FAMILY HEALTH CARE
Child & Adolescent Health Center

School-Based Health Close to Home!

Our clinics are open to patients ages 5-21 and children of adolescent parents on school campuses in Baldwin, Evart, Grant, Reed City, and White Cloud.

As a patient, you can expect the following at each clinic:

- Open year-round, Monday through Friday, 7:30 a.m. to 4:00 p.m., with after-hour medical call coverage available for urgent needs.
- Services are billed to insurance; no one will be turned away regardless of their ability to pay.
- Completing this consent packet allows your child to access routine and acute care health services.
- Parents/guardians are always welcome at our health centers and are encouraged to participate in their child's healthcare.
- Services offered include preventative care, immunizations, sick visits, well-child exams/sports physicals, health education, behavioral health therapy, Medicaid enrollment, dental and vision outreach services.

NOTE: AT NO TIME WILL WE PRESCRIBE OR DISPENSE BIRTH CONTROL OR PROVIDE ABORTION COUNSELING OR REFERRALS.

Our Child & Adolescent Health Centers are staffed with a full-time nurse practitioner or physician assistant, and behavioral health therapist. In addition, an optometrist (vision) and dentist visit the clinics to provide outreach services.

For more information, contact your local Child & Adolescent Health Center.

Baldwin Child & Adolescent Health Center
525 W. Fourth St.
Baldwin, MI 49304
(231) 745-3116

Family Health Care – Evart
321 N. Hemlock St.
Evart, MI 49631
(231) 734-4219

Grant Child & Adolescent Health Center
96 E. 120th St.
Grant, MI 49327
(231) 834-1350

Family Health Care – Reed City Schools
225 W. Church Ave.
Reed City, MI 49677
(231) 791-7435

White Cloud Child & Adolescent Health Center
555 E. Wilcox Ave.
White Cloud, MI 49349
(231) 689-3268

Note: All Family Health Care Child and Adolescent Health Centers are Medicaid Enrollment sites.

FAMILY HEALTH CARE
Child & Adolescent Health Center

Parent/Guardian Consent Form

Review this Parent/Guardian Consent Form and fill in your child's information. Initial next to each section and sign below. You are welcome to contact us at any time with questions or comments.
Parents/guardians are always welcome at our CAHCs and encouraged to participate in their child's healthcare.
I consent to the following for:

Student Name: _____ **Date of Birth:** _____ **Gender:** _____ **Age:** _____

School: _____ **Grade:** _____ **Preferred Language:** _____

_____ Initial

Medical, Behavioral Health, Dental, and Vision Services: I authorize my child to receive medical, behavioral health, dental, and vision services as offered and available by the CAHC. I authorize any medical provider, behavioral health therapist, dentist, optometrist, or designated health care professional employed by or working for Family Health Care, Inc., to provide medical, dental, mental health testing, and vision services that are reasonable, necessary, or advisable to the evaluation and management of my child's health care.

- Well child visits which may include a school, sports or camp physical
- Primary health care services
- Sick care/minor illness
- Treatment for acute & chronic illness & injuries
- Over-the-counter medications
- Immunizations (will require additional signed consent from parents/guardian prior to receiving)
- Education/support programs for smoking cessation, nutrition/fitness, parenting, etc.
- Referrals for specialty services

As you may be aware, Michigan Law Health Code, Act 368 of 1978 requires that minors of certain ages be allowed to receive reproductive health, HIV, STD/STI, substance abuse, and mental health services without parental consent at any medical facility in the State of Michigan. The CAHCs, promote abstinence and always encourage open communication between parents, students, and staff.

AT NO TIME WILL WE PRESCRIBE OR DISPENSE BIRTH CONTROL OR PROVIDE ABORTION COUNSELING OR REFERRALS.

_____ Initial

Exchange of Information:

- By signing this consent form, I certify that I am the legal guardian and legal custodian of the student named above.
- I understand that renewing my consent is not necessary annually. However, having an updated address, phone number, insurance, and my child's current health information is necessary.
- I further authorize the CAHC to release information regarding treatment to the following: CAHC staff, school staff (when needed to coordinate services at school), and third-party payers when needed for payment of services.
- I understand I may withdraw my consent for services at any time upon written request.
- I authorize both the CAHC and my child's primary care provider to exchange health care information to ensure continuity and coordination of care.
- I understand that my child may have the opportunity to participate in health and wellness-related educational programs and give feedback on services and programs through surveys and/or focus groups.
- I understand that my child may be administered a behavioral risk assessment (RAAPS) during their appointment.
- I understand that testing for bloodborne diseases, including HIV/AIDS, may be performed without separate written consent in the event that a health care professional receives a cut or exposure to my child's blood or bodily fluids.
- I understand that services provided at the CAHC are billable to my insurance but no patient will be denied services regardless of their ability to pay.
- I understand that my child's privacy and health information will be handled in a confidential manner as required by the Health Information and Privacy Act (HIPAA) as set forth by Family Health Care (See attached notice).
- I understand that if face-to-face services are not available, telehealth services may be an appropriate alternative. All existing laws that apply to face-to-face services also apply to telehealth for medical and/or behavioral health services.
- I understand that reasonable and appropriate efforts have been made to eliminate any confidential risks associated with telehealth.
- I understand telehealth can include consultation, treatment, transfer of medical/mental health data, emails, telephone conversations and/or education using interactive audio, video, or data communications.
- I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the assigned therapist/program. I am aware that my child may stop treatment with the assigned therapist at any time.
- I understand that Federal laws and regulations protect my child's health information to the extent afforded by the laws (See 42, U/S.S 290dd- 3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations.) Exceptions to this law or instances when the information may be released include:
  - Internal communications within the agency, as necessary, medical emergencies, court orders, crime at program/against program personnel, a duty to warn and protect when patient is suicidal or homicidal, research with no client-identifying information, audit and evaluation by external agency/entity as required for licensure accreditation, suspicion of abuse and/or neglect against a child or vulnerable adult.

Parent or Legal Guardian Signature: _____ **Date:** _____
(Your child will not be eligible for CAHC services unless this consent is signed and verified)

(Office use only) CAHC consent authorization verification:

CAHC Staff Signature: _____ **Date:** _____
Verified by:

☐ _____ **Phone with parent/legal guardian:**

☐ _____ **In-person with parent/legal guardian:**

☐ _____ **By mail certified to parent/legal guardian (SASE returned):**

FAMILY HEALTH CARE
Child & Adolescent Health Center

Child & Adolescent Health Center
Patient Information

Patient/Student Information

Date: _____

Patient: _____ Date of Birth: _____ Gender: _____
First Middle Last

Home Address: _____
Street/Apt # City State Zip Code

Mailing Address: _____
Street/Apt # City State Zip Code

Email Address: _____ Race/Ethnicity: _____ Grade: _____
Current Year

Social Security: _____ Home Phone: _____

Cell Phone: _____ Message Phone: _____

Primary Care Provider: _____ Preferred Pharmacy: _____

Head of Household Information

Parent/Guardian: _____ Relationship: _____ Sex: _____

Home Address: _____
Street/Apt # City State Zip Code

Mailing Address: _____
Street/Apt # City State Zip Code

Date of Birth: _____ Race/Ethnicity: _____ Social Security: _____

Employer: _____ Occupation: _____

Work Address: _____
Street City State Zip Code

Email Address: _____ Work Hours: _____

Work Phone: _____ Home Phone: _____ Parent Preferred Language: _____

Insurance Information

Please attach a copy of your insurance card.

_____ _____
Primary Insurance Company: Name of Insured:

Address: _____
Street City State Zip Code

Policy #: _____ Group #: _____ ID #: _____ Medicare/Medicaid #: _____

Family Member Information

	Name	Sex	Date of Birth	Relationship
1.				
2.				
3.				

(Use the back of paper if needed)

Emergency Contact Information

Non-household Member

Emergency Contact: _____ Phone Number: _____

Relationship: _____ Work Phone: _____

FAMILY HEALTH CARE
Child & Adolescent Health Center

Patient/Student Medical History Form

Name of your doctor & office: _____ Phone: ( ) _____

Date of Last Visit: _____ Preferred Pharmacy: _____

Have you seen a dentist in the last 12 months? ☐ Yes ☐ No Name & Phone Number: _____

Patient/Student History Information

Check all the apply

- ☐ ADD/ADHD
- ☐ Alcohol Abuse
- ☐ Anemia or Bleeding Disorder (hemophilia/bruise easily/excessive bleeding)
- ☐ Asthma or Shortness of Breath
- ☐ Autism/Autism Spectrum Disorder
- ☐ Bladder or Kidney Problems/Infections
- ☐ Cancer (chemotherapy/radiation therapy/ bone marrow or organ transplant)
- ☐ Diabetes
- ☐ Digestive Problems (vomiting/heartburn/acid reflux)
- ☐ Drug Abuse (illegal or prescription)
- ☐ Eye Problems (Previous surgery/glaucoma/impaired vision)
- ☐ Frequent Headaches or Migraines
- ☐ Hearing Problems
- ☐ Heart Problems (high blood pressure/congenital heart defect/heart murmur/rheumatic fever/ irregular heartbeat)
- ☐ Infectious Disease (recurrent sinusitis/measles/ mumps/mononucleosis/pneumonia/meningitis/scarlet fever/chicken pox/TB/strep)
- ☐ Learning Disability
- ☐ Liver Problems (hepatitis/jaundice)
- ☐ Mood Difficulties (depression/anxiety/suicidal thoughts/self-harm/eating disorder)
- ☐ Neurological Problems (cerebral palsy/seizure/ brain injury)
- ☐ Premature Birth or Birth Defects
- ☐ Respiratory Problems (sleep apnea/snoring/cystic fibrosis)
- ☐ School IEP
- ☐ Scoliosis
- ☐ Sexually Transmitted Infections (HIV/AIDS/ gonorrhea/chlamydia/trichomonas)
- ☐ Sickle Cell Disease or Trait
- ☐ Skin Problems (acne/rash)
- ☐ Speech Problems
- ☐ Sports Injuries/Broken Bones/Injury to Face or Teeth
- ☐ Thyroid Problems
- ☐ Tobacco Use (cigarettes/vaping/e-cig/chewing tobacco)

Comments:

Please list any medications or vitamins (prescription or over the counter) that are currently being taken and reason for taking them:

Please check if allergic to any of the following:

☐ Medications (please list) _____

☐ Latex ☐ Dyes _____ ☐ Metals _____ ☐ Foods _____ ☐ Other _____

Have you ever had any surgeries? ☐ Yes ☐ No Age(s) & Reason: _____

Have you ever been hospitalized? ☐ Yes ☐ No Age(s) & Reason: _____

Do you have any health concerns? ☐ Yes ☐ No Age(s) & Reason: _____

Family History Information

Check all the apply

- ☐ Alcohol or Drug Abuse
- ☐ Arthritis
- ☐ Birth Defects
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Learning Disability
- ☐ Lung Disease
- ☐ Mood Problems
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Thyroid Disease
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Other _____

Family Health Care

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT & SIGNATURE FORM

Patients Name (*Please Print*): _____ **Birthdate:**_____

The Notice of Privacy Practices describes how the Facility uses and discloses your health information and the circumstances under which we must seek your written permission to do so. The Notice of Privacy Practices also describes rights you have under federal regulations called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA requires us to provide you with the Facility's Notice of Privacy Practices, and to obtain your written acknowledgment for receiving it.

By signing this form, you are acknowledging that the Facility provided you with its Notice of Privacy Practices; by signing, you are not agreeing or disagreeing with its content. If you do disagree, the Notice of Privacy Practices provides information about how you may address your concerns. By signing below, I acknowledge receiving the Facility's Notice of Privacy Practices.

(X)_____ _____
Signature of Patient or Representative Date

_____
Representative's Relationship to Patient (if applicable)

****

For Office Use Only

If an acknowledgment is not obtained, document below provider's good faith efforts to obtain the acknowledgment and the reason why the acknowledgment was not obtained:

Individual's name: _____
Date of attempt to obtain Acknowledgment: _____
Reason Acknowledgment was not obtained: _____

****

_____ I hereby acknowledge that I have received a copy of BFHC's Mission Statement and Patient Rights and
Initial Responsibilities.

I hereby authorize BFHC and the Provider assigned, as provided by law, to furnish medical/dental/optical, office surgery or diagnostic treatment and any local anesthetic as he/she considers necessary and proper in the treatment of the patient for the purpose of correcting his/her physical condition.

_____ This authorization shall be valid until rescinded in writing or replaced by one of a later date
Initial

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Baldwin Family Health Care for any services rendered to me by them. I authorize any holder of medical/dental/optical information about me to release to the Centers for Medicaid and Medicare Services (CMS) and/or the Insurance Carrier and their Agents any information needed to determine these benefits of the benefits payable for related services. I acknowledge full responsibility for the payment of services and agree to pay for them at the time service is rendered, unless other arrangements are made.

_____ Note: Your blood may be tested for HIV or Hepatitis if an employee is exposed to your body fluids. This is in compliance
Initial with Public Act #448.

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BALDWIN FAMILY HEALTH CARE DISCLOSURE REQUEST

May we disclose health information about you to family members and friends who are involved in your care or the payment thereof?

- ☐ **Yes, you can discuss my care with any of my family members or friends that inquire about me.**
- ☐ **No, you can only disclose information to me.**
- ☐ **Yes, but only to the following individual(s):**

_____ _____ _____ _____
Name Relationship to patient Name Relationship to patient

****

(X)_____ _____
Signature Relationship, if not patient

_____ _____
Witness Date

Family Health Care

NOTICE OF PRIVACY PRACTICES

Family Health Care - Baldwin
1615 Michigan Avenue
Baldwin, MI 49304

Family Health Care – Grant
11 North Maple Street
Grant, MI 49327

Family Health Care
Child & Adolescent Health Center
525 W. Fourth Street
Baldwin, MI 49304

Family Health Care - Evart
321 N. Hemlock Street
Evart, MI 49631

Family Health Care – Big Rapids
730 Water Tower Road
Big Rapids, MI 49307

Family Health Care – McBain
117 North Roland Street
McBain, MI 49657

Family Health Care
Child & Adolescent Health Center
96 East 120th Street
Grant, MI 49327

Family Health Care
Reed City Schools
225 W. Church Ave
Reed City, MI 49677

Family Health Care – Cadillac
520 Cobb Street
Cadillac, MI 49601

Family Health Care – White Cloud
1035 East Wilcox Street
White Cloud, MI 49349

Family Health Care
Child & Adolescent Health Center
555 East Wilcox Street
White Cloud, MI 49349

Effective Date: 9/23/2013

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.

Family Health Care (FHC) is required by law to maintain the privacy of individually identifiable patient health information (this information is "protected health information" and is referred to herein as "PHI"). We are also required to provide patients with a Notice of Privacy Practices regarding PHI. We are required to post this Notice in a prominent place within our facility. We will only use or disclose your PHI as permitted or required by applicable state law. This Notice applies to your PHI in our possession including the medical records generated by us.

FHC understands that your health information is highly personal, and we are committed to safeguarding your privacy. Please read this Notice of Privacy Practices thoroughly. It describes how we will use and disclose your PHI.

This Notice applies to the delivery of health care by FHC.

Our Pledge:

We understand that health information about you and the health care you receive is personal. We are committed to protecting your personal health information. When you receive treatment and other health care services from us, we create a record of the services that you received. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of our records about your care, whether made by our health care professionals or others working in this office, and tells you about the ways in which we may use and disclose your personal health information. This notice also describes your rights with respect to the health information that we keep about you and the obligations that we have when we use and disclose your health information.

I. Permitted Use or Disclosure

A. Treatment: FHC will use and disclose your PHI in the provision and coordination of heath care to carry out treatment functions.

FHC will disclose all or any portion of your patient medical record information to your consulting physician(s), nurses, pharmacists, technicians, medical students and other health care providers who have a legitimate need for such information in your care and continued treatment.

Different departments will share medical information about you in order to coordinate specific services, such as lab work, x-rays and prescriptions.

FHC also will disclose your medical information to people or entities outside FHC who will be involved in your medical care after you leave FHC, such as other care providers who will provide services that are part of your care.

We will share certain information such as your name, address, employment, insurance carrier, emergency contact information and appointment scheduling information in an effort to coordinate your treatment with us and with other health care providers.

FHC will use and disclose your PHI to inform you of, or recommend possible treatment options or alternatives that will be of interest to you.

FHC will use and disclose PHI to contact you as a reminder that you have an appointment for medical care at FHC.

If you are an inmate of a correctional institution or under the custody of a law enforcement officer, FHC will disclose your PHI to the correctional institution or law enforcement official.

B. Payment: FHC will disclose PHI about you for the purposes of determining coverage, eligibility, funding, billing, claims management, medical data processing, stop loss / reinsurance and reimbursement.

The medical information will be disclosed to an insurance company, third party payer, third party administrator, health plan or other health care provider (or their duly authorized representatives) involved in the payment of your medical bill and will include copies or excerpts of your medical records which are necessary for payment of your account. It will also include sharing the necessary information to obtain pre-approval for payment for treatment from your health plan.

We will disclose PHI to collection agencies and other subcontractors engaged in obtaining payment for care.

If requested, FHC will not disclose information about care you received and paid for out of pocket to your health plan unless for treatment purposes or in the rare event the disclosure is required by law.

C. Health Care Operations: FHC will use and disclose your PHI during routine health care operations including quality review, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of FHC, and for educational purposes.

For instance, FHC will need to share your demographic information, diagnosis, treatment plan and health status for population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, and contacting health care providers and patients with information about treatment alternatives, in order for us to operate our business in an efficient, safe and legal manner.

D. Other Uses and Disclosures: As part of treatment, payment and health care operations, we may also use your PHI for the following purposes:

Medical Research: We may disclose your PHI without your Authorization to medical researchers who request it for approved medical research projects; however, with very limited exceptions such disclosures must be cleared through a special approval process before any PHI is disclosed to the researchers. Researchers will be required to safeguard the PHI they receive.

Information and Health Promotion Activities: FHC will use and disclose some of your PHI for certain health promotion activities. For example, your name and address will be used to send you newsletters or general communications. We will also send you information based on your own health concerns. FHC may send you this information if it has determined that a product or service may help you. The communication will explain how the product or service relates to your well-being and can improve your health.

E. More Stringent State and Federal Laws: The State law of Michigan is more stringent than HIPAA in several areas. State law is more stringent when the individual is entitled to greater access to records than under HIPAA and when under state law the records are more protected from disclosure than under HIPAA. Certain federal laws also are more stringent than HIPAA. FHC will continue to abide by these more stringent state and federal laws. The federal laws include applicable internet privacy laws, such as the Children's Online Privacy Protection Act and the federal laws and regulations governing the confidentiality of health information regarding substance abuse treatment.

In Michigan patients have more rights of access to behavioral health information under Michigan law than under HIPAA and the state law defines a minimum necessary standard for release of mental health information. Disclosure is permitted with consent and for treatment without consent but only in an emergency. Minors in Michigan have more rights to confidentiality and protection of certain information (reproductive health, behavioral health and substance abuse) than under HIPAA. State law requires facilities to adopt policies regarding release of information outside the facility. If the facility policy requires consent for release, then consent will be required. State law genetic and HIV testing and disclosure consents remain in place.

II. Permitted Use or Disclosure with an Opportunity for You to Agree or Object

A. Family/Friends: With your permission, FHC will disclose PHI about you to a friend or family member who is involved in your medical care. We will also give information to someone who helps you pay for your care. In addition, we will disclose PHI about you to an agency assisting in a disaster relief effort so that your family can be notified about your condition, status and location. You have a right to request that your PHI not be shared with some or all of your family or friends.

B. Promotional Communications: FHC does not share or sell your PHI to companies that market health care products or services directly to consumers for use by those companies to contact you, such as drug companies. FHC does maintain a database of individuals for promotional communications, disease management and health promotion purposes. We send information to the individuals in this database about the programs and services of FHC. If you wish to be deleted from this database, you may notify the Privacy Official of Family Health Care.

III. Use or Disclosure Requiring Your Authorization

A. Marketing: We are not permitted to provide your PHI to any other person or company for marketing to you of any products or services other than FHC's products or services without a signed authorization from you.

B. Research: FHC will use or disclose your PHI as part of research that includes providing you with treatment. For example, if you are part of a research study that includes treatment, FHC may require that you sign an authorization to allow the researchers to use or disclose your PHI for this research.

C. Fundraising Activities: FHC may use and disclose some of your PHI for certain fundraising activities. For example, FHC may disclose your demographic information and department of service for fundraising activities for requests from you for monetary donations. Any fundraising communication sent to you will let you know how you can exercise your right to opt-out of receiving similar communications in the future.

D. Other Uses: Any uses or disclosures that are not for treatment, payment or operations and that are not permitted or required for public policy purposes or by law will be made only with your written authorization. Written authorizations will let you know why we are using your PHI. You have the right to revoke an authorization at any time, except to the extent that we have taken action in reliance on the authorization.

IV. Use or Disclosure Permitted by Public Policy or Law without your Authorization

A. Law Enforcement Purposes: FHC will disclose your PHI for law enforcement purposes as required by law, such as responding to a court order or subpoena, identifying a criminal suspect or a missing person or providing information about a crime victim or possible criminal conduct as part of a criminal investigation.

B. Required by Law: FHC will disclose PHI about you when required by federal, state or local law to make reports or other disclosures. FHC also will make disclosures for judicial and administrative proceedings such as lawsuits or other disputes in response to a

court order or subpoena. We will disclose your medical information to government agencies concerning victims of abuse, neglect or domestic violence. FHC will report drug diversion and information related to fraudulent prescription activity to law enforcement and regulatory agencies. Specialized government functions will warrant the use and disclosure of PHI. These government functions will include military and veteran's activities, national security and intelligence activities and protective services for the President and others. FHC will make certain disclosures that are required in order to comply with workers' compensation or similar programs.

C. Organ Procurement: FHC will disclose PHI to an organ procurement organization or entity for organ, eye or tissue donation purposes when donation has been authorized or to verify that appropriate organ procurement procedures were followed.

D. Health or Safety: Following the requirements of the Michigan Department of Commerce, FHC will use and disclose PHI to avert a serious threat to health and safety of a person or the public. We will use and disclose PHI to Public Health Agencies for immunizations, communicable diseases, etc. FHC will use and disclose PHI for activities related to the quality, safety or effectiveness of FDA-regulated products or activities, including collecting and reporting adverse events, tracking and facilitating product recalls, etc. and post marketing surveillance. Any patient receiving a medical device subject to FDA tracking requirements may refuse to disclose, or refuse permission to disclose, their name, address, telephone number and social security number, or other identifying information for the purpose of tracking.

V. Your Health Information Rights

Although we at FHC must maintain all records concerning your treatment by FHC, you have the following rights concerning your PHI:

A. Right to Inspect and Copy: You have the right to access your PHI and to inspect and have a copy made of your PHI as long as we maintain it except for: psychotherapy notes, information that may be used in anticipation of, or that will be used in a civil, criminal or administrative action or proceeding, and where prohibited or protected by law.

We will deny your request for access to your PHI without giving you an opportunity to review that decision if:

- You don't have the right to inspect the information; or it is otherwise prohibited or protected by law;
- You are an inmate at a correctional institution and obtaining a copy of the information would risk the health, safety, security, custody or rehabilitation of you or other inmates;
- The disclosure of the information would threaten the safety of any officer, employee or other person at the correctional institution or who is responsible for transporting you;
- You are involved in a clinical research project and FHC created or obtained the PHI during that research. Your access to the information will be temporarily suspended for as long as the research is in progress;
- FHC obtained the information that you seek access to from someone other than the health care provider under a promise of confidentiality and your access request is likely to reveal the source of the information.

You agree to pay a reasonable copying charge. You must make your requests to access and copy your PHI in writing to FHC. We will respond to your request within 30 days of its receipt. If we cannot, we will notify you in writing to explain the delay and the date by which we will act on your request. In any event, we will act on your request within 60 days of its receipt.

You will be provided access to your electronic health record and other electronic records in the electronic form and format requested if they are "readily reproducible" in that format. If not, they will be provided in a mutually agreed electronic format. Hard copies will be provided if you reject all readily reproducible formats.

B. Right to Amend: You have the right to amend your PHI for as long as we maintain it. However, we will deny your request for amendment if:

- FHC did not create the information;
- The information is not part of the designated record set;
- The information would not be available for your inspection (due to its condition or nature); or
- The information is accurate and complete.

If FHC denies your request for changes in your PHI, we will notify you in writing with the reason for the denial. We will also inform you of your right to submit a written statement disagreeing with the denial. You may ask that we include your request for amendment and the denial any time that FHC discloses the information that you wanted changed. We may prepare a rebuttal to your statement of disagreement and will provide you with a copy of that rebuttal.

You must make your request for amendment of your PHI in writing to FHC, including your reason to support the requested amendment. FHC will respond to your request within 60 days of its receipt. If we cannot, we will notify you in writing to explain the delay and the date by which we will act on your request. In any event, we will act on your request within 90 days of its receipt.

C. Right to an Accounting: You have a right to receive an accounting of the disclosures of your PHI that FHC made, except for the following disclosures:

- To carry out treatment, payment or health care operations;
- To you;
- To persons involved in your care;
- For national security or intelligence purposes;
- To correctional institutions or law enforcement officials; or
- That occurred prior to April 14, 2003.

For each disclosure, you will receive the date of the disclosure, the name of the receiving organization and address if known, a brief description of the PHI disclosed and a brief statement of the purpose of the disclosure or a copy of the written request for the information, if there was one.

You must make your request for an accounting of disclosures of your PHI in writing to FHC. You must include the time period of the accounting, which may not be longer than 6 years. We will respond to your request within 60 days from its receipt. If we cannot, we will notify you in writing to explain the delay and the date by which we will act on your request. In any event we will act on your request within 90 days of its receipt.

In any given 12-month period, we will provide you with an accounting of the disclosures of your PHI at no charge. Any additional requests for an accounting within that time period will be subject to a reasonable fee for preparing the accounting.

D. Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your PHI:

- To carry out treatment, payment or health care operations functions; or
- Restricting specific information to only specified family members, relatives, close personal friends or other individuals involved in your care.

For example, you may ask that your name not be used in the waiting room or that information about your condition not be shared with your family. FHC will consider your request but is not required to agree to the requested restrictions.

E. Right to Confidential Communications: You have the right to receive confidential communications of your PHI by alternative means or at alternative locations. For example, you may request that we only contact you at work or by mail. We will make every attempt to honor your request, but we reserve the right to deny unreasonable requests.

F. Right to Receive a Copy of this Notice: You have the right to receive a paper copy of this Notice of Privacy Practices, upon request.

G. Right to Notice of a Breach: You will be notified of any breach of your PHI unless it is determined that there is a low probability of PHI compromise based on the analysis of the following four factors:

- The nature and extent of the PHI involved – issues to be considered include the sensitivity of the information from a financial or clinical perspective and the likelihood the information can be re-identified;
- The person who obtained the unauthorized access and whether that person has an independent obligation to protect the confidentiality of the information;
- Whether the PHI was actually acquired or accessed, determined after conducting a forensic analysis; and
- The extent to which the risk has been mitigated, such as by obtaining a signed confidentiality agreement from the recipient.

VI. Complaints

If you believe your privacy rights have been violated, you may file a complaint with Family Health Care or with the Secretary of the Department of Health and Human Services. To file a complaint with FHC, please contact FHC's Privacy Official at:

1615 Michigan Avenue
Baldwin, MI 49304
(231) 745-5055

or

520 Cobbs Street
Cadillac,MI 49601
(231) 745-5055

All complaints must be submitted in writing directly to FHC; we assure you that there will be no retaliation for filing a complaint.

VII. Sharing and joint use of your Health Information

In the course of providing care to you and in furtherance of FHC's mission to improve the health of the community, FHC will share your PHI with other organizations as described below who have agreed to abide by the terms described below:

A. Business Associates: FHC will use and disclose your PHI to business associates contracted to perform business functions on its behalf. Whenever an arrangement between FHC and another company involves the use or disclosure of your PHI, that business associate will be required to keep your information confidential.

VIII. Additional Information

For further information regarding the subjects covered in this Notice of Privacy Practice, please contact FHC's Privacy Official at (231) 745-5055.

Changes to this Notice

FHC will abide by the terms of the Notice of Privacy Practices currently in effect. FHC reserves the right to change the terms of its Notice of Privacy Practices and to make the new Notice of Privacy Practices provisions effective for all PHI that it maintains. Revised notices will be prominently posted in all FHC locations and copies of the new agreement will be made available

RAPID ASSESSMENT FOR ADOLESCENT PREVENTIVE SERVICES

Our Practice is now using RAAPS.

RAAPS is a risk assessment developed especially for use with pre-teens, teens and young adults. As our younger patients enter adolescence their healthcare needs change. For example, did you know the most serious teen health issues are a result of **preventable** risk behaviors?

According to the CDC, **3 out of 4 serious injuries and deaths in adolescents are caused by risky behaviors, not disease**. And most teens engage in some risky behavior – sometimes without realizing it.

Just as adults are screened for disease, teens should be screened for risky behaviors. The RAAPS survey helps us identify these risks early, in a format that youth are more comfortable using – technology!

And screening youth for risk behaviors helps us meet national recommendations from both the American Medical Association and the American Academy of Pediatrics.

Please ask us if you have any questions or want any additional information about our screening with RAAPS.

Adolescents are faced with lots of health risks – including:

- ***Unsafe driving***
- ***Poor nutrition and lack of physical activity***
- ***Alcohol and drug use***
- ***Bullying and physical abuse***
- ***Dieting disorders (starving and/or binging)***
- ***Sad feelings or struggling with anger***
- ***Early or unprotected sexual experiences***