English

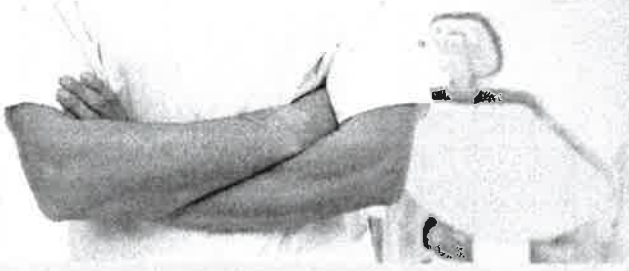
Time to SMILE!

Partnership Community Health Center has teamed up with **your** school to put a smile on **you**.

All Students Welcome

You are on your way to a great smile

- Parent or guardian needs to fill out enrollment forms
- Transportation provided to and from the dental clinic
- Partnership dental staff will take great care of you



Partnership
Community Health Center

Appleton West High School
APPLETON AREA SCHOOL DISTRICT

PARENTAL/LEGAL GUARDIAN CONSENT, WAIVER AND RELEASE FORM FOR FIELD TRIPS AND EXTRACURRICULAR TRIPS

I, as parent or guardian of _____, do hereby grant permission and consent for my child to participate in the following field trip or extracurricular trip:

Destination:

Date: Thursday's during the 2017 - 2018 School Year **Departure Time:** 7:55 am **Return Time:** Varies

Cost: None

Purpose/Curriculum Connection:
To obtain dental care such as cleaning, exam, x-rays, sealants, filling and fluoride. Will receive a treatment plan that will be brought home.

** Please contact the school if there are any financial concerns.*

PERMISSION AND CONSENT

In granting such permission and consent, I:

1. Acknowledge and assume full responsibility for any and all damage to person or property caused by our child during such activity.
2. Expressly authorize emergency medical or dental treatment deemed necessary by the school district, its agents, and employees during such activity.
3. Expressly agree that in the event that any disciplinary action or the health of my child requires that my child be returned home during such activity that such return shall be accomplished at our expense.

WAIVER AND RELEASE OF LIABILITY

In consideration for the participation of the above-named student in the field trip described, we, the student and parent(s) or guardian(s), each agree to the following:

1. The student's participation in the field trip or event described is entirely voluntary and is not a mandatory part of the school's curriculum;
2. We **RELEASE FROM LIABILITY AND WAIVE OUR RIGHT TO SUE** the Appleton Area School District and its administrators, directors, employees, school board members, teachers, chaperones, supervisors, volunteers and drivers (collectively "AASD"), **FOR ALL CLAIMS OR DAMAGES,** we separately or collectively may have, **FOR PERSONAL INJURY, BODILY HARM, INJURY TO OR LOSS OF PROPERTY, EMOTIONAL INJURY OR LOSS OF CONSORTIUM,** that may occur at or traveling to or from the event due to the negligence of AASD. We understand that we are not releasing AASD from liability for claims or damages arising from any reckless or intentional act of AASD;
3. We understand that this **WAIVER AND RELEASE** applies to the above-named student, his or her parent(s) or guardian(s), and their agents, representatives, heirs and assigns; and

WE ACKNOWLEDGE THAT WE HAVE CAREFULLY READ THIS WAIVER AND RELEASE AND UNDERSTAND ITS IMPACT AND EFFECT.

_____ _____

(Date) **(Signature of Parent or Guardian)**

IMPORTANT: REVERSE SIDE MUST ALSO BE COMPLETED

Student's Name: _____ **Date of Birth:** _____

CHILD'S HEALTH INFORMATION

For the safety of your child, please indicate any health conditions, allergies, restrictions, or special precautions that should be taken.

_____
_____
_____
_____
_____

Is it necessary for your child to take any medication while on this field trip (prescribed or over-the-counter)?

☐ Yes ☐ No

If yes, please list:

Name of Medication_____ Dosage_____

Time to be taken_____

If it is necessary for your child to take any medicines while on this field trip, please send the medicine in the original container, clearly labeled with your child's name. All medication must be accompanied with written directions and consent from the parent, and if medication prescribed, written physician consent is also needed (this is state law). The required medication forms can be obtained from the school office (HS-015, HS-017, HS-018) or on the Parent tab of the District's website www.aasd.k12.wi.us.

Physician's Name_____ Clinic_____ Phone_____

In case of emergency please contact _____ at _____
(Name) (Phone)

Alternate emergency contact _____ at _____
(Name) (Phone)

Partnership
Community Health Center

STUDENT REGISTRATION FORM - AASD

First Name:_____ Middle Name:_____ Last Name:_____

Social Security Number:_____ Birth Date:_____ Sex: □ M □ F

Financially Responsible Person, if not Patient:_____ Relationship:_____

Mother (If Minor):_____ Phone/Cell: (____) _____ - _____

Father (If Minor):_____ Phone/Cell: (____) _____ - _____

RESIDENCE: □ House, Apartment or Group Home □ Homeless: Shelter, Street

Street Address:_____

City:_____ County:_____ State:_____ Zip Code:_____

Phone/Cell: (____) _____ - _____

LANGUAGE(s): Spoken: _____ Read: _____

MARITAL STATUS: □ Single □ Married □ Divorced □ Widowed □ Legally Separated □ Significant Other

RACE: □ American Indian/Alaskan Native □ Asian □ Black or African American □ Declined

□ Multi-racial □ Native Hawaiian or other Pacific Islander □ Unavailable □ White

ETHNICITY: □ Declined □ Hispanic/Latino □ Non-Hispanic/Non-Latino □ Unavailable

PARENT EMPLOYER

□ Full-time □ Part-time □ Not Employed □ Student

Name:_____

Address:_____

City:_____

State:_____ Zip:_____

Phone: (____) _____ - _____

INSURANCE INFORMATION

Dental Insurance Name:_____

Dental Insurance Policy Number:_____

Dental Insurance Group Number:_____

Insured's Name:_____

Insured's Date of Birth:_____

Name on Forward Card:_____

ID# on Forward Card:_____

Medicare Number:_____

EMERGENCY CONTACT:

Name:_____ Relationship:_____ Phone/Cell: (____) _____ - _____

Minor

Patient Information

Patient: Date: 08/08/2017
Birth Date: Chart#: SS#:
Provider:
Phone:
Address:

Patient Questionaire

Cardiovascular/Heart

Congenital Heart Defect _____

If Yes, has it been replaced? _____

High Blood Pressure/Hypertension _____

Hematologic/Blood Disorder

Anemia _____

Abnormal Bleeding _____

Respiratory

Asthma _____

If Yes, Do you carry an inhaler with you? _____

Endocrine/Metabolic

Diabetes _____

If Yes, Type 1 or Type 2? _____

Thyroid Problem _____

Gastrointestinal

Acid Reflux/GERD/Frequent Heartburn _____

Frequent Vomiting _____

Hepatic/Liver

Hepatitis _____

If Yes, What type? _____

Liver Disease _____

Neurological

Epilepsy/Seizures _____

If Yes, When was the last one? _____

Injury to the head _____

Any sensory disorders (seeing/hearing) _____

Mental/Behavioral Health

Learning Disabilities _____

Communication Difficulties _____

Autism Spectrum Disorder _____

Eating Disorder _____

Other mental health problems _____

Other

Current on all vaccinations _____

Recent or Current infection (ear, throat, eye, respiratory, etc.) _____

Cancer _____

If Yes, When? Type? _____

Pregnant _____

If Yes, Estimated Due Date: _____

Tobacco/Alcohol/Substance Abuse _____

Anything else we should know about the patient's medical history? _____

Comments: _____

Does the patient regularly see a physician? _____

Recent Surgeries/hospitalizations? _____

Dental History

Is there a current toothache or other immediate dental problem? _____

Has the child ever had a toothache? _____

Has the child had any injury to the mouth, teeth, or jaws? _____

Is this the child's first dental visit? _____

Does the child have a habit of sucking tumb/fingers/pacifiers? _____

Does the child grind his/her teeth? _____

How often is tooth brushing performed? _____

How often does the child floss? _____

Does someone assist the child with brushing and cleaning the teeth? _____

Does someone inspect for thoroughness after brushing/flossing? _____

Does the child use fluoridated toothpaste? _____

Is the primary water suply from a well or the city? _____

Does the child regularly consume beverages such as soda, juice, engergy drinks, or sports drinks? _____

Does the child regularly consume sugar free beverages such as diet soda or flavored water? _____

Has the child been to the ER for dental pain? _____

Does the child have regular dental exams? _____

When was the last dental exam? _____

Allergies/Reactions _____

Allergies/Reactions Continued _____

Medication/Dose and frequency _____

Medication/Dose and frequency Continued _____

Date _____

Signature _____

Email Address: _____

CONSENT FOR TREATMENT OF MINOR
BY PARTNERSHIP COMMUNITY HEALTH CENTER

TREATMENT

(1) I recognize that my child or minor ward requires dental examinations by Partnership Community Health Center – Dental Clinic ("Clinic") on a twice-yearly basis, and I hereby voluntarily consent to dental examinations of my child or minor ward being performed by a Clinic health care professional ("Health Care Professional") on a twice-yearly basis.

(2) I recognize that health care practice is not an exact science and that, although rare, a dental examination may involve risks of injury. I acknowledge that no guarantees have been made to me as to the results of this dental examination.

(3) I understand that, should further dental care, such as cleaning or restorative care, be recommended for my child or minor ward, I will be contacted prior to any such care being provided.

(4) I understand that I can revoke my consent for dental examinations for my child or minor ward at any time by contacting Clinic at 920-731-7445.

RELEASE OF MEDICAL INFORMATION

(1) I hereby authorize release of any and all information from the records of this examination (including but not limited to references to treatment of alcohol, drug abuse, emotional illness, developmental disability and HIV testing/AIDS) to my Health Care Professional(s), my insurance company(ies), the Social Security Administration or its intermediaries or carriers, state and municipal governments or their agencies, medical research, disease collaborative and other study processes, or to any other institution or organization providing funds for my child or minor ward's health care services. I understand that disclosure will enable the Health Care Professional and/or the Clinic to collect payment for services rendered to my child or minor ward during my treatment by the Health Care Professional and/or enhance the continuity of my child or minor ward's care. I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon and will remain in effect for a reasonable time in order to achieve that purpose(s) for which it is given.

(2) I understand that I (or any other person holding an Authorization for the Disclosure of Health Information signed by me) have a right, upon reasonable notice to Clinic, to review my child or minor ward's medical record and/or receive a copy of my child or minor ward's medical record, including this consent, upon payment of reasonable costs.

BILLING, FINANCIAL RESPONSIBILITY & INSURANCE ASSIGNMENT

(1) I hereby authorize direct payment to Clinic of authorized benefits for this treatment. I hereby assign the benefits payable for any Health Care Professionals' services to the Health Care Professional or organization furnishing this service or authorize such Health Care Professional or organization to submit a claim to Medicare/Medicaid/my insurance for payment to me. I

understand that I may be financially responsible to Clinic for charges not covered by this assignment.

(2) I certify that the information given by me in applying for payment under Medicare/Medicaid or any other insurance plan is correct.

Private Insurance: For your convenience, we will submit claims to all primary and secondary insurance carriers.

Medicare: To assist our Medicare patients, we submit and accept assignment on all Medicare claims. If you have supplemental insurance and have provided us with the necessary information, we will file those insurance claims as well.

Medical Assistance: If you are covered by Medical Assistance, you will need to present an eligibility card at each visit.

Uninsured: The Clinic has established payment guidelines based on monthly income of the household. It is your financial responsibility to make payment at the time of service or to establish a payment plan.

For Additional Assistance: We can assist with your insurance or financial arrangements. Call our business office at 920-731-7445.

I have received the Notice of Privacy. ☐ **YES** ☐ **NO**

I have read this form and/or it is been fully explained to me, and I certify that I understand its contents and am authorized to sign it on the patient's behalf.

Minor Patient Name: _____ Date: _____
(Please Print)

Parent / Legal Guardian Name: _____
(Please Print)

_____ Date: _____
Signature of Parent or Legal Guardian

Partnership Community Health Center

Notice of Privacy Practices

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.

This notice applies to the Partnership Community Health Center, Inc. ("PCHC"). In addition, the notice applies to all locations where PCHC provides health care services.

PCHC is required by law to maintain the privacy of your protected health information and to notify you following a breach of your unsecured health information. "Health information" consists of all records related to your health, including demographic information, either created by PCHC or received by PCHC from other health care providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your health information. These legal duties and privacy practices are described in this Notice. PCHC will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your health information.

PCHC reserves the right to change the terms of this Notice and to make any new provisions effective for all health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

How PCHC may use or disclose your health information.

Without your written authorization, we may use your health information for the following purposes:

Treatment – We may use or disclose your health information to provide treatment to you. Treatment may include: providing, coordinating, or managing health care and related services by one or more health care providers; consultations between health care providers concerning a patient; referrals to other providers for treatment; and referrals to nursing homes, foster care homes, or home health agencies. For example, a doctor may use the information in your medical record to determine which treatment option, such as a drug or surgery, best addresses your health needs. The treatment selected will be documented in your medical record so that other care professionals can make informed decisions about your care. Your medical record may be a combination of a paper medical record and an electronic medical record.

Payment activities – We may use and disclose health information about you without your written authorization for payment activities. Payment activities may include: activities undertaken by PCHC to obtain payment for services provided to you; determining your eligibility for benefits or health insurance coverage; managing claims and contacting your insurance company regarding payment; collection activities to obtain payment for services provided to you; reviewing health care services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges; and obtaining pre-certification and pre-authorization of services to be provided to you. For example, PCHC will submit claims to your

insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations – We may use your health information for healthcare operations, which may include: contacting health care providers and patients with information about treatment alternatives; conducting quality assessment and improvement activities; conducting outcomes evaluation and development of clinical guidelines; protocol development, case management, or care coordination; conducting or arranging for medical review, legal services, and auditing functions. For example, we may look at your health information to determine the date and time of your next appointment with us and then send you a reminder letter to help you remember the appointment.

Treatment alternatives – We may use your health information and decide that another treatment or a new service we offer may interest you. For example, we may contact cancer patients to notify them that we have a new cancer research facility that offers new life-saving treatments.

As required by law – Sometimes we must report some or your health information to legal authorities, such as law enforcement officials in response to a court order, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries, or to respond to a court order. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime.

Public health activities – We may disclose your health information to authorities to help prevent or control disease, injury, or disability. This may include using your health information to report certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration or information related to abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure. We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV.

Health oversight activities – We may disclose health information, including treatment records, in response to a written request by any federal or state governmental agency to perform legally-authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. For example, we may disclose your health information to the Joint Commission on Accreditation of Healthcare Organizations and/or state surveyors so that they can monitor, investigate, inspect, discipline or license those who work in the healthcare system or for government benefit programs.

Activities related to death – We may disclose health information to coroners, medical examiners, and funeral directors so they can carry out their duties related to death, such as identifying the body, determining cause of death, or in the case of funeral directors, to carry out funeral preparation activities.

Organ, eye or tissue donation - We may disclose your health information to people involved with obtaining, storing or transplanting organs, eyes, or tissue of cadavers for donation purposes.

Research – Under certain circumstances, we may use and disclose health information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the clinic. We will almost always ask for your specific permission if the researcher will have access to your name, address or other health information that reveals who you are, or will be involved in your care.

To avoid a serious threat to health or safety – As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe in good faith that such disclosure is necessary to prevent or minimize a serious and approaching threat to your or the public's health or safety.

Military, national security, or incarceration/law enforcement custody - If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may disclose your health information to the proper authorities so they may carry out their duties under the law.

Workers' Compensation – We may disclose your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.

To those involved with your care or payment of your care – If people such as family members, relatives, or close personal friends are helping care for you or helping you pay your medical bills, we may disclose important health information about you to those people. The health information disclosed to these people may include your location within our facility, your general condition, or your death. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. In addition, we may disclose your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or health status. We will give you enough information so you can decide whether to object to release of your health information to others involved with your care.

Fundraising – We may contact you for the purpose of raising funds for PCHC's benefit, without a prior authorization. However, you have the right to opt out of receiving these fundraising communications.

Special Notes: There are certain restrictions on uses and disclosures of "treatment records," which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also additional restrictions on disclosing HIV test results.

With your written consent, we may disclose your health information as follows:

Psychotherapy notes - We must obtain your authorization for any use or disclosure of psychotherapy notes, with several exceptions. We may use or disclose psychotherapy notes without your authorization to carry out the following treatment, payment, or health care operations: the originator of the psychotherapy notes may use them for treatment; we may use or disclose psychotherapy notes for our own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or we may use or disclose psychotherapy notes to defend ourselves in a legal action or other proceeding brought by you. We are required to disclose psychotherapy notes, without your authorization, when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with HIPAA. We may also use or disclose psychotherapy notes to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. We may also, under certain circumstances, disclose psychotherapy notes to a health oversight agency for oversight activities authorized by law with respect to the oversight of the originator of the psychotherapy notes. We may also disclose psychotherapy notes to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may also use or disclose psychotherapy notes, consistent with applicable law and standards of ethical conduct, if we believe, in good faith, 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, and if the use or disclosure is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Marketing - We must obtain your authorization for any use or disclosure of health information for marketing, except if the communication is in the form of a face-to-face communication made by us to you or a promotional gift of nominal value provided by us.

Sale of health information - We must obtain your authorization for any disclosure of health information which is a sale of health information.

PCHC will not make any other use or disclosure of your health information without your written authorization. You may revoke such authorization at any time, except to the extent that PCHC has already acted in reliance upon your authorization. Any revocation must in writing.

YOUR HEALTH INFORMATION RIGHTS

You have several rights with regard to your health information. If you wish to exercise any of the follow rights, please contact us. Specifically you have the right to:

Inspect and copy your health information - With a few exceptions, you have the right to inspect and obtain a copy of your health information. As examples of exceptions, this right does not apply to "psychotherapy notes" (information relating to mental health maintained separately from the medical record) or information gathered for judicial proceedings. PCHC may deny access under other circumstances, in which case you have the right to have such a denial reviewed. In addition, we may charge you a reasonable fee if you want a copy of your health information.

Request to correct your health information - If you believe your health information is incorrect, you may ask us to correct it. You may be asked to make such requests in writing and to give a reason why your health information should be changed. However, if we did not create the health information that

you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.

Request restrictions on certain uses and disclosures - You have the right to ask for restrictions on how your health information is used or to whom your health information is disclosed, even if the restriction affects your treatment or our payment or healthcare operation activities. Or, you may want to limit the health information provided to family or friends involved in your care or payment of medical bills. You may also want to limit the health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all circumstances to your request restriction. If you receive certain medical devices (for example, life-supporting devices used outside our facility), you may refuse to release your name, address, telephone number, social security number, or other identifying information for purpose of tracking the medical device.

As applicable, receive confidential communication of health information - You have the right to ask that we communicate your health information to you in different ways or places. For example, you may wish to receive information about your health status in a special, private room or through a written letter sent to a private address. We must accommodate reasonable requests.

Receive a list of disclosures of your health information - You have the right to ask for a list of certain disclosures of your health information we have made during the previous six years, but the request may not include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must comply with your request for a list within 10 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year (in which case we may charge you a reasonable fee). This list will not include: disclosures made to you; disclosures authorized by you; or disclosures made for purposes of treatment, payment, health care operations, our directory, national security, law enforcement/corrections, certain health oversight activities, and certain other purposes.

Obtain a paper copy of this notice - Upon your request you may at any time receive a paper copy of this notice.

Complaint – If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services. We will not retaliate against you for filing such a complaint. We have a system to voice your concerns. Please contact the front desk or any staff member to fill out an incident report. These reports will be reviewed and followed through by the Health Center Privacy Officer and QI Committee.

Again if you have any questions or concerns regarding your privacy rights or the information in this notice, please contact us at 920-731-7445.

This Notice of Privacy Practices is effective May 1, 2013.