Creighton PEDIATRIC THERAPY

Name of Person Completing Form	Relationship to Patient	Today's Date

PATIENT INFORMATION

Patient Full Name (first, MI, last): Nickname: Sex: □ M □ F DOB: / /

Street Address: City: State: Zip:

Preferred Phone Number: *please circle:* Home / Work / Cell

Alternate Phone Number: *please circle:* Home / Work / Cell

E-Mail Address: □ YES! Please send me secure statements via email (NEW & Coming Soon)
Helps keep costs down and allows for ease of online bill pay

PARENT OR GUARDIAN INFORMATION

Responsible Party Name:	Other Parent or Guardian:
Relationship to Patient:	Relationship to Patient:
Birth Date: SSN:	Birth Date: SSN:
Address (if different than above):	Address (if different than above):
City: State: Zip:	City: State: Zip:
Occupation:	Occupation:
Employer:	Employer:
Employer Address:	Employer Address:
City: State: Zip:	City: State: Zip:

REFERRAL/PRIMARY CARE PHYSICIAN INFORMATION

Referring Physician: Clinic:

Child's Pediatrician *(if different from above):* Clinic:

Address:

A copy of your child's evaluation report will be sent to the referring physician and to your child's pediatrician.

EMERGENCY CONTACT INFORMATION

Name: Relationship: Phone:

INSURANCE INFORMATION

Primary Insurance :

Insured's Name: Date of Birth:	Relationship to Patient:

Secondary Insurance :

Insured's Name: Date of Birth:	Relationship to Patient:

TEXT MESSAGE APPOINTMENT REMINDERS

Creighton Pediatric Therapy offers text message appointment reminders for your child/ren's appointments. Reminders are sent one day prior to the appointment. At this time, we are only able to send appointment reminders to one cell number and do not have the ability to receive a text response. If you need to change or cancel an appointment, you will need to call our front desk. To enroll, please provide your name and cell phone number:

Name of Parent/Guardian Enrolling in Text Message Appointment Reminders:	Cell Phone Number:

PLEASE TELL US HOW YOU LEARNED ABOUT US

□ Referring physician in section above □ Other Physician:

□ Friend/Relative/Another Parent □ Insurance Company

□ Radio □ Television □ Brochure/Flyer/Postcard □ Event □ Other:

Thank you for choosing Creighton Pediatric Therapy. Please let us know of any changes to the above information.

Creighton
PEDIATRIC THERAPY

CONSENT TO TREAT/FINANCIAL AGREEMENT

Child/Patient's Name_____

DOB_____

MRN_____

I hereby consent to the evaluation and treatment of the above-named child by a licensed occupational therapist (OT), physical therapist (PT) and/or speech therapist (ST) of Creighton Pediatric Therapy (CPT). The course of therapy will be as determined necessary by the therapist(s) and, as needed, the child's doctor. I understand and agree that CPT makes no guarantee as to the results of the occupational, physical and/or speech therapy.

I understand that CPT is part of Creighton University's School of Pharmacy and Health Professions, which has teaching and research activities. I understand that students and other health care professionals may come to CPT to learn, observe and perform the treatments being provided by my child's therapist(s). I consent to students and other professionals participating in my child's therapy sessions.

I hereby assign and transfer to CPT the right to all third party payments (including Medicaid, Medicare and/or private insurance benefits) to which I or my child may be or become entitled to for the therapy services provided. I authorize CPT to apply and file for all such benefit payments on behalf of the child and direct that such payments be made directly to CPT. I will pay to CPT any such insurance benefit payments received by me for services rendered by CPT.

I understand that I am responsible for payment of all charges for therapy services received by my child. If the therapy services are covered by insurance, I understand that I will be responsible for payment of any deductible, co-payments or co-insurance required by the insurance company. I understand that I am advised to fully know and understand my or my child's insurance benefits prior to my child receiving therapy services. I understand that all insurance plans are different and some plans limit therapy services. I agree to pay all charges for services if my child receives therapy services not covered by insurance.

I have read and fully understand this form. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____
Parent or Guardian Signature

_____
Parent or Guardian Printed Name

_____
Date

Creighton
PEDIATRIC THERAPY

Occupational Therapy • Physical Therapy • Speech Therapy

Thank you for choosing Creighton Pediatric Therapy where we *EMPOWER* children and their families to *OVERCOME* and *ACHIEVE*. We welcome you to our facility. If you have any questions or concerns, please do not hesitate to contact our office at 402-280-2200 or speak with any member of our team. As well, if there is anything additional we can do to enhance your experience, please let us know. We welcome your feedback!

The success of your child's treatment is a team effort. In order for your child to receive the most benefit from therapy, please note the following:

1. A written prescription is required from your child's physician. This is needed to document medical necessity and required if we will be billing insurance or Medicaid for your child's care. Your insurance company will request the diagnosis for your child. Your physician is the one who should provide this information. Please speak with your physician to determine the most appropriate diagnosis for your child. The prescription can be faxed to our office at 402-280-2210.

2. Every effort will be made to verify coverage of services and share this information with you. Because each plan is different and final determination cannot be made until the claim is received by your insurance company, it is ultimately your responsibility to know what your plan will and will not cover. Please pay close attention to the exclusions and limitations section of your policy. Creighton Pediatric Therapy will work with your physician and obtain prior authorization for services when it is required by your plan.

3. Please let us know immediately if you have any changes to your contact information, your physician, or your insurance.

4. Please check in at the front desk or use the check-in kiosk upon arrival to each appointment.

5. We do not double-book our appointments; the time reserved is just for you. Every effort will be made to start appointments on time. If you arrive late for your scheduled appointment, you may be asked to reschedule. Text message appointment reminders are available and sent one day prior to your appointment. To enroll, please inform the front desk.

6. Regular attendance is important to the success of your child's treatment. We understand that each family has unique scheduling needs, and it may not be possible to keep every appointment. We kindly ask that you provide at least 24 hours' notice in the event that you need to reschedule. Excessive cancellations or "no shows" may be cause for dismissal from Creighton Pediatric Therapy. If you have scheduling challenges, please speak with the front desk or a member of your healthcare team.

7. In the event of severe weather, we will follow the closing and delay schedule of Creighton University. As well, our outgoing voicemail will be updated.

8. Your therapist may provide you with instructions and activities to do at home between appointments. This is known as a "home program" and can be an important part of your child's therapy program.

9. The Consent to Treat/Financial Agreement and Notice of Privacy Practices are provided to you during registration. Please review these documents carefully as they contain information important to your child's care. If you would like a hard copy of this information, please inform the front desk. The materials are also available on our website at https://spahp.creighton.edu/cpt.

10. For billing questions or to make a payment by phone, please call us at 402-280-2200. E-statements and online bill pay are coming soon!

Unless extenuating circumstances exist, these policies will be consistently followed.

I have read and received a copy of this notice and agree to abide by the terms and guidelines of my child's therapy.

_____

Parent or Guardian Signature Date

CREIGHTON UNIVERSITY
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of Creighton University's Notice of Privacy Practices.

Patient Name (Please Print): _____

_____ _____

Patient

Parent or Legal Representative
(if Patient is under 19)

_____

Date

Creighton
PEDIATRIC THERAPY

AUTHORIZATION FOR USE OF PHOTOGRAPHS

By my signature below, I authorize Creighton University to use my video image (whether film, video, or digital), as indicated below.

The video, including audio and images, will remain the possession of Creighton University. I understand that the video, as well as pertinent information and quoted statements, will be used in a health education program to be taught at Creighton University. My name will not be used in the class.

The video will not become part of my medical record at Creighton.

This authorization will expire upon termination of health education program.

I understand that I may withdraw this authorization at any time. My withdrawal must be made in writing and addressed to: *Creighton University, Attn: University Privacy Officer, 2500 California, Omaha, NE 68178.*

I understand my written withdrawal will not be effective to the extent that Creighton University has already acted in reliance on this Authorization.

_____ _____

Signature of patient/authorized representative Date

_____ _____

Patient Name (please print) Date of Birth

Creighton
PEDIATRIC THERAPY

Information about video cameras at Creighton Pediatric Therapy

At Creighton Pediatric Therapy, we are committed to providing you and your child the highest quality therapy experience possible. We also strive to provide our therapy students and residents with rich learning experiences to support their development in becoming the best therapists they can be. Consequently, we have placed video cameras in every treatment area that feed to a secure URL that is only available on the Creighton network. The URL is password protected.

These cameras allow you to view your child's therapy session from another room if not getting involved in the session in person is in your child's best interests; they also allow our therapy students and residents to view a child's therapy session for learning purposes in order not to disturb the session. Please be assured no recording will take place.

If you are interested in viewing your child's therapy session from another room, please speak with our clinic support staff or with your child's therapist, and this will be arranged as space and equipment allows.

Thank you for choosing Creighton Pediatric Therapy for your child's therapy needs, where we empower children and their families to overcome and achieve.

Kelly Nelson, Director, Creighton Pediatric Therapy

Lisamarie Hugo, Manager, Creighton Pediatric Therapy

Form approved on 4-11-15

Occupational Therapy, Physical Therapy, Speech Therapy
T 402.280.2200 | F 402.280.2210
17055 Frances Street, Suite 103 Omaha, NE 68130
spahp.creighton.edu/cpt

Creighton PEDIATRIC THERAPY

PATIENT INFORMATION

Patient Name: _____Sex: ☐ Male ☐ Female DOB: _____

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

Language(s) spoken in the home: _____

Child lives with (check all that apply and list names/age): ☐ mother ☐ father ☐ sister(s) _____

☐ brother(s) _____ ☐ grandparent(s) ☐ other _____

Name of person completing form: _____Relationship to child:_____

What are your primary concerns? _____

_____

MEDICAL INFORMATION

Referring Physician: _____ Clinic: _____

Physician/Pediatrician (*if different from referring*): _____Clinic:_____

Child's Primary Diagnosis: _____

Other Diagnosis or Medical Conditions: _____

Other special services child currently receiving or has received in the past:

Service Type	Start Date	End Date	Name of Facility or Person
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A copy of your child's report will be sent to the referring physician and to your child's pediatrician.

GENERAL

Is your child's activity level typical for his/her age?
☐ YES ☐ NO

Is your child's appetite typical for his/her age?
☐ YES ☐ NO

Is your child's growth and development typical for his/her age? ☐ YES ☐ NO

Height: _____ Weight: _____ Percentile: _____

Is your child's speech and language typical for his/her age? ☐ YES ☐ NO

Does your child sleep through the night?
☐ YES ☐ NO How many hours? _____

Does your child take naps? ☐ YES ☐ NO

How long? _____ Time of day? _____

Has your child been hospitalized or had surgery?
☐ YES ☐ NO

Explain: _____

Does your child have allergies? ☐ YES ☐ NO

List allergies: _____

Is your child taking medication? ☐ YES ☐ NO

List medication(s): _____

Are your child's immunizations up to date?
☐ YES ☐ NO

Has your child seen a dentist? ☐ YES ☐ NO

COMMENTS:_____

_____

CARDIOVASCULAR

Does your child get chest pain?
☐ YES ☐ NO

Does your child get palpitations or an irregular heartbeat? ☐ YES ☐ NO

COMMENTS:_____

_____

BIRTH HISTORY

Pregnancy: ☐ Post Term (40+ weeks gestation) ☐ Full Term (37-40 weeks) ☐ Pre term/Premature (less than 37 weeks) Approximate Gestation: _____

Delivery:
☐ Vaginal ☐ Cesarean ☐ Vacuum ☐ Forceps

How much did your child weigh at birth? _____

Did you have complications with pregnancy?
☐ YES ☐ NO

Did you have complications with delivery?
☐ YES ☐ NO If yes, please explain: _____

_____

Was there special care required at birth (e.g., oxygen, intubation, tube feedings, etc.)? _____

_____

Were there any medical problems during the baby's newborn period? _____

COMMENTS:_____

_____

RESPIRATORY

Does your child have problems with coughing?
☐ YES ☐ NO

Does your child have problems with wheezing?
☐ YES ☐ NO

Does your child have problems with shortness of breath?
☐ YES ☐ NO

COMMENTS:_____

_____

PSYCHOLOGICAL/PSYCHIATRIC

Is your child frequently uncooperative or defiant?
☐ YES ☐ NO

Does your child have difficulty getting along with others? ☐ YES ☐ NO

Does your child seem anxious or depressed?
☐ YES ☐ NO

COMMENTS:_____

_____

HEAD/NECK/EAR/NOSE/THROAT

Does your child have frequent headaches?
☐ YES ☐ NO

Does your child have problems with vision?
☐ YES ☐ NO

Does your child have problems with hearing?
☐ YES ☐ NO

Does your child have itchy/watery eyes or a stuffy nose?
☐ YES ☐ NO

Does your child choke while eating/drinking?
☐ YES ☐ NO

COMMENTS:_____

_____

ENDOCRINE/HEMATOPOIETIC

Does your child bruise or bleed easily?
☐ YES ☐ NO

Does your child have difficulty with hot or cold environments? ☐ YES ☐ NO

Does your child have excessive thirst?
☐ YES ☐ NO

Does your child have excessive urination?
☐ YES ☐ NO

COMMENTS:_____

_____

NEUROLOGICAL

Has your child had fainting spells? ☐ YES ☐ NO

Has your child had serious head injuries? ☐ YES ☐ NO

Has your child had seizures or epilepsy? ☐ YES ☐ NO

COMMENTS:_____

_____

SOCIAL HISTORY

Is your child attending school? ☐ YES ☐ NO

What grade? _____ What school? _____

Is your child exposed to cigarette smoke?
☐ YES ☐ NO

GASTROINTESTINAL /GASTROURINARY

Does your child have problems with diarrhea?
☐ YES ☐ NO

Does your child have problems with constipation?
☐ YES ☐ NO

Does your child have abdominal pain? ☐ YES ☐ NO

Does your child have reflux? ☐ YES ☐ NO

Does your child have problems with vomiting?
☐ YES ☐ NO

Does your child have good bladder control?
☐ YES ☐ NO

Does your child have good bowel control?
☐ YES ☐ NO

COMMENTS:_____

_____

DERMATOLOGIC

Does your child have skin rashes? ☐ YES ☐ NO

Does your child have acne? ☐ YES ☐ NO

Does your child have concerning lumps or moles?
☐ YES ☐ NO

COMMENTS:_____

_____

ACTIVITIES OF DAILY LIVING

Does your child indicate when he/she is soiled/wet?
☐ YES ☐ NO ☐ N/A

Does your child use the toilet? ☐ YES ☐ NO ☐ N/A
☐ Urinate ☐ Bowel Movement

Does your child assist with bathing? ☐ YES ☐ NO

Does your child assist with dressing? ☐ YES ☐ NO
☐Hat ☐Socks/Shoes ☐Shirt ☐Pants ☐Buttons ☐Zipper
☐ Coat ☐ Independent with dressing

Does your child use utensils when eating?
☐ YES ☐ NO ☐ Spoon ☐ Fork ☐ Knife

What does your child drink from? ☐ Bottle ☐ Straw
☐ Sippy cup ☐ Open cup

COMMENTS:_____

_____

What are your child's strengths?

_____

_____

What are your child's interests?

_____

_____

What are your goals for therapy? What things would you like to see your child doing?

_____

_____

Additional Comments:

_____

_____

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways we use and disclose health information. We have included some examples of each use and disclosure. Not every use or disclosure within a category will be listed.

• **For Treatment.** We may use or disclose health information about you to doctors, nurses, technicians, residents, healthcare professional students, and/or other personnel who are involved in your care. For example, your treating provider may use your health history in diagnosing your illness. We may disclose health information about you to healthcare providers outside Creighton University who are involved in your ongoing healthcare.

• **For Payment.** We may use and disclose health information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may give your health plan information about treatment you received so the health plan will pay us or reimburse you for the treatment. We may tell your health plan about a scheduled treatment to obtain prior approval or to determine whether your health plan will pay for the treatment. We may share your health information with other entities, such as specialists, who may need this information to bill for services they provided you.

• **For Healthcare Operations.** We may use and disclose health information about you for Creighton's healthcare operations. These uses and disclosures are necessary to operate Creighton and promote quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff. We may disclose information to our professional staff, healthcare professional students and other personnel for review and learning purposes. We may disclose health information about you to entities outside Creighton University for their healthcare operations as long as both Creighton and the other entity have treated you. We may also combine the health information we have with information from other healthcare providers to compare how we are doing and see where we can make improvements in care and services. We may remove information that identifies you from this set of health information so that others may use it to study healthcare and healthcare delivery without learning patient specifics.

• **To Business Associates.** We may disclose health information to other persons or organizations, known as business associates, who provide services on our behalf. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

• **Appointment Reminders.** We may use and disclose health information to contact you by phone, voice mail, e mail, or mail to remind you about a scheduled appointment.

• **Treatment Alternatives.** We may use and disclose health information to tell you about or recommend treatment options or health-related benefits and services of possible interest to you.

• **Fundraising Activities.** We may disclose contact information about you to our fundraising offices and contractors so they may contact you when raising money for Creighton University's healthcare operations, services and research. We will only release your name, address, phone number and the dates you received treatment or services. If you do not want to be contacted for fundraising efforts, you must notify the Creighton University Privacy Officer in writing at the address provided below.

• **Individuals Involved in Your Care or Payment for Your Care.** We may release health information about you to family or any other person you identify as involved in your healthcare or who is involved in the payment for your care. We will release this information if you agree to the disclosure or are given the opportunity to object to such a disclosure and do not. We may also release your health information where, in our professional judgment, it would be common practice and in your best interests to allow a person to act on your behalf. For example, a friend may pick up your prescriptions or medical supplies.

• **Research.** Under certain circumstances, we may use and disclose health information for research. For example, a research project may involve comparing the health of all patients who received one treatment to those who received another for the same condition. Most research projects are conducted only with patient authorization and following approval through our research approval process. There are a few instances where patient authorization is not obtained. Such research projects, however, are subject to a specific approval process. This process evaluates a proposed research project and its use of health information, balancing the research needs with patients' need for privacy of their health information and concluding that patient authorization requirements may be waived. We may disclose health information to people preparing to conduct research, for example, to help them look for patients with specific health needs. We will do so only if the health information does not leave Creighton University and is not used for any purpose other than preparation for research.

• **Limited Data Set.** We may use and disclose your health information (not including your name, address or other direct identifiers) for research, public health or healthcare operations. We will only do so if the recipient signs an agreement to protect the information and not use it to identify you.

• **To Avert a Serious Threat to Health or Safety.** We may use and disclose your health information when necessary to prevent or lessen a serious and imminent threat to a person's or the public's health or safety. Disclosure would only be to someone able to help prevent or lessen the threat.

• **Data Breach Notification Purposes.** We may use or disclose your health information to provide legally required notices of unauthorized access to or disclosure of your health information.

• **Organ and Tissue Donation.** We may release health information to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

• **Disaster Relief.** We may disclose your health information to disaster relief organizations that seek your information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

• **Workers' Compensation.** We may release your health information as authorized by and to the extent necessary to comply with state workers' compensation laws or other similar programs.

• **Public Health Activities.** We may disclose your health information for public health activities, including: • reporting health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; • reporting child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; • reporting information about products and services under the jurisdiction of the U.S. Food and Drug Administration; • alerting a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and • reporting information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

• **Abuse, Neglect or Domestic Violence.** If we reasonably believe a person has been the victim of abuse, neglect or domestic violence, we may disclose health information to the appropriate government authority. We will disclose your health information if you agree or when required or authorized by law.

• **Health Oversight Activities.** We may disclose health information to a health oversight agency for activities authorized by law. Oversight activities are those necessary for the government to monitor the healthcare system, government programs and compliance with civil rights laws including audits, investigations and inspections.

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

• Law Enforcement. We may release your health information if asked to do so by a law enforcement official for the following reasons: • In response to a court order, subpoena, warrant, summons or similar process; • To identify or locate a suspect, fugitive, material witness, or missing person; • In response to inquiries as to the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; • In response to inquiries as to a death we believe may be the result of criminal conduct; • In response to inquiries as to criminal conduct on Creighton premises; and • In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

• **Decedents.** We may release health information to a coroner or medical examiner, as necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

• **Military Activities.** If you are a member of the Armed Forces, we may use or disclose your health information to the appropriate military authorities. If you are foreign military personnel, we may disclose your health information to the appropriate foreign military authority.

• **National Security and Intelligence Activities.** We may release your health information to authorized federal officials for intelligence and other national security activities authorized by law.

• **Medical Suitability Determinations.** We may release your health information to the Department of State for medical suitability determinations.

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

• **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your health information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) to protect the safety and security of the correctional institution.

• **Highly Confidential Information.** Federal and state law requires special privacy protections for certain highly confidential information, such as drug and alcohol treatment information. We will follow any additional laws protecting such information.

• **As Required By Law.** We will disclose health information about you when required to do so by any law not already referenced in this notice.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your health information will be made only with your written authorization: (1) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; and (2) disclosures that constitute a sale of your health information. Other uses and

disclosures of health information not covered by this notice or the laws that apply to us will be made only with your authorization. If you give us authorization to use or disclose your health information, you may revoke that authorization by writing to our Privacy Officer. If you revoke your authorization, we will no longer use or disclose health information for the reasons covered by your written authorization. You understand that: (1) we will make disclosures where required by law; (2) we are unable to take back any disclosures we have already made with your authorization; and (3) we are required to retain records of the care provided.

YOU HAVE THE FOLLOWING RIGHTS REGARDING THE HEALTH INFORMATION WE MAINTAIN ABOUT YOU:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information that may be used to make decisions about your care. Usually, this includes healthcare and billing records. This does not include psychotherapy notes, records made in anticipation of legal proceedings, and certain laboratory records. You must submit your request to inspect and copy health information that may be used to make decisions about you in writing to **University Privacy Officer, 2500 California Plaza, Omaha, NE 68178**. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. If you request a written summary, we may charge you a fee for this service. We may deny your request to inspect and copy health information in certain circumstances. If you are denied access to health information and the law permits, you may request that the denial be reviewed. A licensed healthcare professional chosen by Creighton will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Request forms are available at all Creighton clinics and from the University Privacy Officer.

- **Right to an Electronic Copy of Electronic Medical Records.** If your health information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your health information in the form or format you request, if it is readily producible in such form or format. If the health information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your health information.

- **Right to Amend.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Creighton University. To request an amendment, your request must be in writing and submitted to the University Privacy Officer at the address below. You must provide a reason that supports your request for amendment. We may deny your request for an amendment if it is not in writing or if it does not include a reason to support the request. We reserve the right to deny your request to amend information that is: (1)Not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2)Not part of the health information kept by or for a Creighton University entity; (3)Not part of the information which you would be permitted to inspect and copy under the law; or (4)Accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures, which is a list of disclosures of your health information made without your authorization and unrelated to treatment, payment or operations. To request an accounting of disclosures, you must submit a request in writing to the University Privacy Officer at the address below. Your request may be for disclosures made during any time period prior to the date of your request up to six years. It may not include dates before February 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose to family or friends who are involved in your care or paying for your care. If we do agree to your request, we will comply with your request unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the information you want to limit; how you want to restrict our use or disclosure; and to whom you want the limits to apply. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your health information to a health plan for payment or healthcare operation purposes and such information you wish to restrict pertains solely to a healthcare item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your health information with respect to that item or service not be disclosed to a health plan for purposes of payment or healthcare operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing to the University Privacy Officer at the address below. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice, even if you have agreed to receive this notice electronically. You may obtain a copy of this notice at our website at: **www.creighton.edu/generalcounsel/cupolicies**. To obtain a paper copy of this notice, contact the University Privacy Officer at the address or phone number below.

EFFECTIVE DATE AND CHANGES TO THIS NOTICE

This notice is effective beginning **September 26, 2013.** We reserve the right to change this notice. We may also be required by law to change our privacy practices and this notice. We reserve the right to make the revised notice effective for health information we already have about you as well as new information we receive. If there is a material change in this notice, we will post the new notice in each Creighton University service site and on our website at: **www.creighton.edu/generalcounsel/cupolicies**

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Creighton University Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT CREIGHTON'S PRIVACY OFFICER

For answers to questions or additional information about this notice and our privacy practices, please contact:

Creighton University
Attn: University Privacy Officer
2500 California Plaza
Omaha, NE 68178

Phone: 402.280.3469
E-mail: privacy@creighton.edu

CREIGHTON UNIVERSITY

NOTICE OF PRIVACY PRACTICES

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

WHO WILL FOLLOW THIS NOTICE

This notice describes the privacy practices of Creighton University entities including: Creighton Dental Clinics; Creighton Pediatric Therapy; Creighton Specialty Pediatrics; Creighton Clinic Pharmacy; All employees, residents and healthcare professional students of Creighton University involved in the delivery, quality and payment of your healthcare or authorized to enter information into your health record; Any volunteer we allow to assist in your healthcare

All the above-identified entities, locations and individuals will follow the terms of this notice. In addition, these entities, sites and individuals may share health information with each other for treatment, payment or healthcare operations as described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION

We understand that your health information is personal and we are committed to protecting that health information. We create a record of the care and services you receive to ensure quality care and to comply with contractual and legal requirements. This notice applies to all of the records of your care generated by Creighton University and the persons and entities listed above. It describes your rights and our obligations regarding the use and disclosure of your health information.

We are required by law to:

- Protect the privacy of your health information;
- Give you this notice of our legal duties and privacy practices with respect to your health information; and
- Follow the terms of the notice that is currently in effect.