ElderFit

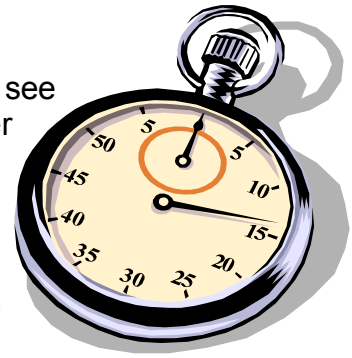
In Home Rehab – North Carolina

Welcome to ElderFit In Home Rehab. Our goal is to provide you with quality services and to exceed your expectations of us. Should you have any questions, comments, suggestions or concerns during your care, please discuss them with your therapist or with our office. We will do our best to meet your needs.

Hours of Operation

Patients are scheduled for treatment on Monday through Friday from 8 a.m. until 6 p.m. and on weekends, evenings and holidays based on need. If you are unable to keep a scheduled appointment, please call to cancel so that we may care for another patient. If you cancel three consecutive appointments without calling to cancel, you will be discharged from therapy and will be required to contact your physician for new orders.

Timeliness



Your time is valuable to us and we will make every attempt to see you on time. Occasionally, patient treatment requires longer than usual and we may arrive a bit late – if this happens, we will always try to call and let you know as soon as possible. Your patience in this instance is appreciated. We believe every patient should receive the treatment time appropriate for him or her and assure you that you will receive the same comprehensive treatment.

Your Rights as a Patient

- The right to dignified and respectful care.
- The right to privacy and confidentiality within the limits of the law.
- The right to access to services.
- The right to make informed decisions about what may or may not be done to you in the course of medical treatment and the right to refuse treatment.
- The right to be told about your condition, the nature of the proposed treatment, the expected results of the treatment, the risks involved in the treatment, alternate procedures available, and who will provide the treatment.
- The right to security of your personal being and possessions.

Your Responsibilities as a Patient

As a patient in our program, you have the responsibility:

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- To provide complete and accurate information about your health.
- To ask questions when you do not understand what you have been told.
- To participate in your care planning and treatment program.
- To consider the rights of other patients, physicians and program staff.
- To follow rules and regulations about your conduct as a patient.
- To pay for services given in accordance with any agreements you have made with the program.

Safety First

Safety for you and our staff is important to us. Please follow these important safety rules:

- Always follow the instructions of your therapist.
- Report any safety hazards immediately to your caregiver.
- Inform your caregiver immediately if you have any unusual responses to your therapy.

Family Involvement

Your family members are an important part of your healthcare team. We encourage family participation in your care when it is appropriate and beneficial.

If you have special needs, please inform your therapist and we will make every attempt to schedule your treatment at a time that is convenient for you and your family.

Therapist Name: _____

Therapist Phone: _____

Your therapist will always try to call you just before coming to your home. This is to check and make sure you are ready for therapy and to coordinate the final arrival arrangements. Please be sure there is someone available to answer the phone and the door for the therapist.

Clothing

Please wear loose fitting clothing that is comfortable for exercise.

Confidentiality

Please do not request information about other patients that you may know are involved in our program. Your therapist is forbidden to share this information.

If you have any concerns about your privacy, please share them with your therapist.

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Advance Directives

If you have a Living Will or other Advance Directive, please notify your therapist so that we can respect your wishes. Have a copy of the Living Will for placement in your medical record.

Caregiver Credentials

You have the right to know the qualifications of your therapist. If you wish more information regarding their training, please ask us.

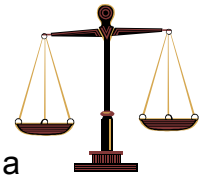
Educational Programs

Our program supports programs that educate and train healthcare providers. During the course of your care, you may be treated by interns or be observed by students. You have the right *NOT* to participate in these educational programs. Please inform your therapist if you would prefer not to participate**.**

Complaint Resolution

If you *DO* have a concern or complaint,
Please report this information to your caregiver or to the office immediately. You have the right to a prompt response to your concern. We will make every attempt to resolve your issues.

Ethics Committee



If you have any questions regarding any aspect of your rights as a patient or have concerns about the care given to you, you may access the Ethics Committee directly by calling the office and asking to be referred to a member of the committee. You may also access the committee by making a request to your therapist.

ElderFit In Home Rehab- North Carolina

2002 Bartlett Circle
Hillsborough, NC 27278
(919) 614-1923
(919) 644-6646 (fax)

Patient Info

PATIENT		**DOB**	
PHONE #		AGE	
ADDRESS		**EMERGENCY CONTACT**	
		RELATION	
MD (full name)		1ST PHONE	
MD NPI		2ND PHONE	
MD PHONE		**OTHER CONTACT**	
MD FAX		RELATION	
MEDICARE #		PHONE	
2ND INSURANCE NAME		**ANOTHER CONTACT**	
		RELATION	
2ND INS #		PHONE	
2ND INSURANCE ADDRESS			
2ND INS PHONE		ICD-9	

SCHEDULE PREFERENCES

	MON	T UES	WED	THURS	FRI	W/E
AM						
PM						

VISIT RECORD

Su	M	Tu	W	Th	F	Sa

Su	M	Tu	W	Th	F	Sa

Su	M	Tu	W	Th	F	Sa

Su	M	Tu	W	Th	F	Sa

Su	M	Tu	W	Th	F	Sa

Su	M	Tu	W	Th	F	Sa

Name: Date:

Medical History

Allergies: _____

Please CIRCLE any of the following conditions that you have:

Diabetes Depression Osteoporosis

High Blood Pressure Seizure Disorder Peripheral Vascular Disease

Neuropathies (problems with sensation) Incontinence or Recurrent Bladder Infections

Heart Disease (heart attack, angina, etc.)

Arthritis—what type? _____ which joint(s)? _____

Respiratory Disease (please specify): _____

Neurological Condition (please specify): _____

Other (please specify): _____

Have you EVER had the following conditions:

Stroke—how did it affect you? _____ when? _____

Joint Replacement—which joint & side? _____ when? _____

Cancer—what type? _____ when?_____

Surgery affecting your current function—what surgery? _____ when?_____

Do you have any medical conditions for which you see a physician regularly? _____
If YES, please describe: _____
_____

How many times have you fallen in the past year? _____
Please describe the approximate date(s), any medical attention required and reason(s) you fell (ex: going down stairs, etc.) _____
_____

MEDICATIONS
Please list the medications that you are currently taking (including over-the-counters, herbals, etc.) List additional medications (if more than 5) on reverse

Medication	For What Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I hereby consent to treatment by ElderFit In Home Rehab.

I authorize payment of medical benefits to ElderFit In Home Rehab by commercial and/or government insurance companies for services rendered, not to exceed my indebtedness.

I understand that I am financially responsible to ElderFit In Home Rehab for all expenses incurred, and that my insurance carrier may apply amounts to deductible, copays, and/or coinsurance for which I will be billed and must pay to ElderFit In Home Rehab.

I authorize the use and disclosure of my protected health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services rendered and any administrative operations related to treatment or payment.

I acknowledge that I have been given a copy of the Notice of Privacy Practices.

Signature: _____ Date:_____

Name: _____

I consent to the use of my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand that I have the right to copy or inspect any information used for these purposes. I also understand that this authorization does not affect my consent to used my protected health information for treatment, billing, or operations related to treatment or billing.

Signature: _____ Date:_____

Name: _____

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ElderFit In Home Rehab – North Carolina
2002 Bartlett Circle
Hillsborough, NC 27278
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fax (919) 644-6646

Notice of Privacy Practices

Effective Date: *9/1/2013*

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.

If you have any questions about this notice, please contact us at (800) 540-0774.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you and your immediate family with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We

also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records.. To inspect and copy this Health Information, you must make your request, in writing, to us. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy

form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to us.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to us.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to us. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to us. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact us at (800) 540-0774 for further directions. All complaints must be made in writing. **You will not be penalized for filing a complaint**.