Yes ☐ No ☐
   b. Are you covered through a spouse's or other family member's employer group health plan? Yes ☐ No ☐
   c. Does the employer employ 100 or more employees? Yes ☐ No ☐
      Give approximate number of employees ___________

3. Is the illness or injury due to any kind of accident? Yes ☐ No ☐
   Please specify type __________________________ and date of accident ___________

4. Do you have coverage through VA _____ Black Lung Program ______
   Federal/State Agency (not including Medicaid, Medical Assistance, Welfare) _____

5. Briefly describe the reason for your visit to this facility:

   ____

   ____

If you have answered yes to any of the above questions, please complete the reverse side

Name of Working Person ______________________________

Date of Birth of Working Person ______________

Relationship to Patient ______________

Employer: ______________________________ Phone No. ______________

Address: ____

City: ______________________ State: __________ Zip: ______________

Insurance Carrier: ______________________________ Phone No. ______________

Address: ____

City: ______________________ State: __________ Zip: ______________

Type of Insurance Involved:

- Employer Group Health: ______________________________
- Workman's Comp: ______________________________
- Auto: ______________________________
- Black Lung: ______________________________
- VA: ______________ Other: ______________

I have completed this form to the best of my ability, I authorize ______________________ to bill the insurance indicated above as the prime carrier.

______________________________ ______________

Signature Patient/Representative Date

PATIENT SELF-DETERMINATION ACT FORM

Patient Identification

(To Be Completed Upon Admission)

1. *Do you have an advance directive?*

   ______ *Yes* *Type:*
   ______ *Living Will*
   ______ *Healthcare Durable Power of Attorney*
   ______ *Mental Health Advanced Directives*
   ______ *Donor Cards*
   ______ *Other:* ______________________________

   ______ *No*

   ______ *Patient unable/unwilling to respond. Please have Social Service contact family for information unless patient self-admitted.*

2. *If yes, do you have your advance directive with you?*

   ______ *Yes* ______ *No*

   a. *If yes, a copy of the advance directive is made and placed on chart by* ______________ ______________ *(Staff) on* ______________ *(Date).* ______________*(initials)*

   b. *If no, patient will be referred to Social Service for follow up by the next working day of* ______________ *(Date).*

3. *If no, are you interested in obtaining more information about advance directives?*

   ______ *Yes* ______ *No*

If you have indicated further interest in advance directive, please contact your family physician, lawyer or a family member. We will assist you in this process if needed. We have also made available to you additional written information concerning advance directives.

______________________________ ______________________________
Patient Signature and/or Surrogate *Date*

______________________________ ______________________________
Witness/Staff Member *Date*

PLACE IN PATIENT'S MEDICAL RECORDS

THE
Horsham
CLINIC

Patient Identification

De-escalation Assessment and Plan

Date: ______________________

Welcome to the Horsham Clinic. Our staff are committed to working with you in ways that will be the most therapeutic and least restrictive. We would like to ask you to help us understand some things that may help during difficult times so we can offer these options. Together we hope to help you feel better, learn new ways to cope and prevent the use of more restrictive interventions.

What are some things that help you calm down and feel better when you are upset or angry?

- ☐ Quiet time alone in your room or a safe room
- ☐ Sitting quietly with an adult
- ☐ Talking with an adult
- ☐ Talking with a family member
- ☐ Talking with a friend/peer
- ☐ Exercising
- ☐ Listening to music
- ☐ Reading
- ☐ Pacing
- ☐ Yelling
- ☐ Writing in a journal
- ☐ Cold compress
- ☐ Hot shower
- ☐ Other (please describe)

What are some things that make it more difficult for you when you are already upset?

- ☐ Being touched
- ☐ Loud noises
- ☐ Yelling
- ☐ Isolation
- ☐ Specific person (who?)
- ☐ Being around men or women (which?)
- ☐ Temperature (heat or cold?)
- ☐ Bright lights
- ☐ Particular time of day (when?)
- ☐ Other (please describe?)

Have you ever been restrained or secluded in a hospital/treatment setting?

- ☐ Physically restrained/held
- ☐ Mechanically restrained
- ☐ Secluded
- ☐ Not applicable

What was your experience with restraint or seclusion?

____

____

____

____

Do you have any medical problems which could place you at greater risk during a restraint or seclusion? ____

____

Have you ever experienced any physical, sexual or emotional trauma that could have an effect on you during a restraint or seclusion?

____

____

If you are in danger of hurting yourself or someone else we need to intervene to keep you safe. Which intervention would you prefer we attempt, if possible?

- ☐ Time out in bedroom
- ☐ Time out in a safe room
- ☐ Medications
- ☐ Physical hold
- ☐ Closed/locked door seclusion
- ☐ Mechanical restraints

Adults: In the event you require seclusion or restraint, would you like us to inform a family member or friend? ☐ Yes ☐ No

If you would like to inform someone, please be sure to sign a release of information allowing us to contact them. ☐ Release of information completed

Patient/Parent/Guardian Signature: ______________________________

Staff Print Name: ______________________________________

Staff Signature: ________________________Date:________Time:_____

Patient Identification

RECEIPT OF NOTICE OF PRIVACY PRACTICES VERSION 10403

Addressograph

- ❑ Over 18 years of age
- ❑ Under 18 years of age
- ❑ Emancipated minor child
- ❑ Over 18 but still dependent

ACKNOWLEDGEMENT

I acknowledge that I have received the Hospital's Notice of Privacy Practices.

______________________________ ____________________
Patient's Signature Date

______________________________ ____________________ __________
Patient's authorized representative signature Relationship to patient Date

____________________________________ ____________________
Witness Signature Witness Job Title

Patient is unable to sign this receipt because ______________________________

____

Patient has requested no exceptions to the use or disclosure of PHI at this time.

Intake/Admissions Staff: Attach original to patient's chart.

Respecting Your Privacy

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.

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect and maintain the privacy of your health information. We call it "Protected Health Information" (PHI).

The basis for federal privacy protection is the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our hospital employees, volunteers, and related personnel.

The practices described in this Notice may also be followed by health care providers, who are members of our Medical Staff, if they have opted to abide by its contents. Many of our doctors follow the practices contained within this Notice.

Each participant who joins in this joint Notice of Privacy Practices serves as their own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For physician specific issues or questions, please feel free to contact your physician directly.

Hospital employees, volunteers, and related personnel, including those members of the Medical Staff who have opted to abide by its contents, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital Contacts for More Information or, if necessary, a Complaint

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

SPECIAL USES

Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. This includes, for example, uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or for any disclosure which is a sale of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES

- Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay. You will receive a unique patient code that can be provided to these contacts
- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a Workers' Compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE

You have the right to request that we do not use or disclose your PHI in a particular way. We must abide by your request to restrict disclosures to your health plan (insurer) if:

- the disclosure is for the purpose of carrying out payment or health care operations and is not required by law; and
- the PHI pertains solely to a healthcare item or service that you, or someone else other than the health plan (insurer) has paid us for in full.

In other situations, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION
You have the right to receive confidential communications of PHI from the hospital at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION
You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY
You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI
If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI
You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

YOUR RIGHT TO BE NOTIFIED OF A BREACH
You have the right to be notified following a breach of unsecured PHI.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE
You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the Notice electronically.

WHAT IF I HAVE A COMPLAINT?
If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with us or the Secretary.

- To file a complaint with us, please contact our Risk Management Department or call the UHS Compliance Hotline at **1-800-852-3449**. Your complaint should provide specific details to help us in investigating a potential problem.
- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington, D.C.20201 or call **1-877-696-6775.**

CONTACT FOR ADDITIONAL INFORMATION
If you have questions about this Notice or need additional information, you can contact our Risk Management Department (or the UHS Compliance Hotline at 1-800-852-3449).

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect to PHI and to notify you following a breach of unsecured PHI. This document is our notice. We will abide by the privacy practices set forth in this notice. We are required to abide by the terms of the notice currently in effect. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide you with a copy to take with you upon request and we will post the new notice.

COMPLIANCE WITH CERTAIN STATE LAWS
When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

Effective Date: This notice takes effect on September 23, 2013 Version # 1

722 E. Butler Pike
Ambler, PA 19002-2398

PARTIAL PROGRAM UR WORKSHEET

Name	DOB/Age:	SOC SEC #:	Carrier:	AUTH#:

Medical Records#:	PT Account#:	Pre-certed By:	# of Days:	Adm Date

Attending:	SW/Case Mgr:	Phone #:

Rev Date	# Days	LCD	Reviewer	HC UR	Rev Date	# Days	LCD	Reviewer	HC UR
Comments:					Comments:				
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