THANK YOU BEING A NEW PATIENT

Once you have completed the enclosed forms, please return them to Accessible Dental Services via the fax, e-mail, or the mailing address listed below:

Fax: (724) 772-9642
E-mail: schedule@accessibledental.org
Mailing Address:
Accessible Dental Services, Inc.
P.O. Box 189
641 Reno Street
Rochester, PA 15074

For any questions, please call or email us at:

Phone: (724) 775-0448 x3009 (Please leave a voicemail – we will return your call)
Email: schedule@accessibledental.org

PREOPERATIVE ANESTHESIA INSTRUCTIONS

You should not eat or drink anything after midnight before your scheduled surgery day. You may take all of your regularly scheduled medications in the morning on day of your operation with either a small sip of water, a tablespoon or less of clear Jell-O, or a tablespoon of Karo Syrup. **(NO APPLESAUCE, NO PUDDING, NO THICK-IT PERMITTED!)** Please contact your PCP to give you specific instructions if you are on diabetic medications or other medications which require special attention. Call with any questions.

You must make arrangements for two responsible adults to take you home after your anesthetic. **For safety reasons, you are *required* to have a responsible adult, in addition to the driver of the vehicle, to care for you and any additional patient who have been sedated and are passengers in your vehicle. This condition will be strictly enforced. You will not be allowed to leave alone or drive yourself home.**

Wear loose fitting clothing with short sleeves. Appropriate footwear: no flip-flops or open toed shoes. Contact lenses, jewelry, and nail polish must be removed prior to your operation.

What to expect the Day of Your Surgery:

You will meet your Anesthesiologist the day of your operation. Your medical history will be reviewed, and all of your questions will be answered. Your consent to proceed with your anesthetic and procedure must be completed. An Intravenous Line (IV) will be started, and appropriate monitors will be attached to you for monitoring purposes and for your safety. Your Anesthesiologist is also responsible for managing medical problems that might arise related to surgery as well as any chronic medical conditions you may have, such as asthma, diabetes, high blood pressure, or heart problems. Your anesthesiologist will remain with you during your entire procedure. When you meet appropriate discharge criteria you will be discharged. Your escorts will be allowed to be with you from this point onward. As you 'awaken' further, staff will assist you in preparing to leave for home.

Should you have any questions whatsoever, you may call our team at the numbers provided.

POST OPERATIVE ANESTHESIA INSTRUCTIONS

Should you have a **LIFE-THREATENING EMERGENCY** after your procedure, please activate your local emergency response (Call an Ambulance, Dial 911) immediately.

Nausea or vomiting may be related to anesthesia, the type of surgical procedure, or postoperative pain medications. Although less of a problem today because of improved anesthetic agents and techniques, these side effects continue to occur for some patients. Most patients are given an antiemetic to help decrease this incidence of nausea and vomiting. Most cases are quickly self-limiting. If these problems persist, please contact either your Surgeon or Anesthesiologist for further instructions.

Patients often experience drowsiness and minor after-effects following anesthesia, including muscle aches, sore throat and occasional dizziness or headaches. These side effects usually decline rapidly in the hours following surgery and anesthesia but might persist for several days before they are gone completely. The majority of patients do not feel up to their typical activities the next day, usually due to general tiredness or surgical discomfort. Plan to take it easy for a few days, until you feel back to normal. Know that a period of recovery at home is common and to be expected. Patients may make you drowsy and unable to concentrate. For the first 24 hours after your anesthetic, it is highly unadvisable to engage in activities such as driving, operating machinery, or making complex decisions.

Special Need Patients must have someone with them continually until they are back to their baseline.

This cannot be overemphasized.

PATIENT INFORMATION

PLEASE PRINT VERY CLEARLY

Patient Name: _____ Date: _____/_____/_____

Address: _____
Street City State Zip Code

Date of Birth: _____ Social Security Number: _____

Patient's Agency: _____ House Name: _____

Day Phone #: _____ Night Phone #: _____

Agency Contact Name: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Medical Insurance: _____
Name Subscriber # Group #

Dental Insurance: _____
Name Subscriber # Group #

Please provide a copy of insurance cards if able.

Does your insurance (Med/Dent) require a Preauthorization? Yes ☐ No ☐

Primary Care Physician: _____
Name Phone #

Address: _____
Street City State Zip Code

Authorization: I hereby authorize payment directly to Accessible Dental Services, Inc. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.
I hereby authorize Accessible Dental Services, Inc. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the anesthesia/dental medical histories are correct to the best of my knowledge. I grant the right to the dentists to release my anesthesia/dental histories and other information about my dental treatment to third party payors and/or other health professionals.

Signature: _____ Date: _____/_____/_____

PRE-ANESTHETIC QUESTIONNAIRE AND MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____/_____/_____

Who is providing this information? Name: _____ Date: _____/_____/_____

Relationship to Patient: ☐ Physician ☐ Nurse ☐ House Manager ☐ Parent ☐ Patient

Patients Information: Age: _____ Height: _____ Weight: _____ lbs. Sex: Male ☐ Female ☐

Patient's Physician Name: _____ Phone Number: _____

Date of last PCP visit: _____/_____/_____ Reason: _____

Has the patient had any emergency medical treatment in the last two years: Yes ☐ No ☐
If Yes, Reason: _____
Has the patient had a serious illness or operation? Yes ☐ No ☐
List if any: _____
Has the patient experienced "trouble" with a previous anesthetic: Yes ☐ No ☐
If yes, please explain_____
Does the patient smoke? Yes ☐ No ☐ If Yes, how many packs per day and how long? _____

Has the patient had any allergies or adverse reactions to any drug or medication? Yes ☐ No ☐
If Yes, List drugs and describe reaction: _____
Does the patient require an antibiotic before dental treatment due to heart defects or artificial joint replacement?
Yes ☐ No ☐ If Yes, what is the reason for antibiotic? _____
Is the patient on any blood thinners (ex: Coumadin, Warfarin, Plavix, or Aspirin)? Yes ☐ No ☐
If Yes, List: _____
List all medications on next page (page 2) ➔
Describe Physical limitations: None ☐ Needs Assistance (i.e. walker) ☐ Non-ambulatory (wheelchair) ☐
Describe the ability to communicate: Good ☐ Somewhat verbal ☐ Non-verbal ☐
Describe the patient's ability to interact: Easily follows instructions ☐ Needs guidance ☐ Combative ☐
Does the patient tolerate injections and/or blood draw: Easily ☐ Needs guidance ☐ Combative ☐

High Blood Pressure	Yes ☐ No ☐	Asthma	Yes ☐ No ☐	Intellectual Disability	Yes ☐ No ☐		
Angina/Chest Pain	Yes ☐ No ☐	COPD/Emphysema	Yes ☐ No ☐	Seizures	Yes ☐ No ☐		
Irregular Heart Beat	Yes ☐ No ☐	Shortness of Breath	Yes ☐ No ☐	Paralysis	Yes ☐ No ☐		
Dizziness/Fainting	Yes ☐ No ☐	Coughing/Wheezing	Yes ☐ No ☐	Autism	Yes ☐ No ☐		
Heart Attack	Yes ☐ No ☐	Sleep Apnea	Yes ☐ No ☐	Downs Syndrome	Yes ☐ No ☐		
Stroke/CVA	Yes ☐ No ☐	Loud Snoring	Yes ☐ No ☐	Psychiatric Disorder	Yes ☐ No ☐		
Mini-Stroke/TIA	Yes ☐ No ☐	Pneumonia	Yes ☐ No ☐	Exhibits Pica (eats objects)	Yes ☐ No ☐		
Mitral Valve Prolapse	Yes ☐ No ☐	Aspirates Food	Yes ☐ No ☐	Crohn's Disease	Yes ☐ No ☐		
Heart Surgery	Yes ☐ No ☐	Gastric Reflux	Yes ☐ No ☐	Ulcerative Colitis	Yes ☐ No ☐		
Congenital Heart Defects	Yes ☐ No ☐	Requires Oxygen	Yes ☐ No ☐	Cancer/Malignancies	Yes ☐ No ☐		
Abnormal Bleeding	Yes ☐ No ☐	Breathing Treatments	Yes ☐ No ☐	Bladder/Kidney Problems	Yes ☐ No ☐		
Aspirin or Blood Thinners	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Artificial Joints	Yes ☐ No ☐		
Anemia	Yes ☐ No ☐	Requires Insulin	Yes ☐ No ☐	Limited neck Movement	Yes ☐ No ☐		
Sickle Cell	Yes ☐ No ☐	Hyper/Hypothyroidism	Yes ☐ No ☐	Visual Impairment	Yes ☐ No ☐		
Blood Transfusion	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐		
		HIV/AIDS	Yes ☐ No ☐	Hearing Impairment (Deaf)	Yes ☐ No ☐		
		TB	Yes ☐ No ☐	Eczema	Yes ☐ No ☐		

PRE-ANESTHETIC QUESTIONNAIRE AND MEDICAL HISTORY (Page 2)

Patient Name: _____

Please list all medications:

Medication	Strength	Frequency (i.e. qid, q6h, etc.)

Please list all Diagnoses:

1.
2.
3.
4.
5.
6.
7.
8.

PRE-ANESTHETIC QUESTIONNAIRE AND MEDICAL HISTORY (Page 3)

Is the Patient regularly treated by the following:

- Cardiologist
- Pulmonologist
- Neurologist

If yes, please attach notes from the last visit with this packet.

Additional Medical Information:

When was the patients last Dental appointment? _____

Does the patient require IV sedation for dental appointments? Yes ☐ No ☐

Does the patient require a pre-sedation medication prior to IV Sedation appointments? Yes ☐ No ☐

If yes, please provide pharmacy information: _____

_____

Any Additional Information: _____

_____

_____

_____

_____

_____

_____

CONSENT FOR ANESTHESIA ADMINISTRATION

Patient Name: _____ Date:____/_____/_____

ACKNOWLEDGEMENT

I understand that I will be receiving Anesthesia and my Anesthesiologist will use their best judgement in my care providing this anesthetic. Anesthesia risks and dangers are rare but can be life threatening. Risks range from minor irritation at the insertion site of the Intravenous insertion all the way up to death. Although uncommon, adverse drug reactions, damage to the throat, teeth, vocal cords, or dental work, do rarely occur. I am aware that the practice of Anesthesia and Medicine is not an exact science and that no guarantee or assurance can be made as to the results that may occur.

I have read the above, my questions have been answered, and I consent to the Administration of Anesthesia.

_____ _____/_____/_____
Name of Parent/Guardian (Please Print Full Name) Date

_____
Signature of Parent/Guardian

_____
Relationship to Patient (please include phone number of Parent/Guardian in case of emergency)

_____
Witness Signature & Print Full Name

CONSENT FOR COMPREHENSIVE DENTAL TREATMENT

Patient Name: _____ Date:_____/_____/_____

ACKNOWLEDGEMENT

I hereby authorize the dental office to administer such medication and provide comprehensive oral rehabilitation. I understand that the treatment may include, but is not limited to the following: comprehensive examination, full mouth x-ray series, cleaning and fluoride treatment, periodontal scaling and root planning, minor periodontal surgery, soft tissue excisions and biopsy of lesions, amalgam and composite restorations, crowns, bridges, root canal treatment and extractions.

I hereby certify that I am the legal guardian of the above referenced client or have otherwise been empowered to give consent on behalf of this client for dental treatment and extractions. This consent shall remain in force until unless otherwise terminated by me.

I have read the above, my questions have been answered, and I consent to Comprehensive Dental Treatment.

_____ _____/_____/_____
Name of Parent/Guardian (Please Print Full Name) Date

_____
Signature of Parent/Guardian

_____
Relationship to Patient (please include phone number of Parent/Guardian in case of emergency)

ACKNOWLEDGEMENT & ACCEPTANCE OF PRIVACY NOTICE

By signing this acknowledgement and acceptance form, you authorize the use or disclosure of your protected health information as described within the Accessible Dental Services, Inc. Privacy Notice.

Please direct any questions regarding the Privacy Notice to:

Accessible Dental Services, Inc.
Attn: Ashley Lovell
163 Thorn Hill Road
Warrendale, PA 15086

Phone: (412) 820-1015 ext. 565

Email: alovell@passavant.org

Compliance Website: https://www.pmhfos.org/compliance/

_____ _____/_____/_____
Signature of Individual or Representative Date

_____
Name (please print)

_____ _____
Name of Personal Representative (if applicable) Relationship

_____ _____/_____/_____
Agency Representative Date

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my protected health/confidential personal information (PHI) described below:

1. _____I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). ***OR***

   _____I authorize the release of my complete health record with the exception of the following information:

   _____ Mental health records

   _____ Communicable diseases (including HIV/AIDS)

   _____ Alcohol/drug abuse treatment

   _____ Other (please specify):_____

2. This authorization for release of PHI covers the period of healthcare beginning with services being provided to me by Accessible Dental Services (ADS) and will automatically expire two years following the termination of my services with ADS.

3. This PHI may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.

4. I understand that I have the right to revoke this authorization **in writing** at any time. However, I understand that this authorization cannot be revoked to the extent that action has been taken in reliance hereupon or this authorization was obtained as a condition of obtaining insurance coverage.

5. I understand that my refusal to sign will not affect my treatment, payment for care, enrollment in health plans or eligibility for benefits.

6. I understand that ADS may receive compensation for the use or disclosure of the information.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of Individual or Representative

_____

Printed Name of Individual

_____

Name of Personal Representative (if applicable)

ACESSIBLE DENTAL SERVICES – PRIVATE PAY AGREEMENT

Patient Name: _____ Date:_____/_____/_____

ACKNOWLEDGEMENT

I have authorized Accessible Dental Services (ADS) to provide comprehensive oral treatment and/or rehabilitation for myself or for the above-named patient. I understand that the treatment and/or rehabilitation (i.e. comprehensive examination, full mouth x-ray series, cleaning and fluoride treatment, periodontal scaling and root planning, minor periodontal surgery, soft tissue excisions and biopsy of lesions, amalgam and composite restorations, crowns, bridges, root canal treatment and extractions) may not be covered entirely by my, or the patient's, insurance.

I hereby certify that I am the patient, the legal guardian of the above referenced patient, or have otherwise been empowered to give consent on behalf of this patient for dental treatment and extractions. As such, I agree that ADS may bill my, or the patient's, Medicare, Medicaid/Department of Public Welfare or other third party insurance for the dental treatment provided. Billing shall be the responsibility of ADS; I will cooperate to the degree necessary to provide documentation regarding insurance coverage, as from time to time it may be necessary to secure payment from the appropriate entity.

I am the patient and/or I agree to act as guarantor for any unpaid services and/or invoices that qualify for private pay. ADS will send a consolidated statement, of 30 days, to me as the patient or designee. Payment will be due 30 days from the consolidated statement date. In the event payment is not received, ADS reserves the right to recoup private pay charges for unpaid services via utilization of a collection agency. In the event that I, or the patient, does not qualify for dental coverage through an insurance plan, I will act as guarantor, and in accordance with the No Surprises Act, ADS will charge for services per the ADS Private Pay Fee Schedule outlined below. The ADS Private Pay Fee Schedule represents a good faith estimate of the fees for the services provided to you by ADS.

ADS Private Pay Fee Schedule

Non-Sedation Services	Services will be billed per the Pennsylvania Medical Assistance Program Dental Fee Schedule published at: https://www.dhs.pa.gov/providers/Documents/Dental%20Care/Dental%20Fee%20Schedule.pdf
Sedation Services	$1,500 for necessary dental services including, but not limited to: • Diagnostic and Preventative Care • Restorations • Periodontal Scaling and Root Planning • Extractions • Professional Anesthesia

I understand that ADS offers payment plans for dental services and that failure to pay in full and/or engage in a qualifying payment plan will disqualify myself and/or the patient from scheduling for future dental appointments with ADS.

I have read, understand, and agree to, the above. My questions have been answered and intending to be legally bound hereby I consent to the Private Pay Agreement for Comprehensive Dental Treatment.

_____ _____/_____/_____

Signature of Parent/Guarantor Date

_____ _____

Printed Name Relationship to Patient (Self/Guarantor)

Patient Name: _____ Date:_____/_____/_____

COMMUNICABLE DISEASES RELEASE STATEMENT

Thank you for your continued trust in our office. Despite our careful attention to health and safety protocols, there is still a chance that you could be exposed to a communicable disease (cold, flu, COVID-19, etc.) in our office. Be assured that we are following State and Federal guidelines and recommended universal personal protection and disinfection protocols to the best of our ability to limit transmission of any disease in our office.

By signing below, you acknowledge that you accept the risk of, and consent to, treatment.

_____ _____

Name of Parent/Guardian (Please print full name) Date

_____

Signature of Parent/Guardian

_____

Relationship to Client (please include phone number of Parent/Guardian in case of emergency)

_____

Witness Signature & Print Full Name

Passavant Memorial Homes Family of Services
Notice of Privacy Practices

In accordance with The Health Insurance Portability and Accountability Act ("HIPAA")'s Privacy Rule, Passavant Memorial Homes Family of Services ("PMHFOS"), including the entities of Passavant Memorial Homes, Passavant Development Corporation, PDC Pharmacy, PDC Pharmacy Colorado, Life Enrichment Trust, Inc., Life Enrichment Trust of New Jersey, Accessible Dental Services, Inc., and Passavant Memorial Homes Foundation, is distributing the attached Notice of Privacy Practices ("NOPP") for your review and authorization.

The Notice of Privacy Practices ("NOPP") is an explanation of a person's individual rights with respect to their Personal Health Information ("PHI") and the privacy practices that PMHFOS follows to ensure the protection of all PHI. Upon completion of your review and in accordance with the HIPAA Security Rule, PMHFOS is respectfully asking for the individual or individual representative, to confirm and acknowledge receipt and acceptance of the Privacy Notice. The "Acknowledgement of Receipt & Acceptance of the Privacy Notice," can be found on Page 11 within the following documentation. If you elect to sign the acknowledgement of receipt and acceptance, PMHFOS is respectfully asking you to kindly return the signed document via mail in the provided self-addressed and stamped envelope.

If you have any questions about this notice or the process of completion of receipt and acceptance, please contact Ashley Lovell, Vice President of Corporate Compliance, Privacy Officer at alovell@passavant.org

Ashley Lovell
Vice President of Corporate Compliance
Passavant Memorial Family of Services (PMHFOS)

cc: Rick D. Senft, Chief Executive Officer and President
Zachary Senft, Chief Operating Officer and Vice President
Lewis Minett, Chief of Staff
Thomas King, Esquire, General Counsel
Andrea Parenti, Esquire, Corporate Attorney

PASSAVANT MEMORIAL HOMES FAMILY OF SERVICES
HIPAA NOTICE OF PRIVACY PRACTICES

Including:
Passavant Memorial Homes
Passavant Development Corporation
PDC Pharmacy, PDC Pharmacy Colorado
Life Enrichment Trust
Life Enrichment Trust of New Jersey
Accessible Dental Services
Passavant Memorial Homes Foundation

Effective Date: 4/14/03,
Rev. 4/1/2013, 6/16/2016, 8/1/2017, 9/10/2018, 8/5/2019, 8/1/2020, 7/13/2021, 10/5/2021, 11/12/2021, 7/12/2022, 7/10/2023

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

If you have any questions about this notice, please contact Ashley Lovell, Passavant Memorial Homes Family of Services ("PMHFOS") Vice President of Corporate Compliance, Privacy Officer at (412) 820-1015 ext. 565. Any terms not defined herein shall have the meanings set forth in the Health Insurance Portability and Accountability Act, as amended ("HIPAA").

WHO WILL FOLLOW THIS NOTICE

This notice describes the privacy practices of PASSAVANT MEMORIAL HOMES FAMILY OF SERVICES, and all of its affiliates and other persons listed below (together, the "Provider" or "we").

- Any health care professional authorized to enter information into your medical chart on behalf of the Provider.
- All departments and units of the organization and its affiliates. All department and unit personnel of the Provider.
- Any member of a volunteer group we allow to help you while you are receiving care from the Provider.
- All employees, staff, Board Members and other personnel of Provider.
- All of these persons and entities follow the terms of this notice and may share protected health information with each other for treatment, payment or health care operations purposes as described in this notice.

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION

We understand that protected health information about you and your health is personal. We are committed to protecting your protected health information. In order to provide you with quality care

and to comply with legal requirements, we create a record of the care and services you receive from the Provider. This notice applies to all of the records of your care maintained by the Provider. Your other health care providers, such as your personal doctor, may have different policies or notices regarding the use and disclosure of your protected health information created and maintained in the doctor's own office or clinic.

This notice describes the ways in which the Provider may use and disclose your protected health information. It also describes your rights and certain of the Provider's obligations regarding use and disclosure of your protected health information.

The Provider is required by law to:

- Safeguard your protected health information;
- Give you this notice of our legal duties and privacy practices with respect to your protected health information;
- Follow the terms of this notice as may be amended from time to time; and
- Notify you of any changes to this notice.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION

The following categories describe different ways that we "use" and "disclose" your protected health information. Each category is followed by an explanation and in some instances an example. For purposes of this notice, the term "use" refers to protected health information that is used within the Provider for your treatment, the Provider's operations, or the payment of your care. The term "disclose" refers to protected health information that is given to outside entities for one of the purposes described in this notice. Whether your protected health information is used or disclosed, the use or disclosure will fall within one of the categories listed below and will be used or disclosed only in the minimal amount necessary to carry out the purpose. The term "may" means that the Provider is permitted under federal law to use or disclose this information without obtaining an additional or specific authorization from you to do so. Even though the Provider may be permitted to use or disclose information in a given instance, it does not mean that we will use or disclose the information. We will still try to assure that any use or disclosure is in your interest or is consistent with practices in the health care field.

For Treatment We may use and disclose protected health information about you to provide you with medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians, medical students, and the Provider's personnel who are involved in taking care of you at the Provider. For example, a doctor treating you for an injury may need to know if you have diabetes because diabetes may slow the healing process. In addition, the Provider may need to tell the dietician if you have diabetes so that the dietician can arrange for appropriate meals. Different departments of the Provider also may share protected health information about you in order to coordinate the different things you need. We also may disclose protected health information about you to people outside the Provider who may be involved in your medical care when you are absent from the Provider, such as family members, clergy, providers of day services, volunteers, Independent Support Coordinators, case managers, respite care workers and others we have engaged to provide services that are part of your care.

For Payment. We may use and disclose protected health information about you so that the treatment and services you receive from the Provider or other providers may be billed to and payment may be collected from you, the government, an insurance company or a third party. For example, we may disclose information to the county or state mental health and/or mental retardation agency in order to receive payments for your treatment. We may also tell your insurer or governmental payor about a treatment you are going to receive to obtain prior approval or to determine whether your plan or the government will cover the cost of the treatment.

For Health Care Operations. We may use and disclose protected health information about you for the Provider's operations or operations of another provider or payor. These uses and disclosures are necessary to run the Provider and make sure that all of our Individuals receive quality care. For example, we may use protected health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine protected health information about many Provider Individuals to decide what additional services the Provider should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, direct care providers, behavioral therapists, special therapists, and other Provider personnel for review and learning purposes. We may also disclose information in order to comply with our incident reporting requirements under state, local, or federal law. We may also combine the protected health information we have with protected health information from other providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of protected health information so others may use it to study health care and health care delivery without learning who the specific Individuals are.

Health Care Quality Units and Other Quality Review Organizations. We may disclose information to the Pennsylvania Department of Public Welfare, the Office of Mental Retardation, and other state and county mental health and mental retardation agencies through their appointed agents, including Health Care Quality Units and independent monitoring groups, in order to comply with Federal, state, and local laws and regulations.

Appointment Reminders. We may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment or medical care at the Provider.

Treatment Alternatives. We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose protected health information to tell you about health-related benefits or services that may be of interest to you.

Fundraising Activities. We may use *contact* information, such as your name, address and phone number, and the dates you received treatment or services from the Provider to contact you and your family members in an effort to raise money for the Provider. We may disclose this contact information to a foundation related to the Provider so that the foundation may contact you and your family members in raising money for the provider. If you do not want the Provider or the foundation to contact you or your family members for fundraising efforts, you must notify the Privacy Officer in writing.

Provider Directory. We may include certain limited information about you in the Provider directory while you are a Individual of the Provider. This information may include your name, location at the Provider, your general condition, and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can visit you at the Provider and generally know how you are doing.

Individuals Involved in Your Care or Payment for Your Care. We may disclose protected health information about you to your family members, your personal friends or any other person identified by you, but we will only disclose information that we feel is relevant to that person's involvement in your care or the payment for your care. If you are feeling well enough to make decisions about your care, we will follow your directions as to who is sufficiently involved in your care to receive information. If you are not present or cannot make these decisions, we will decide based on whether we believe it is in your best interest for a family member or friend to receive private health information and how much information they should receive. Obviously, we are inclined to provide greater information to close family members than to friends.

We may also disclose information to disaster relief agencies or to family, friends or others in an effort to locate or identify family members or personal representatives.

Research. Under certain circumstances, we may use and disclose protected health information about you for research purposes. For example, a research project may involve comparing the progress of all Individuals who received one therapy to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of protected health information, trying to balance the research needs with Individuals' need for privacy of their protected health information. Before we use or disclose protected health information for research, the project will have been approved through this research approval process, but we may, however, disclose protected health information about you to people preparing to conduct a research project, for example, to help them look for Individuals with specific medical needs, so long as the protected health information they review does not leave the Provider. In certain situations, we are required to ask your specific permission, such as when the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Provider.

As Required By Law. We will disclose protected health information about you when required to do so by federal, state or local law. For instance, the Provider is obligated to report to public health officials the occurrence of certain communicable diseases or acts of violence. Additionally, the Provider is required to report certain incidents to the Pennsylvania Department of Public Welfare.

To Avert a Serious Threat to Health or Safety. We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Day Providers. We may use and disclose information about you if necessary to facilitate your application for admission to, or use of, day programs such as supported employment and sheltered employment.

Residential Facilities. We may use and disclose information about you if necessary to facilitate your application for admission into, or use of, residential facilities.

In-home Services. We may use and disclose information about you if necessary to facilitate your application for, or use of, in-home services.

Family Living Arrangements. We may use and disclose information about you if necessary to facilitate your application for admission into, or use of, family-living arrangements.

Supports Coordinators. We may use and disclose information about you as necessary for supports coordinators and case managers to complete their duties for you.

Transfers. We may use and disclose information about you to another health care provider to which you are being transferred or which is considering you as a transfer.

Employers. We may use and disclose information about you to an employer or prospective employer in connection with your application for, or continuation of, employment.

SPECIAL SITUATIONS

Organ and Tissue Donation. If you are an organ or tissue donor, we may release protected health information 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.

Military and Veterans. If you are a member of the armed forces, we may release protected health information about you as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. Under the privacy regulations, workers' compensation claims are exempted from coverage, and thus we may release protected health information about you to your employer for workers' compensation purposes.

Public Health Risks. We may disclose protected health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;

- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a Individual has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. The federal government has determined that it must have access to this information to adequately monitor beneficiary eligibility for government programs (for example, Medicare or Medicaid), compliance with program standards, and/or civil rights laws.

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

Law Enforcement. We may release protected health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Provider; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release protected health information about Individuals of the Provider to funeral directors as necessary to allow them to carry out their duties.

National Security and Intelligence Activities. We may release protected health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

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

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with

health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution and those responsible for your transportation from one facility to another.

DISCLOSURES REQUIRING AUTHORIZATION

- **Psychotherapy Notes**. With limited exceptions, the Provider must obtain your authorization for any use or disclosure of your psychotherapy notes.

- **Marketing**. The Provider must obtain an authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication made by the Provider or a physician of the Provider to you, or (2) a promotional gift of nominal value.

- **Sale of Protected Information**. The Provider must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

  - Public health activities;
  - Research purposes, provided that the Provider receives only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes;
  - Treatment and payment purposes;
  - Health care operations involving the sale, transfer, merger or consolidation of all or part of a Covered Entity and for related due diligence;
  - Payment that is provided by the Provider to a Business Associate for activities involving the exchange of protected health information that the Business Associate undertakes on behalf of the Covered Entity (or the subcontractor undertakes on behalf of a Business Associate) and the only remuneration provided is for the performance of such activities;
  - Providing you with a copy of your health information or an accounting of disclosures;
  - Disclosures required by law;
  - Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration received by the Provider is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
  - Any other exceptions allowed by the Department of Health and Human Services.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding protected health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. If you request a copy of the

information, we customarily charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Append and Amend. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to append or amend the information. You have the right to request an amendment for as long as the information is kept by or for the Provider; however, we are not required to amend the information. If we do not agree to amend your information, you may add a supplemental statement to your records indicating why you believe the information should be changed. We will append or otherwise link your statement to your records.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

Was not created by us, unless the person or entity that created the information is no longer available to make the amendment; Is not part of the protected health information kept by or for the Provider; Is not part of the information which you would be permitted to inspect and copy; or Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of several types of the disclosures we made of protected health information about you.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before February 26, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

***In most circumstances, we are not required to agree to your request*.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations

and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid the Provider in full.

To request restrictions, you must make your request in writing to the Privacy Officer. 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 Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Be Notified of a Breach. You have the right to be notified by the Provider and the Provider shall notify you by phone, mail or similar means, if there is a breach which affects the confidentiality of your unsecured protected health information.

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

You may obtain a copy of this notice at our website, **www.pmhfos.org**

To obtain a paper copy of this notice, please write or call:

Ashley Lovell, Vice President of Corporate Compliance
Passavant Memorial Homes Family of Services
163 Thorn Hill Road
Warrendale, PA 15086
412-820-1015 ext. 565
alovell@passavant.org

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 protected 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 at our website. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at

or are admitted to the Provider for treatment or health care services as a Individual, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services.

To file a complaint with the Provider, contact:

Ashley Lovell, Vice President of Corporate Compliance
Passavant Memorial Homes Family of Services
163 Thorn Hill Road
Warrendale, PA 15086
412-820-1015 ext. 565
alovell@passavant.org

All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

OTHER USES OF PROTECTED HEALTH INFORMATION.

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time, with such revocation being effective once received by the Provider; however, such revocation shall not be effective to the extent that the Provider has taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization, except as otherwise mentioned herein. 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.

PASSAVANT MEMORIAL HOMES FAMILY OF SERVICES

Acknowledgement of Receipt
&
Acceptance of the Privacy Notice

PMHFOS' HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: 4/14/03,
Rev. 4/1/2013, 6/16/2016, 8/1/2017, 9/10/2018, 8/5/2019, 8/1/2020, 7/13/2021, 10/5/2021, 11/22/2021, 7/12/2022, 7/10/2023

By signing this acknowledgement and acceptance form, you authorize the use or disclosure of your protected health information as described within the Passavant Memorial Homes Family of Services Privacy Notice.

Please direct any questions regarding the Privacy Notice to Privacy Officer:

Ashley Lovell, Vice President of Corporate Compliance
Passavant Memorial Homes Family of Services
163 Thorn Hill Road
Warrendale, PA 15086
412-820-1015 ext. 565
alovell@passavant.org

_____ _____
Signature of Individual Date

_____
Print Name

_____ _____
Signature of Individual's Representative (if applicable) Date

_____
Relationship

(Acknowledgement includes privacy notice for PASSAVANT MEMORIAL HOMES FAMILY OF SERVICES. Including: Passavant Memorial Homes, Inc.; Passavant Development Corporation; PDC Pharmacy, PDC Pharmacy Colorado; Life Enrichment Trust, Inc.; Accessible Dental Services, Inc.).