Ohio Living
Palliative Medicine

Admissions Information

PATIENT INFORMATION

Date of Appt _____ ☐ Male ☐ Female Age____ Dr. Requesting _____

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widow Family Dr. _____

Name _____ Home Phone _____
(first) (middle) (last)

Address _____ Date of Birth _____

City_____ State_____ ZIP _____ Cell _____

Employer _____ Work ____ # _____

Email Address_____ SS # _____

RESPONSIBLE PARTY (IF NOT THE PATIENT OR PARENT)

Name_____ Relationship to Patient_____

Date of Birth _____ SS # _____

Address _____

City _____ State_____ ZIP _____ Cell # _____

Employer _____ Work # _____

INSURANCE INFORMATION

Primary Insurance _____ ID#_____ Group #_____

Employee Name _____ DOB _____ SS # _____

Employer _____

Secondary Insurance_____ ID#_____ Group #_____

Employee Name _____ DOB _____ SS # _____

Employer _____

Is the Patient covered by any type of Medicaid? ☐ Yes ☐ No

Ohio Living
Palliative Medicine

HISTORY AND PHYSICAL

Name _____

Date of Birth _____ Date of Appt. _____

Family Dr. _____ Dr. Requesting _____

DRUG/ENVIRONMENTAL/FOOD ALLERGIES

Allergen	Reaction

Allergen	Reaction

SURGICAL HISTORY

Surgery	Year

Surgery	Year

ALCOHOL USE

☐ Currently Drinks ☐ Drank in the Past ☐ Has Never Drunk Alcohol

Years _____ # Per Week _____ ☐ Drinks Rarely

TOBACCO USE

☐ Currently Smokes ☐ Smoked in the Past ☐ Has Never Smoked Tobacco Exposure _____

Type of Tobacco Used _____ Qty/Day _____ #Years _____

RECREATIONAL DRUG USE

☐ Currently Smokes Illigal Drugs ☐ Used Illegal Drugs in the Past ☐ Has Never Used Illegal Drugs

Type of Drug Used _____

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HISTORY AND PHYSICAL – CONTINUED

	Y	N
Acid Reflux		
AIDS/HIV		
Anemia		
Aneurysm Type:		
Angina		
Arthritis		
Asthma		
Bleeding Disorder		
Blood Clots		
Blood Transfusion Received:		
Bronchitis		
Cancer Type:		
Cardiac Birth Defects		
COPD		
Coronary Artery Stints		
Croup		
Defibrillator		
Diabetes		
Eczema		
Emphysema		
Heart Attack		
Heart Bypass		
Heart Disease		
Heart Murmur		
Hepatitis		
High Blood Pressure Diagnosed:		
High Cholesterol		
Hyperthyroidism		
Hypothyroidism		

	Y	N
Irritable Bowel Disease		
Kidney Disease		
Kidney Infections		
Migraines		
Pacemaker		
Pneumonia		
Problems with Anesthesia		
Prostate Disease		
Rheumatic Fever		
Seizures		
Sleep Apnea Diagnosed:		
Sleep		
Tuberculosis		
Ulcers		
Other Important Medical Conditions:		

Ohio Living
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HISTORY AND PHYSICAL – CONTINUED

Employment

☐ Currently Unemployed ☐ Currently Employed ☐ Retired ☐ Student ☐ Other_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Family History Includes

☐ Family History Unknown ☐ Adopted

Condition	Y	N	Who
Bleeding Disorders			
Malignant Hyperthermia			
Diabetes			
Tuberculosis			
Cancer			
High Blood Pressure			
Low Blood Pressure			
Stroke			
Kidney Disease			
Heart Disease			
Other			

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MEDICATION LIST

Name _____ Date _____

Date of Birth _____ Approx. Height _____ Weight _____

Local Pharmacy _____ Phone # _____

Mail-In Pharmacy ☐ None

Drug Allergies _____

_____

_____

_____

Medication	Doses	When Taken	Purpose

Ohio Living
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NOTICE OF PRIVACY PRACTICES

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.

I. Who We Are

This Notice of Privacy Practices ("Notice") describes the privacy practices of Ohio Living ("Ohio Living") including all Ohio Living continuing care retirement communities and Ohio Living Home Health & Hospice, their physicians, nurses, and other personnel. It applies to services furnished to you at any Ohio Living and Ohio Living Home Health & Hospice site or location.

II. Our Privacy Obligations

We are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of our legal duties and privacy practices with respect to your PHI. We are also obligated to notify you following a breach of unsecured PHI. When we use or disclose your PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures Without Your Written Authorization

In certain situations, which we describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures For Treatment, Payment and Health Care Operations. We may use and disclose PHI, but not your "Highly Confidential Information" (defined in Section IV.C below), in order to treat you, obtain payment for services provided to you and conduct our "health care operations" as detailed below:

- Treatment. We may use and disclose your PHI to provide treatment, for example, to diagnose and treat your injury or illness. We may also disclose PHI to other health care providers involved in your treatment.

- Payment. In most cases, we may use and disclose your PHI to obtain payment for services that we provide to you – for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("Your Payor") to verify that Your Payor will pay for health care.

- Health Care Operations. We may use and disclose your PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you.

NOTICE OF PRIVACY PRACTICES - CONTINUED

For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers. We may disclose PHI to our Patient Relations Coordinator in order to resolve any complaints you may have and ensure that you have a comfortable visit with us.

We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

- We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt out at any time by notifying the Medical Records Department.

B. Use or Disclosure for Directory of Individuals in Ohio Living. We may include your name, location in Ohio Living, general health condition and religious affiliation in a patient directory without obtaining your authorization unless you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name or members of the clergy; provided, however, that religious affiliation will only be disclosed to members of the clergy.

C. Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose your PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure.

If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that we believe is directly relevant to the person's involvement with your health care or payment related to your health care. We may also

NOTICE OF PRIVACY PRACTICES - CONTINUED

disclose your PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

D. Fundraising Communications. We may contact you to request a tax-deductible contribution to support important activities of Ohio Living. In connection with any fundraising, we may disclose to our fundraising staff demographic information about you (e.g., your name, address and phone number) and dates on which we provided health care to you, without your written authorization. You have the right to opt out of receiving fundraising communications and may do so by calling 800. 686.7800, ext. 160 or by sending an email to foundation@ohioliving.org.

E. Public Health Activities. We may disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

F. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

G. Health Oversight Activities. We may disclose your PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

H. Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

I. Law Enforcement Officials. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

J. Decedents. We may disclose your PHI to a coroner or medical examiner as authorized by law.

NOTICE OF PRIVACY PRACTICES - CONTINUED

K. Organ and Tissue Procurement. We may disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

L. Research. We may use or disclose your PHI without your consent or authorization if an Institutional Review Board or Privacy Board approves a waiver of authorization for disclosure.

M. Health or Safety. We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

N. Specialized Government Functions. We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

O. Workers' Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

P. As Required By Law. We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

IV. Uses and Disclosures Requiring Your Written Authorization

A. Use or Disclosure with Your Authorization. We must obtain your written authorization for most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute the sale of PHI. Additionally, other uses and disclosures of PHI not described in this Notice will be made only when you give us your written permission on an authorization form ("Your Authorization"). For instance, you will need to complete and sign an authorization form before we can send your PHI to your life insurance company or to the attorney representing the other party in a lawsuit in which you are involved.

B. Uses and Disclosures of Your Highly Confidential Information. Federal and state law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information"). This Highly Confidential Information may include the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and developmental disabilities services; (3) is about alcohol and drug abuse prevention, treatment and referral; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about sexually-transmitted disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (7) is about domestic abuse of an adult with a disability; or (8) is about sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must have Your Authorization.

NOTICE OF PRIVACY PRACTICES - CONTINUED

C. Revocation of Your Authorization. You may withdraw (revoke) Your Authorization, or any written authorization regarding your Highly Confidential Information (except to the extent that we have taken action in reliance upon it) by delivering a written statement to the Privacy Official identified below. A form of Written Revocation is available upon request from the Privacy Official.

V. Your Rights Regarding Your Protected Health Information

A. For Further Information; Complaints. If you would like more information about your privacy rights, if you are concerned that we have violated your privacy rights, or if you disagree with a decision that we made about access to your PHI, you may contact our Privacy Official. Also, you may make a complaint by calling the Ohio Living Corporate Hotline at 877. 780.9366. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Official will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You have the right to request a restriction on the uses and disclosures of your PHI (1) for treatment, payment and health care operations purposes, and (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved in your care or with payment related to your care. For example, you have the right to request that we not disclose your PHI to a health plan for payment or health care operations purposes, if that PHI pertains solely to a health care item or service for which we have been involved and which has been paid out of pocket in full. Unless otherwise required by law, we are required to comply with your request for this type of restriction. For all other requests for restrictions on use and disclosures of your PHI, we are not required to agree to your request, but will attempt to accommodate reasonable requests when appropriate. If you wish to request additional restrictions, please obtain a request form from our Privacy Official and submit the completed form to the Privacy Official. We will send you a written response.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you would like to access your records, please obtain a record request form from the Privacy Official and submit the completed form to the Privacy Official. If you request copies, we will charge you a cost-based fee, consistent with Ohio law, that includes (1) labor for copying the PHI; (2) supplies for creating the paper copy or electronic media if you request an electronic copy on portable media; (3) our postage costs, if you request that we

NOTICE OF PRIVACY PRACTICES - CONTINUED

mail the copies to you; and (4) if you agree in advance, the cost of preparing an explanation or summary of the PHI.

E. Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Official and submit the completed form to the Privacy Official. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

F. Right to Receive An Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years. If you request an accounting more than once during a twelve (12) month period, we will charge you $0.75 per page of the accounting statement. We will inform you in advance of any fee and provide you with an opportunity to withdraw or modify the request.

G. Right to Receive A Copy of this Notice. Upon request, you may obtain a copy of this Notice, either by email or in paper format. Please submit your request to:

Privacy Official
Ohio Living
9200 Worthington Road, Suite 300
Westerville, OH 43082
Phone: 614. 888.7800

VI. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective on January 1, 2014.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting areas around CE and on our Internet site at ohioliving.org/privacy-practices. You also may obtain any new notice by contacting the Privacy Official.

Ohio Living
Palliative Medicine

NOTICE OF PRIVACY PRACTICES - CONTINUED

VII. Privacy Official
You may contact the Privacy Official at:

Privacy Official
Ohio Living
9200 Worthington Road, Suite 300
Westerville, OH 43082
Phone: 614. 888.7800

Ohio Living
Palliative Medicine

PATIENT RIGHTS AND RESPONSIBILITIES

PROVIDER-PATIENT RELATIONSHIP

The Provider-Patient Relationship is respected in this practice. This includes responsibilities on the part of the patient as well as the provider. If at any time either party feels this relationship is no longer in good standing, either party may sever the relationship. If the provider chooses the sever the relationship, they may do so bygiving the patient a 30-day written notice. During the 30 days, the patient should seek a new provider. Ohio Living Palliative Medicine will send over all medical records to the newly-requested provider on behalf of the patient. The provider will provide only emergent care during this 30-day window. No new narcotics will be written during this time. Situations that may result in the provider terminating the relationship include, but are not limited to:

- Disrespectful or abuse behavior toward an Ohio Living Palliative Medicine staff member
- Repeated failure to keep scheduled appointments
- Repeated or prolonged failure or refusal to pay agreed-upon payments for services rendered
- Providing dishonest or deceptive information regarding medical care or financial responsibility
- Obtaining the same medications from several providers

CANCELLATION POLICY

As a courtesy to our team, as well as to other patients who are waiting to schedule with our services, we require you to give us at least 24 hours notice if you are unable to keep your appointment. If you do not cancel or reschedule your appointment with at least 24 hours notice, we may assess a $35 service charge to your account.

OFFICE POLICIES

Ohio Living Palliative Medicine hours are Monday through Friday, from 9 a.m. to 5 p.m. These hours are subject to change. Your appointment may be canceled due to severe weather conditions, illness or other unforeseen incident. We will do our best to notify you in this event. You may call the office after 9 a.m. if in question. Please note that we do NOT make house calls in any level two or three snow emergencies. Providing for the safety of our staff is important to us.

Patients are asked to kindly give us 24 hours notice, if possible, when canceling or rescheduling an appointment. This will allow us to work in a sick patient house call if possible.

Ohio Living
Palliative Medicine

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of:

1. Notice of Privacy Practices

2. Patient Rights and Responsibilities

3. Cancellation Policy

Name (please print) _____ Date _____

Signature _____

Ohio Living
Palliative Medicine

CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name _____ Date of Birth _____

Dear _____,

I, _____, have recently become a patient of Ohio Living Palliative Medicine, for a permanent or undetermined amount of time.

I authorize you to release my medical records, including labs, progress notes, immunizations, diagnostics and any other medical records you may have to the address listed below.

My records are under the following name:

Name _____ Maiden Name _____

Address _____ Date of Birth _____

City _____ State _____ ZIP _____

Please release my records to:

Ohio Living
Palliative Medicine
5916 Cresthaven, Suite 215B
Toledo, Ohio 43614
Phone 844.312.7479
Fax 419.948.4047

Patient Signature _____

Ohio Living
Palliative Medicine

PROTECTED HEALTH INFORMATION

Name _____ Date of Birth _____

In general, the HIPAA Privacy Rule gives an individual the right to request a restriction on the uses and disclosures of the Protected Health Information (PHI). Please indicate your preferences regarding your PHI below.

I wish to be contacted in the following manner: (check all that apply)

ORAL COMMUNICATION

☐ Home Phone _____

☐ Okay to leave detailed message ☐ Leave message with call-back number only

☐ Home Phone _____

☐ Okay to leave detailed message ☐ Leave message with call-back number only

☐ Home Phone _____

☐ Okay to leave detailed message ☐ Leave message with call-back number only

SHARING COMMUNICATION *(use the back of this page if needed)*

☐ Okay to mail my PHI to my home address

☐ Please mail to my work address _____

WRITTEN COMMUNICATION

☐ I permit the practice to discuss and disclose my PHI with:

☐ Spouse _____ Phone _____

☐ Children _____ Phone _____

_____ Phone _____

_____ Phone _____

☐ Other _____ Phone _____

Patient Signature _____

Ohio Living
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INSURANCE INFORMATION

Insurance cards should be provided at the time of your visit. Please notify the office of any changes in insurance information prior to a home visit. Failure to do so may result in a bill for your services that day.

Allow 48 hours for completion of prescription refills when they are requested outside of your visit with your provider.

Pain medication/narcotics will be prescribed at the discretion of the provider. You will be asked to complete and adhere to the Ohio Living Physician Services narcotics policy, which will include random drug screens to ensure appropriate usage of the medications. Lost medication will NOT be replaced under most circumstances. Any long-term usage of pain medications will require pain management intervention and a referral will be provided for you at the discretion of our Ohio Living Physician Services providers.

Thank you, and we look forward to caring for you!

Signature _____ Date _____

Witness Signature _____ Date _____

Ohio Living
Palliative Medicine

INSURANCE INFORMATION

Patient Name _____ Date of Birth _____

I, _____ , hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s), nurse practitioner or physician assistant working for Ohio Living Physician Services. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician or physician extenders. I understand that, should any Ohio Living Physician Services staff member or any contracted employees of Ohio Living Physician Services or other person(s) be exposed or report an exposure of blood or body fluids, my blood will be tested for blood borne infections including Hepatitis B and C as well as HIV/AIDS. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to as a result of treatments or examination from Ohio Living Physician Services provider or staff members.

I, _____ , as the patient or legal guardian of, authorize the insurance carrier to make checks for medical expenses due me payable to the attending staff or associate practice. I also authorize the release of any information regarding treatment to the insurance carrier. I further understand that I am responsible for all medical expenses and agree to pay any expenses not covered by my insurance carrier(s). I understand that after my primary insurance carrier has paid or rejected payment, an effort will be made to collect from my secondary insurance carrier. I fully understand that I am responsible for the remaining balance, co-payment and deductible, and that billing my insurance is done of contractual obligation for

Thank you, and we look forward to caring for you!

Signature _____ Date _____

Witness Signature _____ Date _____