Child & Adolescent
Health Center
of Family Health Care

School-Based Health Close to Home!

Our services are provided on school campuses in Baldwin, Grant and White Cloud; and are open to all children ages 5-21, and children of parenting teens, regardless if they attend school where that clinic is based.

As a patient, you can expect the following at each clinic:

- Open year-round, Monday through Friday, 7:30 a.m. to 4 p.m.
- Everyone will receive services, regardless of ability to pay. Services are funded through insurance.
- Completing this Consent Packet allows your child to access routine and urgent care health services if they are ever needed.
- Services offered include; preventative care, immunizations, sick visits, acute care, well child exams/sports physicals, health education, behavioral health therapy, Medicaid enrollment, dental, vision and more!
    - ***NOTE**: At no time will we provide birth control or abortion counseling*

Teams are comprised of nurse practitioners, physician assistants, behavioral health therapists, dentists, optometrists, medical and dental assistants, outreach workers and program coordinators.

For more information contact your local Child & Adolescent Health Center below.

Baldwin
525 W. Fourth Street
Baldwin, MI 49304
(231) 745-3116

Grant
96 E. 120th Street
Grant, MI 49327
(231) 834-1350

White Cloud
555 E. Wilcox
White Cloud, MI 49337
(231) 689-3268

Parent/Caregiver Consent Form

Child & Adolescent Health Center of Family Health Care

Please review this information and fill in your child's name and date of birth. Then place your initial(s) next to the paragraph headers and sign below. You are welcome to contact us at any time with questions or comments you may have.

I consent to the following for (child's name) _____ (Date of Birth) ____-____-____.

_____ Please Initial **Medical, Dental, and Behavioral Health Services:** I authorize my child to receive medical, dental, and behavioral health services as offered and available by the Child and Adolescent Health Center. I further authorize any physician, dentist, behavioral health provider, or physician/dentist designated health professional employed by or working for Family Health Care, Inc., remaining within their scope of practice, to provide such medical, dental, and mental health tests, counseling, procedures, treatments, prescriptions, and medications as are reasonable, necessary or advisable for the medical, dental, and emotional evaluation and management of my child's health care.

A component of our services includes use of the Michigan Care Improvement Registry (MCIR). After we measure your child's height and weight, we will record that information into the MICR Body Mass Index (BMI) Growth Module. We use this as a tool to prevent and treat weight related issues. Recording of this BMI information is optional. If you wish to decline this service, please let our office know.

As you may be aware, Michigan Law Health Code, Act 368 of 1978 requires that minors of certain ages be allowed to receive reproductive health, HIV, STD/STI, substance abuse, and mental health information and services without parental consent at any medical facility in the State of Michigan. For our part we, your Health Center and Public School staff, promote abstinence and encourage open communication between parents, students, and staff at all times.

_____ Please Initial **Exchange of Information:** I authorize the exchange of information between school officials and clinic staff enabling my child to receive the best available services. Information might include medical, educational, and/or mental health information only as necessary to ensure your child's safety and well-being on a "need to know" basis. We understand and value you and your child's privacy.

_____ Please Initial **Timeframe:** I understand that once I have signed this authorization it will remain in effect until my child is no longer eligible for services at the Child and Adolescent Health Center due to age or location. I may cancel this authorization by written request at any time.

Signature:

(Parent or Legal Guardian):_____ Date: _____

(Your child will not be eligible for Health Center Services unless this consent is signed and verified)

(Office Use Only)

Health Center consent authorization verification:_____ Date:_____
(Health Center Staff Signature)

Verified By: ____ Phone with parent/legal guardian
____ In person with parent/legal guardian
____ By mail certified to parent/legal guardian (SASE returned)

Patient Information

Child & Adolescent Health Center of Family Health Care

DATE_____

PATIENT/STUDENT INFORMATION

PATIENT_____ SEX_____ BIRTH DATE____/____/____
(FIRST) (MIDDLE) (LAST)

Address_____
STREET/P.O. BOX CITY STATE ZIP

Mailing Address_____
STREET/APT# CITY STATE ZIP

GRADE_____ (current year) **SS # (last 4 digits):** _____ RACE/ETHNICITY _____

Employer_____ Occupation_____ Weekly Income_____

Home Phone ( ) _____ Cell Phone ( )_____ Message Phone ( ) _____

Primary Care Provider _____ Preferred Pharmacy_____

HEAD OF HOUSEHOLD

PARENT/GUARDIAN_____Relationship_____Sex_____

Address _____
STREET/APT# CITY STATE ZIP

Mailing Address_____
STREET/APT# CITY STATE ZIP

Birth date:_____ Race/Ethnicity_____ **SS # (last 4 digits):**_____

Employer_____Occupation_____

Work Address_____
STREET CITY STATE ZIP

Home Phone#( )_____ Work Phone# ( )_____ Work hours: _____

(PLEASE ATTACH A COPY OF YOUR INSURANCE CARD FOR OUR FILES)

_____ _____ POLICY#_____
Primary Insurance Company Name of Insured GROUP#_____
CERTIF.#_____

_____
Address/Street

_____ _____
City State Zip MEDICARE/MEDICAID #

FAMILY MEMBER INFORMATION

NAME	SEX	DOB	RELATIONSHIP
1.			
2.			
3.			

(Use back of paper if needed)

Non-Household Member

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT:_____ PHONE:_____

RELATIONSHIP:_____ WORK PHONE:_____

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	☐	☐		Headaches/migraines	☐	☐	
Allergies/hayfever	☐	☐		Low iron in blood (anemia)	☐	☐	
Asthma	☐	☐		Pneumonia	☐	☐	
Bladder or kidney infections	☐	☐		Rheumatic fever or heart disease	☐	☐	
Blood disorders/sickle cell anemia	☐	☐		Scoliosis (curved spine)	☐	☐	
Cancer	☐	☐		Seizures/epilepsy	☐	☐	
Chicken pox	☐	☐		Severe acne	☐	☐	
Depression	☐	☐		Stomach problems	☐	☐	
Diabetes	☐	☐		Tuberculosis (TB)/lung disease	☐	☐	
Eating disorder	☐	☐		Mononucleosis (mono)	☐	☐	
Emotional disorder	☐	☐		Other: _____	☐	☐	
Hepatitis (liver disease)	☐	☐					

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	☐	☐	☐		
Arthritis	☐	☐	☐		
Birth defects	☐	☐	☐		
Blood disorders/sickle cell anemia	☐	☐	☐		

AA59:97-894:11/97

	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type_____)	☐	☐	☐	_____	_____
Depression	☐	☐	☐	_____	_____
Diabetes	☐	☐	☐	_____	_____
Drinking problem/alcoholism	☐	☐	☐	_____	_____
Drug addiction	☐	☐	☐	_____	_____
Endocrine/gland disease	☐	☐	☐	_____	_____
Heart attack or stroke *before* age 55	☐	☐	☐	_____	_____
Heart attack or stroke *after* age 55	☐	☐	☐	_____	_____
High blood pressure	☐	☐	☐	_____	_____
High cholesterol	☐	☐	☐	_____	_____
Kidney disease	☐	☐	☐	_____	_____
Learning disability	☐	☐	☐	_____	_____
Liver disease	☐	☐	☐	_____	_____
Mental health	☐	☐	☐	_____	_____
Mental retardation	☐	☐	☐	_____	_____
Migraine headaches	☐	☐	☐	_____	_____
Obesity	☐	☐	☐	_____	_____
Seiures/epilepsy	☐	☐	☐	_____	_____
Smoking	☐	☐	☐	_____	_____
Tuberculosis/lung disease	☐	☐	☐	_____	_____

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

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

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

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

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

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

Family Health Care
Vision Outreach Program
1035 E. Wilcox Street, PO Box 865
White Cloud, MI 49349
231-689-7697

School: _____

Teacher: _____

This consent is for **Vision** services to be completed at school. Please complete all information completely, circle **YES** or **NO,** signature is required and return to your child's teacher as soon as possible.

_____ ___/___/___ _____ □ Male □Female
CHILD'S LEGAL NAME (PLEASE PRINT) DATE OF BIRTH AGE

_____ _____ _____
ADDRESS CITY ZIP CODE

_____ ___/___/___ _____
MOTHER'S/GUARDIANS NAME (PLEASE PRINT) DATE OF BIRTH PHONE NUMBER

_____ ___/___/___ _____
FATHER'S/GUARDIANS NAME (PLEASE PRINT) DATE OF BIRTH PHONE NUMBER

VISION

You are giving consent for your child to have the following services: Complete exam including dilation using eye drops (Dilation can last from 6-24 hrs and may include blurry vision and sensitivity to light). If glasses are needed, I allow my child to select frames with help from vision staff and understand that glasses will be delivered to school within a few weeks. This consent is valid for 12 months from the date of your signature and applies to any follow up appointments necessary throughout the school year and includes consent to share these results with relevant school staff.

*Services provided at the school will be billed the same as if they were performed in our office and will be billed directly to your insurance. I understand that by circling YES and signing this form that I am the legal guardian and give consent for all services listed above.

PLEASE LIST ***ALL*** INSURANCE POLICIES YOUR CHILD IS COVERED UNDER.

Medicaid Number (if applicable): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (10 digit number)

VISION INSURANCE INFORMATION: _____
Name of VISION INSURANCE

_____ _____
Name of INSURED/PARENT Policy Number (May be subscribers Social Security number)

MEDICAL INSURANCE INFORMATION: _____
Name of Insurance and policy number.

YES or NO _____ _____
CIRCLE ONE PARENT/GUARDIAN SIGNATURE DATE

PATIENT MEDICAL HISTORY

Allergies to medicine, seasonal allergies, etc.:_____

Current medications your child is taking: _____

Has your child ever worn glasses? Y or N

Date of last eye exam with an eye doctor: _____

Does your child currently wear glasses? Y or N

How old are the glasses? _____

Please list any vision problems:

_____

_____

_____

_____

_____

Please circle YES/NO for your CHILD:

Asthma?	YES	NO	Diabetes?	YES	NO
Headaches?	YES	NO	Any smoking in the home?	YES	NO
Heart problems	YES	NO	Individual Education Plan (IEP)?	YES	NO

Other health problems:_____

_____

Family Medical History

Any health problems with parents or siblings? Y or N If yes, please explain: _____

Blindness, glaucoma, or eye diseases with parents or siblings? Y or N If yes, please explain _____

*Services provided at the school will be billed the same as if they were performed in our office and will be billed directly to your insurance. If follow up treatment is needed you will be contacted by a Family Health Care staff member to schedule at the office. I understand that by circling YES and signing this form that I am the legal guardian and give consent for vision services.

FAMILY HEALTH CARE

CHILD AND ADOLESCENT HEALTH CENTER

School: **Grant** **Baldwin** **White Cloud** **Other:**_____ **(Circle one)**

PATIENT INFORMATION

Last name:	First:	M:	School (circle one) Elementary / Middle / High School
Birth Date:	Age:	Sex	
Street address:			Home phone no.: ( )
P.O. Box:	City:	State:	ZIP Code:

Would you like Family Health Care to be your child's primary dentist? ❑ Yes ❑ No ❑ Emergency Care Only (no routine care will be provided)

INSURANCE INFORMATION

Parent:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this parent a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Delta Dental ❑ Medicaid ❑ MetLife ❑ Aetna ❑ Other

Subscriber's name:	Subscriber ID (may be social security #)	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I am a custodial parent or legal guardian of the child named above. I authorize and consent to this child receiving dental treatment at the Child And Adolescent Health Center. I understand that this authorization is valid until I revoke this authorization. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I authorize Family Health Care to bill for the services provided and collect payment from any insurance company or third party payer that covers the services provided. I accept financial responsibility for any outstanding charges for all professional services provided. I acknowledge being informed of Family Health Care's Notice of Privacy (located on the back).

_____ _____

Parent/Guardian signature ***Date***

Family Health Care will be providing x-ray, exam, cleaning, fluoride, sealants, local anesthesia and fillings at the Child and Adolescent Health Center.

FRONT

Health History

Please note that it is the responsibility of the parent to update any new health history information to the Child and Adolescent Health Center in the event that any should occur.

Name of Physician: _____ Physician's Address: _____ Phone #:_____

Last physical? _____ Are immunizations up to date? YES NO

Is patient now under the care of a physician other than routine checkups? YES NO If yes, for what reason? _____

Is patient allergic to (or have an adverse reaction to any medication, food or materials)?

□ Penicillin □ Codeine □ Local Anesthetic □ Aspirin □ Sulfa □ Other_____

Current Medications: _____

Preferred Pharmacy: _____

Is patient sensitive or allergic to latex? (i.e. experienced itching, rash or wheezing after using latex gloves or handling a balloon) YES NO

Has patient had any unusual or unexplained reactions during a dental procedure, including the anesthetic? YES NO

If yes, please explain: _____

Does patient have or has had any of the following: **PLEASE CIRCLE YES OR NO**

Abnormal Blood Pressure	Yes	No	Learning disability	Yes	No
ADHD	Yes	No	Cancer	Yes	No
Anemia	Yes	No	Congenital heart disease	Yes	No
Anorexia	Yes	No	Diabetes	Yes	No
Artificial heart valve	Yes	No	Epilepsy	Yes	No
Artificial joint	Yes	No	Heart disease/surgery	Yes	No
Asthma	Yes	No	Hepatitis __A__B__C	Yes	No
Autism	Yes	No	HIV positive	Yes	No
Tuberculosis	Yes	No	Organ transplant	Yes	No
Had a dental cleaning in the last 6 months	Yes	No	Any problems with teeth	Yes	No
Bleeding when brushing or flossing	Yes	No	Any teeth causing pain	Yes	No

Any serious illness, hospitalization or accident? YES NO

If yes, please explain: _____

Are there any other health issues or concerns that we should be aware of:_____

13 YEARS AND OLDER

Does your child currently smoke or use the following tobacco products? ___ Cigarettes ___ Cigars ___ Pipe ___Chew ___ E-Cigarette ___ none

Has your child used tobacco products in the past? YES NO If yes, how long ago? _____

WHAT IS A SEALANT

One of the services that will be provided at the Child And Adolescent Health Center is the placement of sealants. A dental sealant is a white or clear material painted on the chewing surfaces of permanent molars. The sealant bonds to the tooth and forms a thin protective cover that keeps the bacteria and food out of the grooves of the teeth. This protects the teeth from tooth decay. Placing sealants on the permanent molars of children has been shown to be an effective way to reduce the risk of developing decay. Dental sealants, regular brushing and flossing, use of fluoride, and avoiding sugary foods and beverages are all important practices in protecting teeth from decay.

_____ _____

Health History Reviewed by: (Provider Signature) Date:

ABOUT FAMILY HEALTH CARE'S NOTICE OF PRIVACY PRACTICES

We are committed to protecting your personal health information in compliance with the law. Family Health Cares' Notice of Privacy Practices is posted in the lobbies of our clinics and is available on our website www.familyhealthcare.org.

BACK

BALDWIN FAMILY HEALTH CARE/GREAT LAKES FAMILY CARE
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT & SIGNATURE FORM

Patients Name (*Please Print*): _____ **Birthdate:**_____

The Notice of Privacy Practices describes how the Facility uses and discloses your health information and the circumstances under which we must seek your written permission to do so. The Notice of Privacy Practices also describes rights you have under federal regulations called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA requires us to provide you with the Facility's Notice of Privacy Practices, and to obtain your written acknowledgment for receiving it.

By signing this form, you are acknowledging that the Facility provided you with its Notice of Privacy Practices; by signing, you are not agreeing or disagreeing with its content. If you do disagree, the Notice of Privacy Practices provides information about how you may address your concerns. By signing below, I acknowledge receiving the Facility's Notice of Privacy Practices.

(X)_____ _____
Signature of Patient or Representative Date

_____
Representative's Relationship to Patient (if applicable)

****

For Office Use Only

If an acknowledgment is not obtained, document below provider's good faith efforts to obtain the acknowledgment and the reason why the acknowledgment was not obtained:

Individual's name: _____
Date of attempt to obtain Acknowledgment: _____
Reason Acknowledgment was not obtained: _____

****

_____ I hereby acknowledge that I have received a copy of BFHC/GLFC'S Mission Statement and Patient Rights and
Initial Responsibilities.

I hereby authorize BFHC/GLFC and the Provider assigned, as provided by law, to furnish medical/dental, office surgery or diagnostic treatment and any local anesthetic as he/she considers necessary and proper in the treatment of the patient for the purpose of correcting his/her physical condition.

_____ This authorization shall be valid until rescinded in writing or replaced by one of a later date
Initial

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Baldwin Family Health Care for any services rendered to me by them. I authorize any holder of medical/dental information about me to release to the Centers for Medicaid and Medicare Services (CMS) and/or the Insurance Carrier and their Agents any information needed to determine these benefits of the benefits payable for related services. I acknowledge full responsibility for the payment of services and agree to pay for them at the time service is rendered, unless other arrangements are made.

_____ Note: Your blood may be tested for HIV or Hepatitis if an employee is exposed to your body fluids. This is in compliance
Initial with Public Act #448.

****

BALDWIN FAMILY HEALTH CARE/GREAT LAKES FAMILY CARE DISCLOSURE REQUEST

May we disclose health information about you to family members and friends who are involved in your care or the payment thereof?

- ☐ **Yes, you can discuss my care with any of my family members or friends that inquire about me.**
- ☐ **No, you can only disclose information to me.**
- ☐ **Yes, but only to the following individual(s):**

_____ _____ _____ _____
Name Relationship to patient Name Relationship to patient

****

(X)_____ _____
Signature Relationship, if not patient

_____ _____
Witness Date

This institution is an equal opportunity provider and employer Form #**2005** 07-19-17

Baldwin Family Health Care is a Health Center Program grantee under 42 U.S.C. 254b, and a deemed Public Health Service Employee under 42 U.S.C. 233(g)-(n)

NOTICE OF PRIVACY PRACTICES

Baldwin Family Health Care
1615 Michigan Avenue
Baldwin, MI 49304

Family Health Care – Cadillac
520 Cobb Street
Cadillac, MI 49601

Family Health Care
Child & Adolescent Health Center
525 W. Fourth Street
Baldwin, MI 49304

Family Health Care – Grant
11 North Maple Street
Grant, MI 49327

Family Health Care – McBain
117 North Roland Street
McBain, MI 49657

Family Health Care
Child & Adolescent Health Center
96 East 120th Street
Grant, MI 49327

Family Health Care – White Cloud
1035 East Wilcox Street
White Cloud, MI 49349
White Cloud, MI 49349

Family Health Care
Child & Adolescent Health Center
555 East Wilcox Street
White Cloud, MI 49349

Effective Date: 9/23/2013

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

Family Health Care (FHC) is required by law to maintain the privacy of individually identifiable patient health information (this information is "protected health information" and is referred to herein as "PHI"). We are also required to provide patients with a Notice of Privacy Practices regarding PHI. We are required to post this Notice in a prominent place within our facility. We will only use or disclose your PHI as permitted or required by applicable state law. This Notice applies to your PHI in our possession including the medical records generated by us.

FHC understands that your health information is highly personal, and we are committed to safeguarding your privacy. Please read this Notice of Privacy Practices thoroughly. It describes how we will use and disclose your PHI.

This Notice applies to the delivery of health care by FHC.

Our Pledge:

We understand that health information about you and the health care you receive is personal. We are committed to protecting your personal health information. When you receive treatment and other health care services from us, we create a record of the services that you received. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of our records about your care, whether made by our health care professionals or others working in this office, and tells you about the ways in which we may use and disclose your personal health information. This notice also describes your rights with respect to the health information that we keep about you and the obligations that we have when we use and disclose your health information.

I. Permitted Use or Disclosure

A. Treatment: FHC will use and disclose your PHI in the provision and coordination of heath care to carry out treatment functions.

FHC will disclose all or any portion of your patient medical record information to your consulting physician(s), nurses, pharmacists, technicians, medical students and other health care providers who have a legitimate need for such information in your care and continued treatment.

Different departments will share medical information about you in order to coordinate specific services, such as lab work, x-rays and prescriptions.

FHC also will disclose your medical information to people or entities outside FHC who will be involved in your medical care after you leave FHC, such as other care providers who will provide services that are part of your care.

We will share certain information such as your name, address, employment, insurance carrier, emergency contact information and appointment scheduling information in an effort to coordinate your treatment with us and with other health care providers.

FHC will use and disclose your PHI to inform you of, or recommend possible treatment options or alternatives that will be of interest to you.

FHC will use and disclose PHI to contact you as a reminder that you have an appointment for medical care at FHC.

If you are an inmate of a correctional institution or under the custody of a law enforcement officer, FHC will disclose your PHI to the correctional institution or law enforcement official.

B. Payment: FHC will disclose PHI about you for the purposes of determining coverage, eligibility, funding, billing, claims management, medical data processing, stop loss / reinsurance and reimbursement.

- To persons involved in your care;
- For national security or intelligence purposes;
- To correctional institutions or law enforcement officials; or
- That occurred prior to April 14, 2003.

For each disclosure, you will receive the date of the disclosure, the name of the receiving organization and address if known, a brief description of the PHI disclosed and a brief statement of the purpose of the disclosure or a copy of the written request for the information, if there was one.

You must make your request for an accounting of disclosures of your PHI in writing to FHC. You must include the time period of the accounting, which may not be longer than 6 years. We will respond to your request within 60 days from its receipt. If we cannot, we will notify you in writing to explain the delay and the date by which we will act on your request. In any event we will act on your request within 90 days of its receipt.

In any given 12-month period, we will provide you with an accounting of the disclosures of your PHI at no charge. Any additional requests for an accounting within that time period will be subject to a reasonable fee for preparing the accounting.

D. Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your PHI:

- To carry out treatment, payment or health care operations functions; or
- Restricting specific information to only specified family members, relatives, close personal friends or other individuals involved in your care.

For example, you may ask that your name not be used in the waiting room or that information about your condition not be shared with your family. FHC will consider your request but is not required to agree to the requested restrictions.

E. Right to Confidential Communications: You have the right to receive confidential communications of your PHI by alternative means or at alternative locations. For example, you may request that we only contact you at work or by mail. We will make every attempt to honor your request, but we reserve the right to deny unreasonable requests.

F. Right to Receive a Copy of this Notice: You have the right to receive a paper copy of this Notice of Privacy Practices, upon request.

G. Right to Notice of a Breach: You will be notified of any breach of your PHI unless it is determined that there is a low probability of PHI compromise based on the analysis of the following four factors:

- The nature and extent of the PHI involved – issues to be considered include the sensitivity of the information from a financial or clinical perspective and the likelihood the information can be re-identified;
- The person who obtained the unauthorized access and whether that person has an independent obligation to protect the confidentiality of the information;
- Whether the PHI was actually acquired or accessed, determined after conducting a forensic analysis; and
- The extent to which the risk has been mitigated, such as by obtaining a signed confidentiality agreement from the recipient.

VI. Complaints

If you believe your privacy rights have been violated, you may file a complaint with Family Health Care or with the Secretary of the Department of Health and Human Services. To file a complaint with FHC, please contact FHC's Privacy Official at:

1615 Michigan Avenue
Baldwin, MI 49304
(231) 745-2743

All complaints must be submitted in writing directly to FHC; we assure you that there will be no retaliation for filing a complaint.

VII. Sharing and joint use of your Health Information

In the course of providing care to you and in furtherance of FHC's mission to improve the health of the community, FHC will share your PHI with other organizations as described below who have agreed to abide by the terms described below:

A. Business Associates: FHC will use and disclose your PHI to business associates contracted to perform business functions on its behalf. Whenever an arrangement between FHC and another company involves the use or disclosure of your PHI, that business associate will be required to keep your information confidential.

VIII. Additional Information

For further information regarding the subjects covered in this Notice of Privacy Practice, please contact FHC's Privacy Official at (231) 590-6164.

Changes to this Notice

FHC will abide by the terms of the Notice of Privacy Practices currently in effect. FHC reserves the right to change the terms of its Notice of Privacy Practices and to make the new Notice of Privacy Practices provisions effective for all PHI that it maintains. Revised notices will be prominently posted in all FHC locations and copies of the new agreement will be made available

RAPID ASSESSMENT FOR ADOLESCENT PREVENTIVE SERVICES

RAAPS

A PRODUCT OF POSSIBILITIES FOR CHANGE

Our Practice is now using RAAPS.

RAAPS is a risk assessment developed especially for use with pre-teens, teens and young adults. As our younger patients enter adolescence their healthcare needs change. For example, did you know the most serious teen health issues are a result of **preventable** risk behaviors?

According to the CDC, **3 out of 4 serious injuries and deaths in adolescents are caused by risky behaviors, not disease**. And most teens engage in some risky behavior – sometimes without realizing it.

Just as adults are screened for disease, teens should be screened for risky behaviors. The RAAPS survey helps us identify these risks early, in a format that youth are more comfortable using – technology!

And screening youth for risk behaviors helps us meet national recommendations from both the American Medical Association and the American Academy of Pediatrics.

Please ask us if you have any questions or want any additional information about our screening with RAAPS.

Adolescents are faced with lots of health risks – including:

- *Unsafe driving*
- *Poor nutrition and lack of physical activity*
- *Alcohol and drug use*
- *Bullying and physical abuse*
- *Dieting disorders (starving and/or binging)*
- *Sad feelings or struggling with anger*
- *Early or unprotected sexual experiences*