Patient Name: _____ Site of Service: _____

PATIENT/PARTICIPANT BILL OF RIGHTS

GSC Therapy Services is committed to providing the highest quality in health care services. Employees promise to uphold the rights of the patients/participants to receive services in a professional, courteous and efficient manner. Patients have the right to be notified, in writing, of their rights and obligations prior to the initiation of treatment.

The patient/participant will be referred to GSC Therapy Services when determined to be medically necessary and justified and/or is the result of a professional assessment requested by the participant.

- A patient's responsible party may exercise the patient's rights when the patient has been judged incompetent or is unable to understand his/her rights.

- The participant/patient has the right:
  - To be treated with respect and dignity and care will be based on honesty and ethical standards of behavior, including the right to have his/her property treated with respect.
  - To confidentiality with regard to information about his/her health, social and financial circumstances, and about what occurs throughout the course of service.
  - To a clear and understandable explanation of his/her medical situation, identified limitations, of the treatments and procedures needed, and of the expected outcomes within the scope of the care provider, including informed consent.
  - To an assessment of needs and an appropriate plan of care, jointly developed by patient/participant and rehabilitation professional, utilizing a coordinated delivery of services with referral to other qualified care providers, and to participate in the relationship between the parties as these may relate to the patient's/participants services, care or treatment.
  - To be advised of any change in the care before the change is made, whether it relates to the medical care plan, the service interventions, the care provider or the agency policies that affect the patient/participant.
  - To be advised of the types of caregivers (healthcare discipline) who will furnish the care, the type of therapy service frequency, and upon request, the name, title, and qualifications of the participating caregivers.
  - To be provided with all medically related care in accordance with physicians' orders.
  - To considerate care that respects his/her personal values, beliefs, cultural and spiritual preferences and lifelong patterns of living.
  - To expect the care provider to release information concerning the patient/ participant only as required by law or authorized by the patient/participant/responsible party.
  - To refuse any portion of planned treatment, including the provision of care by students, without relinquishing other portions of the treatment plan, except where medical contraindications to partial treatment exist.
  - To refuse to participate or not to participate in research, investigation, or clinical trials and to informed consent of participation.

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- To privacy during medical treatment or other rendered care.
- To participate in the collaboration and planning of his/her medical treatment and/or service plan.
- To inspect their medical or service record and to receive a copy thereof at a specified copy fee.
- To be informed of the extent to which charges will or will not be covered by Medicare, Medicaid, or other payer known to the care provider which includes:
    - To be informed of charges for which the patient may be liable, to be made aware of any changes in the charges in a timely manner; and have access, upon request, to all bills for service(s) related to his/her care; and to be informed of all items and services furnished by GSC Therapy Services for which payment may be made by the Medicare Program.
- To voice complaints without fear of reprisal or discrimination upon filing a complaint; to know about the disposition of such complaints.
- To have all reasonable requests responded to promptly and efficiently within the capacity of the service provider.

Patient Name: _____ Site of Service: _____

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CONSENT AND ASSIGNMENT FORM

Consent for Treatment and Patient Bill of Rights

On this date_____(dd/mm/yy) I authorize GSC Therapy Services to perform the physical therapy, occupational therapy and/or speech language pathology examinations, tests, and/or treatments that it considers necessary for my care. I agree to work with GSC Therapy Services to maximize my progress toward mutually established treatment goals, which have been authorized by my physician.

***Indicate the SOC for each discipline authorized. ***

PT SOC: _____

OT SOC: _____

SLP SOC: _____

Release of Information, Assignment of Benefits, and Financial Liability

I, intending to be legally bound, authorize GSC Therapy Services and its representatives to share records and information with third parties participating in my Rehab, including any party through which an insurance program or otherwise is paying for all or part of my Rehab. I authorize GSC Therapy Services to act on my behalf with any reasonable and necessary appeals in regard to services provided by GSC Therapy Services.

I authorize payment of medical benefits by any third-party payer to be made directly to GSC Therapy Services for any Rehab services rendered to me. I, the Patient, understand that I am financially responsible, as required by federal, state, and insurance company regulations, for any benefits not covered by a third-party payer.

Verbal Consent given by _____

(Patient Representative)

Patient Representative's phone number: _____

Witnessed by: _____ and _____

(Signature/Date) *(Signature/Date)*

Date Consent and Assignment Form mailed to Patient Representative: _____

I warrant that I have read the Consent for Treatment above and have received a copy of the Patient Bill of Rights.

Signature: _____

(Patient/Patient's Representative)

If any of the above is signed by an authorized representative due to the incapacity of the patient, what is the relationship of this representative to the patient?

_____

GSC THERAPY SERVICES

THIS LOCATION SUBSCRIBES TO THE FOLLOWING 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.

This location is required by law to maintain the privacy of your medical information and to provide you with this notice so you will understand how we may use or share your medical information and GSC's legal duties and privacy practices relative to your medical information. GSC is required to follow the terms of the notice currently in effect. GSC will notify affected individuals in writing in the event of a breach of unsecured protected health information.

If you have any questions about this notice, please contact Kris Smith at GSC Therapy Services.

UNDERSTANDING YOUR HEALTH AND MEDICAL RECORD INFORMATION

Every time you access or receive services from a GSC Therapy Services site, documentation in your health/medical record is made. Typically, this record contains information about your condition and the treatment that we provide. We use and disclose this information to:

□ Plan your care and treatment
□ Document the care you received
□ Educate health professionals
□ Provide information for medical research
□ Provide data for GSC Therapy Services' planning
□ Help transition your care to persons arranging for or directly providing for your care in the Community following your discharge
□ Communicate with other health professionals involved in your care
□ Provide a means by which an insurance company can verify and pay for services
□ Provide information to public health officials
□ Evaluate and improve the care we provide

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe the ways we may use and disclose your medical information. We are unable to describe every possible way that we may use or disclose medical information under each category below. However, all of the ways we are permitted or required to use and disclose information will fall into one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment. We may disclose medical information about you to doctors, nurses, therapists, or other persons who are involved in taking care of you. For example, specialists may need access to your health information. A doctor treating you for a broken leg may need to know that you have diabetes because diabetes may slow the healing process. The doctor may also need to involve the dietitian, the pharmacist and therapist in your treatment plan. Different departments of a location also may share medical information about you in order to coordinate your care and provide you with medication, lab work and x-rays. We may also disclose medical information about you to people outside this location who may assist in transitioning your care to community providers, or directly to community providers that may be involved in your care after discharge. This may include visiting nurses that provide care in your home. In addition, we may disclose medical information about you to your healthcare services providers following your discharge.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to you, an insurance company, or a third party. For example, in order to be paid, we may need to share information with your health plan about services that GSC provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for health care operations, such as in conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, case management and care coordination. This is necessary to ensure that all our residents/patients receive quality care. For example, we may use medical information to review our services for quality improvement or compliance activities. We may combine medical information about groups of residents/patients to evaluate our programs. We may also disclose information to doctors, nurses, therapists and other GSC personnel for review and learning purposes. We may remove information that identifies you so others may see it to study health care and health care delivery without learning the identities of residents/patients.

We may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if that each entity provided or will be consulted to provide treatment to you. These disclosures may be made when the protected health information will pertain to such treatment, and the disclosure is for health care operations related to those providers or for the purpose of health care fraud and abuse detection or compliance.

OTHER ALLOWABLE USES OF YOUR MEDICAL INFORMATION

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose medical information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. We will only disclose the information which is directly relevant to the person's involvement in your care or payment related to your care.

We may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Our Practices.

- We may post your birthday or other special event on a calendar or bulletin board that is visible to the public.
- We may include your name and/or photo in an internal newsletter or other publication, including information regarding your admission, discharge, memorial or obituary information.
- We may display your name on a place (name) card at the dining room table.
- We may display your photo on a bulletin board within the center. However, we will not give photographs of you to anyone outside of our location unless we have your permission.

Business Associates. There are some services provided in our organization through contracts with business associates. Examples include outside attorneys and a copy service we use when making copies of your health record. When we contract with a business associate to provide these services, we may disclose your medical information so they can perform the job we've asked them to do. We do require that the business associate appropriately safeguards your information.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all residents/patients who received one medication to those who received another for the same condition. A special approval process evaluates a proposed research project before it is implemented. Before we use or disclose your medical information for research, the project will have been approved through this process. We may, however, disclose medical information about you to people preparing to conduct a research study so long as the medical information they review does not leave the GSC location.

Health Information Exchange. If we participate in a Health Information Exchange or "HIE", as permitted by law, we may share your health information electronically with this exchange in order to provide faster access to information and improved coordination of care to assist providers and others in making more informed decisions. If we participate in an HIE, you will have the opportunity to opt out or in some cases you will be asked to consent to the exchange of information. If you opt out or withhold your consent to the exchange of information through the HIE, your personal health information will continue to be used in accordance with this Notice and the law, but will not be made available through the HIE. If we participate in an HIE, we will do so in a manner that protects the confidentiality, privacy, and security of your information.

Health Care Benefits and Reminders. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Workers' Compensation. We may disclose medical information to the extent necessary to comply with laws relating to worker's compensation or other similar programs. These programs provide benefits for work-related illness or injuries.

Reporting. Federal and state laws may require or permit GSC to disclose certain medical information related to the following:

- *Public health risks:*
  - prevention or control of disease, injury or disability
  - reporting births and deaths
  - reporting child abuse or neglect
  - reporting reactions to medications or problems with products
  - notifying people of product recalls
  - notifying persons who may have been exposed to a disease
- *Reporting abuse, neglect or domestic violence:* Notifying the appropriate government agency if we believe a resident/patient has been the victim of abuse, neglect, or domestic violence.
- *Health oversight:* We may disclose medical information to a health oversight agency for activities such as audits, investigations, inspections, and licensure.
- *Judicial and Administrative proceedings:* If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Law Enforcement. We may disclose your medical information for law enforcement purposes as required by law or in response to a valid subpoena.

Correctional Institution. Should you be an inmate of a correctional institution, we may disclose to the institution or its agents medical information necessary for your health and the health and safety of others.

As Required by Law. GSC may use or disclose medical information if the use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of the law.

GSC may, in accordance with the law, disclose medical information that it believes in good faith is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or public. GSC would disclose such information to a person reasonably able to prevent or lessen the serious and imminent threat.

OTHER USES OF MEDICAL INFORMATION REQUIRING WRITTEN PERMISSION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. This includes most disclosures of psychotherapy notes, the use of your medical information for marketing purposes, disclosures that constitute the sale of medical information, and other uses and disclosures not described in this Notice. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. You also will be unable to revoke written permission to disclose medical information that you gave as a condition of obtaining insurance coverage where the law allows the insurer to contest a claim under the policy or the policy itself.

YOUR MEDICAL INFORMATION RIGHTS

Although your health record is the physical property of GSC, the information in your health record belongs to you. You have the following rights:

- **Right to Request Restrictions**. You may request that we not use or disclose your medical information for a particular reason related to treatment, payment, or health care operations or that we not disclose medical information to a family member or other specific relative or close friend involved in your care. We must comply with this request if you pay for your care entirely out-of-pocket and the disclosure is not required by law. If we are unable to agree to a requested restriction, we are not required to comply with the request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. *You must submit your request for restrictions in writing to the Privacy Officer Designee. In your request, you must tell us 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply, for example, disclosures to your spouse.*

- **Right to Request Alternative Locations or Confidential Communications.** During the course of treatment, we will routinely communicate with you regarding your care. As stated above, we will only disclose to other authorized people the information which is directly relevant to the person's involvement in your care or payment related to your care. You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we contact you via mail to a post office box. *You must submit your request in writing to the Privacy Officer Designee. We will*

not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to Inspect and Copy.** You have the right to review and copy your medical information. You have the right to request an electronic copy of your medical information. You may request that we send a copy of your medical information directly to another person. *You may verbally request to review your record. You must submit your request for a paper or electronic copy of your medical record in writing to the Privacy Officer Designee. We may charge a fee for the costs of copying, mailing or other supplies (including electronic media, if applicable) associated with your request.*

- **Right to Amend.** If you believe that any medical information in your records is incorrect or if you believe that important information is missing, you may request that we amend the existing information or add the missing information. We may deny your request for an amendment if it is not in writing or does not specify in what way the information is incorrect or incomplete. In addition, we may deny your request if you ask us to amend information that was not created by us, is not part of the medical information kept by GSC, or is accurate and complete. *You must submit your request in writing to the Privacy Officer Designee. In addition, you must provide a reason for your request.*

- **Right to an Accounting of Disclosures.** You may request that we provide you with a written accounting of all disclosures made by us during a certain time period. This is a list of certain disclosures we made of your medical information. It will not include certain disclosures such as those made for treatment, payment or healthcare operations purposes. *You must submit your request in writing to the Privacy Officer Designee. Your request must state a time period, which may not be longer than six years from the date the request is submitted and may not include dates before Jan 1st, 2017. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists during any 12-month period, we may charge you for the costs of providing the list.*

- **Right to a Paper Copy of This Notice**. You have the right to obtain a paper copy of our Notice of Information Practices upon request, even if you agreed to receive the notice electronically. *You may obtain a paper copy of this notice from the Privacy Officer Designee*.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with GSC or with the Secretary of the Department of Health and Human Services. To file a complaint with GSC, contact the GSC Compliance Officer by calling 480-855-8866 or by contacting krissmith@gsconsultinggroup.com. There will be no retaliation for filing a complaint.

CHANGES TO THIS NOTICE

GSC reserves the right to change its privacy practices as set forth in this notice and to make the new provisions effective for all medical information that GSC maintains. We will post a copy of the current notice in the GSC location. The notice will specify the effective date (on the first page in the bottom left corner). In addition, if material changes are made to this notice, the notice will contain an effective date of the revisions and copies can be obtained by contacting the Privacy Officer Designee.

FOR QUESTIONS, MORE INFORMATION, OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact the GSC Privacy Officer listed in your New Patient Documents. The Privacy Officer or representative will advise you in the steps necessary to exercise these rights.

Patient Name: _____ Site of Service: _____

INSTRUCTIONS FOR COMPLETING THE NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGMENT OF RECEIPT OF NOTICE

After providing the patient (or patient's representative) with a copy of the *Notice of Privacy Practices (NPP)*:

1. Print the patient's full name (and patient's representative, as appropriate) in the top section of this form.

2. Complete the name of the site of service in the top section of this form.

3. If the patient is able to complete the form independently, insert "N/A" for the name of the patient's representative in the bottom section of the form.

4. If needed, complete and send the NPP and NPP Acknowledgement to the patient's representative.

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGMENT OF RECEIPT OF NOTICE

I have reviewed the GSC Therapy Services Notice of Privacy Practices and understand that it describes how medical information about me may be used and disclosed, as well as how I can access this information.

_____
Patient or Patient Representative Signature

_____ _____
Name of Patient Representative *(please print)* Date

_____ _____
GSC Representative Date

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MEDICARE SECONDARY PAYOR QUESTIONNAIRE

Customer Name:_____ Health Insurance or SSN #: _____

Has this customer been confirmed to a hospital or skilled nursing facility within the last 60 days?

[ ] **YES** [ ] **NO**

Part I

1. Are you receiving Black Lung (BL) Benefits? *(BL is primary only for claims related to BL.)* [ ] **YES**
   Date benefits began: ___/__/___ [ ] **NO**
2. Are the services to be paid by a government program such as a research grant?
   [ ] **YES** *Government Program will pay primary benefits for these services.* [ ] **NO**
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this center? [ ] **YES** *DVA is primary for these services.* [ ] **NO**
4. Was the illness/injury due to a work-related accident/condition?
   [ ] **YES** Date of injury/illness:___/___/___
   [ ] **NO**
   Name and address of Workers' Compensation (WC) plan:

   _____

   _____

   Policy or identification number: _____

   Name and address of employer:

   _____

   _____

   WC is the primary payor only for claims related to work related injuries or illness.

Part II

1. Was illness/injury due to non-work related accident? [ ] **YES** Date of Accident: _/_/_ [ ] **NO**
   Go to Part III.
2. What type of accident caused illness/injury?
   [ ] Automobile
   [ ] Non-automobile
   Name and address of no-fault or liability insurer:

   _____

   _____

   Insurance claim # _____

   No-fault insurer is primary payor only for those claims related to the accident. Go to Part III.

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3. Was another party responsible for this accident?
[ ] **YES**
[ ] **NO** *Go to Part III.*
Name and address of liability Insurer:

_____

_____

Insurance claim number _____

Liability insurer is primary only for those claims related to the accident. Go to Part III.

Part III

1. Are you entitled to Medicare based on:
[ ] Age *Go to Part IV.*
[ ] Disability *Go to Part V.*
[ ] ESRD *Go to Part VI.*

Part IV - Age

1. Are you currently employed?
[ ] **YES** [ ] **NO** Date of retirement: _/___/_ Name and address of employer:

_____

_____

2. Is your spouse currently employed?
[ ] **YES** [ ] **NO** Date of retirement: _/___/_ Name and address of employer:

_____

_____

Medicare is the primary payor if the customer answered "no" to both questions 1 and 2, unless the customer answered "yes" to questions in Parts I or II. Do not proceed any further.

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?
[ ] **YES** [ ] **NO** *STOP! Medicare is the primary payor unless the customer answered "yes" to the questions in Parts I or II.*

4. Does the employer that sponsors your GHP employ 20 or more employees?
[ ] **YES** *STOP! Group health plan is the primary payor. Obtain the following information:* Name and address of GHP:

Policy identification number: _____
Group identification number: _____
Name of policyholder: _____
Relationship to customer: _____

Questions in Parts I or II.

NO *STOP! Medicare is the primary payor unless the customer answered "yes" to*

Part V - Disability

1. Are you currently employed?
   [ ] **YES**
   Name and address of employer:

   _____

   _____

   [ ] **NO** Date of retirement? ___/___/___

   Medicare is the primary payor if the customer answers "no" to both questions 1 and 2, unless the customer answered "yes" to questions in Parts I or II. Do not proceed any further.

2. Do you have group health plan (GHP) coverage based on your own or a family member's current employment? [ ] **YES** [ ] **NO** *Stop! Medicare is the primary payor unless the customer answered "yes" to the questions in Parts I or II.*

3. Does the employer that sponsors your GHP employ 100 or more employees?
   [ ] **YES** *STOP! Group health plan is the primary payor. Obtain the following information:* Name and address of GHP:

   _____

   Policy identification number: _____

   Group identification number: _____
   Name of policyholder: _____
   Relationship to customer: _____
   [ ] **NO** *STOP! Medicare is the primary payor unless the customer answered "yes" to questions in Parts I or II.*

Part VI - End Stage Renal Disease (ESRD)

1. Do you have group health plan (GHP) coverage?
   [ ] **YES**
   Name and address of GHP:

   _____

   _____

   Policy identification number: _____
   Group identification number: _____
   Name of policyholder: _____
   Relationship to customer: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

_____

[ ] **NO** *STOP! Medicare is the primary payor.*

2. Have you received a kidney transplant?
   [ ] **YES** Date of transplant:___/___/
   [ ] **NO**
3. Have you received maintenance dialysis treatments?
   [ ] **YES** Date dialysis began:____/____/
   If you participated in a self-dialysis training program, provide date training started:____/___/
   [ ] **NO**
4. Are you within the 30-month coordination period? [ ] **YES**
   [ ] **NO** *STOP! Medicare is the primary payor.*
5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?
   [ ] **YES**
   [ ] **NO** *STOP! GHP is the primary payor during the 30-month coordination period.*
6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?
   [ ] **YES** *STOP! GHP continues to pay as primary payor during the 30-month coordination period.*
   [ ] **NO** *Initial entitlement based on age or disability.*
7. Does the working aged or disability MSP provision apply (i.e., is the GHP Primary Payor based on age or disability entitlement)?
   [ ] **YES** *GHP continues to pay as primary payor during the 30-month coordination period.*
   [ ] **NO** *Medicare continues to pay as primary payor.*

NOTICE OF NON-DISCRIMINATION

GSC service locations comply with civil rights laws and do not exclude, deny benefits to, or otherwise discriminate against any person (i.e. patients, employees, or visitors) because of race, color, religion, national origin, gender, gender expression, gender identity, sexual orientation, age, disability, marital status, pregnancy, ancestry, genetic information, amnesty or veteran status in admission to, participation in, or receipt of the services and benefits under any of its programs and activities whether carried out by the location directly, or through a contractor or any other entity with which the location arranges to carry out its programs or activities.

- GSC service locations will take appropriate steps to ensure that persons who have disabilities, including persons who are deaf, hard of hearing, or blind, or who have other sensory or manual impairments have an equal opportunity to participate in our services, activities, programs, and other benefits.

- Examples of auxiliary aids and services include, but are not limited to:
    - Communication devices such as writing materials, iPads, flashcards, and communication boards.

If you need these services, or believe that a GSC service location has failed to provide these services or has engaged in discrimination, or if you need help filing a grievance, you may contact the GSC Therapy Services at:

480-855-8866

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington,
D.C. 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.