PROGRESSIVEHEALTH at Deaconess

EVAL DATE:

PATIENT INFORMATION

LAST NAME	FIRST	MI

ADDRESS (STREET, CITY, STATE ZIP)

ADDRESS CON'T	SSN	DOB

HOME PHONE	WORK PHONE EXT.	CELL PHONE

IS INJURY RELATED TO: ☐ WORK ☐ AUTO ☐ OTHER IF WORK, COMPLETE WORK RELATED INJURY INFORMATION BELOW.
IS A HOME HEALTH AGENCY CURRENTLY PROVIDING NURSING SERVICES IN YOUR HOME? ☐ YES ☐ NO
HAVE YOU HAD ANY THERAPY SERVICES IN THE LAST 12 MONTHS? ☐ YES ☐ NO

EMERGENCY CONTACT NAME	**RELATIONSHIP**	**PHONE NUMBER**

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME (PARENT/GUARDIAN/OTHER, WHO BROUGHT MINOR FOR THERAPY)

RELATIONSHIP TO PATIENT	DATE OF BIRTH	SSN

ADDRESS (STREET, CITY, STATE ZIP)

HOME PHONE	WORK PHONE EXT.	CELL PHONE

WORK RELATED INJURY

EMPLOYER NAME:	CASE MANAGER NAME:	CASE MANAGER PHONE:
EMPLOYER ADDRESS (STREET, CITY, STATE ZIP)		CASE MANAGER FAX:
EMPLOYER LIABILITY CARRIER	LIABILITY CARRIER ADDRESS	

DATE OF INJURY	CLAIM #:	NUMBER OF VISITS APPROVED:

TO BE COMPLETED BY OFFICE

IS THE PATIENT THE SUBSCRIBER? ☐ YES ☐ NO	IF NO, THEN: SUBSCRIBER/ POLICYHOLDER NAME:	DOB

SUBSCRIBER/POLICYHOLDER ADDRESS (IF OTHER THAN PATIENT):

PRIMARY INSURANCE	**ID #**	**GROUP #**

INSURANCE EFFECTIVE DATE:		PRE-CERT REQUIRED: ☐ YES ☐ 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? ☐ YES ☐ 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.

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.

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 the Deaconess Hospital's Physical Medicine Dept. Payment Policy.

I have read and understand the above and foregoing Informed Consent, Consent for Release of Information, Authorization for Disclosure and Assignment of Benefits, and agree to the terms thereof.

_____	_____	_____	_____
PATIENT NAME	**SIGNATURE OF PATIENT/GUARDIAN**	**DATE**	**WITNESS**

PROGRESSIVEHEALTH at Deaconess

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? ☐ *YES* ☐ *NO*	*IF YES, TYPE OF SURGERY:*	*DATE OF SURGERY:*	
HAVE YOU HAD PREVIOUS PHYSICAL THERAPY FOR THIS CONDITION? ☐ *YES* ☐ *NO*	*HAVE YOU BEEN ADMITTED OR DISCHARGED FROM A PART A STAY AT DEACONESS HOSPITAL WITHIN THE PAST 72 HOURS?* ☐ *YES* ☐ *NO*		
DO YOU SMOKE? ☐ *YES* ☐ *NO*	*ARE YOU PREGNANT OR THINK YOU MIGHT BE PREGNANT?* ☐ *YES* ☐ *NO*		
HOW HAS YOUR INJURY AFFECTED YOU EMOTIONALLY? ☐ *DEPRESSION* ☐ *WITHDRAWAL* ☐ *ANGER* ☐ *ANXIETY* ☐ *NONE* ☐ *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? ☐ YES ☐ 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?			

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?

YES	NO		YES	NO	
☐	☐	Cancer	☐	☐	Infectious Diseases
☐	☐	Chest Pain or Shortness of Breath	☐	☐	Hepatitis
☐	☐	Heart Diseases	☐	☐	Headaches Frequent/Severe
☐	☐	High Blood Pressure	☐	☐	Hearing/Vision Difficulties
☐	☐	Pacemaker	☐	☐	Numbness or Tingling
☐	☐	Heart Attack	☐	☐	Dizziness
☐	☐	Stroke or TIA	☐	☐	Weakness
☐	☐	Congestive Heart Disease			
☐	☐	Blood Clots	**Surgery or Injury of any of the following:**		
☐	☐	Circulation Problems	☐	☐	Neck-Type:_____
☐	☐	Seizure Disorder or Epilepsy	☐	☐	Back-Type:_____
☐	☐	Thyroid Problems	☐	☐	Shoulder-Type:_____
☐	☐	Asthma, Emphysema or Bronchitis	☐	☐	Elbow-type:_____
☐	☐	Chemical Dependency	☐	☐	Hand-Type:_____
☐	☐	Diabetes	☐	☐	Hip-Type:_____
☐	☐	Rheumatoid Arthritis	☐	☐	Knee-Type:_____
☐	☐	Other Arthritis Conditions	☐	☐	Ankle or Foot-Type:_____
☐	☐	Fibromyalgia			

THERAPIST SIGNATURE **DATE**

Effective Date of Notice: September 23, 2013

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 health records that we maintain for you. We are required by law to maintain the confidentiality of your health information, to give you this Notice describing our practices and legal duties, to follow the terms of the current Notice, and to notify you if your unsecured protected health information has been breached. 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 at Deaconess Gateway, The Women's Hospital (including Boston Invitro Fertilization), Deaconess Clinic, Evansville Surgery Centers, 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 without your verbal or written permission.

Treatment: Information gathered by the persons treating you is entered into your record and used to determine your plan of care and progress. This information may be shared with other parties involved in your care including consulting health care providers, your primary care physician, other facilities where you may be transferred, and other health care providers treating you. In some cases the sharing of your protected health information with other healthcare providers and hospitals may be done electronically, including through an electronic health information exchange such as the Indiana Health Information Exchange. By using an electronic health information exchange, we may be able to make your protected health information available to those who care for you in a more timely and effective manner, and thus help to improve the coordination of your care.

Payment: We may use your information to verify your insurance coverage. A bill and explanation of benefit will be sent to you, your insurer or 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, email 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 DHS. 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 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.

Fundraising: We may use certain of your information (including name, address, telephone number, dates and departments of service, age, and gender) to contact you to raise funds for Deaconess. You have a right to opt out of receiving these communications.

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 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 (active duty service members 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 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. If your therapist maintains private notes regarding your care (i.e. notes that are not recorded in the medical record), we will not release these to you or any other party except with a written authorization.

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.

Disclosures requiring your written authorization: We will not sell your information without your written authorization. We will not use or share your information for the purpose of marketing the services or products of non-Deaconess entities without your written authorization. Other 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 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: 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 have the right to obtain an electronic copy of your electronically maintained medical records if those records are readily producible in the electronic form or format you request. We will encrypt electronic information provided to you (requiring that you use a password to access the information) unless you direct us not to use encryption. 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 if 1) you do not provide a reason for the requested changes, or 2) the information was not created or maintained by us, or 3) the information is not within the records you are permitted to inspect and copy, or 4) the information in your records is accurate and complete. Any corrections we accept will be included in your record.

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 cannot be longer than the preceding six years. 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 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. For any services for which you paid out-of-pocket in full, we will honor your request to not disclose information about those services to your health plan, provided that such disclosure 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 unless the information is needed to provide you emergency treatment. If we later 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 or to a person designated by 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.

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

Changes to This Notice

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

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with the facility or with the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**

TO FILE A COMPLAINT, PLEASE CONTACT:

Facilities	Contact
Deaconess Hospital – all inpatient campuses and all outpatient services including COMP Center, Chancellor Center, Deaconess Urgent Care	**Privacy Officer 812 450-7223**
The Women's Hospital	**Compliance/Regulatory Officer 812 842-4332**
The Heart Hospital	**Quality Compliance Officer 812 842-3228**
Deaconess Clinic	**Clinical Staff Coordinator 812 492-5122**
Evansville Surgery Centers	**HIPAA/Compliance Coordinator 812 250-0124**
Progressive Health of Indiana	**Compliance Officer 812 491-3856**
Not sure who?	**Deaconess Health System Privacy Officer 812 450-7223**

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

Acct # - _____

Patient - _____

MRN - _____

Deaconess Health System

FINANCIAL RESPONSIBILITY

Thank you for choosing Deaconess. Our goal is to provide you with quality medical services. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bill is vital to our ability to continue to provide medical care within the community. We accept **Cash, Check, Visa, MasterCard and Discover.**

ALL ACCOUNTS

In consideration of Deaconess Hospital, Inc. of Evansville, Indiana rendering services for the above named patient, we the undersigned, and each of us, agree to be jointly and severally responsible with the patient for payment for this hospitalization and any other account that the patient had at any time in the past, at the present, or may have in the future with Deaconess Hospital, Inc. In the event we do not pay the balance at the time of discharge, we agree that Deaconess Hospital, Inc. or its assigns may add a finance charge to any such uninsured balance. Please contact the Deaconess Financial Counseling Services at 812-450-3435 if you need assistance. Past due patient accounts that do not have agreed upon financial arrangements with Deaconess Health System will be submitted to a collection agency. We agree that we will pay all attorney fees and court costs incurred by Deaconess Hospital, Inc. in the collection of all sums due Deaconess Hospital, Inc. If I provide Deaconess or its agents with my cell phone number, I authorize Deaconess or its agents to call my cell phone either manually or by auto-dialer in order to collect any amounts I owe. I understand that any email I provide is my personal email and I authorize Deaconess or its agents to contact me via that email address. All accounts are due and payable at the time of the patient's discharge.

WORKER'S COMP / LIABILITY / AUTO ACCIDENT

If the reason for your visit is related to a workers comp claim, liability claim, or auto accident, you are responsible for providing Deaconess Health System with complete billing information, including police report, claim number, etc. as appropriate, within seven (7) business days. You should be aware that if you do not provide this information or these claims are denied, the balances then become the patient's responsibility.

INSURANCE

If you have active insurance coverage, we will bill your insurance company. It is the patient's responsibility to understand his/her insurance coverage. You will receive a monthly statement if your account has a patient due balance. Payment of deductibles, non-covered services and co-payments are the patient's responsibility.

ASSIGNMENT OF INSURANCE BENEFITS

I assign insurance payments to be made directly to Deaconess Health System, Inc. for services rendered.

I have read, understand and agree to the terms listed above.

Signature: _____ Printed Name: _____ _____

Patient, Parent or Guardian, or Representative — Date

_____ _____

Witness — Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I have received a Notice of Privacy Practices from Deaconess Hospital.

_____ _____

Signature — Date

(May only be signed by patient, guardian, power of attorney or parent of minor child.)

A Notice of Privacy Practices was provided but no acknowledgment received due to:

___ Patient Refused ___ Patient unable/no lawful representative available

___ Emergent condition ___ Other _____

_____ _____

Witness (Family or Staff) — Date

PAYMENT AT TIME OF SERVICE

As a courtesy to you, we will bill your insurance directly for the services you receive from us. As a standard practice, we collect all expenses that are the responsibility of the patient at the time of service.

Our request for payment will include any deductible, co-pay and coinsurance amounts that apply to your visit.

In some cases, the amount of charges is an estimate based upon information provided directly by your insurance company regarding your particular plan and eligibility and the procedures performed. However, the exact amount of all charges may not be known at the time of service as your insurance may process differently than anticipated. So it is possible that additional expenses that are the responsibility of the patient may be reflected on your final statement. In such a case, the payment collected at the time of service serves as a deposit towards your final balance. In order for us to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Additionally, any overpayment will be promptly refunded to you after all claims have been processed by all applicable payers.

If you anticipate problems paying your portion of your bill, please let the front office coordinator know as soon as possible to discuss payment alternatives that may be available to you should you qualify.

CANCELLATION / NO-SHOW POLICY

We strive to provide not simply good, but absolutely the best care to our clients. We schedule our clients according to care plans that optimize their wellness outcomes. Making your appointment as scheduled is very important, not just for us, but for you. We are convinced that if you make your wellness a life priority, you will achieve not only a higher level of function, but a greater degree of happiness.

We have the most highly trained and experienced clinicians in the region. You are working with the best. Their services and time are in high demand, with waiting lists for many of their services. As you know, we attempt to schedule all new clients within 24-48 hours of their initial request for service. Thus, appointment time is a valuable commodity for both you and us.

*If negative circumstances require you to cancel a scheduled appointment, we request that you do so at least 48 hours in advance**. If you must cancel within 24 hours of your appointment or fail to show up for your appointment, a $20 fee will be applied to your account, which will be patient responsibility and is not billable to insurance**. This facility also reserves the right to cease rescheduling new appointments due to habitual no shows or cancellations and reserves the right to discharge any patient who fails to give proper notice three consecutive times.***

While we are not fond of the negative connotation of any cancellation policy, we believe such a policy is in the best interest of accommodating all of our clients who are dedicated to improving their wellbeing. Thank you for your consideration.

You are not required to sign the agreement (directly or indirectly), or agree to enter into such agreement as a condition of purchasing any property, goods or services.

By signing below, I understand and agree to the terms of the above Payment at Time of Service Policy and Cancellation/No-show Policy.

_____

NAME DATE WITNESS

Rev. 0713