Notice of Health Information Practices

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

Introduction

Senior Journeys, LLC and the testing team are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 9/15/15 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

When you undergo the Functional Snow Screen, Senior Journeys, LLC keeps a record of your test. Typically, this record contains your symptoms, examination and test results, pertinent past medical history, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- A tool in educating heath professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of Senior Journeys, LLC, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Senior Journeys, LLC is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, Agnes F. Schrider, PT at 540-470-7967.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

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

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

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

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Functional Snow Screen Participation
Consent, Waiver, and Release Form

Please list and describe any medical changes in your health in the past 12 months: (i.e. surgery, broken bones, muscle or joint injuries, heart attack, trauma).

_____
_____
_____

_____ No changes in my health in the past 12 months.

_____ I attest that the above information is true and accurate.

Signature: _____ date: _____

Parent signature (if participant is under 18 years old): _____ date: _____

I understand that the Functional Snow Screen (FSS) test that I am about to undergo is an intense physical activity. I understand that this activity will cause my heart rate and blood pressure to increase. In rare instances, fainting and chest pain may occur. It is possible that I may suffer joint, muscle, tissue, or bone aching, bruising, sprains, breakage, or other injuries as a result of my participation in this test.

The screening will be comprised of six tests: a 5-minute step test; a jumping test; lifting 50lbs from floor, 25lbs from waist to shoulder, and 15 lbs from my shoulder level to above my head; balance test on one leg for 20 seconds and balance on foam cushion for 10 seconds; plank test; and an abdominal endurance test. I have seen a video depicting each of these tests or I have had the opportunity to view the video and declined. The screening tests have been fully explained to me, I have been offered an opportunity to ask questions about each test, I understand that the testing team and Senior Journeys, LLC is not requiring me to take these tests, and I understand that I can stop the FSS at any time if I cannot continue.

I understand and agree that although the testing team and Senior Journeys, LLC may perform some physiological tests on me prior to beginning the screening test, or may otherwise allow me take the screening tests, by so doing the testing team is merely collecting my physiological data for their own internal purposes, and that they are not making any representations, guarantees, or conclusions that I am sufficiently healthy to perform the screening tests, nor have I relied upon the testing team in concluding that I am sufficiently healthy to perform these tests. Instead, I understand that it is solely my responsibility to determine whether I am sufficiently healthy to take these tests, that I have been given an adequate opportunity to do so, and that my involvement in each test is my assertion that I am sufficiently healthy to do so. I have been given adequate time and information to assess the degree, scope, and nature of the risks involved to my satisfaction, and I fully understand all the risks associated with my involvement with this screening test, or I hereby waive the opportunity to perform such a risk assessment.

Accordingly, I hereby freely, intelligently, and voluntarily consent to these tests and assume liability for all risk and injury that relates to my participation in this screening test and I specifically release Senior Journeys, LLC and the testing team from any liability or claim for any injury or loss I suffer that occurs during or results from my participation in the FSS. I intend this waiver to bind my family, heirs, successors, assignees, agents, and my estate.

Consent for: _____ date: _____
(Print your legal name)

Signature: _____ phone number: _____

Parent signature: (if participant is under 18 years old): _____

Functional Snow Screen

PHYSICIAN CONSENT

I have knowledge of the medical history of _____. I understand the fact that exercise and the physical activity required during the Functional Snow Screen (FSS) presents a potentially hazardous stress to the body. I give my recommendation to allow him/her to participate in the Functional Snow Screen. The assessment include different tests: 1) Five minute step Test. 2) Quadrant jumping test 3) Lifting: a)lifting 50lbs from the floor b)lifting 25lbs from knuckle to waist height and c)lifting 15lbs overhead. 3) Single leg balance test for 20seconds on the floor and ten seconds on a foam cushion. 4) Abdominal endurance test up to 45 seconds 5)Plank holds up to 45 seconds. Also, it is expected that this individual will be able to function independently during the screening.

Each test is demonstrated for the participant with cueing for safety. The tester will stop the test at any time that it looks unsafe for the participant and the participant is free to refuse to take the test.

If there is any information that the tester should know in advance, prior to testing of this individual, for safety reasons, please contact have the participant fill out a release of information form and inform Agnes F. Schrider, PT at 540-470-7967.

_____ _____ _____

PHYSICIAN'S NAME (please print) PHYSICIAN'S SIGNATURE DATE

Specific recommendations or restrictions (please comment if necessary):

_____

_____

_____

_____

Functional Snow Screen Score Sheet

Name: _____ Date: _____

BP: _____mmhg HR: _____ bpm SpO2_____ %

TESTS	Completed	Did not complete	OBSERVATION
1. Five Minute Step Test*			
2. Quadrant Agility Test*			
3. Lift Test: 12" to knuckle (50#)*			
Knuckle to shoulder lift (25#)*			
Shoulder to overhead lift (15#)*			
4. Single leg balance on floor and cushion(seconds)	**Floor** R= L= **Cushion** R= L=		
5. Plank test (45 sec hold)		seconds	
6. Abdominal endurance test (45 sec hold)		seconds	

Results:

1. **_____Successfully completed**
2. _____ Completed with recommended exercises
3. **_____Retest**
    a. _____Retest with no reservations
    b. _____Retest with physician consent
    c. _____Completed vitals but not able to start test
    d. _____Started but not able to complete test
4. **_____Did not show up for scheduled appointment**

Comments/Recommendations: _____

_____

_____

_____

Tester Name: _____

Revised 9/12/15