MEDICAL DENTAL OPTOMETRY
ENROLLMENT FORM

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

Health Establishments At Local Schools

Part of the Solution

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.

Demographics

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

Gender/Sexo: O M O F Date of Birth:__ __ / __ __ / __ __ __ __ SSN:__ __ __ - __ __ - __ __ __ __

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

Address:_____

City/Ciudad:_____ State/Estado:_____ Zip Code/Código Postal:__ __ __ __ __

Home phone/ teléfono de casa _____ School/Escuela:_____

Parent/Legal Guardian's Name(s)_____

Parent/Guardian's Date of Birth: _____

Cell Phone/Celular _____ O Prefered Work Phone/teléfono del trabajo _____

Email/Correo electrónico_____Other phone we may contact:_____

Siblings (names and ages)/Nombre de los hermanos (con edades):

Name	Age	Name	Age

Responsible Party

Name of the responsible party (Parent/Guardian)_____

Social Security #: _____ DOB: _____ Gender: O Male O Female

Employment Status: O Employed. O Self-Employed O Unemployed O Retired O Student

Employer's Name: _____ Hire Date: __/___/_____ Telephone: _____

Address: _____ Job Position: _____

My child is uninsured / Mi Hijo no tiene seguro: O Yes/Sí O No (If your child is uninsured please fill out the Financial application)

My child has Medicaid / Mi Hijo tiene Medicaid: O Yes/Sí O No

Medicaid number/Número de Medicaid: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

My child has other insurance/Mi hijo tiene otro seguro:_____

(Company Name, i.e., BCBS, All Kids, United)/ (Compañía, por ejemplo, BCBS, All Kids, United)

Insurance number/Número de Seguro:_____ Group number/Grupo:_____

Insured person's name/Nombre del asegurado:_____

Relationship to child/ Relación con el niño (a):_____

Insured's date of birth/Fecha de nacimiento del asegurado:_____

Is dental care included?/¿Tiene seguro dental incluido? O Yes/Sí O No

Initial only <u>ONE</u> for <u>MEDICAL SERVICES</u>:

_____My child **may receive medical services** at any HEALS Medical Clinic **<u>without me being present</u>**. 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 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 **<u>only if I am present</u>**. 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 <u>NOT</u> 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 <u>ONE</u> for <u>DENTAL SERVICES</u>:

_____My child **may receive dental services** at any HEALS Dental Clinic **<u>without me being present</u>**. 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 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 **<u>only if I am present</u>**. 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 <u>NOT</u> 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 <u>ONE</u> for <u>OPTOMETRY SERVICES</u>:

_____My child **may receive optometry services** at any HEALS Optometry Clinic **<u>without me being present</u>**. 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 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 **<u>only if I am present</u>**. 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 <u>NOT</u> 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.

<u>Name/Nombre</u>	<u>Relation to Child</u> <u>Relación con el menor</u>	<u>Phone Number</u> <u>Teléfono</u>	<u>Leave Message (Y/N)</u> <u>Podemos dejar mensaje (Si/No)</u>
_____	_____	_____	_____
_____	_____	_____	_____

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. / ¿Cómo le gustaría que nos comuniquemos en cuetión de las citas, tratamiento, o alguna otra información respecto al cuidado de salud de su hijo (a) con HEALS, seleccione todas las que usted desee.

☐ Home Phone Teléfono de casa ☐ Work Phone Trabajo ☐ Cell Phone Celular ☐ Note sent home Eviar nota a casa ☐ Patient Portal (ask HEALS staff for login info) Portal electrónico de HEALS

☐ Text Texto ☐ Email Correo electrónico

Voicemail opt-out: If you prefer that we do not leave a voicemail at the number(s) you have given us.
Opción para no dejar mensaje de voz: Si usted prefiere que no dejemos mensaje de voz, ponga sus iniciales
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:_____

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 lists, allergies, and immunization records.
- Receive appointment reminders and confirm appointments.

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

MEDICAL HISTORY/ HISTORIA MÉDICA

Please print
Por favor llene el formulario con letra legible

Health Establishments At Local Schools
Part of the Solution

Child's Name/Nombre de su hijo:_____
First *Middle Initial* *Last*

Date of Birth/Fecha de Nacimiento:_____*(MM/DD/YYYY)*
Primary Care Doctor or Nurse Practitioner (assigned by insurance or the doctor your child sees when sick)/Médico o Enfermera que visita cuando su hijo está enfermo:

Name/ Nombre:_____ Phone/Teléfono:_____

Name of child's dentist/Dentista:_____ Dentist's Phone/ Teléfono_____

Does your child have allergies (bee stings, foods, medicines, etc.)? ¿Su Hijo tiene alergias? OYes/Sí ONo

If yes, please list/Si respondió SÍ, por favor, mencione las alergias:

Allergy/ Alergia	**1st Onset** 1era Aparición	**Reactiong (Itching, Swelling, Hives, Anaphylactic, etc)/**Tipo de Reacción

Is your child taking any daily medications? ¿Su Hijo toma algún medicamento diariamente? ☐ Yes / Si ☐ No

If yes, please list:

Name/ Nombre	**Dosage/** Dosis	**Route Taken(Orally, Injected, Etc)/** Ruta (oral, inyectada, etc)	**Frequency/** Frecuencia

Is your child allergic to any of the following? ¿Es su hijo alérgico a alguno de estos?:

☐ Aspirin Aspirina ☐ Penicillin Penicilina ☐ Codeine Codeína ☐ Local Anesthetics Anestésicos Locales ☐ Acrylic Acrílicos ☐ Metal Metales ☐ Latex Látex

☐ Sulfa drugs Sulfas ☐ Others If yes, please explain: Otros, en este caso, por favor, explique: _____

Has your child ever had any of the following illnesses or conditions?

Disease or Disorder / Enfermedad o Desorden	**YES/ Sí**	**NO**	**Disease or Disorder/**Enfermedad o Desorden	**YES/ Sí**	**NO**	**Disease or Disorder/**Enfermedad o Desorden	**YES/ Sí**	**NO**
ADHD or Attention Deficit Disorder/ Déficit de Atención e Hiperactividad			**Easily Winded/** Dificultad para respirar			**Liver Disease/** Enfermedades del Hígado		
AIDS/HIV Positive/SIDA			**Emphysema/** Enfisema pulmonar			**Low Blood Presure/** Presión Arterial Baja		
Anaphylaxis/ Anafilaxis			**Emotional Problems/** Problemas Emocionales			**Lung Disease/** Enfermedad Pulmonar		

Disease or Disorder / Enfermedad o Desorden	**YES/ Sí**	**NO**	**Disease or Disorder/** Enfermedad o Desorden	**YES/ Sí**	**NO**	**Disease or Disorder/** Enfermedad o Desorden	**YES/ Sí**	**NO**
Anemia/ Anemia			**Epilepsy or Seizures/** Epilepsia o convulsiones			**Pain in Jaw Joints/** Dolor de la Articulación Mandibular		
Angina/ Angina de pecho			**Excessive Bleeding/** Sangrado Excesivo			**Parathyroid Disease/** Enfermedad Paratiroidea		
Anxiety/Ansiedad			**Excessive Thirst/** Sed Excessiva			**Psychiatric Care/** Cuidados Psiquiátricos		
Arthritis/ Artrítis			**Fainting Spells or Dizziness/** Desmayos o Mareos			**Radiation Treatments/** Radioterapias		
Artificial Heart Valve/ Válvula cardiáca artificial			**Frequent Cough/** Tos Frecuentes			**Recent Weight Loss/** Pérdida Espontánea de peso		
Artificial joint/ Articulaciones Artificiales			**Frequent Ear infections/** Infecciones frecuentes de oidos			**Renal Dialysis/** Diálisis Renal		
Asthma/ Asma			**Frequent Eye infections/** Infecciones de ojos frecuentes			**Rheumatic Fever/** Fiebre Reumática		
Autism/ Autismo			**Frequent Headaches/** Dolores de cabeza frecuentes			**Rheumatism/** Reumatismo		
Bladder Problems/ Problemas de la vejiga o vías urinarias			**Genital Herpes/** Herpes genital			**Scarlet Fever/** Escarlatina		
Blood Disease/ Enfermedades de la sangre			**Glaucoma/** Glaucoma			**Sickle Cell Disease/** Anemía Falciforme		
Blood Transfusion/ Transfusiones sanguíneas			**Growth Problems/** Problemas del Crecimiento			**Sinusitis/** Sinusitis		
Breathing Problem/ Problemas para respirar			**Hay Fever or Seasonal Allergies/** Fiebre del Heno o Alergias estacionales			**Spina Bifida/** Espina bífida		
Bruise easily/ Moretones			**Hearing Problems/** Problemas de Audición			**Stomach or Intestinal Disease/** Enfermedades del Estómago o Intestino		
Cancer/ Cáncer			**Heart Attack/** Ataques cardiacos o del corazón			**Stroke/** Ataques cardiacos		
Cerebral Palsy/ Parálisis Cerebral			**Heart Conditions/** Enfermedades cardiacas			**Swelling of Limbs/** Hinchazón de extremidades		
Chemotherapy/ Quimioterapias			**Hemophilia/** Hemofilia			**Thyroid Disease/** Enfermedad Tiroidea		
Chest pains/ Dolores de pecho			**Hepatitis A , B, or C.**			**Tonsillitis/** Amigdalitis		
Cold Sores or Fever Blisters/ Fuegos labieles of fogazos			**Herpes or Shingles/** Herpes o Culebrilla			**Tuberculosis**		
Congenital Heart Disorder/ Desorden cardiaco congénito			**High Blood Pressure/** Presión Arterial Alta			**Tumors or Growths/** Tumoraciones o Crecimientos anormales		
Convulsions/ Convulsiones			**High Cholesterol/** Colesterol Alto			**Ulcers/** Úlceras		
Cortisone Medicina/ Medicamentos con Cortisona			**Hives or Rash/** Urticaria o Sarpullido			**Venereal Diseases/** Enferemedades Venereas		
Deverlopmental Issues/ Problemas del Desarrollo			**Hypoglycemia (low blood sugar)/** Azúcar baja en la sangre			**Yellow Jaundice/** Ictericia		
Depression/ Depresión			**Irregular Heartbeat/** Palpitaciones cardiacas Irregulares			**Other (Please specify) /** Otros (Por favor espcifique)		
Diabetes/ Diabetes			**Kidney Problems/** Problemas de los riñones			_____		
Drug Addiction/ Drogadicción			**Leukemia/** Leucemia			_____		

Please provide the dates of Diagnosis and Explanations if you answered “YES” to any of the conditions above_____
_____
_____

Has your child any serious illness not listed above O Yes O No
Please explain: _____

Is your child currently being treated for any condition (s) or illness (es)? O Yes O No
What illness: _____
When did it start: _____

Was your child born prematurely? O Yes O No
Please explain:
_____

Has your child ever been in the hospital overnight or longer: OYes ONo
Please explain when and why: _____
Has your child ever had surgery? O Yes O No
Please explain: _____
Has your child ever been given a general OR local anesthetic? O Yes O No
Please explain: _____

Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist? O Yes O No
Please explain why and provide the name of the doctor making that recommendation:
Why: _____
Doctor’s name: _____Phone: _____

Does your child have any genetic (inherited) conditions? O Yes O No
Please explain: _____

Do you have any concerns about your child’s physical health? O Yes O No
Please explain: _____
Do you have any concerns about your child’s emotional health? O Yes O No
Please explain:_____
How would you describe your child’s eating habits? _____
What does your child’s eating schedule look like?

	Morning	Snacks	Lunch	Dinner
Time				
Type of food, examples				

How often does your child drink sodas? _____ juices _____
Energy drinks _____ water _____ coffee _____

How often does your child eat candies? _____ chips _____ crackers _____
chocolate bars _____ granola/other type of bars _____ jelly/butters _____
fruits _____ vegetables _____ cereals _____

Is your child up-to-date with immunizations related to patienthood diseases (tetanus, measles, mumps, etc.)?
O Yes O No
If of the appropriate age, what is the patient’s Human Papillomavirus/HPV immunization status?
O Immunized O Not Immunized

SIGN HERE:_____Relationship to child:_____ Date:_____

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 and dental 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 "respondeat 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: _____

HEALS IMMUNIZATION SCHEDULE

It is the policy of all HEALS physicians that your child/children receive all immunizations required by the Centers for Disease Control and Prevention and the American Academy of Pediatrics. This is a non-negotiable policy of all HEALS physicians. It is our policy that all 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*
9 months	PPD
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, refuse to comply with the required immunizations, 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 a patient of HEALS, I agree to comply with the required immunizations.

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

Parent/Guardian Name: _____

SIGN HERE: _____

Relationship to the child:_____ Date:_____

Patient Name: _____ DOB: _____

Any physician, staff, employee, or representative of HEALS, Inc. has my permission to discuss and / or disclose information regarding medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information to facilitate and coordinate my care and treatment with the following persons:

Contact Name: _____ Relationship to the patient: _____
Phone number: _____
Contact Name: _____ Relationship to the patient: _____
Phone number: _____

Consent to call: O YES O NO Consent to text: O YES O NO

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

This is a summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is available for your review. We encourage you to review and read it and ask any questions regarding our privacy practices.

Signature: _____ Date: _____
The patient's signature is required if over the age of 14

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 the 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 electronically 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 healthcare professionals who provide you treatment and/or service. 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 be involved 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 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 a 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 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 includes: 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 from disclosing PHI without 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(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 Dr. NW Huntsville, Al. 35816

heals

Health Establishments At Local Schools

Part of the Solution

HEALS, Inc.
Health Establishments at Local Schools

515 Sparkman Drive

#66959

HUNTSVILLE CITY SCHOOLS
A Legacy of Leading & Learning

Jean Wessel Templeton Community Health Initiative

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I HEREBY RELEASE A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORDS

Full Name of Patient: _____

Patient's Birth Date: _____Chart# _____

Please provide the information of the Medical Office or Physician to whom we have to request the records:

Physician's name/Practice name: _____
Phone number/Fax: _____
Address: _____

INFORMATION TO BE RELEASED (X) ( ) Medical Record ( ) Psychiatric Records

****If only a portion of the Medical record or Psychiatric record is required, please specify. ****

( ) Discharge Summary	( ) Emergency Room	( ) Laboratory Results
( ) History & Physical	( ) X-Ray Report	( ) Immunization Records
( ) Orders	( ) Operative Reports	( ) Nurses' Notes
( ) Radiology Film/Imaging/CD-ROM	( ) Progress Notes	( ) Entire Record

( ) Other (Specify) _____

Information is requested by: Lainey Miller, Clinic Coordinator at the HEALS Mobile Clinic.

This record is requested to be released to:

HEALS, Inc.
_____
_____
Phone: 256-428-7560
Fax: 256-428-7561

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON (X):
( ) Continued Medical Care ( ) Insurance purposes ( ) Other _

The authorization must be signed and dated and may be revoked by notifying HEALS, Inc. in writing at any time except to the extent that action has been taken prior to revocation. This consent will expire 120 days after the date below or sooner by my choice., in which case this consent will expire on this date or event: _____

Signature: _____Date: _____
Parent or Legally Authorized Representative

Relationship to the Patient: _____Phone Number: _____

If your child is Uninsured, please fill out this form and return it with the previous enrollment form. Also, fill out the Medicaid Application

EXHIBIT A: FINANCIAL STATEMENT

Patient Name: Last		First		MI	
Account Number(s):					
Date of Enrollment:					
Reason:					
Social Security #:	DOB:	Age:		Male	Female
Marital Status (circle one)	Married	Common-law married	Single	Widowed	Divorced / Separated — How long?
Parent/Guardian #1's Name			Social Security #:		
Home #:	Work #:		Cell #:		
Current Address:	Street				
		City	State	Zip	
County:		How long at current address:			
Parent/Guardian Employer:		Hire Date: (month/day/year)			
If unemployed – last date worked (month/day/year)		Reason:			
Spouse's Name:		Spouse's Social Security #:			
Home #:	Work #:		Cell #:		
Current Address:	Street				
		City	State	Zip	
County:		How long at current address:			
Spouse's Employer:		Hire Date: (month/day/year)			
If unemployed – last date worked (month/day/year)		Reason:			

List **ALL** Bank Accounts (Name and Account #s)

Account Name	Account #	Checking	Savings	Other

Property Owned	House	Land	Auto (year and make)

Are you Renting	Buying	Own	Living with and/or supported by someone?	Who?

Number of people living in household:	Relation to you?
List the ages of **YOUR** children still living in the household:	
Have you ever applied for SSI/Social Security Disability?	Date of last application:
Is the case still open and pending a decision?	If denied, have you filed an appeal?
Do you have an attorney working on your case? Attorney Name: Attorney's Phone # and Address:	

Income and Expenses

MONTHLY INCOME

MONTHLY EXPENSES

*If expenses are shared, please list **your** portion only

Income Type	**Amount**	**Expense Type**	**Amount**
Gross wages/unemployment (parent/guardian #1)		Rent, house, or trailer payment	
Net wages after taxes (parent/guardian #1)		Land/lot payment	
Gross wages (spouse)		Utilities / Gas / Water	
Net wages after taxes (spouse)		Food / Phone Bill	
Gross wages/salary (parents/guardians and spouse)		Car payment / Car Insurance	
Net wages after taxes (parents/guardians and spouse)		Car payment / Car Insurance	
*Since the patient is a child, list income for both parents/guardians		Child support/alimony payment	
Social Security check amount (parent/guardian#1)		Daycare/childcare expense	
Social Security check amount (spouse)		Education/college loans	
Social Security check amount (child)		List all insurance premiums paid:	
SSI Income (list amount & recipient)		Hospital/daily indemnity	
Military/Reserves/VA income		House/renters insurance	
Short/long term disability income		Health insurance	
Child support/alimony received		Student insurance	
Unemployment check amount		Life/burial insurance	
Retirement/pension check amount		Cancer insurance	
Workman's Compensation		Doctor and medical expenses (monthly)	
Rental income received		Prescription costs (out of pocket)	
AFDC/Family Assistance		Credit Card Name:	
Food Stamps received		Credit Card Name:	
Church assistance received		Credit Card Name:	
Other income or money received		Other expense	

Applicant's statement: I do hereby certify that the information on this form is correct and true to the best of my knowledge and that no pertinent items of information have been concealed or omitted from this application. I also understand that HEALS, Inc. has the right to reverse its decision concerning charity discounts when discovery of information is made that indicates the patient/guarantors has or had the ability to pay for their services. I am giving HEALS, Inc.; permission to access my credit file and to provide my financial information to those companies contracted by HEALS, Inc. for the purpose of financial or product recovery programs for which I may qualify. If there is anyone you would like to allow us permission to speak with regarding completing the financial application process, please list them below as a designated person in the space provided.

Parent/Guardian#1 Signature	Patient's Name
Spouse's Signature	Date
Witness Signature	Date