



Ascension MI School-Based Health Centers
Hazel Park School High School
1620 East Elza Ave.
Hazel Park, MI 48030

Dear Parent or Guardian,

Ascension Southeast Michigan School-Based Health Centers and Hazel Park High School are pleased to provide health services for students at Hazel Park High School. The Health Center's hours of operation are 7:30 a.m. to 4:00 p.m., Monday and Tuesday, closed Wednesday - Friday, weekends and holidays.

Ascension Southeast Michigan School-Based Health Center is overseen by a Medical Director who is Family Practice Physician board-certified. A certified Nurse Practitioner, and a Registered Medical Assistant. We provide a wide range of medical services and a variety of school and community educational programs.

Our goal is to improve the health and well-being of students. All interactions between the health center staff and the student will be kept confidential to the extent provided by law.

We have received approval from the Michigan Department of Community Health to bill medical insurance companies for services provided. Ascension Southeast Michigan School-Based Health Centers transmits claims directly from our office to your insurance company for payment. Parents or Guardians of students will never be responsible for unpaid bills or portions of unpaid bills. Therefore, please do not discourage your child from participating because of lack of insurance or uncertainty about bill payment. Health Center management will address all billing issues.

If you do not have medical insurance, please call, 586-558-8765, for assistance; we can help you enroll your child/children in Healthy Kids or MICHild. It is important that you help us by providing Ascension Southeast Michigan Community Health Staff the most accurate and up-to-date information possible.

Attached are the consent form, medical insurance registration form, and a parent questionnaire. Please return these completed forms to us as soon as possible. By providing us with up-to-date information about your child's health, it will further help us to better serve the needs of your child.

We look forward to serving you and your child. If you have any questions or would like further information, please call. In case of a medical emergency, please call 911 or go to the nearest emergency room. For mental health crisis, please contact Wayne County's 24 hour Crisis Line for information and referrals at: 1-800-241-4949 TDD 866-870-2599.

Available Services:

Personal Counseling Referrals for counseling and referrals for various concerns related to school age children and adolescents including depression, behavioral issues, personal relationships, violence prevention, family problems and substance abuse.

Health Education Student and parent educational programs related to the school age child's health issues; i.e. abstinence, depression prevention, resilience, substance abuse prevention, and conflict resolution.

Sincerely,

Ascension Southeast Michigan School-Based Health Center Staff

Ascension Southeast Michigan School-Based Health Center Staff



PATIENT REGISTRATION FORM

Ascension

Student/Patient Name: <i>(last, first, middle)</i>		Birth Date	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN#:
Race (Optional): <input type="checkbox"/> African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Arab American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Unreported/Refused to Report					
Ethnicity (Optional): <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Arabic					
9. Address		10. City	11. Zip Code	12. Home Phone #:	
Parental/Legal Guardian Information					
Mother's Full Legal Name:		Date of Birth:	SSN#:	Marital Status: Single Married Widow Divorced	Race
Address:			Home Phone#:		
Employer Name & Address			Cell Phone#:		
Employer Name & Address			Employer Phone #:		
Father's Full Legal Name:		Date of Birth:	SSN#:	Marital Status: Single Married Widow Divorced	Race
Address:			Home Phone#:		
Employer Name & Address			Cell Phone#:		
Employer Name & Address			Employer Phone #:		
Legal Guardian Name: <i>(if not mother or father)</i>		Date of Birth:	SSN#:	Marital Status: Single Married Widow Divorced	Race
Address			Home Phone#:		
Employer Name & Address:			Cell Phone#:		
Employer Name & Address:			Employer Phone #:		
Emergency Contact Name:		Relationship to Student/Patient:	Telephone#:		
Name of Student's/Patient's Doctor/Clinic:			Telephone#:		
Name of Student's/Patient's Dentist:			Telephone#:		
Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> HAP <input type="checkbox"/> Total <input type="checkbox"/> Midwest <input type="checkbox"/> Great Lakes <input type="checkbox"/> Molina <input type="checkbox"/> Other: _____					
Medicaid#:		Is Medicaid your only insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Other Insurance:			
Primary Insurance Name:		Subscriber Name:			
Group#:		Policy#:		Co-Pay:	
Patient Relationship to Subscriber: <input type="checkbox"/> Self		<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Secondary Insurance Name:		Subscriber Name:			
Group#:		Policy#:		Co-Pay:	
Patient Relationship to Subscriber: <input type="checkbox"/> Self		<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	



Ascension Consent For Health Services

Name: _____

Birth date: _____

Although crisis intervention and emergency care do not require consent, medical services require a signed consent before services are provided. The following services are available from your **St. John Providence School-Based Health Center**:

- Physical exams
- Diagnosis and management of acute and chronic illnesses/disease
- Immunizations
- Dental, Vision, and Hearing screenings
- Basic Laboratory tests including urinalysis, glucose, rapid strep test, cholesterol, hemoglobin
- Health education, activity groups, risk prevention counseling
- Counseling and referrals for mental health, physical/sexual abuse, substance abuse*
- Crisis intervention
- Group and Family Counseling
- Referral for resources such as food, shelter, financial issues, transportation

* Current Michigan Law mandates for confidential services to minors in these areas, as well as Pregnancy/STI/HIV testing and counseling.

LIMITATION OF SERVICES

- **NO** birth control pills or devices are dispensed or prescribed at **ANY** St. John Providence School-Based/Community Health Center located on school property.
- **NO** abortion counseling, referrals or services are provided at **ANY** St. John Providence School-Based/Community Health Center.

I consent to all the following:

- I have reviewed and understand the services offered by the **St. John Providence School-Based Health Center**. I give consent for my child to receive the services indicated on this document. By signing this consent form I certify that I am the legal guardian and legal custodian of: _____
- I understand this consent will remain valid until my child graduates, and that I may withdraw my consent for services upon written notice to the **St. John Providence School-Based Health Center** at any time.
- I further authorize the **St. John Providence School-Based Health Center** to release/exchange information regarding treatment to 1) my child's primary care physician or mental health providers when needed for coordination of care, 2) school staff when needed to coordinate services at school, 3) third party payers or others for the purpose of receiving payment for services. **However services will be provided regardless of insurance and/or ability to pay.**
- The School-Based and Community Health Program may obtain a copy of the above name student's/patient's immunization record from the student's/patient's school office, primary care provider's office, and/or local health department.
- I understand all St. John Providence School-Based Health Center's medical records are part of the SJPHS electronic medical records system.
- I understand that testing for bloodborne diseases, including HIV / AIDS, may be performed upon a patient without a separate written consent in the event that a healthcare professional from the Center sustains exposure to blood or bodily fluids from the patient's open wound, percutaneous mucous membrane or occupational hazard.

Signature of Parent/Guardian/Patient: _____

Date: _____

Guidelines for Adolescent Preventive Services

Parent/Guardian Questionnaire

Confidential

(Your answers will not be given out.)

Date _____

Adolescent's name _____ Adolescent's birthday _____ Age _____

Parent/Guardian name _____ Relationship to adolescent _____

Your phone number: Home _____ Work _____

Adolescent Health History

1. Is your adolescent allergic to any medicines?
 Yes No If yes, what medicines? _____

2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Has your adolescent ever been hospitalized overnight?
 Yes No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem
_____	_____
_____	_____

4. Has your adolescent ever had any serious injuries?
 Yes No If yes, please explain. _____

5. Have there been any changes in your adolescent's health during the past 12 months?
 Yes No If yes, please explain. _____

6. Please check (✓) whether your adolescent ever had any of the following health problems:
 If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies/hayfever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Low iron in blood (anemia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder or kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic fever or heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood disorders/sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Scoliosis (curved spine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	_____	Severe acne	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis (TB)/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mononucleosis (mono)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis (liver disease)	<input type="checkbox"/>	<input type="checkbox"/>	_____				

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?
 Yes No Not sure

Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's blood relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blood disorders/sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drinking problem/alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Endocrine/gland disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart attack or stroke <i>before</i> age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart attack or stroke <i>after</i> age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tuberculosis/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

9. With whom does the adolescent live most of the time? (Check all that apply.)

- Both parents in same household
 Stepmother
 Sister(s)/ages _____
 Mother
 Stepfather
 Other _____
 Father
 Guardian
 Alone
 Other adult relative
 Brother(s)/ages _____

10. In the past year, have there been any changes in your family? (Check all that apply.)

- Marriage
 Loss of job
 Births
 Other _____
 Separation
 Move to a new neighborhood
 Serious illness
 Divorce
 A new school or college
 Deaths

Parental/Guardian Concerns

11. Please review the topics listed below. Check (✓) if you have a concern about your adolescent.

	Concern About My Adolescent		Concern About My Adolescent
Physical problems	<input type="checkbox"/>	Guns/weapons	<input type="checkbox"/>
Physical development	<input type="checkbox"/>	School grades/absences/dropout	<input type="checkbox"/>
Weight	<input type="checkbox"/>	Smoking cigarettes/chewing tobacco	<input type="checkbox"/>
Change of appetite	<input type="checkbox"/>	Drug use	<input type="checkbox"/>
Sleep patterns	<input type="checkbox"/>	Alcohol use	<input type="checkbox"/>
Diet/nutrition	<input type="checkbox"/>	Dating/parties	<input type="checkbox"/>
Amount of physical activity	<input type="checkbox"/>	Sexual behavior	<input type="checkbox"/>
Emotional development	<input type="checkbox"/>	Unprotected sex	<input type="checkbox"/>
Relationships with parents and family	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
Choice of friends	<input type="checkbox"/>	Sexual transmitted diseases (STDs)	<input type="checkbox"/>
Self image or self worth	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>
Excessive moodiness or rebellion	<input type="checkbox"/>	Sexual identity (heterosexual/homosexual/bisexual)	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Work or job	<input type="checkbox"/>
Lying, stealing, or vandalism	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>
Violence/gangs	<input type="checkbox"/>		

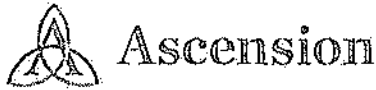
12. What seems to be the greatest challenge for your teen? _____

13. What is it about your teen that makes you proud of him or her? _____

14. Is there something on your mind that you would like to talk about today?

What is it? _____

15. Can we share your answers to Question 13 with your teen? Yes No



VACCINE PREVENTABLE DISEASE INFORMATION/CONSENT FORM

CHILD'S NAME: _____ CHILD'S BIRTHDATE _____

_____ have read or had the risks associated with vaccination explained to
(Parent/guardian name - Print)
me. I have had the opportunity to ask questions and feel satisfied with the answers given. I give permission to vaccinate my child

Child's Name

Signature of Parent/Guardian: _____ Date: _____

Chickenpox (Varicella) Chickenpox is a common childhood disease which can be serious. Chickenpox can lead to pneumonia, brain damage, or death. Children who receive the chickenpox vaccination may experience fever, soreness, a mild rash, or swelling where the shot was given. In rare cases a child may experience a seizure (less than 1 out of 1,000 cases). It may be possible for someone who gets a rash from the chicken pox shot to give chickenpox to another person. If the person getting the vaccine has an immune system that is not working properly, or is in close contact with anyone whose immune system is not working properly, please inform the nurse/doctor. If the person who is getting the vaccine has ever had a serious allergic reaction to the chickenpox vaccine, neomycin, or gelatin, please inform the nurse/doctor.

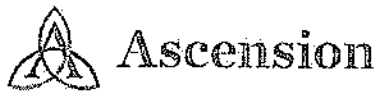
Diphtheria, Tetanus, Pertussis (DTaP, Tdap, DT, Td) Diphtheria is a serious illness in which a thick membrane is formed in the back of the throat. This covering can cause breathing problems and even death. Tetanus (Lockjaw) causes muscles in the body to painfully tighten. Pertussis can cause severe coughing spells that can last for weeks. DTaP is for children younger than 7 years; DT is for a child younger than 7 years who should not have the pertussis vaccine. Adolescents 11 through 18 years of age should receive 1 dose of Tdap; Td should be given for later booster doses. Children who receive the DTaP, Tdap, or Td vaccine commonly experience soreness at the injection site, fever, fussiness, and poor appetite. Children who receive this vaccine rarely experience seizures, become less alert, or develop difficulty breathing.

Hepatitis A (HAV) is a serious liver disease caused by the Hepatitis A virus. Hepatitis A is spread by close personal contact and sometimes by eating food or drinking water containing Hepatitis A virus. Persons at risk should have this vaccine. Two doses, 6 months apart, are needed for lasting immunity. Soreness at the injection site, headache, loss of appetite and tiredness may occur 3 - 5 days after the shot has been given. Rarely does serious allergic reaction occur. People who have had an allergic reaction to one dose should not receive the second dose.

Hepatitis B (HBV) Hepatitis is a serious liver infection caused by the Hepatitis B virus. People with this infection are at risk for developing diseases such as liver cancer, cirrhosis, or even death. Three doses are required for total immunity. Potential side effects of this vaccine include soreness at the injection site and fever. People who are allergic to baker's yeast should not receive this vaccine.

Haemophilus Influenzae Type b (HIB) is a bacterium that can cause children to develop serious illness such as infection of his/her brain or heart. These infections can cause permanent problems such as brain damage or even death. HIB vaccination is recommended for anyone under the age of 60 months (5 years). Potential side effects of this vaccine include fever, swelling, or redness at the site of the injection. These reactions generally start within 24 hours of the vaccination and subside within 48 hours. People who have had an allergic reaction to one dose should not receive another dose

Human Papillomavirus (HPV) is spread through sexual contact. HPV is important mainly because it can cause cervical cancer in women. HPV vaccine is an inactivated (not live) vaccine which protects against 4 major types of HPV. HPV vaccine can prevent some genital warts and some cases of cervical cancer. HPV vaccine is routinely recommended for girls and boys 11-12 years of age. The vaccine is also recommended for females 13-26 years of age and males 12 through 21 who did not receive it when they were younger. Protection from HPV vaccine is expected to be long-lasting but vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer. HPV vaccine is given as a 3-dose series. Anyone who has ever had a life-threatening allergic reaction to yeast, to any other component of HPV vaccine, or to a previous dose of HPV vaccine should not get the vaccine.



VACCINE PREVENTABLE DISEASE INFORMATION/CONSENT FORM

Influenza is a serious disease caused by a virus that spreads from infected persons via the nose or throat of others. The "Influenza Season" in the U.S. is from November through April of each year. Influenza viruses change often. Therefore, influenza vaccine is updated each year to make sure it is as effective as possible. Annual flu shots should be given to people at risk for getting a serious case of influenza or influenza complications and people in close contact with them. This includes people with long-term health problems (example: Asthma) or a compromised immune system. The risk of the vaccine causing serious harm is extremely small. The virus in the vaccine is killed, so you cannot get influenza from the vaccine. Mild problems such as soreness at the injection site, fever, or aches may occur soon after shot and last 1-2 days. Talk with a Doctor/Nurse before getting vaccine if you have had a serious allergic reaction to eggs or to a previous dose of influenza vaccine, or have a history of Guillain-Barre' Syndrome (GBS). If your child has a fever or is severely ill, postpone the Influenza vaccine until the child has recovered.

Measles, Mumps and Rubella (MMR) Measles and Rubella (German Measles) are diseases that can cause rashes, fever, seizures, brain damage, and death. Children with Mumps often experience fever, headache, and swollen glands. Less often these children may develop hearing loss and infections of their brain or spine. Risks associated with taking the MMR vaccine include soreness at the injection site, fever, and swollen glands in the cheeks or under the jaw, and joint pain/stiffness. Although rare, other problems that your child may develop include severe allergic reactions, bleeding, and seizures. Persons should not be given this vaccine if they have experienced a severe allergic reaction to gelatin or to the drug neomycin, seizures, transfused with blood or blood products, or those who may be pregnant.

Meningococcal Conjugate (MCV4) Meningitis is a serious illness caused by a bacterial infection which is the leading cause of bacterial meningitis in children 2 -18 years of age. The vaccine can prevent 4 types of Meningococcal disease. The vaccine is recommended for all children at the pre-adolescent visit (11-12 years) or college freshmen. MCV4 is also recommended for individuals 11-55 years of age.

Meningococcal Polysaccharide (MPSV4) prevents 4 types of Meningococcal disease, the same as the conjugate vaccine, and should be used for children 2 -10 years of age and adults over 55 who are at risk.

Pneumococcal Conjugate (PVC) Pneumococcal infection causes serious illness and death. Pneumococcal infection causes serious disease in children less than 5 years of age and is the leading cause of bacterial meningitis in the United States. Risks associated with the PVC vaccine are redness, tenderness, or swelling at the site and/or mild fever. Severe reactions are rare. Children should not get this vaccine if they had a severe allergic reaction to a previous dose.

Pneumococcal Polysaccharide (PPV) is recommended in addition to PCV for certain high-risk groups.

Inactivated Polio Vaccine (IPV) Polio is a disease that can cause severe muscle weakness, paralysis, and death. The risk of IPV causing serious harm is extremely small. A risk associated with the vaccine is soreness at the injection site. Anyone who has ever had a serious allergic reaction to Neomycin, Streptomycin, or Polymyxin B should not receive IPV.

Tuberculosis (PPD) Tuberculosis (TB) is a disease that is caused by mycobacterium tuberculosis that is spread through the air from one person to another. The bacteria is put in the air when a person with active TB disease coughs or sneezes. Tuberculosis can cause disability and/or death if not detected and treated appropriately. TB skin testing is recommended for children with risk factors. Peri-odic skin testing is also recommended if exposure is suspected.

WITH ANY VACCINE THERE IS A POSSIBILITY THAT A REACTION MAY OCCUR. Children, adolescents, or adults who are moderately or severely ill at the time the shot is scheduled should wait until they recover before getting the vaccine(s). IF ANY UNUSUAL PROBLEMS OCCUR SUCH AS TROUBLE BREATHING OR MAJOR CHANGES IN BEHAVIOR SEEK IMMEDIATE MEDICAL ATTENTION.



St. John Providence Notice of Privacy Practices

1. 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.

2. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. We call this information "protected health information" or "PHI" for short, and it includes information that can be used to identify you that we have created or received about your past, present, or future health or condition, the provision of healthcare to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice near the main entrance to each St. John Providence Health System facility. You can also request a copy of this notice from the contact person listed in Section 7 below at any time and can view a copy of the notice on our website at www.stjohnprovidence.org.

3. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each.

3.1. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations.

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

- 3.1.1. **For treatment.** We may disclose your PHI to physicians, nurses, medical students and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to the physical therapy department in order to coordinate your care.
- 3.1.2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.
- 3.1.3. **For health care operations.** We may disclose your PHI in order to operate our hospitals, clinics, urgent care centers and other health care service locations. For example, we may use your PHI in order to evaluate the quality of health care services that you received or evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, and consultants who perform services on our behalf.

3.2. Other Uses and Disclosures That Do Not Require Your Authorization

- 3.2.1. **When disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot and other wounds, or when ordered in a judicial or administrative proceeding.
- 3.2.2. **For public health activities.** For example, we report information about births, deaths and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.
- 3.2.3. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
- 3.2.4. **For purposes of organ donation.** We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.
- 3.2.5. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct research.
- 3.2.6. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
- 3.2.7. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
- 3.2.8. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.
- 3.2.9. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders through the mail or by telephone or give you information about treatment alternatives, or other health care services or benefits we offer.
- 3.2.10. **Fundraising activities.** We may use PHI to raise funds for our organization. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed at the end of this notice.

3.3. Uses and Disclosures to Which You Have an Opportunity to Object

- 3.3.1. **Patient directories.** We may include your name, location in this facility, general condition in our patient directory and disclose it to visitors who ask for you by name, unless you object in whole or in part. We also may include your religious affiliation (if any) in the facility directory and disclose facility directory information to clergy members, unless you object in whole or in part.
- 3.3.2. **Disclosure to family, friends, or others.** We may provide your PHI to a family member, friend or other person to the extent that person is involved in your care or the payment for your health care, unless you object in whole or in part.
- 3.3.3. **Special Legal Restrictions** Frequently, Michigan law and/or Federal Regulations require explicit authorization for the disclosure of PHI of patients treated for mental health, substance abuse and HIV/AIDS conditions.

3.4. All Other Uses and Disclosures Require Your Prior Written Authorization

In any other situation not described in this section, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

4. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

- 4.1. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. However, if you pay in full out-of-pocket and you request that we not disclose any information to your health plan about that service, we must grant that request. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make related to your treatment.
- 4.2. **The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you at an alternate address (for example, to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.
- 4.3. **The Right to See and Get Copies of Your PHI.** In most cases you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. If you request copies of your PHI, we will charge you a reasonable copying fee.
- 4.4. **The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include any of the uses or disclosures for treatment, payment and health care operation and some other purposes per the law. The list also will not include any uses or disclosures made before April 14, 2003. We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you \$25 for each additional request.
- 4.5. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not required to be disclosed to you, or (iv) not part of your medical record. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.
- 4.6. **Notice by E-Mail.** If you agree to receive this notice via e-mail, you still have the right to request a paper copy of this notice.
- 4.7. **Psychotherapy Notes.** We must obtain your written authorization before we may use or disclose your psychotherapy notes, except for: use by the originator of the psychotherapy notes for treatment; use or disclosure by Covered Entity for its own mental health training programs; or use or disclosure by Covered Entity to defend itself in a legal action or other proceeding brought by the individual.
- 4.8. **Marketing.** We must obtain your written authorization before we may use or disclose your PHI for marketing purposes, except for face-to-face communications made by us to you or a promotional gift of nominal value provided by us to you.
- 4.9. **Sale of PHI.** We must obtain your written authorization before we sell your PHI.
- 4.10. **Breach of PHI.** We are required to notify you in the event of a breach of your unsecured PHI.

5. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI,

you may file a complaint with: **St. John Providence HIPAA Privacy Office** - (See section 7 of this Notice.)

You also may send a written complaint to: Secretary of the Department of Health and Human Services

We will take no retaliatory action against you if you file a complaint.

6. WHO WILL FOLLOW THIS NOTICE OF PRIVACY PRACTICES

This notice describes the practices of the employees, medical staff, volunteers, departments, units and joint ventures of the following entities:

Brighton Center for Recovery	Ascension Physician Services	Michigan Ear Institute
Eastwood Clinics	Beecher Ballenger Services	Michigan Institute for Sleep Medicine/ Cardiopulmonary Services
Medical Resources Group	Bone & Joint Surgery Center of Novi	Michigan Pain Management Consultants, PC
Providence Hospital and Medical Centers	Cardiology Associates of Michigan	Newland Medical Associates, PC
Providence Park Hospital	Cardiology Associates of Pt. Huron	Northland Anesthesia Associates, PC
St. John Hospital and Medical Center	Cardiovascular Therapeutics Management, LLC	Novi Pediatric Associates, PC
St. John Macomb-Oakland Hospital	Diagnostic Radiology Consultants	Open MRI of Michigan LLC
St. John River District Hospital	Eastpointe Radiologists, PC	Partners in Care
Providence Health Foundation, Inc	Eastside Associates/Eastside Endoscopy	Pathology Specialists of SE Michigan, PC
St. John Providence Health Foundation	Emergency Medicine Specialists, PC	PMHC Cancer Center
St. John Providence Health Occupational Health Partners	Great Lakes Physiatrists, PC	Radiation Oncology Specialists, PC
St. John Providence Health System	Independent Emergency Physicians, PC	St. John Anesthesiologists, PC
St. John Providence Health Partners	Lakeshore ENT	Southfield Radiology Associates, PC
St. John Providence Physician Network	Lakeshore Sleep Diagnostics	Vinay Malviya, MD, PC
St. John Providence Community Health Investment Corp.	Langston, Walker & Associates	X-Ray Associates of Pt. Huron
Affiliated Health Services, Inc	Meemac Associates, PC	
Reverence Home Health & Hospice	Michigan Diagnostic Pathologists, PC	

Also, these entities, sites and locations may share medical information with physicians and other healthcare professionals within St. John Providence Health System and as a Member of a Regional Health Information Organization ("RHIO") or other Health Information Exchange ("HIE"). If you want to "opt out" of the RHIO or HIE, please notify the Privacy Officer listed under Section 7.

7. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact the HIPAA Privacy Officer at 248-849-5302. All complaints must be submitted in writing to:

St. John Providence - HIPAA Privacy Officer
28000 Dequindre Road
Warren, MI 48092

8. EFFECTIVE DATE OF THIS NOTICE: April 14, 2003. REVISED: August 6, 2013



Notice of Privacy Practices

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction but if they agree they will be bound by the agreement.

By signing this form, I acknowledge that I have been offered and/or received the St. John Providence Notice of Privacy Practices.

Signature of Parent/Guardian/Patient