OHI School Based Wellness Program - Parental Consent

OCEAN HEALTH INITIATIVES, INC.
Your Patient Centered Medical Home

Please complete, sign & return to school.
Questions? Please call (732) 363-6655

COMMUNITY HEALTH CENTER FQHC QUALITY

PATIENT-CENTERED MEDICAL HOME NCQA RECOGNIZED PRACTICE

1 TELL US ABOUT YOUR CHILD

School or Program Name: _____ County: _____
Teacher: _____ Room #: _____ Grade:_____ AM/PM
Child's Legal Name: _____ Child's Date of Birth: _____ Male/Female
Child's Social Security Number: ____ ____ ____ - ____ ____ - ____ ____ ____ ____
Parent/Guardian Name: _____
Address: _____ City/Zip: _____
Email: _____ Phone: ( ) _____ Alt. Phone: ( ) _____

Contact Options:
☐ Send Note Home with Student ☐ Call me with Instructions
☐ Mail me with Instructions ☐ Text me with Instructions
☐ Email me with Instructions

Emergency Contact: _____
Emg. Phone: ( ) _____

2 CHILD'S MEDICAL HISTORY

CHECK EACH CONDITION THAT APPLIES TO YOUR CHILD

☐ ADHD/ADD	☐ Eczema or Skin Infections	☐ Mental Illness	☐ Sickle Cell Anemia
☐ Anemia/Fainting/Dizziness	☐ Epilepsy/Seizures	☐ Murmur/ Heart Problems	☐ Stomach Problems
☐ Asthma or Wheezing	☐ Headaches/Migraines	☐ Nose Bleeds	☐ Thyroid Disease
☐ Behavioral Problems	☐ Hemophilia/Bleeding Problems	☐ Pregnancy	☐ Tuberculosis
☐ Cancer	☐ HIV/AIDS	☐ Recent Dental Problems	☐ Other:
☐ Chronic Ear Infection	☐ Kidney Problems or Bladder Infections	☐ Rheumatic Fever	_____
☐ Communicable Diseases	☐ Latex Allergy	☐ Scoliosis	
☐ Diabetes	☐ Liver Problems/Hepatitis	☐ Severe Acne	

Does your child have any allergies? _____
Does your child take any medications? _____

3 INSURANCE INFORMATION

☐ CHILD HAS MEDICAID/NJ FAMILY CARE

Enter Child's 16-digit CCN Number HERE: 7 7 7 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ CHILD HAS PRIVATE INSURANCE

Insurance Company Name (Other than Medicaid): _____ Group #: _____
Ins. Phone: _____ **Employer:** Name: _____ Phone #: _____
Name of Insured Adult: _____ **BIRTH DATE of Insured Adult:** _____
Member ID/Policy #: _____ Social Security # of Insured Adult: __ __ __ - __ __ - __ __ __ __

In order for your child to receive services at the Wellness Program they must have OHI as their primary care provider. If you need to change your primary care provider you may do so by calling your insurance carrier at:

- **Amerigroup- 1-800-600-4441**
- **Horizon NJ Health- 1-877-765-4325**
- **UHC- 1-800-941-4647**

4 FINANCIAL RESPONSIBILITY

In consideration of service rendered and to be rendered by Ocean Health Initiatives (OHI) and my child's treating physician(s), I hereby authorize my health insurer(s) – (Medicare, Medicaid, Blue Cross Blue Shield, Commercial Insurance Company, County Welfare program, Union or Company Self Insurance and/or any other third party payer) to reimburse OHI and/or my child's treating physician(s) directly for any covered services. I accept sole responsibility for all charges incurred as a result of services rendered and agree to pay amounts not covered by my insurer(s). I understand that it is my responsibility to provide the correct information regarding insurances as well as any authorization and/or referrals necessary for billing. I understand that if I have not provided OHI with accurate and current information regarding my insurer or other benefit plan/third party payor which provides my child with health care coverage, I will be personally responsible for the cost of all care rendered by OHI. I understand that a sliding fee scale is available for uninsured patients.

5 OTHER FEES

I understand that OHI charges may not include fees charged by my child's treating physician(s) or other health care providers (e.g., fees for laboratory tests or other diagnostic tests). As a matter of record, I understand that I am financially responsible for all services provided to my child. In the case of denial by an insurance carrier, I hereby consent to OHI appealing the denial on my behalf.

6 USE OF INFORMATION

I authorize OHI to use my child's personal health information and to release such information to: (a) any requesting health care provider for further care, treatment, payment or health care operations purposes; (b) any entity which may assist the Practice in performance of its health care operations or may be responsible for billing and/or collection of claims; (c) any person or entity which is or may be liable for all, or part of the Practice's charges or physicians' fees including, but not limited to, insurance companies, health maintenance organizations, workers' compensation carriers, or other third party payers (e.g., Medicaid or other health care payors); or (d) any governmental agency or other organization responsible for oversight of OHI. I understand that my information may be transmitted electronically, by fax or through a health information exchange.

7 PLEASE READ AND SIGN BELOW

I give permission for my child to be examined and treated by an Ocean Health Initiatives provider if my child demonstrates signs, or complains, of injury or illness while at school during the 2015-2016 school year.

I certify that I have received a copy of OHI's HIPAA PRIVACY NOTICE.

Signature _____ Date _____

Print Name _____

Please <u>complete, sign & return</u> to school.
Questions? Please call (732) 363-6655

OCEAN HEALTH INITIATIVES, INC.
Your Patient Centered Medical Home
www.ohinj.org ***(732) 363-6655***

101 Second St., Lakewood, NJ 08701
301 Lakehurst Rd., Toms River, NJ 08753
333 Haywood Rd., Manahawkin, NJ 08050
Lakehurst Circle Center II, 686 Route 70, Lakehurst, NJ 08733
Clifton Ave. Elementary School, 625 Clifton Ave., Lakewood, NJ 08701
Lakewood High School, 855 Somerset Ave., Lakewood, NJ 08701

Student and Family Patient Information Form

STUDENT INFORMATION: (Please print full legal name, no nicknames)

Name of Patient (Student): Last: _____ First: _____

Is your child now or have they ever been a patient of OHI? Yes ☐ No ☐

Does your child currently have a Pediatrician/Doctor? Yes ☐ No ☐

If yes:

Name of Pediatrician/Doctor: _____

Location: _____

Phone #: _____

Has your child had a checkup in the past year? Yes ☐ No ☐

Is your child up to date with all immunizations? Yes ☐ No ☐

PARENT/LEGAL GUARDIAN INFORMATION: (Please print full legal name, no nicknames)

Name of Parent/ Legal Guardian: Last: _____ First: _____

Are you or have you ever been a patient of OHI?

If yes, what type of services do you currently receive? Please check all that apply:

☐ Behavioral Health ☐ Dental ☐ Family Medicine ☐ Internal Medicine

☐ OB/GYN ☐ Pediatrics ☐ Podiatry ☐ Social Services

If no, would you like to be registered as a patient to make an appointment? Yes ☐ No ☐

Phone # where you may be reached: _____

Email: _____

Are any of your family member's current patients of OHI? Yes ☐ No ☐

We provide primary and preventative care services in our multi-specialty practice:
Behavioral Health • Dental • Family Medicine • Internal Medicine
OB/GYN • Pediatrics • Podiatry • Social Services
To schedule an appointment at any of our locations, please call (732) 363-6655 - Visit us at ***www.ohinj.org***

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Patient Bill of Rights

1. Is informed of these rights and the facility's rules and regulations, including the patient's responsibility to respect the personal rights and private property of others.

2. Is informed of services available in the facility; of names and professional status of personnel providing and/or responsible for his or her care, and of fees and charges including any fees and charges for services not covered by sources of third-party payment.

3. Is assured of medical care and is informed of his or her current condition unless medically contraindicated (as documented by a physician in the patient's medical/health record).

4. Has the right to participate in the planning of his or her healthcare and treatment; has the right to refuse medication and treatment; is informed of available treatment options including the option of no treatment, and of possible benefits and risks of each option.

5. Has the right to express grievances to the facility's staff and governing authority and to recommend changes in policies and services.

6. Has the right to refuse to participate in experimental research. (If he or she chooses to participate, his or her written informed consent shall be obtained).

7. Is free from mental and physical abuse, free from exploitation, and is free from chemical, physical, and other types of restraints.

8. Is assured confidential treatment of his or her medical/health record, and shall approve or refuse its release to any individual outside of the facility, except as required by law or third-party payment contract.

9. Is treated with consideration, respect, and full recognition of his or her dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy and confidentiality concerning patient treatment and disclosures.

10. Is not required to perform services at the facility.

11. May join with other patients or individuals to work for improvements in patient care.

12. Is assured of exercising civilian and religious liberties including the right to independent personal decisions.

13. Is not the object of discrimination because of age, race, sex, sexual preference, nationality, disability, diagnosis, ability to pay, or source of payment.

14. Is not deprived of any constitutional civil and/or legal rights solely because of receiving from the facility.

15. Has the right to appropriate assessment and treatment of pain.

16. To receive care in a safe setting.

Patient Responsibilities

1. To provide, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, medications, and other health related matters.

2. To report unexpected changes in his or her condition to the responsible practitioner.

3. To report whether he or she clearly comprehends a contemplated course of action and what is expected of them.

4. To follow the treatment recommended by the practitioner. This may include following instructions of nurses and allied health professionals as they carry out a coordinated plan of care.

5. To keep appointments and, when unable to do so, he or she should notify the responsible practitioner or department.

6. For his or her actions of refusing treatment or not following the practitioner's instructions.

7. To assure that the financial obligations of his or her health care are fulfilled as promptly as possible.

8. To follow rules and regulations affecting patient care and conduct.

9. To be considerate of the rights of other patients and healthcare personnel.

10. To be respectful of the property of other persons and the healthcare facility.

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Behavioral Health • Dental • Family Medicine • Internal Medicine
OB/GYN • Pediatrics • Podiatry • Social Services
To schedule an appointment at any of our locations, please call (732) 363-6655 - Visit us at ***www.ohinj.org***

HIPAA JOINT PRIVACY NOTICE

THIS JOINT 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.

INTRODUCTION

This Joint Notice is being provided to you on behalf of Ocean Health Initiatives, Inc. ("OHI") and the employees and practitioners that work at OHI with respect to services provided at OHI (collectively referred to herein as "We" or "Our"). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" or "PHI" includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. We will share protected health information with one another, as necessary, to carry out treatment, payment or health care operations relating to the services to be rendered at OHI facilities.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a written copy of our most current privacy notice from OHI's Privacy Officer at OHI or you can access it on our website at www.ohinj.org.

PERMITTED USES AND DISCLOSURES

We can use or disclose your PHI for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

• Treatment means the provision, coordination or management of your health care, including consultations between health care providers relating to your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate for your treatment.

• Payment means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and other utilization review activities. For example, we may need to provide PHI to your Third Party Payor to determine whether the proposed course of treatment will be covered or if necessary to obtain payment. Federal or state law may require us to obtain a written release from you prior to disclosing certain specially protected PHI for payment purposes, and we will ask you to sign a release when necessary under applicable law.

• Health care operations means the support functions of OHI, related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your PHI to evaluate the performance of our staff when caring for you. We may also combine PHI about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose PHI for review and learning purposes. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may also use your PHI in the following ways:

• To provide appointment reminders for treatment or medical care.

• To tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

• To your family or friends or any other individual identified by you to the extent directly related to such person's involvement in your care or the payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.

We may include certain limited PHI in the OHI directory. This may include your name, location at OHI, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. You may request not to be listed in the directory.

• When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.

• We will allow your family and friends to act on your behalf to pick-up filled prescriptions, medical supplies, X-rays, and similar forms of PHI, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

• We may contact you as part of our fundraising and marketing efforts as permitted by applicable law. You have the right to opt out of receiving such fundraising communications.

• We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.

• We will use or disclose PHI about you when required to do so by applicable law.

• In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or OHI as required by applicable law.

Note: Incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

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

• Military and Veterans. If you are a member of the Armed Forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

• Worker's Compensation. We may release PHI about you for programs that provide benefits for work-related injuries or illnesses.

• Public Health Activities. We may disclose PHI about you for public health activities, including disclosures:

* to prevent or control disease, injury or disability;
* to report births and deaths;
* to report child abuse or neglect;
* to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
* to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
* to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

• Health Oversight Activities. We may disclose PHI to federal or state agencies that oversee our activities (e.g., providing health care, seeking payment, and civil rights).

• Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI subject to certain limitations.

• Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

* In response to a court order, warrant, summons or similar process;
* To identify or locate a suspect, fugitive, material witness, or missing person;
* About the victim of a crime under certain limited circumstances;
* About a death we believe may be the result of criminal conduct;
* About criminal conduct on our premises; or
* In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

• Coroners, Medical Examiners an d Funeral Directors. We may release PHI to a coroner or medical examiner. We may also release PHI about patients to funeral directors as necessary to carry out their duties.

• National Security and Intelligence Activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, other national security activities authorized by law or to authorized federal officials so they may provide protection to the President or foreign heads of state.

• Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) 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.

• Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

Note: HIV related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION

Certain uses and disclosures of PHI will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of PHI under the Privacy Rule. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment and health care operations. However, we are not required to agree to your request unless the disclosure is to a health plan in order to receive payment, the PHI pertains solely to your health care items or services for which you have paid the bill in full, and the disclosure is not otherwise required by law. To request a restriction, you may make your request in writing to the Privacy Officer.

2. You have the right to reasonably request to receive confidential communications of your PHI by alternative means or at alternative locations. To make such a request, you may submit your request in writing to the Privacy Officer.

3. You have the right to inspect and copy the PHI contained in our records, except:

(i) for psychotherapy notes, (i.e., notes that have been recorded by a mental health professional documenting counseling sessions and have been separated from the rest of your medical record);

(ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

(iii) for PHI involving laboratory tests when your access is restricted by law;

(iv) if you are a prison inmate, and access would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, any officer, employee, or other person at the correctional institution or person responsible for transporting you;

(v) if we obtained or created PHI as part of a research study, your access to the PHI may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;

(vi) for PHI contained in records kept by a federal agency or contractor when your access is restricted by law; and

(vii) for PHI obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect or obtain a copy your PHI, you may submit your request in writing to the Medical Records Custodian. If you request a copy, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to PHI under certain circumstances if there is a potential for harm to yourself or others. If we deny a request for access for this purpose, you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request an amendment to your PHI but we may deny your request for amendment, if we determine that the PHI or record that is the subject of the request:

(i) was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;

(ii) is not part of your medical or billing records or other records used to make decisions about you;

(iii) is not available for inspection as set forth above; or

(iv) is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your PHI, you must submit your request in writing to Medical Record Custodian at OHI, along with a description of the reason for your request.

5. You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

(i) to carry out treatment, payment and health care operations as provided above;

(ii) incidental to a use or disclosure otherwise permitted or required by applicable law;

(iii) pursuant to your written authorization;

(iv) to persons involved in your care or for other notification purposes as provided by law;

(v) for national security or intelligence purposes as provided by law;

(vi) to correctional institutions or law enforcement officials as provided by law;

(vii) as part of a limited data set as provided by law.

To request an accounting of disclosures of your PHI, you must submit your request in writing to the Privacy Officer of OHI. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

6. You have the right to receive a notification, in the event that there is a breach of your unsecured PHI, which requires notification under the Privacy Rule.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact OHI's Privacy Officer at (732) 719-1508. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of the U. S. Department of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact OHI's Privacy Officer at (732) 719-1508.

This notice is effective as of July 2013.

OHI
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