Le Bonheur On the Move: Mobile Medical Unit
Consent for Medical Examination and Care

Dear Parent/Guardian,
During the school year “Term” your child will have the opportunity to receive annual (or sports) physicals and medical care including sick visits provided by a Le Bonheur Children’s Hospital “Le Bonheur” provider right at your child’s school/community site. The care will be provided on Le Bonheur’s state of the art Mobile Medical Unit or at a designated site. There is no need for you to be present when your child is on the mobile unit, but we invite you to be present anytime your child is being seen.

In order for your child to participate in this program, you will need to sign this consent form and complete the information in this booklet. We will be scheduling children for annual (or sports) physicals starting with those that are uninsured or underinsured.

Children will be seen on the Mobile Medical Unit or designated site regardless of their ability to pay for services provided. Insurance will be filed when available. Please complete all of the information in this booklet to allow us to provide the best care for your child and to bill your insurance provider, if necessary.

Please read the following statements related to care provided on the mobile unit.

CONSENT TO EVALUATE AND PROVIDE TREATMENT FOR THE CONSENT YEAR AS IDENTIFIED ABOVE
I give permission for my child to receive a medical examination by a physician or nurse practitioner of Le Bonheur Mobile Medical Unit for the purpose of evaluation and/or treatment of medical conditions as well as routine health maintenance. All medical examinations are overseen by a board certified physician or nurse practitioner. I understand that I must give my consent on this form in order to receive medical evaluation and/or treatment. Medical evaluation includes obtaining test results from blood tests, urine tests, saliva tests, and/or other medical tests as required by the physician or nurse practitioner. According to the guidelines established by the American Academy of Pediatrics, all EPSDT/Wellness exams will be unclothed. A drape/gown will be provided and children will keep on their undergarments. The child’s privacy will be protected at all times and two healthcare professionals will be present during the unclothed exam for your child’s protection.

RELEASE OF INFORMATION AND CONSENT FOR FOLLOW-UP
I give permission for Le Bonheur Mobile Medical Unit clinical and case management staff to receive relevant information about my child’s health from a doctor’s office, clinic, school, or agency from which additional information may need to be gathered. I also authorize release of information about my child’s health to a doctor’s office, clinic, school, or agency to which he/she may be referred. I give permission for Le Bonheur Mobile Medical Unit clinical and case management staff to contact me by telephone or mail regarding the results of my child’s exam, possible care options, tips for improving my child’s health, specialist appointments, and/or other health related topics. I give permission for my child to be involved in case management activities (such as individual and group meetings) offered after the initial clinic visit. I authorize Le Bonheur Mobile Medical Unit to leave a message regarding appointment or test at my residence or cell phone. I authorize Le Bonheur Mobile Medical Unit to send appointment reminders or other reminders via text message or automated voice message. It is my responsibility to provide Le Bonheur the most up to date contact information. I authorize for my child to have a photo taken for the electronic medical record. I authorize Le Bonheur to electronically access my prescription history through RX Hub (a prescription database compiling all prescription history).

SHARING INFORMATION WITH PARENTS/GUARDIANS
Le Bonheur Mobile Medical Unit follows state regulations and American Academy of Pediatric guidelines regarding adolescent care, adolescent age of consent for medical care, and parent/guardian notification for medical treatment. Adolescent patients will be encouraged to maintain open communication with parents. However, Le Bonheur Mobile Medical Unit will disclose medical information according to Tennessee state law. Please contact Le Bonheur with any questions about age of consent or release of information.

DATA COLLECTION
I understand information about my child’s progress may be used by Le Bonheur for data collection and reporting purposes. I understand my child’s name will not be used without my permission. Le Bonheur, Methodist Le Bonheur Community Outreach, Le Bonheur Mobile Medical Unit, and their affiliates are hereby released from all legal liability that may arise from the release of the information or from the publication of data obtained.
NOTICE OF PRIVACY PROCEDURES (HIPPA)
I have received a copy of the “Notice of Privacy Procedures” for Le Bonheur, in compliance with HIPAA regulations.

NOTIFICATION OF GRIEVANCE PROCEDURE
I understand that if I believe either I or my child has been treated unfairly during the course of this screening because of my gender, race, color, national origin, religion, or disability, I have the right to file a complaint. Such complaints are to be addressed in writing to Le Bonheur, Director of Health Services, 1535 Vann Drive, Jackson, TN 38305. More information may be obtained by calling Le Bonheur at 731-984-9961.

CONSENT TO BILL THIRD PARTY PAYOR (INSURANCE)
I authorize UT Le Bonheur Pediatric Specialists, Inc., Le Bonheur Children’s Hospital, Methodist Le Bonheur Community Outreach, and or their affiliates, to release any information pertaining to treatment to enable the collection of insurance benefits for the services rendered. Release of information is also authorized to any providers of follow-up medical care.

I understand and agree that this consent is valid during the Term identified above unless I cancel it in writing. To the best of my knowledge the information provided is complete and correct. I understand it is my responsibility to inform Le Bonheur and its staff if I or my child/ward, has a change in health, insurance coverage or contact information,

For more information, please contact Le Bonheur Mobile Health at:
731-984-9954 (Direct Line)

_____________________________   __________________
Signature of Parent/Guardian   Date

PARENT/GUARDIAN INFORMATION

Name: ________________________   DOB: ________________   SS#: ______________________

Last  First  MI

Parents/Guardian Email:  ________________________

Relationship to Patient: ________________________  Phone Number for Parent/Guardian: ________________________

Questions About Your Child’s Health Care Provider

Has your child visited the doctor or health care provider because he/she was sick in the last 12 months? □ Yes  □ No  □ I don’t know.

Reason: ________________________

Who is your child’s doctor or health care provider? ________________________  Phone: ________________________

Who is your preferred pharmacy? ________________________  Phone: ________________________
Insurance Information

Primary Insurance Information:

☐ Private Insurance (Other: ____________________________)
☐ BlueCare (TennCare)
☐ United Community Health Plan (TennCare)
☐ Amerigroup (TennCare)
☐ CoverKids (TennCare)
☐ My child is uninsured.

Member ID Number: ____________________________ Group ID Number: ____________________________

Policy Holder Name: ____________________________

Policy Holder DOB: ____________________________ Policy Holder SS#: ____________________________

Secondary Insurance Information:

☐ Private Insurance (Other: ____________________________)
☐ BlueCare (TennCare)
☐ United Community Health Plan
☐ Amerigroup (TennCare)
☐ CoverKids
☐ My child is uninsured.

Member ID Number: ____________________________ Group ID Number: ____________________________

Policy Holder Name: ____________________________

Policy Holder DOB: ____________________________ Policy Holder SS#: ____________________________
Health Questions

Child’s Name: ______________________ Age: _______ Sex: M F

School: __________________________ Phone Number for Parent/Guardian: __________________________

Child’s Date of Birth: ______________________ Child’s Social Security Number: __________________________

No. Day Year

Address of Child: __________________________ __________________________ __________________________ __________________________

Street Addr. P.O. Box City State Zip

Child’s Race/Ethnicity: □ Black □ Hispanic □ White □ Other: __________________________

□ English □ Spanish □ Other: __________________________

Primary Language Spoken at Home:

Child’s Medical History (please mark any of the following medical conditions that apply to your child)

□ ADHD/ADD □ Congenital Heart Disease □ Diabetes □ Asthma □ Kidney Disease □ Elevated Blood Pressure

□ Other Medical Conditions: __________________________ □ No Known Health Problems

Has your child ever required hospitalization? □ Yes □ No Reason: __________________________ Date ________

Has your child had any surgical procedures? □ Yes □ No Reason: __________________________ Date ________

Please list all medications the child is currently taking. □ No Medications

Include all prescription and nonprescription medication.

1. __________________________

2. __________________________

3. __________________________

4. __________________________

5. __________________________

Please list any allergies your child has. □ No Allergies

1. __________________________

2. __________________________

3. __________________________

4. __________________________

5. __________________________

Is your child current on all immunizations and vaccinations? □ Yes □ No □ I don’t know.

Is your child having any problems, or are you having any concerns?

Family Medical History (Please mark any of the following medical conditions that members of your child’s family have.)

Child’s Mother: □ Living □ deceased □ No Known Health Problems

□ High Cholesterol □ High Blood Pressure □ Heart Disease □ Diabetes □ Stroke

□ Mental Illness □ Cancer □ Heart Attack (Under the Age of 55) □ Other Medical Conditions:

Does the mother take cholesterol medication? □ Yes □ No

Child’s Father: □ Living □ deceased □ No Known Health Problems

□ High Cholesterol □ High Blood Pressure □ Heart Disease □ Diabetes □ Stroke

□ Mental Illness □ Cancer □ Heart Attack (Under the Age of 55) □ Other Medical Conditions:

Does the father take cholesterol medication? □ Yes □ No

Child’s Grandparent: □ High Cholesterol □ High Blood Pressure □ Heart Disease □ Diabetes □ Stroke

□ Mental Illness □ Cancer □ Heart Attack (Under the Age of 55) □ Other Medical Conditions:
Ages and Stages Questionnaire
Overall Developmental Screening

Ages: Birth – 5 Years

Child’s Name: ____________________________  Child’s School: ____________________________

Please answer the following questions and explain any details that you feel are important.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>If no, explain:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you think your child hears well?</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□</td>
<td></td>
<td>If no, explain:</td>
</tr>
<tr>
<td>2. Do you think your child talks like other children her age?</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□</td>
<td></td>
<td>If no, explain:</td>
</tr>
<tr>
<td>3. Can you understand most of what your child says?</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□</td>
<td></td>
<td>If no, explain:</td>
</tr>
<tr>
<td>4. Do you think your child walks, runs, and climbs like other children his age?</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□</td>
<td></td>
<td>If no, explain:</td>
</tr>
<tr>
<td>5. Does either parent have a family history of childhood deafness or hearing impairment?</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□</td>
<td></td>
<td>If yes, explain:</td>
</tr>
<tr>
<td>6. Do you have any concerns about your child’s vision?</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□</td>
<td></td>
<td>If yes, explain:</td>
</tr>
<tr>
<td>7. Has your child had any medical problems in the last several months?</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□</td>
<td></td>
<td>If yes, explain:</td>
</tr>
<tr>
<td>8. Does anything about your child worry you?</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□</td>
<td></td>
<td>If yes, explain:</td>
</tr>
</tbody>
</table>
Pediatric Symptom Questionnaire
Checklist 17 (PSC-17)

Child's Name:_________________________  Child's School:__________________

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions.

**Please mark under the heading that best describes your child:**

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Fidgety, unable to sit still.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Feels sad, unhappy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Daydreams too much</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Refuses to share</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Does not understand other people's feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Feels hopeless</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Has trouble concentrating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Fights with other children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Is down on him or herself</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Blames others for his or her troubles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Seems to be having less fun</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Does not listen to rules</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Acts as if driven by a motor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Teases others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Worries a lot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Takes things that do not belong to him or her</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Distracted easily</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any concerns regarding your child's behavior, emotions, or learning?________________________

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**OFFICE USE ONLY**

Total (*) _____  Total (●) _____  Total (☐) _____  * + ● + ☐ = _____
If your child has asthma, please complete the following section:

**Questionnaire for Patients with Asthma**

Child’s Name: ___________________________  Child’s School: ___________________________

*Please answer the following questions about your child’s asthma symptoms:*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your child been diagnosed with asthma by a nurse practitioner or doctor? If Yes, when:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Has your child been having asthma symptoms this week?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Does anyone smoke inside your home?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do you think your child uses tobacco products?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Does your child have any exercise or activity limitations due to asthma?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Has your child been prescribed an asthma controller medication? (ex. Pulmicort, Singular, Flovent, etc.)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Is your child using the asthma controller medication? If not, why? (ex. Pulmicort, Singular, Flovent, etc.)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How many times per week did your child use a <strong>rescue medication</strong> in the past 4 weeks? (ex. Albuterol, inhaler, etc.)</td>
<td>☐ ≤ 2 days/week</td>
<td>☐ ≥ 2 days/week</td>
</tr>
<tr>
<td>How often did the patient have <strong>daytime</strong> asthma symptoms for the past 4 weeks?</td>
<td>☐ 0 nights/month</td>
<td>☐ 1-2 nights/month</td>
</tr>
<tr>
<td>How often did the patient <strong>awake at night</strong> with asthma symptoms this past 4 weeks?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>How many times in the past 12 months has the patient had to take oral steroids?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Has your child seen a provider for asthma symptoms during the past 12 months?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td># of Visits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child visited the emergency room for asthma symptoms during the past 12 months?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td># of Visits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child missed school for asthma symptoms during the past 12 months?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td># of Days:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child been admitted to the hospital for asthma symptoms during the past 12 months?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td># of Times:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Risk Assessment Information

### Lead Screening

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever been told your child has an elevated blood lead level?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child live in or regularly visit a house/school/child care facility built before 1978 that has recently been renovated?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child live in or regularly visit a house/school/child care facility built before 1950?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever seen your child eating paint chips or other non-food substances such as paper?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Tuberculosis Screening

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was your child born in a country that is at high risk for tuberculosis (other than the US)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child traveled outside the USA? If so, Where?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child been around someone who has been in jail or a shelter?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child been exposed to anyone with TB or a positive TB skin test?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is your child infected with HIV?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Tobacco Use Screening

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is your child exposed to second-hand tobacco smoke?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Dental Screening

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the Parent/Guardian of child have dental decay or gum disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the Parent/Guardian of child see a dentist regularly?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Hunger/Anemia

<table>
<thead>
<tr>
<th>Question</th>
<th>Often</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the past 12 months, we worried whether our food would run out before we got money to buy more.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within the past 12 months, the food we bought just did not last and we did not have money to get more.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child’s diet include iron-rich foods such as meat, eggs, iron-fortified cereals and beans?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Childhood Asthma Control Test for children 4 to 11 years

Know your score.

Parent or Guardian: The Childhood Asthma Control Test® is a way to help your child’s healthcare provider determine if your child’s asthma symptoms are well controlled. Take this test with your child (ages 4 to 11). Share the results with your child’s healthcare provider.

Step 1: Have your child answer the first four questions (1 to 4). If your child needs help, you may help, but let your child choose the answer.

Step 2: Answer the last three questions (5 to 7) on your own. Don’t let your child’s answers influence yours. There are no right or wrong answers.

Step 3: Write the number of each answer in the score box to the right.

Step 4: Add up each score box for the total.

Step 5: Take the COMPLETED test to your child’s healthcare provider to talk about your child’s total score.

Have your child complete these questions.

1. How is your asthma today?

- 0 Very bad
- 1 Bad
- 2 Good
- 3 Very good

2. How much of a problem is your asthma when you run, exercise or play sports?

- 0 It’s a big problem, I can’t do what I want to do.
- 1 It’s a problem and I don’t like it.
- 2 It’s a little problem but it’s okay.
- 3 It’s not a problem.

3. Do you cough because of your asthma?

- 0 Yes, all of the time.
- 1 Yes, most of the time.
- 2 Yes, some of the time.
- 3 No, none of the time.

4. Do you wake up during the night because of your asthma?

- 0 Yes, all of the time.
- 1 Yes, most of the time.
- 2 Yes, some of the time.
- 3 No, none of the time.

Please complete the following questions on your own.

5. During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

- 0 Not at all
- 1-3 days
- 4-10 days
- 11-18 days
- 19-24 days
- Everyday

6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

- 0 Not at all
- 1-3 days
- 4-10 days
- 11-18 days
- 19-24 days
- Everyday

7. During the last 4 weeks, how many days did your child wake up during the night because of the asthma?

- 0 Not at all
- 1-3 days
- 4-10 days
- 11-18 days
- 19-24 days
- Everyday

*The Childhood Asthma Control Test was developed by GSK.

© 2017 GSK group of companies. All rights reserved. Produced in USA 816205R0 January 2017
Take this test if you are 12 years or older.
Share the score with your healthcare provider.

Name: ___________________  Today's Date: _____________

ASTHMA CONTROL TEST™

Know your score.
The Asthma Control Test™ provides a numerical score to help you and your healthcare provider determine if your asthma symptoms are well controlled.

Step 1: Write the number of each answer in the score box provided.
Step 2: Add up each score box for the total.
Step 3: Take the completed test to your healthcare provider to talk about your score.

IF YOUR SCORE IS 19 OR LESS, Your asthma symptoms may not be as well controlled as they could be. No matter what the score, bring this test to your healthcare provider to talk about the results.
NOTE: If your score is 15 or less, your asthma may be very poorly controlled. Please contact your healthcare provider right away. There may be more you and your healthcare provider could do to help control your asthma symptoms.

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home?  
   - All of the time [1]  
   - Most of the time [2]  
   - Some of the time [3]  
   - A little of the time [4]  
   - None of the time [5]  
   SCORE

2. During the past 4 weeks, how often have you had shortness of breath?  
   - More than once a day [1]  
   - Once a day [2]  
   - A week [3]  
   - Twice a week [4]  
   - Not at all [5]  
   SCORE

3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?  
   - 4 or more nights a week [1]  
   - 2 to 3 nights a week [2]  
   - Once a week [3]  
   - Once or twice a week [4]  
   - Not at all [5]  
   SCORE

4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?  
   - 3 or more times per day [1]  
   - 1 to 2 times per day [2]  
   - 2 or 3 times per week [3]  
   - Once a week or less [4]  
   - Not at all [5]  
   SCORE

5. How would you rate your asthma control during the past 4 weeks?  
   - Not Controlled at All [1]  
   - Poorly Controlled [2]  
   - Somewhat Controlled [3]  
   - Well Controlled [4]  
   - Completely Controlled [5]  
   TOTAL: 

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Asthma Control Test is a trademark of QualityMetric Incorporated.

This material was developed by GSK.
Do not return this document to Le Bonheur. This is for your records.

Effective Date: April 1, 2008

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

WHO WILL FOLLOW THIS NOTICE:

This notice describes Le Bonheur Community Health and Well-Being practices and that of:

- Any health care professional authorized to enter information into your medical record.
- Any clinical student or physician training on the medical unit
- Any member of a volunteer group we allow to help you while you are in our care.
- All employees, staff and other personnel.
- Le Bonheur Community Health and Well-Being and its medical staff members are considered an organized health care arrangement and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Your healthcare provider may have different policies or notices regarding their use and disclosure of medical information related to you, which is created in their offices or clinics.
- Le Bonheur Community Health and Well-Being and each of its medical staff members are distinct and separate legal entities. The issuance of this joint notice is for convenience purposes only and is not a representation that such parties assume any liabilities and/or responsibilities of each other regarding your medical care.

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 from Le Bonheur Community Health and Well-Being. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records related to your care generated by Le Bonheur Community Health and Well-Being, whether made by health care professionals or other personnel.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:
- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD:

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or others who are involved in your care. For example, we may disclose medical information about you to pharmacy to fill a prescription or to a lab to order a blood test. We also may disclose medical information about you to people outside the Mobile Unit who may be involved in your medical care after you leave the unit, such as long-term care facilities or others we use to provide services that are part of your care.

- **For Payment.** We may use and disclose medical information about you, so that the treatment and services you receive at the mobile unit may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received on the unit so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about the medical treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
For Health Care Operations, We may use and disclose medical information about you for the mobile unit’s operations. These uses and disclosures are necessary to run the Mobile unit and make sure that all of 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 or we or our designee may send you a patient satisfaction survey. We may also combine medical information about many mobile unit patients to decide what additional services the mobile unit should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other mobile unit personnel for review and learning purposes. We may also combine the medical information we have with medical information from other mobile units 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 to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders, We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the mobile unit.

Treatment Alternatives, We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you. We may communicate to you via newsletters, mail outs or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facilities participate.

Health-Related Benefits and Services, We may use and disclose medical information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care, We may release medical information about you to a caregiver who may be a friend or family member. We may also give information to a family member or friend who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. You may choose to object to any such disclosures by notifying mobile unit staff.

As Required By Law, We will disclose medical information about you when required to do so by federal, state or local law.

SPECIFIC SITUATIONS:

Organ and Tissue Donation, If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military, If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Work-Related Illness and Injuries, We may release medical information about you to your employer and others for purposes related to occupational health and safety programs and/or worker’s compensation matters.

Public Health Risks (Health and Safety to you and/or others), We may disclose medical information about you for public health activities. We may use and disclose medical information about you to agencies when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. These activities generally include, but are not limited to, the following situations:

• to prevent or control disease, injury or disability;
• to report births and deaths;
• to report child abuse or neglect;
• to report reactions to medications or problems with products;
• to notify people of recalls of products they may be using;
• to notify a person who may have been exposed to a disease or may be at risk for contacting or spreading a disease or condition;
• to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when required or authorized by law.

Health Oversight Activities, We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights law.

Lawsuits and Disputes, If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

Law Enforcement, We may release medical information if asked to do so by a law enforcement official:

• In response to a court order, subpoena, warrant, summons or similar process;
• To identify or locate a suspect, fugitive, material witness, or missing person; about a death we believe may be the result of criminal conduct; and
• In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

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

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

For Quality Assessment and Improvement Activities. We may disclose medical information about you, along with information concerning other patients, as part of our participation in other organized health care arrangements. For example, local hospitals and other types of health care providers may comprise an organized health care arrangement for the purpose of assessing and improving the quality of healthcare rendered in the community.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, contact the unit’s Administrative Director. If you request a copy of the information, we will charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the mobile unit will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the mobile unit. To request an amendment, your request must be made in writing and submitted to the unit’s Administrative Director. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the mobile unit;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is not part accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you to others except for purposes of treatment, payment and operations identified above. To request this list or accounting of disclosures, you must submit your request in writing to the unit’s Administrative Director. Your request must state a time period which may not be longer than six years and may not include dates before April 1, 2008. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the unit’s Administrative Director. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain on the first page,
the effective date thereof. In addition, if you present to Le Bonheur Community Health and Well-Being for health care services following a change or revision to this notice, we will offer you a copy of the current notice in effect.

COMPLAINTS:

If you have questions regarding this Notice or believe your privacy rights have been violated, you may contact or submit your complaint in writing to the center's Administrative Director. If we cannot resolve your concern, you also have the right to file a written complaint with the Secretary of the Department of Health and Human Services. The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.

I understand that if I believe I have been treated unfairly during the course of treatment because of my gender, race, color, national origin, religion, or disability, I have the right to file a complaint. Such complaints are to be addressed in writing to Le Bonheur Community Health, Director of Community Health, 77 Stonebridge Boulevard, Jackson, TN 38305. More information may be obtained by calling Le Bonheur Community Health at 1-866-466-1544.

OTHER USES OF MEDICAL INFORMATION:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission. We will then no longer use or disclose medical information about you for the reasons covered by your written authorization. By this document, you are notified that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.