HEALS MEDICAL / DENTAL / OPTOMETRY ENROLLMENT FORM

Thank you for choosing HEALS, Inc. as the health care provider for your child

Please complete all pages in this packet to register your child with HEALS. If not completed in its entirety, we will NOT be able to see your child.

PLEASE PRINT.

Child's Name: _____
First *Middle* *Last*

Gender: ☐M ☐F Date of Birth: __ __ / __ __ / __ __ __ __ SSN: __ __ __ - __ __ - __ __ __ __

Race/Ethnicity (optional): ☐African-American ☐Caucasian ☐Hispanic ☐Native American ☐Asian

Address: _____

City: _____ State: _____ Zip: __ __ __ __ __

Home phone: _____ School: _____

Parent/Legal Guardian's Name(s): _____

Cell Phone: _____ Work Phone: _____

Email: _____ Patient Contact Phone: _____

Siblings (names and ages):

Name	Age	Name	Age

My child has Medicaid: ☐Yes ☐No Medicaid number: __ __ __ __ __ __ __ __ __ __ __ __ __ __

My child has other insurance: _____
(Company Name, i.e., BCBS, All Kids)

Insurance number: _____ Group number: _____

Insured person's name: _____ Relationship to child: _____

Insured's date of birth: _____ Is dental care included? ☐Yes ☐No

If NO to any of the above, why is your child not enrolled in either MEDICIAID or ALLKIDS?

Not Eligible ☐

Have not Applied ☐

Other Reason: _____

HEALS Patient Portal

Get secure and easy access to your medical records and the HEALS professional staff.

Through the Patient Portal you can:

- View your lab results.
- Send messages to the HEALS staff.
- View your medical information such as medication lists, problem list, allergies and immunization records.
- Receive appointment reminders and confirm appointments.

To Get Started: Ask for your login information at your next office visit.

Initial only ONE for MEDICAL SERVICES:

_____My child **may receive medical services** at any HEALS Medical Clinic **without me being present**. I authorize HEALS medical staff to perform health, dental, and vision screenings as well as supply my child with patient education concerning health, dental and vision related concerns. HEALS staff may see my child and will send a note home or will call to let me know about the visit. HEALS Professional staff may administer medications to my child, if necessary.
*****If you checked this option PLEASE COMPLETE THE ENTIRE FORM*****

_____My children **may receive medical services** at any HEALS Medical Clinic **only if I am present**. I understand that if my child is hurt or sick, HEALS clinic staff will not see my child and that the school office will call me at home or at work.
*****If you checked this option, PLEASE COMPLETE THE ENTIRE FORM*****

_____My child **may NOT receive medical services** at any HEALS Medical Clinic. If you would like dental and/or optometry services (see below), please complete the entire form. If you do not want medical, dental or optometry services, you can stop completing this form.

Initial only ONE for DENTAL SERVICES:

_____My child **may receive dental services** at any HEALS Dental Clinic **without me being present**. I authorize HEALS dental staff to perform dental screenings as well as supply my child with patient education concerning dental related concerns. HEALS staff may see my child and will send a note home or will call to let me know about the visit. HEALS Professional staff may administer medications to my child, if necessary.
*****If you checked this option PLEASE COMPLETE THE ENTIRE FORM*****

_____My children **may receive dental services** at any HEALS Dental Clinic **only if I am present**. I understand that if my child is hurt or sick, HEALS clinic staff will not see my child and that the school office will call me at home or at work.
*****If you checked this option, PLEASE COMPLETE THE ENTIRE FORM*****

_____My child **may NOT receive dental services** at any HEALS Dental Clinic. If you would like medical or optometry services (see above/below), please complete the entire form. If you do not want dental, medical or optometry services, you can stop completing this form.

Initial only ONE for OPTOMETRY SERVICES:

_____My child **may receive optometry services** at any HEALS Optometry Clinic **without me being present**. I authorize HEALS optometry staff to perform optometry screenings as well as supply my child with patient education concerning optometry related concerns. HEALS staff may see my child and will send a note home or will call to let me know about the visit. HEALS Professional staff may administer medications to my child, if necessary.
*****If you checked this option PLEASE COMPLETE THE ENTIRE FORM*****

_____My children **may receive optometry services** at any HEALS Optometry Clinic **only if I am present**. I understand that if my child is hurt or sick, HEALS clinic staff will not see my child and that the school office will call me at home or at work.
*****If you checked this option, PLEASE COMPLETE THE ENTIRE FORM*****

_____My child **may NOT receive optometry services** at any HEALS Optometry Clinic. If you would like medical or dental services (see above), please complete the entire form. If you do not want medical, dental or optometry services, you can stop completing this form.

If my child is sick or hurt and receives healthcare at a HEALS Clinic, **I give permission for HEALS to share detailed health information with the following persons**. They may also receive information about appointments, treatments and/or other information about healthcare provided to my child at HEALS.

Name	Relation to Child	Phone Number	Leave Message Y/N)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How would you like to be contacted regarding appointments, treatment and/or other information concerning your child's healthcare at HEALS? Please check all that apply.

☐Home Phone ☐Work Phone ☐Cell Phone ☐Note sent home ☐Patient Portal (ask HEALS staff for login info)

☐Text ☐Email

Voicemail opt out: if you prefer that we do not leave a voicemail at the number(s) you have given us, **initial here**:_____

I understand that all information in my child's health record is confidential. I give my consent for HEALS clinic staff to speak with appropriate school personnel concerning my child's school and health records, attendance, academic performance, and other information affecting his/her learning and/or behavior.

_____ **Initial here that you understand**.

I authorize the HEALS clinics to release information regarding treatment to doctors, dentists, and third party payers (insurance companies) for the purpose of obtaining authorization for services, for billing and for any reason in accordance with acceptable medical practice pursuant to the law. I authorize payment to be made directly to the provider of services.

_____ **Initial here that you understand**.

HEALS No-Show Policy: I understand that if I fail to bring my child for two (2) appointments, the Medicaid social worker will be notified. If I have three (3) no-shows, my child will be dismissed from HEALS for the remainder of the school year.

_____ **Initial here that you understand**.

HEALS No-Show for Multiple Children Policy: I understand that if I fail to bring my multiple children for their same-day appointment, I will not be able to schedule their next appointments to occur on the same day. The above no-show policy also applies.

_____ **Initial here that you understand.**

HEALS Late Arrival Policy: If I arrive 10 minutes or more late for my scheduled appointment, HEALS has the right to reschedule my child's appointment.

_____ **Initial here that you understand**.

SIGN HERE:_____

Relationship to child:_____ Date:_____

MEDICAL HISTORY
Please print

Child's Name:_____ Date of Birth:_____
First *Middle Initial* *Last*

Primary Care Doctor or Nurse Practitioner (assigned by insurance or the doctor your child sees when sick):

Name:_____ Phone:_____

Name of child's dentist:_____ Dentist's Phone_____

Does your child have allergies (bee stings, foods, medicines, etc.)? ☐Yes ☐No
If yes, please list:

Allergy	1st Onset	Reactiong(Itching, Swelling, Hives, Anaphylactic, etc)

Is your child taking any daily medications? ☐Yes ☐No
If yes, please list:

Name	Dosage	Route Taken(Orally, Injected, Etc)	Frequency

Has your child ever had any of the following illnesses or conditions? If 'yes,' please give dates.

		Date				Date	
Tuberculosis	☐Yes	_____	☐No	Asthma	☐Yes	_____	☐No
Pneumonia	☐Yes	_____	☐No	Frequent ear infections	☐Yes	_____	☐No
Diabetes	☐Yes	_____	☐No	Hypoglycemia	☐Yes	_____	☐No
Seizure	☐Yes	_____	☐No	Hepatitis	☐Yes	_____	☐No
Epilepsy	☐Yes	_____	☐No	Heart problems	☐Yes	_____	☐No
Anemia (low iron)	☐Yes	_____	☐No	Sickle cell disease	☐Yes	_____	☐No
Kidney problems	☐Yes	_____	☐No	Frequent bed wetting	☐Yes	_____	☐No
Frequent diarrhea	☐Yes	_____	☐No	Frequent constipation	☐Yes	_____	☐No
Skin problems	☐Yes	_____	☐No	Frequent urine infection	☐Yes	_____	☐No
Hearing problems	☐Yes	_____	☐No	Frequent headaches	☐Yes	_____	☐No
Attention deficit problems	☐Yes	_____	☐No	Vision problem	☐Yes	_____	☐No
HIV positive	☐Yes	_____	☐No	Eye glasses/contacts	☐Yes	_____	☐No

Was your child born prematurely? ☐Yes ☐No
Please explain:

Has your child ever been in the hospital overnight or longer: ☐Yes ☐No
Please explain:

Has your child ever had surgery? ☐Yes ☐No
Please explain:

Do you have any concerns about your child's physical health? ☐Yes ☐No
Please explain:

Do you have any concerns about your child's emotional health? ☐Yes ☐No
Please explain:

SIGN HERE: _____

Relationship to child: _____ Date: _____

HEALS IMMUNIZATION SCHEDULE

It is the policy of all HEALS physicians that your child/children receive all immunizations required by our public school systems, the Centers for Disease Control and Prevention, and the American Academy of Pediatrics. It is our policy that all of HEALS patients keep all scheduled well child checkup appointments yearly until eighteen years old.

Newborn	Newborn Screen
2 months	Dtap, IPV, Hepatitis B, HIB, Pneumococcal 13, Rotavirus*
4 months	Dtap, IPV, Hepatitis B, HIB, Pneumococcal 13, Rotavirus*
6 months	Dtap, IPV, Hepatitis B, HIB, Pneumococcal 13, Rotavirus*
12 months	MMR. Varicella, Pneumococcal 13, Hepatitis A,
15 months	Dtap, HIB
18 months	Hepatitis A*
4 year	Dtap, MMR, Varicella, IPV
11 year & up	HPV*, Tdap, Meningococcal*

The following immunizations are not required but are recommended by the physicians at HEALS Pediatrics:

*Rotavirus
*Hepatitis A
*Meningococcal
*HPV

If you miss three consecutively scheduled well-child checkup appointments or excessively abuse scheduled appointments, your child/children will be considered for dismissal from HEALS.

I acknowledge receipt of the immunization policy of HEALS Pediatrics, and by registering my child as patient of HEALS and signing below, I grant permission and otherwise agree that my child/children is/are to receive all required vaccinations or immunizations reference above.

_____ _____

Parent/Guardian Signature Date Signed

HEALS LIABILITY WAIVER

HEALS, INC. AND THE MEDICAL PROFESSIONALS IN THIS FACILITY ARE NOT LIABLE FOR DAMAGES RESULTING FROM THE PROVISION OF MEDICAL OR DENTAL CARE, EXCEPT IN THE CASE OF MISCONDUCT.

HEALS, Inc. provides medical treatment, dental treatment, optometry treatment, diagnosis, advice, or nursing services as a part of the services of an established free medical clinic. As a free medical clinic, HEALS, Inc. and the medical, dental and optometry professionals who provide care at this facility shall not be liable for civil damages as a result of his or her acts or omissions in providing medical treatment, dental treatment, optometry treatment, diagnosis, advice, or nursing services, unless the act or omission was the result of the licensed healthcare provider's willful or wanton misconduct.

The immunity from civil liability also applies to medical professionals who provide, without fee or compensation, further medical treatment, diagnosis, advice, or nursing services to a patient upon referral from this facility.

Acceptance by this facility of a contribution made by a person receiving services at this facility will not constitute a waiver of immunity.

In any suit against HEALS, Inc. for civil damages based upon the negligent act or omission of a volunteer medical professional, proof of such act or omission shall not be sufficient to establish the responsibility of HEALS, Inc. under the doctrine of "respondent superior," notwithstanding the immunity granted to the volunteer medical professional with respect to any act or omission included under Ala. Code (1975) §6-5-663(a), unless such act or omission is found to be willful or wanton.

Ala. Code (1975) §6-5-663.

Child/Children: _____ _____

_____ _____

_____ _____

Parent/Guardian Printed Name:_____

Parent/Guardian Signature:_____

Date:_____

I have read and understand the *Notice of Privacy Practices* below.

SIGN HERE: _____

Relationship to child: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION.

PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on November 1, 2013 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by the HEALS Administration Office. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable

inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)

We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. There will not be a fee for copies, if requested. If you want the copies mailed to you, postage will be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US:

Practice Name: HEALS, Inc.

Privacy Officer: Executive Director

Telephone: 256-428-7560

Fax: 256-428-7561

Address: 515 Sparkman Drive Huntsville, AL 35816