PATIENT HANDBOOK

WELCOME TO RISE Pediatric Therapy

MISSION STATEMENT:

Helping children RISE towards their functional abilities in order to gain independence to more fully participate in meaningful activities of life through Occupational Therapy, Physical Therapy, and Speech/Language Therapy. We provide personalized holistic care incorporating gross motor, fine motor, speech/language, developmental milestones, play skills, and self-care skills. Our team strives to empower children and families with the tools and knowledge to incorporate therapeutic interventions into daily life. Our mission is to provide genuine and compassionate care to enrich the lives of those we serve.

SERVICES:

At RISE Pediatric Therapy we offer a comprehensive therapy team including physical therapy, occupational therapy, and speech therapy services. Therapists provide clinical assessment, therapeutic interventions, and caregiver education in order to promote increased overall functional performance. All therapy services are provided in the community or home environment in order to improve functioning in the child's natural settings.

We are providing you with information about our care for you and information for your future use. It is important for you to read and understand the information in this handbook. Your home health care professional will review the contents with you and answer any questions you may have. Please take time to review this handbook and use as a reference during your care. The home health agency will partner with you to achieve the best possible outcome of your care. It is your responsibility to make sure you understand this information and work with your team of professionals in an effort to best meet your health care needs.

We are grateful you have chosen the team at RISE Pediatric Therapy. We look forward to working with you and your child to provide professional and compassionate quality services.

RISE
PEDIATRIC THERAPY

www.risepediatrictherapy.com
info@risepediatrictherapy.com
Phone 720-602-0384
Fax 720-302-2932

Your Professional Home Health Care Team

Your Physical Therapist: _____

Your Occupational Therapist: _____

Your Speech Therapist: _____

Office Hours and On-Call Coverage

Our normal office hours are 9:00 a.m. to 4:00 p.m. Monday through Friday, except during company holidays.

Office Phone Number **720-602-0384**

Medical Emergencies

Your homecare agency is in place to work with your medical conditions to prevent re-hospitalizations. We would like to be your first line of defense, but in the case of a true emergency (significant trouble breathing, life- or limb- threatening emergency) **call 911.**

In the case of a serious medical emergency, immediately call 9-1-1 or proceed to the nearest hospital emergency department.

Agency Overview

Criteria for Admission

Admission can only be made with directions from a physician, based upon the patients identified care needs and the type of services required that we can provide directly or through coordination with other organizations.
Upon Admission to home health care your clinician and you will establish a plan for your care and identify your goals. Once these goals are met you will be ready for discharge from services.

Services

We provide Physical Therapy, Occupational Therapy, and Speech Therapy in the home.
There must be a willing, able and available caregiver to be responsible for your care between agency visits. This person can be you, a family member, a friend or a paid caregiver.

Medicaid Requirements & Payment Information

Charges

Rise Pediatric Therapy LLC accepts payment from Medicaid and private pay. We will inform you and/or your authorized representative of all charges and payer sources before initiating your care.

Rise Pediatric Therapy LLC will bill your insurance directly for all services. We will accept Medicaid assigned payment as long as you meet the eligibility requirements established by Medicaid. If services are ordered that are not covered by your insurance, we will notify and assist you, as appropriate, to make any arrangements required for your care.

Please notify the agency immediately if you decide to change insurance carriers or enroll in another plan. Your continued care with the agency may have to be evaluated based on your new situation and whether the agency is able to provide care under your changed circumstances. We will make that determination based on the information you provide and attempt to assist you in finding alternate care if appropriate.

Medicaid clients eligibility will be verified before therapy begins and then each month thereafter for duration of therapy. You will be notified if your child is ineligible and therapy will be put ON HOLD until your child's Medicaid is active again. If your child continues ineligibility, discharge may occur. Please contact and notify your child's therapist if you are aware of losing future benefits.

Insurance reimbursement should be sent directly to your child's therapy provider. Sometimes, the checks can be sent to the family. If that should occur, please notify your therapist and then sign the insurance check over to Rise Pediatric Therapy LLC and your therapist will collect the check and explanation of benefits from you at the next session with your child.

Please call our office if you have any questions about coverage, charges or billing.

Visit Schedule

The agency works in cooperation with the patient and the patient's family to determine appropriate days and times of the visit. It is our goal to provide care to the patient in a manner to maintain or enhance the health of the patient. The patient and the family should work together with the therapist to assure that the proposed days and times of the week for visits is appropriate and that the family will work to assure compliance with the visit schedule. We are aware that missed visits are unavoidable, but the following is our policy. If the visit is missed the therapist will work to provide other times during the week to make up the visit during that week. We will offer another therapist to see the patient if appropriate. If you need to cancel a visit we know that there are appointments and trips that are a part of your life.

NOTICE OF PRIVACY PRACTICES

09/01/2013

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.

As part of the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, the Agency has created this Notice of Privacy Practices (Notice). This Notice describes the Agency's privacy practices and the rights you, the individual, have as they relate to the privacy of your Protected Health Information (PHI). Your PHI is information about you, or that could be used to identify you, as it relates to your past and present physical and mental health care services. The HIPAA regulations require that the Agency protect the privacy of your PHI that the Agency has received or created.

This Agency will abide by the terms presented within this Notice. For any uses or disclosures that are not listed below (Including Marketing and Selling of PHI), the Agency will obtain a written authorization from you for that use or disclosure, which you will have the right to revoke at any time, as explained in more detail below. **The Agency reserves the right to change the Agency's privacy practices and this Notice.**

HOW THE AGENCY MAY USE AND DISCLOSE YOUR PHI

The following is an accounting of the ways that the Agency is permitted, by law, to use and disclose your PHI.

Uses and disclosures of PHI for Treatment: We will use the PHI that we receive from you to fill your prescription and coordinate or manage your health care.
Uses and disclosures of PHI for Payment: The Agency will disclose your PHI to obtain payment or reimbursement from insurers for your health care services.
Uses and disclosures of PHI for Health Care Operations: The Agency may use the minimum necessary amount of your PHI to conduct quality assessments, improvement activities, and evaluate the Agency workforce.

The following is an accounting of additional ways in which the Agency is permitted or required to use or disclose PHI about you without your written authorization.

Uses and disclosures as required by law: The Agency is required to use or disclose PHI about you as required and as limited by law.
Uses and disclosure for Public Health Activities: The Agency may use or disclose PHI about you to a public health authority that is authorized by law to collect for the purpose of preventing or controlling disease, injury, or disability. This includes the FDA so that it may monitor any adverse effects of drugs, foods, nutritional supplements and other products as required by law.
Uses and disclosure about victims of abuse, neglect or domestic violence: The Agency may use or disclose PHI about you to a government authority if it is reasonably believed you are a victim of abuse, neglect or domestic violence.
Uses and disclosures for health oversight activities: The Agency may use or disclose PHI about you to a health oversight agency for oversight activities which may include audits, investigations, inspections as necessary for licensure, compliance with civil laws, or other activities the health oversight agency is authorized by law to conduct.
Disclosures to Individuals Involved in your Care: The Agency may disclose PHI about you to individuals involved in your care.
Disclosures for judicial and administrative proceedings: The Agency may disclose PHI about you in the course of any judicial or administrative proceedings, provided that proper documentation is presented to the Agency.
Disclosures for law enforcement purposes: The Agency may disclose PHI about you to law enforcement officials for authorized purposes as required by law or in response to a court order or subpoena.
Uses and disclosures about the deceased: The Agency may disclose PHI about a deceased, or prior to, and in reasonable anticipation of an individual's death, to coroners, medical examiners, and funeral directors.
Uses and disclosures for cadaveric organ, eye or tissue donation purposes: The Agency may use and disclose PHI for the purpose of procurement, banking, or transplantation of cadaveric organs, eyes, or tissues for donation purposes.
Uses and disclosures for research purposes: The Agency may use and disclose PHI about you for research purposes with a valid waiver of authorization approved by an institutional review board or a privacy board. Otherwise, the Agency will request a signed authorization by the individual for all other research purposes.
Uses and disclosures to avert a serious threat to health or safety: The Agency may use or disclose PHI about you, if it believed in good faith, and is consistent with any applicable law and standards of ethical conduct, to avert a serious threat to health or safety.
Uses and disclosures for specialized government functions: The Agency may use or disclose PHI about you for specialized government functions including; military and veteran's activities, national security and intelligence, protective services, department of state functions, and correctional institutions and law enforcement custodial situations.
Disclosure for workers' compensation: The Agency may disclose PHI about you as authorized by and to the extent necessary to comply with workers' compensation laws or programs established by law.

Disclosures for disaster relief purposes: The Agency may disclose PHI about you as authorized by law to a public or private entity to assist in disaster relief efforts and for family and personal representative notification.
Disclosures to business associates: The Agency may disclose PHI about you to the Agency's business associates for services that they may provide to or for the Agency to assist the Agency to provide quality health care. To ensure the privacy of your PHI, we require all business associates to apply appropriate safeguards to any PHI they receive or create.

OTHER USES AND DISCLOSURES

The Agency may contact you for the following purposes:

Information about treatment alternatives: The Agency may contact you to notify you of alternative treatments and/or products.

Health related benefits or services: The Agency may use your PHI to notify you of benefits and services the Agency provides.

Fundraising: If the Agency participates in a fundraising activity, the Agency may use demographic PHI to send you a fundraising packet, or the Agency may disclose demographic PHI about you to its business associate or an institutionally related foundation to send you a fundraising packet. No further disclosure will be allowed by the business associates or an institutionally related foundation without your written authorization. You will be provided with an opportunity to opt-out of all future fundraising activities.

FOR ALL OTHER USES AND DISCLOSURES

The Agency will obtain a written authorization from you for all other uses and disclosures of PHI, and the Agency will only use or disclose pursuant to such an authorization. In addition, you may revoke such an authorization in writing at any time. To revoke a previously authorized use or disclosure, please contact Aleksey Zhivotov to obtain a *Request for Restriction of Uses and Disclosures*.

YOUR HEALTH INFORMATION RIGHTS

The following are a list of your rights in respect to your PHI. Please contact Aleksey Zhivotov for more information about the below.

Request restrictions on certain uses and disclosures of your PHI: You have the right to request additional restrictions of the Agency's uses and disclosures of your PHI. The Agency is not required to accommodate a request, except that the Agency is required to agree to a request to restrict disclosures to health insurance plans related to products and services you pay out-of-pocket for.

The right to have your PHI communicated to you by alternate means or locations: You have the right to request that the Agency communicate confidentially with you using an address or phone number other than your residence. However, state and federal laws require the Agency to have an accurate address and home phone number in case of emergencies. The Agency will consider all reasonable requests.

The right to inspect and/or obtain a copy your PHI: You have the right to request access and/or obtain a copy of your PHI that is contained in the Agency for the duration the Agency maintains PHI about you. There may be a reasonable cost-based charge for photocopying documents. You will be notified in advance of incurring such charges, if any.

The right to amend your PHI: You have the right to request an amendment of the PHI the Agency maintains about you, if you feel that the PHI the Agency has maintained about you is incorrect or otherwise incomplete. Under certain circumstances we may deny your request for amendment. If we do deny the request, you will have the right to have the denial reviewed by someone we designate who was not involved in the initial review. You may also ask the Secretary, United States Department of Health and Human Services ("HHS"), or their appropriate designee, to review such a denial.

The right to receive an accounting of disclosures of your PHI: You have the right to receive an accounting of certain disclosures of your PHI made by the Agency.

The right to receive additional copies of the Agency's Notice of Privacy Practices: You have the right to receive additional paper

copies of this Notice, upon request, even if you initially agreed to receive the Notice electronically

Notification of Breaches: You will be notified of any breaches that have compromised the privacy of your PHI.

REVISIONS TO THE NOTICE OF PRIVACY PRACTICES

The Agency reserves the right to change and/or revise this Notice and make the new revised version applicable to all PHI received prior to its effective date. The Agency will also post the revised version of the Notice in the Agency.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Agency and/or to the Secretary of HHS, or his designee. If you wish to file a complaint with the Agency, please contact Aleksey Zhivotov if you wish to file a complaint with the Secretary, please write to:

http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html

The Agency will not take any adverse action against you as a result of your filing of a complaint.

CONTACT INFORMATION

If you have any questions on the Agency's privacy practices or for clarification on anything contained within the Notice, please contact:

RISE Pediatric Therapy LLC
5610 Ward Rd. #300, Arvada, CO 80002
Megan Ruder
720-602-0384

Home Health Agency
Outcome and Assessment Information Set (OASIS)
STATEMENT OF PATIENT PRIVACY RIGHTS

As a home health patient, you have the privacy rights listed below.

- **You have the right to know why we need to ask you questions.**
  We are required by law to collect health information to make sure:
  1) You get quality health care, and
  2) Payment for Medicare and Medicaid patients is correct.
- **You have the right to have your personal health care information kept confidential.**
  You may be asked to tell us information about yourself so that we will know which home health services will be best for you. We keep anything we learn about you confidential. This means, only those who are legally authorized to know, or who have a medical need to know, will see your personal health information.
- **You have the right to refuse to answer questions.**
  We may need your help in collecting your health information. If you choose not to answer, we will fill in the information as best we can. You do not have to answer every question to get services.
- **You have the right to look at your personal health information.**
  - We know how important it is that the information we collect about you is correct. If you think we made a mistake, ask us to correct it.
  - If you are not satisfied with our response, you can ask the Centers for Medicare & Medicaid Services, the federal Medicare and Medicaid agency, to correct your information.

You can ask the Centers for Medicare & Medicaid Services to see, review, copy, or correct your personal health information which that Federal agency maintains in its HHA OASIS System of Records. See the back of this Notice for CONTACT INFORMATION. If you want a more detailed description of your privacy rights, see the back of this Notice: PRIVACY ACT STATEMENT - HEALTH CARE RECORDS.

NOTICE ABOUT PRIVACY
For Patients Who DO NOT Have Medicare or Medicaid Coverage

- As a home health patient, there are a few things that you need to know about our collection of your personal health care information.
  - Federal and State governments oversee home health care to be sure that we furnish quality home health care services, and that you, in particular, get quality home health care services.
  - We need to ask you questions because we are required by law to collect health information to make sure that you get quality health care services.
  - We will make your information anonymous. That way, the Centers for Medicare & Medicaid Services, the federal agency that oversees this home health agency, cannot know that the information is about you.
- We keep anything we learn about you confidential.

This is a Medicare & Medicaid Approved Notice.

CMS
CENTERS for MED/CARE & MEDICAID SERWCES

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

PRIVACY ACT STATEMENT- HEALTH CARE RECORDS

THIS STATEMENT GIVES YOU ADVICE REQUIRED BY LAW (the Privacy Act of 1974).

THIS STATEMENT IS NOT A CONSENT FORM. IT WILL NOT BE USED TO RELEASE OR TO USE YOUR HEALTH CARE INFORMATION.

I. AUTHORITY FOR COLLECTION OF YOUR INFORMATION, INCLUDING YOUR SOCIAL SECURITY NUMBER, AND WHETHER OR NOT YOU ARE REQUIRED TO PROVIDE INFORMATION FOR THIS ASSESSMENT. Sections 1102(a), 1154, 1861(o), 1861(z), 1863, 1864, 1865, 1866, 1871, 1891(b) of the Social Security Act.

Medicare and Medicaid participating home health agencies must do a complete assessment that accurately reflects your current health and includes information that can be used to show your progress toward your health goals. The home health agency must use the "Outcome and Assessment Information Set" (OASIS) when evaluating your health. To do this, the agency must get information from every patient. This information is used by the Centers for Medicare & Medicaid Services (CMS, the federal Medicare & Medicaid agency) to be sure that the home health agency meets quality standards and gives appropriate health care to its patients. You have the right to refuse to provide information for the assessment to the home health agency. If your information is included in an assessment, it is protected under the federal Privacy Act of 1974 and the "Home Health Agency Outcome and Assessment Information Set" (HHA OASIS) System of Records. You have the right to see, copy, review, and request correction of your information in the HHA OASIS System of Records.

II. PRINCIPAL PURPOSES FOR WHICH YOUR INFORMATION IS INTENDED TO BE USED

The information collected will be entered into the Home Health Agency Outcome and Assessment Information Set (HHA OASIS) System No. 09-70.9002. Your health care information in the HHA OASIS System of Records will be used for the following purposes:

- support litigation involving the Centers for Medicare & Medicaid Services;
- support regulatory, reimbursement, and policy functions performed within the Centers for Medicare & Medicaid Services or by a contractor or consultant;
- study the effectiveness and quality of care provided by those home health agencies;
- survey and certification of Medicare and Medicaid home health agencies;
- provide for development, validation, and refinement of a Medicare prospective payment system;
- enable regulators to provide home health agencies with data for their internal quality improvement activities;
- support research, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for health care payment related projects; and
- support constituent requests made to a Congressional representative.

III. ROUTINE USES

These "routine uses" specify the circumstances when the Centers for Medicare & Medicaid Services may release your information from the HHA OASIS System of Records without your consent. Each prospective recipient must agree in writing to ensure the continuing confidentiality and security of your information. Disclosures of the information may be to:

1. the federal Department of Justice for litigation involving the Centers for Medicare & Medicaid Services;
2. contractors or consultants working for the Centers for Medicare & Medicaid Services to assist in the performance of a service related to this system of records and who need to access these records to perform the activity;
3. an agency of a State government for purposes of determining, evaluating, and/or assessing cost, effectiveness, and/or quality of health care services provided in the State; for developing and operating M9dicaid reimbursement systems; or for the administration of Federal/State home health agency programs within the State;
4. another Federal or State agency to contribute to the accuracy of the Centers for Medicare & Medicaid Services' health insurance operations (payment, treatment and coverage) and/or to support State agencies in the evaluations and monitoring of care provided by HHA's;
5. Quality Improvement Organizations, to perform Title XI or Title XVIII functions relating to assessing and improving home health agency quality of care;
6. an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects;
7. a congressional office in response to a constituent inquiry made at the written request of the constituent about whom the record is maintained.

IV. EFFECT ON YOU, IF YOU DO NOT PROVIDE INFORMATION

The home health agency needs the information contained in the Outcome and Assessment Information Set in order to give you quality care. It is important that the information be correct. Incorrect information could result in payment errors. Incorrect information also could make it hard to be sure that the agency is giving you quality services. If you choose not to provide information, there is no federal requirement for the home health agency to refuse you services.

NOTE: This statement may be included in the admission packet for all new home health agency admissions. Home health agencies may request you or your representative to sign this statement to document that this statement was given to you. Your signature is NOT required. If you or your representative sign the statement, the signature merely indicates that you received this statement. You or your representative must be supplied with a copy of this statement.

CONTACT INFORMATION

If you want to ask the Centers for Medicare & Medicaid Services to see, review, copy, or correct your personal health information that the Federal agency maintains in its HHA OASIS System of Records:

Call 1-800-MEDICARE, toll free, for assistance in contacting the HHA OASIS System Manager.
TIY for the hearing and speech impaired: 1-877-486-2048.

Written Notice of Home Care Consumer Rights

As a consumer of home care and services you are entitled to receive notification of the following rights both orally and in writing.

You have the right to exercise the following rights without retribution or retaliation from agency staff:

1. Receive written information concerning the agency's policies on advance directives, including a description of applicable state law;

2. Receive information about the care and services to be furnished, the disciplines that will furnish care, the frequency of proposed visits in advance and receive information about any changes in the care and services to be furnished;

3. Receive care and services from the agency without discrimination based upon personal, cultural or ethnic preference, disabilities or whether you have formulated an advance directive;

4. Authorize a representative to exercise your rights as a consumer of home care;

5. Be informed of the full name, licensure status, staff position and employer of all persons supplying, staffing or supervising the care and services you receive;

6. Be informed and participate in planning care and services and receive care and services from staff that are properly trained and competent to perform their duties;

7. Refuse treatment within the confines of the law and be informed of the consequences of such action;

8. Participate in experimental research only upon your voluntary written consent;

9. Have you and your property to be treated with respect and be free from neglect, financial exploitation, verbal, physical and psychological abuse including humiliation, intimidation or punishment;

10. Be free from involuntary confinement, and from physical or chemical restraints;

11. Be ensured of the confidentiality of all of your records, communications, and personal information and to be informed of the agency's policies and procedures regarding disclosure of clinical information and records;

12. Express complaints verbally or in writing about services or care that is or is not furnished, or about the lack of respect for your person or property by anyone who is furnishing services on behalf of the agency.

If you believe your rights have been violated you may contact the agency directly:

RISE Pediatric Therapy LLC
5610 Ward Rd. #300, Arvada, CO 80002
Megan Ruder
720-602-0384

You may also file a complaint with the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment via mail or telephone:
4300 Cherry Creek Drive South
Denver, CO 80246
303-692-2910 or 1-800-842-8826

I attest to verbal and written receipt of the aforementioned notice of rights:

_____ _____
Consumer or Authorized Representative Signature Date

_____ _____
Agency Representative Signature Date

RISE Pediatric Therapy LLC

AGENCY DISCLOSURE NOTICE

Agency Type: ☐ Home Care Placement ☒ Home Health Care ☐ Personal Care or Non-Medical

Each home care agency or home care placement agency is required to provide the consumer information as to the responsibilities of the agency, the home care worker, and the consumer regarding the employment and duties of each.

- ☐ Agency is the employer of record for all staff providing direct care services and is responsible for all items listed below.
- ☐ Responsibilities are delineated below:

Consumer	Worker	Agency	
	X		Employer of the home care worker.
	X		Supervision of the home care worker.
	X		Scheduling of the home care worker.
	X	X	Assignment of duties to the home care worker.
		X	Hiring, firing and discipline of the home care worker.
	X		Provision of supplies or materials for use in providing services to the consumer.
		X	Training and ensuring qualifications that meet the needs of the consumer.
	X	X	Liability for the home care worker while in the consumer's home.
Consumer	Worker	Agency	Payment of:
		X	Wages to the home care worker.
	X		Employment taxes for the Home Care Worker.
	X		Social Security taxes for the Home Care Worker.
	X		Unemployment insurance for the Home Care Worker.
	X		General liability insurance for the Home Care Worker.
	X		Worker's Compensation for the Home Care Worker.
	X		Bond Insurance (if provided).

The above information and areas of responsibility have been explained and any questions have been answered in regard to responsibilities held by the consumer, the home care worker and the agency.

Consumer or Authorized Representative: _____ Date: _____

Home Care Worker: _____ Discipline: _____ Date: _____

(If not employee or contractor to the agency where the agency holds full responsibility)

Agency Representative: _____ Title: _____ Date: _____

Printed Name of Consumer: _____ Start of Care Date: _____

Advance Directives

Patients have the right to make decisions concerning their care, including the right to accept or refuse treatment, and the right to formulate advanced directives as permitted under state statutory and case law.

Following are some examples of Advance Directives:

- Living Will – allows you to make your medical wishes known in the event you become terminally ill or are in a persistent vegetative state and lack decision making capacity.
- Medical Durable Power of Attorney - allows you to name an individual (or individuals) who can make health care decisions for you.
- CPR Directive - a directive instructing emergency and other health care personnel not to perform cardiopulmonary resuscitation (CPR) on you.
- Medical Orders for Scope of Treatment - summarizes your preferences for medical treatment, CPR, artificial nutrition/hydration and antibiotics when you have a chronic, serious, advanced or terminal illness.

Most health care providers have a policy which requires that resuscitation be done unless there are written physician orders (DNR or Do Not Resuscitate Orders) or CPR Directives to the contrary. DNR orders are written by a physician when in the physician's judgment, and often after consultation with the patient, resuscitation would not be appropriate.

AGENCY POLICY ON ADVANCE DIRECTIVES

- Prior to the start of care, Homecare provider will inform the patient concerning, any Colorado specific laws concerning Advance directives, your right to formulate advanced directives, to ask you about any advanced directives that you may already have, to provide education on advanced directives if desired, and to provide information to the patient about refusing or terminating care after the consequences of refusing the care or treatment are fully presented.
- Homecare provider will document in the patient's medical record whether the patient has executed any advance directives. Any copies will become a part of the permanent record.
- No individual will be discriminated against or have care conditioned upon whether and advance directive has been executed.
- In the event that the patient does not have any advanced directives but would like additional information, such information will be provided.

Keeping You Safe at Home

Your safety is important to us. There are many situations that can pose a threat to your personal safety. This section is to identify those safety concerns with you and help prevent further problems with your health. Please speak with your therapist or call the agency at any time if you have any concerns or questions about safety.

MEDICATION SAFETY:

- Medications and treatments are ordered and given under the indirect supervision of your physician.
- Take your medicine exactly as prescribed by your physician.
- Do not discontinue your medications without physician permission.
- Never use someone else's prescription medication.
- If your physician has changed your medication but the label on your bottle has not changed, be sure and tell the health care provider.
- Store your medication in a safe place according to the storage instructions on the label.
- Keep all medications together in one location if storage instructions are the same.
- Medications that you no longer take should be disposed of in a safe manner.
- If you miss a dose DO NOT take a double dose or alter the time or the dose in any way without checking with the nurse, pharmacist, or physician.
- Attempt to understand your medicine and what it does as much as you can. Read the medication

information provided or ask a nurse or pharmacist for reading material about the medication.
- Keep an accurate record of ALL medication that you take. This includes prescription medication, over the counter medication, and any vitamins or herbal products. Include on this record any medical alerts, allergies, or suspected allergies that you might have.

OXYGEN SAFETY:

- Do not smoke while using oxygen.
- Do not use oxygen by open flames such as gas stove.
- Turn off all oxygen if an open flame is present.
- Make sure portable tanks are stored lying down. Do not store standing up in a closet or room.
- In an electrical outage be sure portable tanks are easily accessible.
- Check portable tanks monthly if not using to be sure tanks remain full.
- Notify the utility company that you are on oxygen in the event of a power outage.

FIRE SAFETY/BURN PREVENTION:

The following is a list that you can put into action in your home that will minimize the chance of fires and burns.

- Never smoke in bed or lying on the couch.
- Have water heaters set at 120 degrees or lower.
- Be cautious about cooking in clothes that are too loose or that are made of very flammable material.
- Keep handles turned inward on the stove and check to ensure burners and oven are shut off after use.
- Keep exits out of the home clear of clutter.
- Have an escape plan in the event of fires. This is especially important for where you sleep.
- Have your furnace and other potentially dangerous equipment checked annually.
- Have smoke alarms in every room. Check them monthly. Replace the batteries every six months.
- If smoke is present get down as low as possible and crawl out of the area.
- If a door is closed and feels hot to the touch, DO NOT OPEN IT. Take a different way out of the room or house.

FALLS SAFETY:

Falls are the most common cause of injury and can cause serious health results. It is important that you protect yourself from the possibility of falling. Follow these tips to help prevent the likelihood of falling.

- Keep pathways where you walk open and clear of clutter.
- Place handrails that you can easily grasp in areas where fall risks increase.
- Make sure loose small objects are off the floor.
- Make sure that carpet is not loose or uneven.
- Throw rugs should be removed or secured to the floor.
- Do not run cords under rugs.
- Use your walker, cane and/or wheelchair as directed.
- Select non-skid soles on your footwear.
- Be cautious of spills and liquids on floors.
- Have a grab bar and tub mat in your shower area.
- Keep adequate lighting throughout your home (i.e., night lights, basement lights, etc.).
- Use non-skid mats in the bathtub and on shower floors.
- Keep outside walks and steps clear of snow and ice in the winter.

PERSONAL SAFETY:

- Keep emergency numbers posted by all telephones.
- Keep all doors and windows locked.
- Do not open doors for strangers. Ask for identification.

- Keep the telephone within reach.
- Replace burned out light bulbs.
- Keep flashlight with fresh batteries by the bed for emergencies.
- Keep personal information such as social security number, credit cards, etc., in safe place.
- Keep frequently used items within easy reach.

Infection Control:

Infection control is a safety issue since managing the spread of infections is a major part of maintaining your health. The single most important way to decrease the spread of infections is good hand washing. Hand washing should last 15-30 seconds using soap and water. Rub your hands together vigorously in a circular motion to generate friction. Rub all sides of your hands and between your fingers. Point hands downward and rinse with water. Dry your hands with a clean towel or paper towels.

DISPOSAL OF ITEMS AND EQUIPMENT:

You will need to assist in disposing of care items and equipment. Place items such as disposable diapers, plastic tubing, or dressings in a garbage bag. It is best to have a separate waste basket or lined box to use to dispose of patient care items. When the bag is almost full, secure the opening with a tie. Place the bag inside another bag and place beside your other trash. If your state or local authority has more specific guidelines, your health care professional will provide you with instructions.

CARING FOR ITEMS THAT ARE NOT DISPOSABLE:

Equipment used by the patient should be cleaned regularly and when obviously soiled. Equipment can be cleaned with hot, soapy water, wiped down with a household cleaner, or with a disposable antibacterial cleaning wipe, unless instructed otherwise by the manufacturer. Thermometers should be cleaned with alcohol before and after each use.

PRESENCE OF BLOOD AND/OR BODY FLUIDS:

If there are blood or body fluids that the care provider has to manage, gloves should be worn. Spills should be cleaned up after putting on gloves. Use paper towels to wipe up the spill and follow with a household bleach solution of 1 part bleach to 10 parts water to clean the area. Double bag anything you must dispose of and place in the trash unless otherwise instructed.

*If the patient you are caring for has a condition that affects the immune system, further instruction will be provided for you and your family.

SHARP OBJECTS:

Because there is the potential for sharp objects used on the patient to contaminate another person by inadequate disposal it is important to understand appropriate disposal of sharp objects. The following items are to be disposed of in a NON FLEXIBLE container such as a sharps container or an empty liquid laundry detergent bottle.

- Needles
- Syringes
- Glass tubes
- I.V. Catheters
- Razor Blades or lancets
- Staples from surgical incisions
- Scissors

Disaster/Emergency Preparation

It is important to plan ahead for events that you can't control as it relates to the weather and environment. This way you are more likely to be able to implement a safe and effective plan.

In the event that a natural disaster occurs such as a tornado; your services could be interrupted as the situation warrants. The agency has an emergency plan to make sure your health care needs are met. Once an official clearance is given by weather officials and conditions permit, your services will continue as planned.

It is not uncommon to experience one of the following during a community emergency situation:

- Interruptions in electrical and/or water service.
- Un-availability of telephone service.
- Impassable roads.
- Contaminated water/food.

It is good to have an emergency kit on hand. Depending on the region you live in the kit could vary slightly. The following are standard supplies for most emergency situations:

- Flashlight
- Battery operated radio
- Extra batteries for both the flashlight and the radio
- First aid supplies including your personal medications
- Sleeping supplies/blankets
- Canned foods and bottled water
- Non electric can opener
- Medications
- Extra blankets

It is also beneficial to discuss your emergency plan with family members in advance of the emergency situation. Additional things to be considered are:

- Keep a list of telephone numbers with emergency contacts on it and know how to access them if assistance is needed.
- Know how to use any manual backup systems that you may have.
- Wear footwear if you go outside of your home.
- Know how to turn off your gas, water, and electricity in your home.

When should you seek emergency shelter and evacuate your home?

- Persons that are instructed by the local radio or TV station to leave their homes.
- Persons that live in a mobile house.
- Persons who require additional support or have special needs that could be endangered by the loss of electricity or lack of assistance.

The following is a list of items to take in the event you evacuate your home:

- Two-week supply of medications
- Medical supplies and oxygen
- Wheelchair, walker, cane, etc.
- Special dietary foods/can opener
- Air mattress or cot, bedding or sleeping bag
- Lightweight folding chair
- Extra clothing, hygiene items, glasses
- Important papers
- Valid ID with current name and address

- Home Health folder

Most shelters have electric power from a generator. If you evacuate to a shelter, bring your electrical device (such as an oxygen concentrator) with you.

NOTE: Pets are not usually allowed in shelters, so make arrangements for them in the event of an evacuation. If your shelter does accept pets, please include the following items with your shelter supplies:

- Vaccination records
- Leash
- Portable kennel
- Medications
- Insurance papers and identification papers
- A few hygiene items should be included as well

Following are specific recommendations for anticipated emergencies typical or appropriate for your area:

Severe Weather/Tornadoes

- Have emergency equipment and medical supplies readily available.
- Close all drapes.
- Move away from windows.
- CLOSE exit doors.
- Go to inside room of building with no windows, if available.
- Do not enter damaged portions of the building until instructed.
- Monitor weather bulletins/radio announcements.
- Do not exit building until instructed.
- REMAIN CALM. DO NOT PANIC.

Floods (flood warnings, alerts, or an actual flood)

- Precautions before the flood:
  - Make sure emergency supplies and equipment are readily available.
  - Do not touch any electrical equipment unless it is dry.

- Precautions if evacuation of building is ordered:
  - Travel only routes designated.
  - Do not try to cross a stream or other water areas unless you are sure it is safe.
  - Monitor local radio broadcast.
  - Watch for fallen trees, live wires, etc.
  - Watch for washed-out roads, earth slides, broken water lines, etc.
  - Watch for areas where rivers, lakes, or streams may flood suddenly.

- After the flood:
  - Do not enter the building until an all-clear has been given.
  - Do not use any open flame devices until the building has been inspected for possible gas leaks.
  - Do not turn on any electrical equipment that may have gotten wet.
  - Shovel out mud while it is still moist.

- Flash floods:
  - Remember, flash floods can happen without warning.
  - When a flash flood warning is issued, take immediate action.
  - Follow all instructions issued without delay.

Snow Emergency (snow emergency or winter storms)

- Keep a one (1) to two (2) week supply of heating fuel, food, and water on hand in case of isolation at home.

- Keep your car properly serviced, with snow tires and filled with gas.
- Keep emergency supplies in the car:
  - Container of sand
  - Shovel
  - Windshield scraper
  - Tow chain or rope
  - Flares
  - Blanket
  - Flashlight
- Dress appropriately—wear several layers of loose, lightweight, warm clothing, mittens, and winter headgear to cover head and face.
- Carry a cellular phone (if available).
- Drive with all possible caution. If caught in a blizzard, seek refuge immediately. Keep car radio on for weather information
- If your car breaks down—turn flashers on or hang a cloth from the radio aerial; stay in your car. If your car is stuck in snow or traffic jam and the car is running, crack windows to prevent carbon monoxide poisoning and keep exhaust pipe free of snow. If engine is not running, you do not need to crack windows.

RISE Pediatric Therapy LLC
5610 Ward Rd. #300, Arvada, CO 80002
Phone 720-602-0384 Fax 720-302-2932

Patient Name: _____ SOC Date: _____

Consent for Treatment

I consent and authorize Rise Pediatric Therapy LLC ("the Agency"), it agents and associates to provide care and treatment to me in my home as prescribed by my physician and per agency policy. I understand that I am required to have an attending physician at all times and that my plan of treatment may change depending on my physician's orders. I have received an explanation of the services that will be provided to me, including disciplines and proposed frequency of visits, and understand that I have the right to participate in developing my plan of care. The initial services are as follows:

Physical Therapy Frequency and Duration: _____
Occupational Therapy Frequency and Duration: _____
Speech Therapy Frequency and Duration: _____

Authorization for Release of Information

I hereby consent and authorize the Agency to release and receive information for the purposes of treatment, payment, and health care operations. The exchange of information may occur between, but is not limited to, physicians, third party payers, other health providers, and regulatory and/or accrediting reviewers.

Statement to Permit Payment for Home Health Services

I hereby request that payment of authorized medical home health services be made on my behalf to the Agency.

I understand that agency will bill ☐ Medicaid ☐ Insurance Co.: _____
☐ Patient for the services being provided to me by the Agency. I understand that I will be responsible for the following amount._____

Acknowledgements

I have received verbal and written information on the following, and have had the information explained to me:

1. Patients' Bill of Rights
   a. Including receipt of the Agency complaint process and the state toll free hotline number.
2. Home Health Care Patient Handbook
   a. Including agency contact information to include emergency and after hours.
3. Notice of Agency Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by the Agency and my rights with respect to my health information.
   a. I acknowledge that I have been provided with the opportunity to discuss concerns regarding the privacy of my health information.
4. OASIS Statement of Privacy Rights for patient's over the age of 18
5. Agency Disclosure Notice
6. Emergency Preparedness, Infection Control and Safety Education

Advance Directives

I have an Advance Directive ☐ Yes ☐ No
If yes, I have the following ☐ Living Will ☐ Medical Durable Power of Attorney ☐ Do Not Resuscitate Order
Other Advanced Directives ☐ Yes ☐ No Explain
I have requested and received more information _____
I certify that I have read and agree with the information on this document and have been provided a copy for my records. I have participated in the formation of my plan of care.

_____ _____
Patient Signature or responsible party *Date*

_____ _____
Witness Signature *Date*

RISE PEDIATRIC THERAPY

NEW PATIENT INFORMATION SHEET

PATIENT NAME _____BIRTHDATE____/____/____ SEX M F

HOME ADDRESS_____
STREET APT# CITY STATE ZIP CODE

HOME TELEPHONE (___)_____ SOCIAL SECURITY_____-_____-_____

RACE (OPTIONAL) ASIAN BLACK CAUCASIAN HISPANIC NATIVE AMERICAN OTHER _____

DOCTOR'S INFORMATION

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

PHONE (_ _ __)_____ FAX (_ ____)_____

REFERRAL SOURCE: _____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____

ID# _____GROUP#_____

NAME OF INSURED _____

RELATION TO PATIENT _____ SOCIAL SECURITY_____-_____-_____ D.O.B. ____/___/_____

PHONE (____)_____ ALTERNATE PHONE (___)_____

ADDRESS _____

EMPLOYER_____ OCCUPATION_____

SECONDARY INSURANCE_____

ID# _____GROUP#_____

NAME OF INSURED _____

RELATION TO PATIENT _____ SOCIAL SECURITY_____-_____-_____ D.O.B. ____/___/_____

PHONE (____)_____ ALTERNATE PHONE: _____

ADDRESS _____

EMPLOYER_____ OCCUPATION_____

Emergency Contact_____

Relationship_____ Phone (____)_____

Other services receiving: _____

_____

_____

Patient Signature or Responsible Party Date

_____