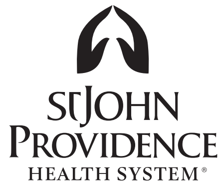


35200 Little Mack
Clinton Township, MI 48035
586-790-4096

Dear Parent or Guardian:

St. John Providence Health System and the Clintondale School System are pleased to provide health services for students in the Clintondale School. The Health Center's hours of operation are 7:30 a.m. to 4:00 p.m., Monday – Friday, closed weekends and holidays.

Our facility has as its **Medical Director** a board certified **Family Practice Physician.** A certified **Nurse Practitioner**, a **Therapist** who is a Licensed Mental Health Professional, and a **Medical Assistant** provide care to Clintondale students. We provide a wide range of services, including physical exams, sick visits, individual/group counseling, and a variety of school and community educational programs.

Our goal is to improve the physical and mental health of students of Clintondale School. All interactions between the health center staff and students will be **kept confidential** to the extent provided by the law.

We are approved by the Michigan Department of Community Health to bill medical insurance companies for services provided in the Health Center. Claims will be submitted from our office directly to your insurance company for payment. **Parents or Guardians of students will never be responsible for any portion of unpaid balances on these bills.** Please do not discourage your child from visiting the health center because of lack of insurance or problems with bill payment. Health center management will address all billing issues.

Attached are the **consent form, medical insurance registration form, immunization consent, and a parent questionnaire.** Please return these completed forms to us as soon as possible. By providing us with up-to-date information about your child's health, it will further help us to better serve the needs of your child.

We look forward to serving you and your child. If you have any questions or would like further information, please call Monday – Friday, between 7:30 a.m. – 4:00 p.m. In case of an emergency during non-business hours, please call 911 or go to the nearest emergency room. For mental health crisis, please contact Macomb County Crisis Center, a 24-hour support, information and resource helpline at 586-307-9100.

Available Services

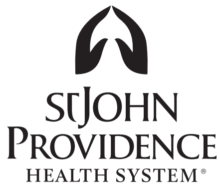
Medical General health assessment, school/sports physicals, sick care, immunizations, vision, and hearing testing, laboratory screening, health education, and nutrition counseling.

Personal Counseling Counseling and referrals for various concerns related to school age children and adolescents including depression, behavioral issues, personal relationships, violence prevention, family problems and substance abuse.

Health Education Student and parent educational programs related to the school age child's health issues; i.e. asthma, hypertension, diabetes, nutrition, abstinence, substance abuse prevention, and conflict resolution.

Sincerely,

St. John Providence School-Based Health Center Staff



PATIENT REGISTRATION FORM

Student/Patient Name:	Birth Date	Age	☐Male ☐Female	SSN#:	School:
Race (Optional): ☐African American ☐White ☐Native Hawaiian ☐Arab American ☐American Indian/Alaska Native ☐Asian ☐Other Pacific Islander ☐Unreported/Refused to Report					
Ethnicity (Optional): ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Arabic					
9. Address		10. City		11. Zip Code	12. Home Phone #:

Parental/Legal Guardian Information

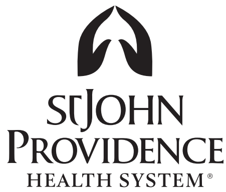
Mother's Full Legal Name:	SSN#:	Birth Date:
Address:	Home Phone#: Cell Phone#:	
Employer Name & Address	Employer Phone #:	
Father's Full Legal Name:	SSN#:	Birth Date:
Address:	Home Phone#: Cell Phone#:	
Employer Name & Address	Employer Phone #:	
Legal Guardian Name (if not mother or father)	SSN#:	Birth Date:
Address	Home Phone#: Cell Phone#:	
Employer Name & Address:	Employer Phone #:	

Emergency Contact Name:	Relationship to Student/Patient:	Telephone #:
Name of Student's/Patient's Doctor/Clinic:		Telephone #:
Name of Student's/Patient's Dentist:		Telephone #:

Insurance: ☐Medicaid ☐Blue Cross Blue Shield ☐HAP ☐Total ☐Midwest ☐Great Lakes ☐Molina ☐Other: ________

Medicaid #:		Is Medicaid your only Insurance? ☐Yes ☐No Name of Other Insurance:		
Primary Insurance Name:		Subscriber Name:		
Group#:		Policy#:		
Patient Relationship to Subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other
Secondary Insurance Name:		Subscriber Name:		
Group#:		Policy#:		
Patient Relationship to Subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Is patient employed? ☐Yes ☐No	Patient's Yearly Income:	Household Yearly Income:	# of family members in household:



Consent Form

Name: ____________________

Birth date: ____________________

Although crisis intervention and emergency care do not require consent, medical services require a signed consent before services are provided. The following services are available from your **St. John Providence School-Based Health Center**:

- Physical exams
- Diagnosis and management of acute and chronic illnesses/disease
- Immunizations
- Dental, Vision, and Hearing screenings
- Basic Laboratory tests including urinalysis, glucose, rapid strep test

- Health education/risk prevention counseling
- Counseling and referrals for mental health, physical/sexual abuse, substance abuse*
- Crisis intervention
- Group and Family Counseling
- Referral for resources such as food, shelter, financial issues, transportation

* Current Michigan Law mandates for confidential services to minors in these areas, as well as Pregnancy/STI/HIV testing and counseling.

LIMITATION OF SERVICES

- ***NO*** birth control pills or devices are dispensed or prescribed at ***ANY*** St. John Providence School-Based/Community Health Center located on school property.
- ***NO*** abortion counseling, referrals or services are provided at ***ANY*** St. John Providence School-Based/Community Health Center

I consent to all the following:

- I have reviewed and understand the services offered by the **St. John Providence School-Based Health Center**. I give consent for my child to receive the services indicated on this document. By signing this consent form I certify that I am the legal guardian and legal custodian of: ____.

- I understand this consent will remain valid until my child graduates, and that I may withdraw my consent for services upon written notice to the **St. John Providence School-Based Health Center** at any time.

- I further authorize the **St. John Providence School-Based Health Center** to release/exchange information regarding treatment to 1) my child's primary care physician or mental health providers when needed for coordination of care, 2) school staff when needed to coordinate services at school, 3) third party payers or others for the purpose of receiving payment for services. ***However services will be provided regardless of insurance and/or ability to pay.***

- The School-Based and Community Health Program may obtain a copy of the above name student's/patient's immunization record from the student's/patient's school office, primary care provider's office, and/or local health department.

____ ____________________

Signature of Parent/Guardian/Patient: **Date:**

Guidelines for Adolescent Preventive Services
Parent/Guardian Questionnaire

Confidential (Your answers will not be given out.)

Date __________________

Adolescent's name ______________________ Adolescent's birthday ____________ Age ____________

Parent/Guardian name ______________________ Relationship to adolescent ______________________

Your phone number: Home ______________________ Work ______________________

Adolescent Health History

1. Is your adolescent allergic to any medicines?
   ☐ Yes ☐ No If yes, what medicines? ______________________

2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken
____________	____________	____________
____________	____________	____________
____________	____________	____________

3. Has your adolescent ever been hospitalized overnight?
   ☐ Yes ☐ No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem
______	______________________
______	______________________

4. Has your adolescent ever had any serious injuries?
   ☐ Yes ☐ No If yes, please explain. ______________________

5. Have there been any changes in your adolescent's health during the past 12 months?
   ☐ Yes ☐ No If yes, please explain. ______________________

6. Please check (✔) whether your adolescent ever had any of the following health problems:
   If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability	☐	☐	______	Headaches/migraines	☐	☐	______
Allergies/hayfever	☐	☐	______	Low iron in blood (anemia)	☐	☐	______
Asthma	☐	☐	______	Pneumonia	☐	☐	______
Bladder or kidney infections	☐	☐	______	Rheumatic fever or heart disease	☐	☐	______
Blood disorders/sickle cell anemia	☐	☐	______	Scoliosis (curved spine)	☐	☐	______
Cancer	☐	☐	______	Seizures/epilepsy	☐	☐	______
Chicken pox	☐	☐	______	Severe acne	☐	☐	______
Depression	☐	☐	______	Stomach problems	☐	☐	______
Diabetes	☐	☐	______	Tuberculosis (TB)/lung disease	☐	☐	______
Eating disorder	☐	☐	______	Mononucleosis (mono)	☐	☐	______
Emotional disorder	☐	☐	______	Other: ______________	☐	☐	______
Hepatitis (liver disease)	☐	☐	______				

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?
   ☐ Yes ☐ No ☐ Not sure

Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	☐	☐	☐	________	______________
Arthritis	☐	☐	☐	________	______________
Birth defects	☐	☐	☐	________	______________
Blood disorders/sickle cell anemia	☐	☐	☐	________	______________

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

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

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

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

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

Parental/Guardian Concerns

11. Please review the topics listed below. Check(✓) if you have a concern about your adolescent.

	Concern About My Adolescent
Physical problems	☐
Physical development	☐
Weight	☐
Change of appetite	☐
Sleep patterns	☐
Diet/nutrition	☐
Amount of physical activity	☐
Emotional development	☐
Relationships with parents and family	☐
Choice of friends	☐
Self image or self worth	☐
Excessive moodiness or rebellion	☐
Depression	☐
Lying, stealing, or vandalism	☐
Violence/gangs	☐

	Concern About My Adolescent
Guns/weapons	☐
School grades/absences/dropout	☐
Smoking cigarettes/chewing tobacco	☐
Drug use	☐
Alcohol use	☐
Dating/parties	☐
Sexual behavior	☐
Unprotected sex	☐
HIV/AIDS	☐
Sexual transmitted diseases (STDs)	☐
Pregnancy	☐
Sexual identity (heterosexual/homosexual/bisexual)	☐
Work or job	☐
Other: ______	☐

12. What seems to be the greatest challenge for your teen? ______

13. What is it about your teen that makes you proud of him or her? ______

14. Is there something on your mind that you would like to talk about today?

What is it? ______

15. Can we share your answers to Question 13 with your teen? ☐ Yes ☐ No

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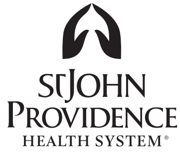


GENERAL CONSENT TO OUTPATIENT TREATMENT

CONSENT TO PHYSICIAN OFFICE, CLINIC, OR OUTPATIENT SERVICES

I request and authorize physician office, clinic, or outpatient care as my physician, his assistants or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient's) care is directed by my (the patient's) physicians, and that other personnel render care and services to me (the patient) according to the physicians' instructions.

> **I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of such diagnostic procedure or treatment.**

I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) during routine diagnostic procedures. I authorize the facility to perform other tests on these body fluids and/or tissues in order to further medical research and knowledge and/or to dispose of these fluids and tissues.

I authorize the facility to contact healthcare providers from whom I have received treatment to obtain medical information and/or records including but not limited to ***commercial pharmacies i.e., Walgreen, CVS and alcohol and other drug treatment records*** for verification of my medications.

I have been informed and understand that HIV (human immunodeficiency virus)/AIDS and HBV (hepatitis B virus) test may be performed on me without my consent if a health professional, facility employee or First Responder sustains an exposure to my blood or other body fluid.

ASSIGNMENT OF INSURANCE BENEFITS

Medicare Certification: I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

I hereby authorize and instruct my insurance carrier to make payment directly to the facility benefits otherwise payable to me. **I agree to personally pay for any facility or physician charges that are not covered by or collected from any applicable insurance program, including any deductibles and coinsurance amounts.**

PERSONAL VALUABLES

I understand that I (the patient) am responsible for any and all personal valuables that I bring with me to the facility, clinic or physician's office. I hereby release the facility, clinic or physician's office from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my care and treatment.

TEACHING INSTITUTION

I have been informed and understand that this facility is affiliated with a teaching institution and the procedures performed may require observation, cooperation, and services of multiple health care providers. I authorize residents and/or students to participate in my care.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The St. John Providence Health Notice of Privacy Practices provides information about how protected health information about me (the patient) – including information about human immunodeficiency virus (HIV), AIDS-related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any; and psychological and social services records, including communications made by me to a social worker or psychologist (if any) – may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Notice may change and that I may obtain a revised copy by accessing the St. John Providence Health website at www.stjohnprovidence.org or by contacting the Privacy Officer listed in the notice.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction, but if they agree, they will be bound by the agreement.

By signing this form, I acknowledge that I have been offered and/or received the St. John Providence Health Notice of Privacy Practices.

Name of Patient (print) ____

Signature of Patient ____

Date_____________________

Signature of Spouse ____

Date ____________________

Signature of Witness____

Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is Unable to Sign or is a Minor

Signature of Guardian, Patient Advocate or Nearest Relative_________________________________

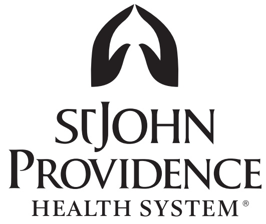
Date_____________________

Relationship____

Address____

Phone Number______________________

Signature of Witness____



St. John Providence School-Based Health Center

Confirmation of Patient Rights, Responsibilities, and After Hours Care

Child's Name: ______________________________ Date of Birth: ______________
Last First

I have been informed of my rights and responsibilities. I have been informed of my right to confidentiality and under what circumstances my rights will be violated. I have also received the phone numbers for weekend and after hours care information.

______________________________ ______________
Student Signature Date

______________________________ ______________
St. John Staff Providence Signature/Credentials Date

____
Title

Patient Rights

1. You cannot be discriminated on the basis of race, color, national origin, religion, sex, handicap, or health insurance.
2. You will be treated with courtesy and respect by all health center staff.
3. All information is **confidential**.
4. You will receive the best possible care and have other options for care explained to you.
5. You have a right to refuse treatment.
6. You have a right to review your health center record.
7. You have a right to review a copy of any bills submitted to your insurance company.
8. If you feel that your rights have been violated, you should inform the health center staff.
9. You will not be denied services because of inability to pay.

Patient Responsibilities

1. Being on time for your appointments.
2. Calling the health center at least 24 hours in advance if you are unable to keep an appointment.
3. Providing the health center with current information on your insurance, address, name, or phone number changes.
4. Providing a complete and accurate medical history to staff.
5. Advising us if you do not understand any aspect of your treatment.
6. Following our recommendations and advice.
7. Telling us about unexpected complications that may happen during the course of your treatment.
8. Being considerate of the rights of other patients and of health center personnel and property.
9. Pay as you can to help support the continuation of this center.

Confidentiality

Every patient has the right to confidential treatment. Your right to confidentiality may be broken under the following circumstances:

1. If you plan to hurt yourself.
2. If you plan to hurt someone else.
3. If someone is hurting you.
4. If mandated by the court.

After Hours Care

The St. John Providence Clintondale School-Based Health Center is open Monday through Friday from 7:30 AM to 4:00 PM. We are closed during the evening, on Saturdays and Sundays, on Holidays, and limited times during the school year for staff meetings, programs, etc.

The health center will provide a 24-hour answering machine, seven days a week that will direct students to the appropriate health care providers after hours. Students that call this number will be directed to call their primary care provider or proceed to the nearest emergency room. The 24-hour answering machine phone number is 586-790-4096. In case of emergency call 911, or go to the nearest emergency room. For mental health crisis, please contact Macomb County Crisis Center, a 24-hour support, information, and resource hotline at 586-307-9100.

St. John Providence Health System

St. John Providence Health System
Notice of Privacy Practices

1. 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.

2. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. We call this information "protected health information" or "PHI" for short, and it includes information that can be used to identify you that we have created or received about your past, present, or future health or condition, the provision of healthcare to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice near the main entrance to each St. John Providence Health System facility. You can also request a copy of this notice from the contact person listed in Section 7 below at any time and can view a copy of the notice on our website at www.stjohnprovidence.org.

3. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each.

3.1. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations.

We may use and disclose your PHI for the following reasons:

3.1.1. For treatment. We may disclose your PHI to physicians, nurses, medical students and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to the physical therapy department in order to coordinate your care.

3.1.2. To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of you PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.

3.1.3. For health care operations. We may disclose your PHI in order to operate our hospitals, clinics, urgent care centers and other health care service locations. For example, we may use your PHI in order to evaluate the quality of health care services that you received or evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants and others in order to make sure we are complying with the laws that affect us.

3.2. Certain Other Uses and Disclosures That Do Not Require Your Consent

3.2.1. When disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot and other wounds, or when ordered in a judicial or administrative proceeding.

3.2.2. For public health activities. For example, we report information about births, deaths and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.

3.2.3. For health oversight activities. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

3.2.4. For purposes of organ donation. We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.

3.2.5. For research purposes. In certain circumstances, we may provide PHI in order to conduct research.

3.2.6. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

3.2.7. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

3.2.8. For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.

3.2.9. Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders through the mail or by telephone or give you information about treatment alternatives, or other health care services or benefits we offer.

3.2.10. Fundraising activities. We may use PHI to raise funds for our organization. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed at the end of this notice.

3.3. Uses and Disclosures to Which You Have an Opportunity to Object

3.3.1. Patient directories. We may include your name, location in this facility, general condition and religious affiliation (if any) in our patient directory for use by clergy and visitors who ask for you by name, unless you object in whole or in part.

3.3.2. Disclosure to family, friends, or others. We may provide your PHI to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

3.3.2.1. Michigan law and/or Federal Regulations require explicit authorization for the disclosure of PHI of patients treated for mental health, substance abuse and HIV/AIDS conditions.

3.4. All Other Uses and Disclosures Require Your Prior Written Authorization

In any other situation not described in this section, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

4. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

4.1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

4.2. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

4.3. The Right to See and Get Copies of Your PHI. In most cases you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.
If you request copies of your PHI, we will charge you a reasonable copying fee.

4.4. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include any of the uses or disclosures listed in section 3.1, 3.2 and 3.3. The list also will not include any uses or disclosures made before April 14, 2003.
We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $25 for each additional request.

4.5. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

4.6. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

5. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with: **St. John Providence Health System HIPAA Privacy Office -** (See section 7 of this Notice.)
You also may send a written complaint to:

Secretary of the Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

We will take no retaliatory action against you if you file a complaint about our privacy practices.

6. WHO WILL FOLLOW THIS NOTICE OF PRIVACY PRACTICES

This notice describes the practices of the employees, medical staff, volunteers, departments and units of the following entities:

Brighton Hospital
Providence Hospital and Medical Centers
Providence Park Hospital
St. John Hospital and Medical Center
St. John Macomb - Oakland Hospital
St. John North Shores Hospital
St. John River District Hospital
Father Murray Nursing Center
St. John Senior Community
St. John Home Care
St. John Hospice
St. John Home Infusion
St. John Home Medical Equipment
Medical Resources Group
St. John Health Partners
Eastwood Clinics
St. John Health Foundation
St. John Health Occupational Health Partners
Affiliated Health Services, Inc.
St. John Community Health Investment Corp.
St. John Providence Health System

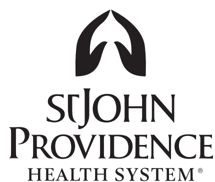
All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share medical information with each other for purposes of treatment, payment, or hospital operations as described in this notice. Finally, these entities, sites and locations may share medical information with physicians and other healthcare professionals within St. John Providence Health System and as a Member of of a Regional Health Information Organization.

7. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact the St. John Providence Health System Corporate HIPAA Privacy Officer at 248-849-5302. All complaints must be submitted in writing to:

St. John Providence Health System
HIPAA Privacy Officer
28000 Dequindre Road
Warren, MI 48092

8. EFFECTIVE DATE OF THIS NOTICE: April 14, 2003.



VACCINE PREVENTABLE DISEASE INFORMATION/CONSENT FORM

CHILD'S NAME: ____ **CHILD'S BIRTHDATE** ____________

I ________________________ have read or had the risks associated with vaccination explained to me. I have had the opportunity to ask
(Parent/guardian name - Print)
questions and feel satisfied with the answers given. I give permission to vaccinate my child ____________________________
(Child's name)
Signature of Parent/Guardian: ____ Date: ________________________

Chickenpox (Varicella) Chickenpox is a common childhood disease which can be serious. Chickenpox can lead to pneumonia, brain damage, or death. Children who receive the chickenpox vaccination may experience fever, soreness, a mild rash, or swelling where the shot was given. In rare cases a child may experience a seizure (less than 1 out of 1,000 cases). It may be possible for someone who gets a rash from the chicken pox shot to give chickenpox to another person. If the person getting the vaccine has an immune system that is not working properly, or is in close contact with anyone whose immune system is not working properly, please inform the nurse/doctor**. If the person who is getting the vaccine has ever had a serious allergic reaction to the chickenpox vaccine, neomycin, or gelatin, please inform the nurse/doctor.**

Diphtheria, Tetanus, Pertussis (DTaP, Tdap, DT, Td) Diphtheria is a serious illness in which a thick membrane is formed in the back of the throat. This covering can cause breathing problems and even death. Tetanus (Lockjaw) causes muscles in the body to painfully tighten. Pertussis can cause severe coughing spells that can last for weeks. **DTaP is for children younger than 7 years; DT is for a child younger than7 years who should not have the pertussis vaccine. Adolescents 11 through 18 years of age should receive 1 dose of Tdap; Td should be given for later booster doses.** Children who receive the DTaP, Tdap, or Td vaccine commonly experience soreness at the injection site, fever, fussiness, and poor appetite. Children who receive this vaccine rarely experience seizures, become less alert, or develop difficulty breathing.

Hepatitis A (HAV) is a serious liver disease caused by the Hepatitis A virus. Hepatitis A is spread by close personal contact and sometimes by eating food or drinking water containing Hepatitis A virus. Persons at risk should have this vaccine. Two doses, 6 months apart, are needed for lasting immunity. Soreness at the injection site, headache, loss of appetite and tiredness may occur 3 – 5 days after the shot has been given. Rarely does serious allergic reaction occur. **People who have had an allergic reaction to one dose should not receive the second dose.**

Hepatitis B (HBV) Hepatitis is a serious liver infection caused by the Hepatitis B virus. People with this infection are at risk for developing diseases such as liver cancer, cirrhosis, or even death. Three doses are required for total immunity. Potential side effects of this vaccine include soreness at the injection site and fever. **People who are allergic to baker's yeast should not receive this vaccine.**

Haemophilus Influenzae Type b (HIB) is a bacterium that can cause children to develop serious illness such as infection of his/her brain or heart. These infections can cause permanent problems such as brain damage or even death. **HIB vaccination is recommended for anyone under the age of 60 months (5 years).** Potential side effects of this vaccine include fever, swelling, or redness at the site of the injection. These reactions generally start within 24 hours of the vaccination and subside within 48 hours. **People who have had an allergic reaction to one dose should not receive another dose**

Human Papillomavirus (HPV) is spread through sexual contact. HPV is important mainly because it can cause cervical cancer in women. HPV vaccine is an inactivated (not live) vaccine which protects against 4 major types of HPV. HPV vaccine can prevent some genital warts and some cases of cervical cancer. **HPV vaccine is routinely recommended for girls 11-12 years of age. The vaccine is also recommended for girls and women 13-26 years of age who did not receive it when they were younger.** Protection from HPV vaccine is expected to be long-lasting but vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer. HPV vaccine is given as a 3-dose series. **Anyone who has ever had a life-threatening allergic reaction to yeast, to any other component of HPV vaccine, or to a previous dose of HPV vaccine should not get the vaccine.**

Influenza is a serious disease caused by a virus that spreads from infected persons via the nose or throat of others. The "Influenza Season" in the U.S. is from November through April of each year. Influenza viruses change often. Therefore, influenza vaccine is updated each year to make sure it is as effective as possible. **Annual flu shots should be given to people at risk for getting a serious case of influenza or influenza complications and people in close contact with them. This includes people with long-term health problems (example: Asthma) or a compromised immune system.** The risk of the vaccine causing serious harm is extremely small. The virus in the vaccine is killed, so you **cannot** get influenza from the vaccine. Mild problems such as soreness at the injection site, fever, or aches may occur soon after shot and last 1 – 2 days. **Talk with a Doctor/Nurse before getting vaccine if you have had a serious allergic reaction to eggs or to a previous dose of influenza vaccine, or have a history of Guillain-Barré Syndrome (GBS). If your child has a fever or is severely ill, postpone the Influenza vaccine until the child has recovered.**

Measles, Mumps and Rubella (MMR) Measles and Rubella (German Measles) are diseases that can cause rashes, fever, seizures, brain damage, and death. Children with Mumps often experience fever, headache, and swollen glands. Less often these children may develop hearing loss and infections of their brain or spine. Risks associated with taking the MMR vaccine include soreness at the injection site, fever, and swollen glands in the cheeks or under the jaw, and joint pain/stiffness. Although rare, other problems that your child may develop include severe allergic reactions, bleeding, and seizures. **Persons should not be given this vaccine if they have experienced a severe allergic reaction to gelatin or to the drug neomycin, seizures, transfused with blood or blood products, or those who may be pregnant.**

Meningococcal Conjugate (MCV4) Meningitis is a serious illness caused by a bacterial infection which is the leading cause of bacterial meningitis in children 2 – 18 years of age. The vaccine can prevent 4 types of Meningococcal disease. **The vaccine is recommended for all children at the pre-adolescent visit (11- 12 years) or college freshmen. MCV4 is also recommended for individuals 11 – 55 years of age.**

Meningococcal Polysaccharide (MPSV4) prevents 4 types of Meningococcal disease, the same as the conjugate vaccine, and should be **used for children 2 – 10 years of age and adults over 55 who are at risk.**

Pneumococcal Conjugate (PVC) Pneumococcal infection causes serious illness and death. Pneumococcal infection causes serious disease in children less than 5 years of age and is the leading cause of bacterial meningitis in the United States. Risks associated with the PVC vaccine are redness, tenderness, or swelling at the site and/or mild fever. Severe reactions are rare. **Children should not get this vaccine if they had a severe allergic reaction to a previous dose.**
Pneumococcal Polysaccharide (PPV) is recommended in addition to PCV for certain high risk groups.

Inactivated Polio Vaccine (IPV) Polio is a disease that can cause severe muscle weakness, paralysis, and death. The risk of IPV causing serious harm is extremely small. A risk associated with the vaccine is soreness at the injection site. **Anyone who has ever had a serious allergic reaction to Neomycin, Streptomycin, or Polymyxin B should not receive IPV.**

Tuberculosis (PPD) Tuberculosis (TB) is a disease that is caused by mycobacterium tuberculosis that is spread through the air from one person to another. The bacteria is put in the air when a person with active TB disease coughs or sneezes. Tuberculosis can cause disability and/or death if not detected and treated appropriately. TB skin testing is recommended for children with risk factors. Periodic skin testing is also recommended if exposure is suspected.

WITH ANY VACCINE THERE IS A POSSIBILITY THAT A REACTION MAY OCCUR. Children, adolescents, or adults who are moderately or severely ill at the time the shot is scheduled should wait until they recover before getting the vaccine(s). IF ANY UNUSUAL PROBLEMS OCCUR SUCH AS TROUBLE BREATHING OR MAJOR CHANGES IN BEHAVIOR SEEK IMMEDIATE MEDICAL ATTENTION.