



ElderFit

In Home Rehab – North Carolina

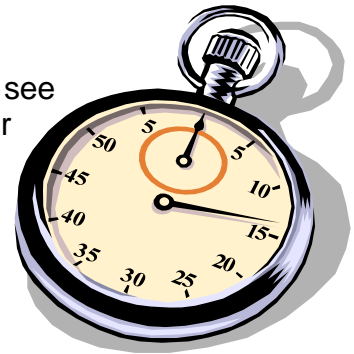
Welcome to ElderFit In Home Rehab. Our goal is to provide you with quality services and to exceed your expectations of us. Should you have any questions, comments, suggestions or concerns during your care, please discuss them with your therapist or with our office. We will do our best to meet your needs.

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.



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

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

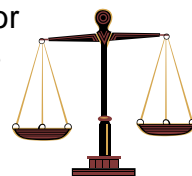
Our program supports programs that educate and train healthcare providers. During the course of your care, you may be treated by interns or be observed by students. You have the right *NOT* to participate in these educational programs. Please inform your therapist if you would prefer not to participate.

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
1101 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)		1 ST PHONE	
MD UPIN		2 ND PHONE	
MD PHONE		OTHER CONTACT	
MD FAX		RELATION	
MEDICARE #		PHONE	
2ND INSURANCE NAME		ANOTHER CONTACT	
		RELATION	
2 ND INS #		PHONE	
2 ND INSURANCE ADDRESS			
2 ND INS PHONE		ICD-9	

SCHEDULE PREFERENCES

	MON	TUES	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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North Carolina**
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Hillsborough, NC 27278
(919) 614-1923
fax (919) 644-6646



Notice of Privacy Practices

Effective August 30, 2005

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ElderFit In Home Rehab is dedicated to protecting your medical information. The medical record is the physical property of ElderFit In Home Rehab, and the health information contained in the medical record is yours. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information.

Who will follow this Notice?

ElderFit In Home Rehab provides health care to our patients and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this Notice will be followed by:

- Any health care professional that treats you at any of our locations.
- All locations included within ElderFit In Home Rehab.
- All employed associates, staff or volunteers of our organization, including staff at our parent organizations.
- Any business associate or partner of In Home Rehab with whom we share health information.

Our pledge to you

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive and to provide quality care and to comply with legal requirements. This Notice applies to all of the records of your care that we maintain, whether created by facility staff, your personal physician or records disclosed to us per your authorization from other providers.

We are required by law to:

- Keep medical information about you private.
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the Notice that is currently in effect.

Changes to this Notice

We reserve the right to change the terms of this Notice, making any revision applicable to all of the health information that we maintain. If ElderFit In Home Rehab revises the terms of this Notice, we will post a revised Notice at all In Home Rehab locations and on our web site: www.elderfitpt.com.

We will also provide paper copies of this Notice upon request. You also will be asked to acknowledge in writing your receipt of this Notice.

How Your Medical Information Will Be Used And Disclosed

- We may use and disclose medical information about you for treatment (such as sending medical information about you to a specialist as part of referral); to obtain payment for treatment (such as sending billing information to your insurance company or Medicare); and for health care operations (such as review for quality assessment and the appropriateness of the care you receive).
- Subject to several requirements, we may use or disclose medical information about you without prior authorization including but not limited to public health purposes, abuse and neglect reporting, health oversight audits or inspections, research studies, worker's compensation or other similar programs.
- We may disclose medical information in specific circumstances when required by law (such as a request from law enforcement for a blood alcohol level) or in response to valid judicial or administrative orders.
- We may contact you for appointment reminders or to tell you about our recommended possible treatment options, alternatives, health-related benefits or services that may be of interest to you or to support fund-raising efforts.
- You may be asked for your comments on the care that you received at ElderFit In Home Rehab.
- Unless you object, and with the exception of Behavioral Health Patients, ElderFit In Home Rehab may disclose your medical information to family members, other relatives or close personal friends involved in your medical care.
- ElderFit In Home Rehab may disclose your medical information to a public or private entity for the purpose of coordinating with that entity to assist in disaster relief efforts.
- ElderFit In Home Rehab may disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or the public.

Other uses of medical information

In any other situation not covered by this Notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Patient Rights

Your rights regarding your medical information include:

- The right to request restrictions on certain uses and disclosures of your medical information. In Home Rehab is not required to agree to your requested restriction.
- The right to receive communications from In Home Rehab in a confidential manner (such as sending mail to an address other than your home).
- The right to inspect and obtain a copy of your medical information. You may be charged a reasonable fee for any copies of your records.
- The right to request an amendment of your medical information. Your request must be in writing and may be denied if the information was not created by In Home Rehab; is not part of the medical information maintained by In Home Rehab; or if it is determined that the information in the record is accurate. You may appeal the denial in writing.
- The right to receive an accounting of the disclosures of your medical information made by ElderFit In Home Rehab except for the disclosures made for treatment, payment or healthcare operations and for those specifically authorized by you.
- The right to receive a paper copy of the Notice.

Complaints

If you are concerned that your privacy rights may have been violated or you disagree with a decision ElderFit In Home Rehab has made, you may register your complaint with the Privacy Officer by leaving a message on our Ethics Line at 1(919) 614-1923

- Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. The address can be requested from the Values Line.
- Under no circumstances will you be penalized or retaliated against for filing a complaint.