



PEDIATRIC HEALTH HISTORY FORM

Child/Adolescent Name		Birth Date	Age	Gender	Grade	School/Teacher
Street Address		Mailing Address (PO Box)	City		Zip Code	
Race (Optional) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> More Than One <input type="checkbox"/> Other						
Ethnicity (Optional) <input type="checkbox"/> Non-Arabic/Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Arabic						
Mother/Parent Name		Mother/Parent Birth Date	Occupation		Phone Number	
Father/Parent Name		Father/Parent Birth Date	Occupation		Phone Number	
Preferred Telephone Number		May We Leave a Message? Yes No		Best Time of Day to Be Contacted?		
Guardian Last Name (if different than mother/father)		Guardian First Name		Guardian Telephone Number		Relationship To Student
Name of Emergency Contact (other than parent/guardian)			Relationship		Telephone Number	
Name of Student's Physician or Clinic		Physician or Clinic Telephone Number				
HEALTH INSURANCE (Please complete all information)						
<input type="checkbox"/> None (uninsured) Please contact me about MI Child/Healthy Kids health insurance for my child. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medicaid/Medicaid HMO Child's Card Number _____						
<input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Blue Care Network <input type="checkbox"/> Priority Health <input type="checkbox"/> TriCare <input type="checkbox"/> Other: _____				Name of Policy Holder _____ Insurance Policy Number _____ Insurance Group Number _____ Birth Date of Policy Holder _____ Relationship of Policy Holder to child? _____ Does your insurance pay for immunizations? <input type="checkbox"/> Yes <input type="checkbox"/> No		

******If all information has not changed, please initial****** _____

We offer a [Sliding Fee program](#) to qualified patients that reduce the cost of medical care at our facility. Ask our staff for an application! We will need to know your annual income when determining eligibility for this program. You can be sure we will hold this information in the strictest of confidence!



"Your family health center"

BEHAVIORAL HEALTH TREATMENT CONSENT FORM

Alcona Health Center (AHC) is offering behavioral health services (BHS) at LINCOLN ELEMENTARY SCHOOL. These services will be provided by Aimee O'Neil, a State of Michigan licensed master's Social Worker employed by AHC as a behavioral health therapist. As a condition for offering these services to your child, AHC is requiring that a parent or legal guardian must give written, informed consent, as outlined below. This consent may be revoked at any time.

As the parent or legal guardian of _____ DOB: _____

1. I understand Behavioral Health Services will include a behavioral health assessment of my child, during which I may be asked to provide information about my child's emotional needs and behavior at home and school. I may be invited to be actively involved in the treatment planning for my child. My acceptance of counseling services for my child is on a voluntary basis, and I may terminate these services at any time.
2. I understand that Aimee O'Neil LMSW, maintains professional liability coverage and follows federal and state laws protecting client's rights to confidentiality of personal information. I understand these laws allow the exchange of Protected Health Information with others only when the parent/guardian signs a release of information naming a specific person(s) or entity with whom the information is to be exchanged.
3. I understand that counseling is a fee for service agreement and that my insurance company will be billed for services. I further understand that I will be responsible for any portions of fees and/or additional fees not covered by my insurance provider. AHC encourages parents/guardians to contact their child's insurance company directly, so you are informed about Behavioral Health services coverage for your child. It is a parent/guardian responsibility to know your insurance benefits. Alcona Health Center will not be contacting your insurance company directly to inquire about Behavioral Health services coverage in order to begin services with your child. You may be eligible for AHC's Sliding Fee program. Ask your therapist for details. Services will not be denied based on the inability to pay.
5. I understand that AHC has taken steps to minimize exposure to COVID-19 in all school locations based on CDC guidelines. I understand that if my child appears in poor health, I may be contacted to reschedule their appointment until symptoms are evaluated by a medical professional. If I have any concerns regarding COVID-19, I will contact my child's therapist prior to their scheduled appointment.
6. I understand that federal and state regulations protect the confidentiality of my child's records maintained by this program, except when the following conditions exist:
 - a. There is suspected evidence of child abuse, neglect, or danger to my child; or
 - b. The Michigan Department of Health and Human Services, Child Protective Services requests Behavioral Health information by directly submitting the DHS-1163-P form to Alcona Health Center and/or this Behavioral Health Therapist; or
 - c. A medical emergency that may require a referral to medical personnel or
 - d. "Duty to Warn (homicide threat/injury to another person) or Duty to Protect (suicide threat/injury to oneself)" or,
 - e. If your child displays signs, symptoms and/or verbal confirmation of recent use of alcohol or another substance use that is causing some type of observable impairment.

I HAVE READ AND UNDERSTAND THE CONDITIONS OUTLINED ABOVE, AND BY SIGNING BELOW AUTHORIZE Aimee O'Neil, LLMSW TO OFFER BEHAVIORAL HEALTH SERVICES TO MY CHILD. I acknowledge this consent will remain active until rescinded or the student reaches age 18.

Signature of Parent(s) or Legal Guardian Signature of Witness

Date: ___/___/____ Date: ___/___/____

_____ My initials indicate that I have been offered a copy of AHC's Notice of Privacy Practices.
<https://www.alconahealthcenters.org/patient-privacy/>

CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION

Michigan Department of Health and Human Services

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as “behavioral health” throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as “substance use disorder” throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

Why This Form Is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

- To **give** consent, fill out Sections 1, 2, 3, and 4.
- To **take** away consent, fill out Sections 5.
- Sign the completed form, then give it to your health care provider. They can make a copy for you.

Section 1: About You

Child's Information Below

First Name	Middle Initial	Last Name	Date of Birth	Date Signed

Section 2: Who Can See Your Information and How They Can Share It

Section 2a: Sharing Information Between Individuals and Organizations

Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

1. Lincoln Elementary School Staff
2. Physician's Name:
3. Char-Em
4. _____
5. _____
6. _____

Section 2b: Sharing Information Electronically

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

Choose only one option:

- Share my information through the organizations listed below. This information will be shared with the individuals and organizations listed under Section 2a.
- Do not share my information through the organizations listed below.
- Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only. List all health information exchanges or networks:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Section 3: What Information You Want to Share

Choose one option:

- Share **all** my behavioral health and substance use disorder records. This does not include “psychotherapy notes.”
- Share **only** the types of behavioral health and substance use disorder records listed below. For example, what I am being treated for, my medications, lab results, etc.

- | | |
|--|----------|
| 1. <u>Scheduling, attendance, engagement</u> | 4. _____ |
| 2. <u>Care Plan as needed for support</u> | 5. _____ |
| 3. _____ | 6. _____ |

Section 4: Your Consent and Signature

Read the statements below, then sign and date the form.

By signing this form below, I understand:

- I am giving consent to share my behavioral health and substance use disorder records. This includes referrals and services for alcohol and substance use disorders, but other information may also be shared.
- I do not have to fill out this form. If I do not fill it out, I can still get treatment, health insurance or benefits. But, without this form, my provider or health plan may not have all the information needed to treat me.
- My records listed above in Section 3 will be shared to help diagnose, treat, manage, and pay for my health needs.

- My records may be shared with the people or organizations as stated in Section 2.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share “psychotherapy notes”.
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form. Or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.
- This signature is good for **1 year** from the date signed. Or I can choose an earlier date or have it end after the event or condition listed below. (For example, at the end of my treatment.)

Date, event, or condition: _____

State your relationship to the person giving consent and then sign and date below:

Self

Parent (Print Name) _____

Guardian (Print Name) _____

Authorized Representative (Print Name) _____

Signature

Date

Witness Signature (If Appropriate)

Date

TAKE AWAY YOUR CONSENT

Complete Section 5 if you no longer want to share your records listed above in Section 3.

Section 5: Who Can No Longer See Your Information

I no longer want to share my records with those listed in Sections 2a and 2b. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

Self

Parent (Print Name) _____

Guardian (Print Name) _____

Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Appropriate)	Date

FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

<p>Verbal Withdrawal of Consent</p> <p><input type="checkbox"/> The individual listed above in Section 1 has taken away his/her consent. List the individual who requested the withdrawal below, then sign and date below.</p> <p><input type="checkbox"/> Individual listed above in Section 1.</p> <p><input type="checkbox"/> Parent (Print Name) _____</p> <p><input type="checkbox"/> Guardian (Print Name) _____</p> <p><input type="checkbox"/> Authorized Representative (Print Name) _____</p>		
Signature of Person Who Received the Verbal Withdrawal	Print Name	Date
<p>Other Information for Health Care Providers and Health Plans</p> <p>This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at michigan.gov/bhconsent.</p>		
<p>Additional Identifiers (Optional)</p> <p>Medicaid _____ Last 4 of the Social Security Number _____</p>		
<p>Form Copy (Optional, Choose One Option)</p> <p><input type="checkbox"/> The individual in Section 1 received a copy of this form.</p> <p><input type="checkbox"/> The individual in Section 1 declined a copy of this form.</p>		

AUTHORITY:	This form is acceptable to the Michigan Department of Health and Human Services as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.
COMPLETION:	Is Voluntary, but required if disclosure is requested.
<p>The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.</p>	

HEALTH HISTORY FORM

Please list ALL doctors, clinics, specialists, etc. who have treated your child in the past:

If you need to elaborate on any of the topics, simply enter any additional information on the back of the forms.

PLEASE ANSWER THE FOLLOWING HEALTH-RELATED QUESTIONS

1. Did the patient's mother have prenatal care? No Yes Where? _____
2. Were there any complications during pregnancy? No Yes What? _____
3. Did the mother take any meds during pregnancy? No Yes List: _____
4. Did the mother take any controlled meds during pregnancy? No Yes List: _____
5. Did mother use any street drugs during pregnancy? No Yes List: _____
6. Did mother drink alcoholic beverages during pregnancy? No Yes How much? _____
7. Were there any problems with the labor or delivery? No Yes List: _____
8. Was the baby full-term? No Yes If not, delivered at how many weeks? _____
9. What was the baby's weight at birth? _____ lbs _____ oz. What was baby's length? _____ inches
10. Did the baby have any problems at birth? No Yes List: _____
11. Does your child have regular bowel movements? No Yes _____ Constipation _____ Frequent loose stools
12. Does your child have normal urination? _____ Does your child have burning with urination? _____ since when? _____
13. If older than 3 years old, does your child wet the bed? _____
14. Do you have any concerns with your child's development? _____

15. List the following people live in the same household as your child:

NAME	AGE	RELATIONSHIP TO PATIENT

16. List people who take care of your child: _____

17. Describe your child's behavior by marking the appropriate boxes:

Behavior	Major Problem	Minor Problem	No Problem
Clinging			
Temper Tantrums			
Easily Frightened			
Short Attention Span			
Difficulty sitting still			
Aggressive			
Dislikes School/ Poor Grades			

18. What is the main reason(s) you are seeking support for your child? (Please include how long he/she has had these symptoms/concerns and any recent/past events contributing to these symptoms.)

19. What are your hopes regarding your child's therapy? _____

20. Please list any current or past behavioral health therapy your child/family has participated in.

21. Has your child experienced any recent or past stressors? Yes No (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)? If yes, please describe: _____

22. How stressful would you rate your family life? 1 2 3 4 5 Highly Stressful
Please explain:

List any issues you may want to discuss with the healthcare provider at this first appointment:

HEALTH HISTORY FORM

Lincoln Elementary School-Aimee O’Neil, LMSW

Patient Name: _____ **Date of Birth:** _____

Please check yes or no.

- | | | | | | | | | |
|---------------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|
| Bee sting allergies | <input type="checkbox"/> yes | <input type="checkbox"/> no | Seizures (epilepsy) | <input type="checkbox"/> yes | <input type="checkbox"/> no | Psychological disorder | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Anemia | <input type="checkbox"/> yes | <input type="checkbox"/> no | Stomach problems | <input type="checkbox"/> yes | <input type="checkbox"/> no | Thyroid disease | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Seasonal allergies | <input type="checkbox"/> yes | <input type="checkbox"/> no | Heart problems | <input type="checkbox"/> yes | <input type="checkbox"/> no | Frequent sore throats | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Asthma | <input type="checkbox"/> yes | <input type="checkbox"/> no | Bladder problems | <input type="checkbox"/> yes | <input type="checkbox"/> no | Nosebleeds | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Diabetes | <input type="checkbox"/> yes | <input type="checkbox"/> no | Cancer | <input type="checkbox"/> yes | <input type="checkbox"/> no | Backaches | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Eczema/rashes | <input type="checkbox"/> yes | <input type="checkbox"/> no | Headaches/migraines | <input type="checkbox"/> yes | <input type="checkbox"/> no | Frequent urination | <input type="checkbox"/> yes | <input type="checkbox"/> |
| no | | | | | | | | |
| ADD/ADHD | <input type="checkbox"/> yes | <input type="checkbox"/> no | High blood pressure | <input type="checkbox"/> yes | <input type="checkbox"/> no | Kidney disease | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Sickle cell disease/trait | <input type="checkbox"/> yes | <input type="checkbox"/> no | Fainting | <input type="checkbox"/> yes | <input type="checkbox"/> no | Shortness of breath | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Pounding of heart | <input type="checkbox"/> yes | <input type="checkbox"/> no | Pneumonia | <input type="checkbox"/> yes | <input type="checkbox"/> no | Learning Disability | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Depression | <input type="checkbox"/> yes | <input type="checkbox"/> no | Anxiety | <input type="checkbox"/> yes | <input type="checkbox"/> no | | | |

Does anyone smoke in the household? yes no

If additional space needed for below questions, please use the back of the form.

1. Student’s Daily Medications? _____
2. Condition for Medications? _____
3. Any Medication Allergies? _____
4. Any Food Allergies? _____
5. Any Surgeries? _____
6. Any Hospitalizations? _____
7. Other health problems? _____

Family Medical History	
Check any illnesses that relatives (i.e. mother, father, aunt, uncle, grandparents, sibling) and note which relative has them	
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Diabetes (high blood sugar)
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma/Emphysema/Bronchitis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Death under age 50 – Cause:	<input type="checkbox"/> Kidney or Thyroid Disease
<input type="checkbox"/> Sickle Cell Anemia/Blood problems	<input type="checkbox"/> Other

Signature (Parent/Guardian): _____ **Date:** _____

PCMH- PATIENT CENTERED MEDICAL HOME

ALCONA HEALTH CENTERS IS A PATIENT-CENTERED MEDICAL HOME. We are focused on your child's wellness.

We have created a wide range of services and resources designed to:

- Track and monitor the care received from all of health care providers
- Help your child meet health-related goals and grow into healthy adults
- Offer your child extended access to our health care team

Welcome to Alcona Health Centers. We are honored to be considered for your child's healthcare management. We are committed to providing your child with the best care.

It is our expectation that you will take responsibility for guiding your child in adapting a healthy lifestyle as that is so important to your child's well-being.

We will be discussing with you some important steps you can encourage with your child to maintain or achieve good health. Your cooperation is vitally important.

It will give our staff and providers great pleasure to work with you on these goals, either through our own expertise, through reading materials that we might give you, or by referral to other health professionals. We want everyone to be involved in our health maintenance program. Everyone who joins our practice should start by having a complete physical exam followed by periodic check-ups that may include health assessments and education.

We are looking forward to working with you as your family healthcare providers. Please contact us whenever you would like to talk about anything you think may be affecting your child's health. It's our hope that we can have a relationship where the lines of communication are open, and communication goes both ways. We will help you remember when your child is due for wellness exams and/or immunizations.

Self-management goals are a series of small steps you can take to help your child work towards achievable health care goals. We will support you and assist you in identifying achievable action steps, when needed.

Revised: 10/22/2015 MW, 02/28/2018 AAG

School-Based Health Care Client Rights and Responsibilities

YOUR RIGHTS:

1. You have the right to receive services in our clinic: regardless of race, religion, national origin, gender, sexual orientation, handicap, or ability to pay.
2. You have the right to be treated with respect and dignity.
3. You have the right to receive the best possible care and have all options for care explained to you.
4. You have the right to privacy.
5. You have the right to discuss any questions or problems you may have about your care provider.
6. You have the right to refuse any services you do not want or do not understand.
7. You have the right to make a complaint if you are not satisfied with your care.

YOUR RIGHT TO CONFIDENTIAL SERVICES:

1. You have the right to confidential services.
2. You have the right to confidential services without a parental consent for these services:
 - a) Behavioral Health services for students age 14 and older
 - b) Sexual and Reproductive Health Services **for students age 12 and older** (Note: birth control devices and prescriptions, abortions and abortion referrals are restricted services and not provided).
 - c) Substance abuse screening, brief intervention and referral **for students age 12 and older**
3. You have the right to OK or refuse the release of confidential information unless law requires otherwise. *
4. Confidentiality may be broken when we are concerned about your safety or the safety of others.

**If you are under age 18, parents and legal guardians do have the right to see your record, except for information identified as confidential above. When we receive a request from a parent or guardian to view your record, we will meet with you first and will also be available to review the information together with you and your parent/legal guardian. School staff may be notified of the time you are with us for your appointment, if this information is needed for attendance purposes.*

YOUR RESPONSIBILITIES:

You are responsible for:

1. Participating in the development of your individual treatment plan.
2. Working towards your treatment goals and objectives.
3. Treating program staff with respect.
4. Showing respect and privacy for others using school-based health services.
5. Asking questions about anything you don't understand.
6. Telling program staff about any changes in your health.
7. Arriving on time for your appointments.
8. Informing staff if you can't make an appointment.
9. Giving us the correct information about your insurance, address, name, or phone number. If any of this information changes, you are responsible to tell the health center.
10. Asking any questions if you do not understand any information given to you in writing or verbally.

If you feel your rights have been violated, please inform the Behavioral Health Director: 989-358-3966

Notice of Privacy Practice

The physicians and staff of Alcona Health Centers, Inc. have always held any medical or personal information gathered during your care in the strictest of confidence. However, the federal government now mandates health care entities give notice of their privacy practices in writing, to all patients. The information contained here fulfills that requirement and contains a few changes from our previously applied policies and procedures.

This Notice describes how information about you may be used and disclosed and how you can get access to this information. Please read it carefully. You may contact our Privacy Officer at (989) 736-8157 for further information about this Privacy Notice and the complaint process. This notice was first published in December of 2002 and was reviewed and revised in 2014. **This policy was last revised on August 31, 2018.**

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal.

We are committed to protecting medical information about you. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. **This Privacy Notice applies to all the records of your care generated by this practice,** whether made by office personnel, or your personal doctor, physician assistants, nurse practitioner, dentist, hygienist, dental assistant, or behavioural health therapist. Physicians, physical assistants, nurse practitioners, dentist, hygienist, and behavioural health therapist are referred to as providers in this Notice.

Understanding Your Health Information

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information and images that may identify you and that relate to your past, present or future physical or mental health or condition and related healthcare services. We are required to abide by the terms of this Notice of Privacy Practices. A current Notice will remain permanently posted in the patient lobby and paper copies will be available upon request. We may change the terms of our Notice, at any time. The new Notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based upon Your Written Acknowledgement:

You will be asked to sign a one-time acknowledgement form. Alcona Citizens for Health Inc, hereafter referred to as AHC, will use or disclose your protected health information as described in this Section. 1. Your protected health information may be used and disclosed by your provider, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you. **Your protected health information may also be used and disclosed to receive payment for your healthcare series to support the operations of the Alcona Citizens for Health, Inc.**

Following are examples of the types of uses and disclosures of your protected healthcare information that AHC is permitted to make once you have been provided with the Notice of Privacy Practice brochure.

Treatment: **We will use and disclose your protected health information to provide coordination, or manage your healthcare and any related services.** This includes the coordination or management of your healthcare with a third party that has already obtained your permission to have access to your protected health information. For example, we will disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose your protected health information to medical equipment suppliers and third party payors (for example, insurance companies and Medicare) for treatment or payment purposes. We will also disclose protected health information to other providers who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be faxed to a physician or healthcare provider to which you have been referred to ensure they have the necessary information to diagnose or treat you. We may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate the reason for your visit. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you or remind you of your appointment.

In addition, we may disclose your protected health information from time-to-time to another physician or healthcare provider (e.g., a specialist or laboratory) that, at the request of the provider, becomes involved in your care by providing assistance with our healthcare diagnosis or treatment to our provider.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health care plan may undertake before it approves or pays for the healthcare services, we recommend for you such as; making a determination of eligibility of coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We will only use or disclose your protected health information to the extent necessary for AHC to operate. The uses and disclosure are necessary to run AHC and make sure that all our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many AHC patients to decide what additional services AHC should offer, what services are not needed, and whether certain new treatments are not effective. We may also disclose information to doctors, nurses, technicians, students and other AHC personnel for review and learning purposes. We may also combine the medical information we have with medical information from other facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it study health care and health care delivery without learning who the specific patients are.

We will share your protected health information with the third party “billing associates” that perform various activities (e.g., billing, transcription services) for AHC. We will have a written agreement that will protect the privacy of your protected health information whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information.

We may use or disclose your protected health information as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also send you information about products or services that we believe may be beneficial to you. You may notify our PRIVACY OFFICER, the individual at AHC who is responsible for healthcare privacy matters, to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time,

in writing, except to the extent that your provider or AHC has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object.

We may use and disclose your protected health information in the following instances. You can agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your healthcare will be disclosed.

Registries: Unless you object, we may disclose protected health information to registries such as the (PECS) Patient Electronic Care System; or Michigan Childhood Immunization Registry (MCIR). If you do not wish to participate in a registry, send a written letter to our Health Information Supervisor

Health Information Exchange (HIE): Unless you object, the HIE records and transmits health information, including prescription information, electronically. Health information is shared and protected electronically through local, state and national health information exchanges. This organization participates in the Great Lakes Health Connect (GLHC) information network. GLHC has rules regarding how health information can be accessed through GLHC, and limits on use or disclosures of that information. For more information about GLHC, and your rights associated with transmission of your information through this and other health information exchanges, please contact our Privacy Officer. If you do not wish to participate in an HIE, send a written letter to our Health Information Supervisor.

Appointment Reminders and Messages: Unless you object, we may leave appointment reminders and messages on the answering machine at the home telephone number that you have provided. If you do not want reminders or messages left on your home recorder, send a written letter to the Health Information Supervisor.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable or object to such a disclosure, we may disclose such information as necessary if we determine that is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, legal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens your provider shall try to obtain your consent as soon as reasonably practical after the delivery of treatment. If your provider or another provider in the practice is required by law to treat you and the provider has attempted to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your provider or another provider in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the provider determines, using professional judgment, that your intent is to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency that is authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs and civil rights laws.

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Abuse or Neglect: We may disclose our protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been the victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to make sure repairs or replacements, or conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), We may, in certain conditions, disclose protected health information in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on premises of AHC, and (6) medical emergency (not on AHC premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.

How do I establish my child's care with Alcona Health Centers?

Call one of our many offices, and simply request to become an established patient of Alcona Health Centers. We will send you this **New Patient Pediatric Health History Form** to **complete and return to our office, preferably at least a week before your child's appointment.**

Our staff will schedule you for an appointment so that we may determine if we can meet your healthcare needs. This appointment is usually 60 minutes long. **If you find you cannot keep the appointment, please call at least 24 hours in advance to cancel.**

Welcome to Alcona Health Centers! Listed below are our locations:

Alpena Services	P.O. Box 857, Alpena, MI 49707	(989) 356-4049
Cheboygan Campus	740 S. Main St. Cheboygan, MI 48721	
	Suite 2A	(231) 627-7118
	Suite 2B	(231) 627-7118
	Suite 2C	(231) 627-7118
	Suite 3A	(231) 627-3002
Gaylord Youth Support Program	Gaylord Intermediate 240 E 4 th St. Gaylord, MI 49735	(231) 412-6457
Gaylord Youth Support Program	North Ohio Elementary School 912 N. Ohio Ave. Gaylord MI 49735	(231) 412-6457
Gaylord Youth Support Program	South Maple Elementary School 650 E 5 th St. Gaylord, MI 49735	(231) 412-6457
Health Center of Northern Michigan	3434 M-119, Harbor Springs 49740	(231)348-9900
Harrisville Services	205 N. State, P.O. Box 130, Harrisville 48740	(989) 724-5655
Indian River Campus	6135 Cressy St, Indian River, MI 49749	(231) 238-8908
Lincoln Services	177 N. Barlow Road, P.O. Box 279, Lincoln, MI 48742	(989) 736-8157
Long Rapids Plaza	346 Long Rapids Plaza, Alpena, MI 49707	(989) 358-3500
Oscoda Services	5671 N. Skeel Ave., <u>Aune Medical Center</u> , Suite 8, Oscoda 48750	(989) 739-2550
Ossineke Services	11745 US-23, PO Box 83 Ossineke, MI 49766	(989) 471-2156
Pellston Services	421 Stimpson Dr. Unit 102, Pellston, MI 49769	(231) 844-3051
Petoskey Child Health Associates	2390 Mitchell Park Drive Suite A Petoskey, MI 49770	(231) 487-2250
Petoskey Wellness Program	Petoskey High School 1500 Hill St. Petoskey, MI 49770	(231)-412-6456
Petoskey Wellness Program	Petoskey Middle School 801 Northmen Dr. Petoskey, MI 49770	(231)-412-6455
Petoskey Wellness Program	Central Elementary School 410 State St. Petoskey, MI 49770	(231) 412-6452
Petoskey Wellness Program	Lincoln Elementary School 616 Connable Ave. Petoskey, MI 49770	(231) 412-6453
Petoskey Wellness Program	Ottawa Elementary School 871 Kalamazoo Ave. Petoskey, MI 49770	(231) 412-6454
Petoskey Wellness Program	Sheridan Elementary School 1415 Howard St. Petoskey, MI 49770	(231) 412-6458
Pickford Campus	416 M-129, Pickford, MI 49774	(906) 647-2217
Tiger Health Extension	Alcona Elementary School, 181 N. Barlow Road, Lincoln, MI 48742	(989)736-8716
Wildcat Health Extension	Lincoln Elementary school at 309 W. Lake St, Alpena, MI 49707	(989) 358-3998