DOS

UK HealthCare

- University of Kentucky A.B. Chandler Hospital
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

**UK Pediatric Therapies at Child Development Center of the Bluegrass**

# MEDICAL HISTORY and PEER MODEL CONSENT FORM

(Patient Label Here)

I am requesting services for my child in: ☐ OT ☐ PT ☐ SLP

Child's Name: _____ Date of Birth: _____

Child's Gender: Male Female Child's Diagnosis: _____

Child's Address: _____
(Street) (City) (Zip)

Child is in the custody of: _____ Child resides with: _____

Mother's Name: _____ Father's Name: _____

Mother's Contact Number: _____ Father's Contact Number: _____

Mother's Email Address: _____ Father's Email Address: _____

Preferred Method of Contact: ☐ Phone ☐ Email Preferred Method of Contact: ☐ Phone ☐ Email

## Medical History

Was your child full term? _____ If not, how premature? _____

Has your child had any significant illnesses? _____ If yes, explain: _____

Does your child have any allergies? _____ If yes, explain: _____

Has your child ever been hospitalized? _____ If yes, explain: _____

_____

Has your child had any surgeries? _____ If yes, please list type and date of surgery: _____

_____

Is your child currently taking any medications? _____ If yes, please list: _____

_____

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**UK Pediatric Therapies at Child Development Center of the Bluegrass**

**MEDICAL HISTORY and PEER MODEL CONSENT FORM (cont.)** (Patient Label Here)

Does your child struggle with any of the following? (Please mark all that apply.)

| | | |
|---|---|---|
| ☐ Feeding Difficulties | ☐ Sleep Difficulties | ☐ Tripping / Falling |
| ☐ Behavioral Concerns | ☐ Reflux | ☐ Attention and / or following directions |
| ☐ Fine Motor / Handwriting | ☐ Peer Interaction | ☐ Communicating with peers and / or caregivers |

What is your primary concern? _____

_____

What are your child's strengths / interests? _____

_____

Has your child been examined by any of the following:

| Specialist | Date | Results | Diagnosis |
|---|---|---|---|
| Allergist | | | |
| Audiologist | | | |
| Cardiologist | | | |
| Dentist | | | |
| Developmental Pediatrician | | | |
| Geneticist | | | |
| Ophthalmologist | | | |
| Otolaryngologist (ENT) | | | |
| Neurologist | | | |
| Occupational Therapist | | | |
| Physical Therapist | | | |
| Psychiatrist | | | |
| Psychologist | | | |
| Speech Language Pathologist | | | |
| Developmental Interventionists | | | |
| Other | | | |

List any other concerns you would like your child's therapist(s) to know: _____

_____

_____

Peer Consent:

I give permission for my child to interact with a peer model during therapy sessions (PT, OT, SLP). The peer model will be another child enrolled at Child Development Center of the Bluegrass. The purpose of integrating a peer model is to enhance participation in the therapy session. ☐ Yes ☐ No, thank you.

Completed by: _____ Date: _____

Relationship to child: _____

Reviewed by: _____ Date / Time: _____

UK HealthCare

- University of Kentucky Hospital A.B. Chandler Medical Center
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

**UK Pediatric Therapies at Child Development Center of the Bluegrass**
**-- INSURANCE DEMOGRAPHICS FORM** (Patient Label Here)

Child's Name: _____ Date of Birth: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder Address: _____

Carrier: _____ UKHMO ☐

ID#: _____ Group #: _____

Child's Doctor: _____ Doctor's Office: _____

Parent / Guardian Name: _____

Phone Number: _____ Email: _____

Preferred Method of Contact: ☐ Phone ☐ Text ☐ Email

Are you currently receiving therapy services at another office? Yes No

If yes, what services are you receiving? _____

Services Requested: OT ☐ PT ☐ SLP ☐

Therapist Requested / Assigned: _____

**********OFFICE USE ONLY**********

Co-pay: _____ # of Visits: _____ Cal / Plan: _____ Combined: _____

Network: In / Out Deductible: _____ Met / Not Met Effective Date: _____

Referral Required: Yes / No At what visit: _____

Authorization #: _____ Expires: _____

Notes: _____

_____

Reference Number: _____

UK UNIVERSITY OF KENTUCKY **H-328 Authorization to Obtain/Utilize Images**

## ADULT

☐ **General Use** ☐ Specific Project: _____

I, (*print full name*) _____, being eighteen (18) years of age or over, hereby grant permission to the University of Kentucky and its affiliates and subsidiaries, including but not limited to the UK Alumni Association, UK Athletics Association, and UK Research Foundation, to interview, photograph, and/or videotape me; and/or to supervise any others who may do the interview, photography, and/or videotaping; and/or to use and/or permit others to use information from the aforementioned interview and/or the aforementioned images in educational and promotional activities for the following without compensation:

Please check all that apply:
☐ UK Educational Publications/Videos
☐ UK Electronics Publishing (e.g., World Wide Web)
☐ UK Promotion/Advertising
☐ Local/Regional/National News Media (w/permission of UK)

Signature: _____ Date: _____
*Signature*

Witness: _____ Date: _____
*Signature*

**Name and mailing address (please print)**

Name: _____

Address: _____

E-mail: _____ Phone: _____

Send copy of form to:
University of Kentucky
Office of Public Relations
102 Mathews Building
Lexington, KY 40506-0047

## MINOR CHILD

☐ **General Use** ☐ Specific Project: _____

I, (*print full name*) _____, hereby grant permission to the University of Kentucky and its affiliates and subsidiaries, including but not limited to the UK Alumni Association, UK Athletics Association, and UK Research Foundation to interview, photograph, and/or videotape my minor child, _____, and/or to supervise any others who may do the interview, photography, and/or videotaping; and/or to use and/or permit others to use information from the aforementioned interview and/or the aforementioned images in educational and promotional activities for the following without compensation:

Please check all that apply:
☐ UK Educational Publications/Videos
☐ UK Electronics Publishing (e.g., World Wide Web)
☐ UK Promotion/Advertising
☐ Local/Regional/National News Media (w/permission of UK)

Signature of Parent or Guardian: _____ Date: _____
*Signature*

Relationship: _____

Witness: _____ Date: _____
*Signature*

10/27/2004

HealthCare

- University of Kentucky A.B. Chandler Hospital
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

## UK Pediatric Therapies at Child Development Center of the Bluegrass-- AUTHORIZATION FOR RELEASE OF INFORMATION (for Use and Disclosure)

**Please fill out all sections or the form may be returned to you.**

Patient Name: _____ Social Security Number: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

**Type of Release** ☐ TRACQuest ☐ CD ☐ Paper ☐ Permission to discuss care ☐ Review records at UK (must make an appointment)

**Send Information from:**

☐ All UK HealthCare facilities

☐ UK College of Dentistry

☒ Other Services provided through UK Pediatric Therapies at Child Development Center of the Bluegrass

**Send to:** For children enrolled in CDCB's childcare/preschool program permission to share therapeutic strategies with the child's teaching team. Other agencies in which your child is dually enrolled or in which at our/your request, enrollment is sought (ie First Steps, Private Insurance, other outpatient facilities, doctor office).

**I would like records from the following dates:** _____ through _____
(This can be a very specific date or more general. Examples: July 15, 2007 or June 2006 - Feb 2007)

**Please check the records you would like:**

☐ Records related to (specify): _____ (examples: car accident or appendectomy)

| | | |
|---|---|---|
| ☐ Discharge Summary | ☐ Pathology Report(s) | ☐ X-Ray Report(s) |
| ☐ TB Screening | ☐ Laboratory Report(s) | ☐ X-Ray Image(s) |
| ☐ Immunization Record | ☐ Photo/Video/Other | ☐ All records |
| ☐ ER Notes | ☐ Outpatient Notes | ☐ Other: (specify) _____ |
| ☐ Surgery Reports | ☐ Psychological Test Report | |

**Sharing of Special Protected Records: I authorize the sharing of information about:**

a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS) ☐ YES ☐ NO / NA

b. The diagnosis or treatment of drug and/or alcohol abuse ☐ YES ☐ NO / NA

c. The treatment and/or consultation for mental health or psychiatric disorders ☐ YES ☐ NO / NA

**Reason records are needed (check all that apply):**

☐ For another doctor or hospital ☐ Social Security/disability ☐ Legal ☐ Personal use ☐ Other (specify) _____

**This Authorization will expire on** _____ **(date).**

**If no date is included the Authorization will expire in 90 days.**

- I understand that I may revoke this Authorization at any time, unless the Authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing to the Registration Office at the Facility/location where I originally submitted/filed this authorization; and that the revocation shall be effective except to the extent that the Facility has already used or disclosed information in reliance on the Authorization.
- I further understand that treatment payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however, Facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this Authorization, and Facility may condition the provision of research-related treatment on my signing this Authorization.
- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

**I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.**

_____ _____

**Date** **Signature of Patient**

If patient is unable to sign, secure consent of Legal Representative and indicate reason below:

☐ Minor ☐ Incompetent ☐ Deceased

Proof of designation must be filed in the chart or sent with this request.

_____

**Signature of Legal Representative and Relationship to Patient**

_____

Signature of Witness for Psychiatric Records

UKHealthCare

Place Label Here

- ☐ University of Kentucky Hospital A.B. Chandler Medical Center
- ☐ UK HealthCare Good Samaritan Hospital
- ☐ UK HealthCare Ambulatory Services
- ☐ UK College of Dentistry

## PERMISSION TO COMMUNICATE HEALTH INFORMATION

Date:_____ Time:_____

**Note to Staff: This form does not constitute an authorization for release of written information. Only authorized personnel may release written information and then pursuant to University policies.**

| | YES | NO |
|---|---|---|
| May we leave information regarding your diagnosis, treatment and follow-up on your home answering machine? (Pt must provide number _____ ) | | |

May we discuss your diagnosis, treatment, and follow-up with the family member(s) and/or caregiver(s) listed below:

| Name (Please print) | Phone |
|---|---|
| Name (Please print) | Phone |
| Name (Please print) | Phone |
| Name (Please print) | Phone |

**This authorization applies to this treatment area only and will remain in effect until I give a written or verbal notice to revoke it.**

_____

**Patient Signature/Patient Representative** **Date**

_____

**Verbal Authorization From Patient Received By** **Date**

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- University of Kentucky Hospital A.B. Chandler Medical Center
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- UK HealthCare Ambulatory Services

## RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date:_____ Time:_____

I understand that as part of my health care, University of Kentucky and its affiliates originates and maintains health records. These health records describe my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and medical treatment information to my bill
- a means by which a third-party payer (i.e. insurance company) can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

The University of Kentucky and its affiliates' ***Notice of Privacy Practices*** gives a more complete description of how my health information may be used or disclosed. The notice also explains my rights regarding my personal health information, including the right to access my own records and the right to request restrictions as to how my health information is used or disclosed.

I understand it is my responsibility to notify University of Kentucky and its affiliates regarding any restrictions to disclosure of my health information regarding this or any subsequent visit.

**I have been provided with a *Notice of Privacy Practices* and have been given the opportunity to review this notice.**

_____

Signature of Patient or Legal Representative Date

_____

Witness Date

UK HealthCare

- University of Kentucky A.B. Chandler Hospital
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

**UK Pediatric Therapies at Child Development Center of the Bluegrass**

## EXPECTATIONS AND FAMILY RIGHTS

UK Pediatric Therapies at Child Development Center of the Bluegrass is located inside an operating childcare facility (Child Development Center of the Bluegrass). The following expectations have been established to help ensure the safety and wellbeing of all children receiving services at or visiting this facility:

1. A parent or guardian must stay on premises during the therapy session. If you are going to be outside during the treatment session, please let your child's therapist know.
2. Families may observe therapy sessions in the observation room or with a therapist in the therapy areas.
3. Siblings must remain with parents during treatment sessions. Please be mindful that other children / families are engaged in treatment during these times.
4. Food and beverages must be kept in the lobby. The only exception is when a child is engaged in therapeutic activities involving food.
5. Be mindful of others in treatment and please silence your cell phones.
6. Therapy equipment is only to be used in conjunction with a therapist during a therapy session.
7. If a child receiving therapy services exhibits extremely aggressive behavior, that could endanger themselves or others, University of Kentucky Pediatric Therapies at Child Development Center of the Bluegrass may suspend services.
8. Families are expected to demonstrate appropriate behavior while on campus and when communicating with UK Pediatric Therapies staff. Unprofessional behavior will not be tolerated (i.e., vulgar language, aggressive tone, loud volume of voice or electronic devices).
9. In the event of inclement weather please follow University of Kentucky for delays and closing. Please tune into LEX-18 or WKYT-27 for up-to-date information.
10. In an effort to keep all families as healthy as possible, we ask you to please keep your child home if they exhibit any of the following:
    - More than one episode of diarrhea that is not associated with a change in diet
    - One episode of vomiting
    - Abdominal pain of more than a 2 hour duration
    - Fever above 101 Fahrenheit
    - Mouth sores with drooling
    - Pink or red conjunctiva (pink eye)
    - Unexplained rash
    - Severe sore throat
    - Chickenpox
    - Head lice or nits

I have read the above Expectations and Family Rights. By signing below I agree to abide by these statements and understand that any violation could result in a suspension of service.

Child's Name: _____

Parent / Guardian Name: _____

Parent/Guardian Signature: _____ Date / Time: _____

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## AUTHORIZATIONS & AGREEMENTS

(Patient Label Here)

**CONSENT TO TREATMENT:** I consent to receiving medical care from the University of Kentucky. Medical care includes exams, testing, appropriate immunizations, medical treatment and treatment with controlled substances. I may be tested for HIV (the virus that causes AIDS), hepatitis and other diseases. My consent covers care from the agents, employees and medical staff of the University of Kentucky. No one has guaranteed me that the medical care will have certain results. I have the right (i) to make decisions about my health care, (ii) to refuse medical care, and (iii) to revoke this consent at any time except to the extent medical care has already been provided. *The patient or the authorized parent, guardian, responsible party or surrogate of the patient must give consent.*

**Photographs:** I consent to let the medical staff document my condition upon and during my admission, including taking photographs moving pictures, or other pictures or videotapes.

**Teaching Institution:** I understand that the University of Kentucky teaches and trains doctors, nurses and other health care providers (an academic medical center). Doctors in training (fellows, residents, interns, and housestaff), medical students and other medical trainees may be involved in my care with the appropriate supervision of my doctor.

**Research:** I understand that someone from the University of Kentucky may contact me in the future to ask me about my health or to take part in research.

### ADVANCE DIRECTIVES: (Please check all statements that apply:)

☐ I have signed Advance Directives (living will, health care surrogate declaration) and request that these directives govern my course of care, as much as possible under the law. I understand that I must provide the Hospital with a copy of my Advance Directives and that those directives will not govern any course of my care until they have been filed in my medical record.

- ☐ Advance Directives **attached**
- ☐ Advance Directives **not attached.**

☐ I have not signed Advance Directives (living will, health care surrogate declaration), but I understand that I have the right to make decisions about my health care, including executing advanced directives.

### FINANCIAL RESPONSIBILITY

**Guarantee of Payment:** I agree that I am responsible to the University of Kentucky and Kentucky Medical Services Foundation Inc. (KMSF) for charges resulting from services rendered at their prevailing rates. I agree that all bills are due in full upon demand. Should I fail to honor this agreement, I agree to pay any collection cost or attorney fees resulting from the collection of my accounts. Neither the University of Kentucky nor KMSF in enforcing any rights shall in any manner release me or any responsible party of liability. If the undersigned is more than one person, this obligation shall be joint and several. I agree that the University of Kentucky or KMSF is not a party to any disputed claim or peer-review, which affects payment of any claim filed on my behalf and that upon request for payment from the University of Kentucky or KMSF; I agree to pay any outstanding balance. If any legal action should be sought by the University of Kentucky or KMSF in connection with the collection of charges resulting from services rendered, I agree to be subject to (and hereby consent to) the jurisdiction and venue of any such action or proceeding in the courts within the County of Fayette, Commonwealth of Kentucky, and that I agree to waive any objection that I may have based on improper venue or inconvenient forum. For collection purposes, I authorize UK HealthCare and all of its entities and 3rd party agencies, to contact me on my cell phone or any other phone which I have provided as my contact information, or any number assigned to me that is available to the public, using methods which include pre-recorded/artificial voice messages or the use of automated dialer. Furthermore, I authorize UK HealthCare and all of its entities and 3rd party agencies, to communicate with me at the e-mail address provided or through text messaging.

**Assignment of Benefits:** I hereby assign all rights and privileges and authorize payment directly to the University of Kentucky and KMSF for any claim filed on my behalf or on behalf of the person for whom I am duly authorized to sign for insurance benefits. I agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees. I also understand that I am financially responsible to the University of Kentucky and KMSF for charges not covered by this assignment or not paid on a timely basis by the insurance company.

**Certification:** I certify that I have read and understand the consent and authorizations given above and that I am the patient or I am duly authorized by the patient to execute this document and accept its terms.

**Rights and Responsibilities:** I have received a copy of the Patient Rights and Responsibilities.

**Advance Directives:** I have received written information about Advanced Directives (Living Will).

| | | | |
|---|---|---|---|
| Date | Time | X<br>Signature of Patient or Duly Authorized Agent | |

Relationship to Patient: ☐ Patient ☐ Guardian ☐ Attorney-in-Fact ☐ Spouse ☐ Adult child ☐ Parent ☐ Nearest Living Relative

| | |
|---|---|
| Date | Signature of Witness |

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## AUTHORIZATIONS & AGREEMENTS

(Patient Label Here)

### Your Rights & Responsibilities as a UK HealthCare Patient

You have the right to:

- Receive care no matter what your age, race, color, national origin, ethnic origin, creed, physical or mental disability, veteran status, uniformed service, political belief, sex, sexual orientation, gender identity or expression, appearance, socio-economic status, religion or diagnosis consistent with the services that UK HealthCare provides.
- Know what is medically wrong and how we can help you get better. We will also tell you the things you will need to know when you get home so that you can stay well.
- Know the names of your doctors and nurses.
- Receive care in a safe environment free from all forms of abuse neglect or harassment.
- Be free from restraints and seclusion in any form that is not medically necessary.
- Say "no" to anything we suggest.
- Not be involved with research unless you want to be involved.
- Receive treatment for pain.
- Have your religious beliefs respected.
- Have your regular doctor or a family member notified that you are in the hospital.
- Have your choices about end-of-life decisions respected.
- Be treated politely and with consideration.
- Have your privacy respected.
- Know about any rules that might affect you or your family.
- Receive a copy of your medical records; request amendment to your records and request a list of disclosures of your record.
- Have your questions about any costs or bills answered at any time.
- You can complain about anything without worry. If you don't want to talk to your doctor or nurse, please contact the Office of Patient Experience (859) 257-2178. If you have conflicts about your care, you may ask your nurse or any other hospital staff member to contact the Ethics Consultation Service on your behalf through UKMDs or call Hospital Administration at (859) 323-5000 to help resolve those conflicts. If you still have a complaint, you may contact the Kentucky Office of Inspector General at 1-800-372-2973. You may also contact The Joint Commission at 1-800-994-6610; or email to: complaint@joint commission.org; or mail to: Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.

**To help us help you, please ...**

- Tell us everything we need to know about your condition and history.
- Do what your doctor recommends or tell your doctor why you do not want to follow the recommendations.
- Be considerate of the people with whom you come in contact.
- Take part in making your hospital stay safe; be an involved part of your health care team.
- Provide your health insurance information or ask us about other options available to assist you with your payments.
- Let us know if you have legal papers about end-of-life decisions, such as a living will, health care surrogate declaration or other advance directives. Tell your nurse if you want to make an advance directive, or contact Patient & Family Services for more information at 859-323-5501.

### What everyone needs to know about AIDS

Kentucky law requires that we inform you about AIDS. AIDS stands for acquired immunodeficiency syndrome. It is a disease caused by a virus (human immunodeficiency virus or HIV) that can destroy the body's ability to fight illness.

People can protect themselves if they take reasonable precautions. AIDS is spread in three main ways:

- Having sex with someone who has HIV
- Sharing drug needles and syringes with users of heroin, cocaine, and other drugs
- Babies can be born with the virus if the mother has been infected

It is true that some people have acquired AIDS through infected blood transfusions or transplanted organs in the past, but that is very rare. Today, all donated blood and organs are tested for the AIDS virus. There is no proof that the virus is spread through casual contact -- you can touch someone with AIDS without getting it. There is no reason to avoid an infected person in ordinary social contact.

## AUTHORIZATIONS & AGREEMENTS

(Patient Label Here)

**Treatment with Controlled Substances**

Federal and state laws regulate controlled substances (drugs) that may be abused. Kentucky law requires that you consent to treatment with these drugs before you can receive them. Some illnesses and injuries can result in pain. Some drugs can make the pain more tolerable. Some other drugs can increase focus and reduce hyperactivity. Use of these drugs can cause nausea, sleepiness, drowsiness, vomiting, constipation, sleeplessness, loss of appetite, agitation, aggravation of depression, dry mouth, confusion, slower breathing, and loss of coordination making it unsafe to drive or operate machinery. These drugs can result in physical dependence, meaning that abrupt stopping may lead to withdrawal symptoms, psychological dependence, meaning that stopping may cause you to crave the drug, tolerance, meaning you need more drugs to get the same effect and addiction, meaning you may develop problems based on genetic or other factors. You must tell your doctor if you are pregnant or are considering pregnancy.

**Living Wills In Kentucky**

A Living Will gives you a voice in decisions about your medical care when you are unconscious or too ill to communicate. As long as you are able to express your own decisions, your Living Will will not be used and you can accept or refuse any medical treatment. But if you become seriously ill, you may lose the ability to participate in decisions about your own treatment.

You have the right to make decisions about your medical care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

The Kentucky Living Will Directive Act of 1994 was passed to ensure that citizens have the right to make decisions regarding their own medical care, including the right to accept or refuse treatment. This right to decide -- to say yes or no to proposed treatment -- applies to treatments that extend life, like a breathing machine or a feeding tube. In Kentucky a Living Will allows you to leave instructions in four critical areas. You can:

- Designate a Health Care Surrogate
- Refuse or request life prolonging treatment
- Refuse or request artificial feeding or hydration (tube feeding)
- Express your wishes regarding organ donation

Everyone age 18 or older can have a Living Will. The effectiveness of a Living Will is suspended during pregnancy.

It is not necessary that you have an attorney draw up your Living Will. Kentucky law (KRS 311.625) actually specified the form you should fill out. You probably should see an attorney if you make changes to the Living Will form. The law also prohibits relatives, heirs, health care providers or guardians from witnessing the Will. You may wish to use a Notary Public in lieu of witnesses.

The Living Will form includes two sections. The first section is the Health Care Surrogate section, which allows you to designate one or more persons, such as a family member or close friend, to make health care decisions for you if you lose the ability to decide for yourself. The second section is the Living Will section in which you may make your wishes known regarding life-prolonging treatment so your Health Care Surrogate or Doctor will know what you want them to do. You can also decide whether to donate any of your organs in the event of your death.

When choosing a surrogate, remember that the person you name will have the power to make important treatment decisions, even if other people close to you might urge a different decision. Choose the person best qualified to be your health care surrogate. Also, consider picking a back-up person, in case your first choice is not available when needed. Be sure to tell the person that you have named them a surrogate and make sure that the person understands what is most important to you. Your wishes should be laid out specifically in the Living Will.

If you decide to make a Living Will, be sure to talk about it with your family and your doctor. The conversation is just as important as the document.

A copy of any Living Will should be put in your medical records. Each time you are admitted for an overnight stay in a hospital or nursing home, you will be asked whether you have a Living Will. You are responsible for telling your hospital or nursing home that you have a Living Will.

If there is anything you do not understand regarding the form, you might want to discuss with an attorney. You can also ask your doctor to explain the medical issues. When completing the form, you may complete all of the form, or only the parts you want to use. You are not required by law to use these forms. Different forms, written the way you want, may also be used. You should consult with an attorney for advice on drafting your own forms.

You are not required to make a Living Will to receive health care or for any other reason. The decision to make a Living Will must be your own personal decision and should only be made after serious consideration.

While you are a patient at University of Kentucky Hospital or the UK HealthCare Good Samaritan Hospital, you may contact the Department of Patient & Family Services in room H149 or call (859) 323-5501 if you would like more information on advance directives.

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- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

## AUTHORIZATIONS & AGREEMENTS

(Patient Label Here)

**Section 1557 of the Affordable Care Act (ACA)**
**NOTICE OF NONDISCRIMINATION FOR UK HEALTHCARE PROGRAMS AND ACTIVITIES**

The University of Kentucky complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The University of Kentucky does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The health programs and activities of the University of Kentucky:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified medical interpreters
    - Information written in other languages

If you need these services, contact any employee of a UK health program or activity.

If you believe the University of Kentucky has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Patty Bender, Section 1557 Coordinator and Associate Vice President
Institutional Equity and Equal Opportunity
University of Kentucky
13 Main Building, Lexington, KY 40506-0032

Telephone: (859) 257-8927
Fax: (859) 323-3739
E-mail: pbender@uky.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, UK HealthCare Office of Patient Experience or Patty Bender, Section 1557 Coordinator is available to help.

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 at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Telephone number: 1-800-368-1019
(TDD) number: 1-800-537-7697

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

# YOUR RIGHT TO AN INTERPRETER

**You have the right to an interpreter at no cost to you.**

**American Sign Language (ASL)**

You have the right to an interpreter at no cost to you. Please point to this line. An interpreter will be called. Please wait.

ENGLISH If you speak English, language assistance services, free of charge, are available to you.

SPANISH Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno.

CHINESE 如果您讲汉语普通话，则可以免费向您提供语言协助服务。

GERMAN Wenn Sie deutsch sprechen, stehen Ihnen kostenlos Sprachhilfen zur Verfügung.

VIETNAMESE Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị, nếu quý vị nói tiếng Việt.

ARABIC إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية مجانا.

SERBO-CROATIAN Ukoliko govorite srpski, na raspolaganju su vam besplatne usluge jezične pomoći.

JAPANESE 日本語を話される場合には、無償の言語支援サービスがご利用いただけます。

FRENCH Si votre langue est le français, des services d'assistance linguistiques sont mis gratuitement à votre disposition.

KOREAN 모국어가 한국어일 경우 무료 언어지원 서비스가 제공됩니다.

PENNSYLVANIA DUTCH Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch.

NEPALI यदि तपाई नेपाली बोल्नुहुन्छ भने, तपाईले बिना कुनै शुल्क भाषा सहायता सेवाहरू प्राप्त गर्न सक्नुहुन्छ।

OROMO Yoo qooqa Oromo dubbatta tahe, tajaajilli gargaarsaa, baasi (kaffaltii malee) siif jira.

RUSSIAN Если ваш язык — русский, то вам могут быть предоставлены бесплатные услуги переводчика.

TAGALOG Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo sa lengguahe na walang bayad.

KIRUNDI Niba uvuga Ikirundi, hari servisi itishurwa yo gusobanura indimi.

Services available in 200+ languages.

HealthCare

7-7/02

* PARENT COPY *

UKHealthCare

# Notice of Privacy Practices

Effective April 14, 2003
Revised September 23, 2013

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

## OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

We are committed to protecting the privacy of all health information we create and maintain as a result of the health care we provide you. Your "protected health information" (PHI) includes information about your past, present or future health, health care we provide you and payment for your health care contained in the record of care and services provided by University of Kentucky health care facilities. The purpose of this Notice is to explain who, what, when, where and why your protected health information may be used or disclosed, and assist you in making informed decisions when authorizing anyone to use or disclosure your PHI.

## YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- To request in writing to the treatment area a restriction on the uses and disclosures of protected health information as described in this Notice. We are not required to agree to the restriction you request. We may not be able to comply with your request in certain situations, which include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services and uses and disclosures that do not require your authorization.

- To request in writing a restriction on disclosures for payment or health care operations when paying out-of-pocket in full for health care item or service. We are required to agree to this restriction.

- To obtain a paper copy of this Notice and upon written request submitted to the UK health care facility maintaining the record, inspect and/or obtain a copy of your health record.

- To amend your health record by submitting a written request with the reasons supporting the request to the Medical Records department. We may deny your request if a) the record was not created by us, unless the person that created the record is no longer available to make the amendment; b) the record is not part of the health information used to make decisions about you; c) we believe the record is correct and complete; or d) you would not have the right to inspect and copy the record as described herein.

- To request in writing to the Privacy Officer a written list of disclosures we made of your health information, except that we are not required to account for disclosures for purposes of treatment, payment, operations, directory notification, disaster relief, as allowed under certain circumstances by law or pursuant to your authorization.

- To request in writing to the treatment area that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter or telephone.

- To revoke your authorization to use or disclose PHI at any time except, unless your authorization was obtained as a condition of obtaining insurance coverage, and except to the extent your PHI has already been disclosed pursuant to your authorization. Your revocation request must be made in writing to the Medical Records unit of the facility where you originally filed your authorization.

- To be notified of a breach of your unsecured protected health information

- To receive a copy of your medical record in electronic format, if possible.

## OUR RESPONSIBILITIES

**Maintain** the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

**Abide** by the terms of the Notice currently in effect. We have the right to change our Notice of Privacy Practices and we will apply the change to all of your personal health information, including information obtained prior to the change.

**Post** notice of any changes to our Privacy Practices in the lobby and make a copy available to you upon request.

## CONTACT FOR QUESTIONS/COMPLAINTS/REQUESTS

Direct your questions, complaints and requests made pursuant to this Notice to: **Privacy Officer, 2333 Alumni Drive, Suite 200, Lexington, KY 40517, (859)323-1184 or (859)323-8002.** You may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

## HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI for the following purposes:

**Treatment:** We may use and disclose your protected health information to anyone involved in the provision of health care to you, including for example, University physicians, nurse practitioners, nurses and other medical professionals, including our medical students, residents and volunteers. We may also disclose your protected health information to outside treating medical professionals and staff as deemed necessary for your health care.

**Payment:** We may use and disclose your protected health information to billing and collection agencies, insurance companies and health plans to collect payment for our services.

**Heath Care Operations:** We may use and disclose your protected health information for our own health care operations. For example, we may use your protected health information to assess your care in an effort to improve the quality and safety of our service to you; to evaluate the skills, qualifications and performance of our health care providers; to provide training programs to students, trainees and other health care providers. In addition, our accountants, auditors and attorneys may use your protected health information to assist our compliance with applicable law.