# NISWONGER CHILDREN'S VIRTUAL HEALTH CLINIC

*A service of First Assist Urgent Care*

## WE CAN SEE YOU NOW.

*When your child needs medical attention during the school day, you've always been able to rely on the caring touch of your school nurse. Now, for illnesses or injuries that need a higher level of care, your child can have virtual access to our medical professionals without leaving the nurse's office.*

- Your child will be seen by a physician or licensed nurse practitioner who can assess the child, work with the school nurse to perform basic labs, and write prescriptions if needed.
- The school will call you before initiating a visit to obtain your consent.
- Parents can come to the school to participate in the virtual visit if they wish.
- Our professionals will follow up with your child's primary care physician and help arrange any necessary follow-up appointments.
- We will bill your insurance, or you can pay a flat fee of $49 for the visit.
- To enroll in the program, fill out the form in your back-to-school packet, or contact your school nurse.

NISWONGER Children's HOSPITAL

**Where Hope Rises**

NiswongerChildrens.org

# DEAR PARENT/GUARDIAN

Lisa Carter, CEO
*Niswonger Children's Hospital*

At Niswonger Children's Hospital, we care about you and your family. That's why we're excited to announce a new service in conjunction with Mountain States Medical Group, First Assist Urgent Care and eMD Anywhere that will be offered to your child's school.

This program was created in partnership with your school to offer kids instant access to a team of health care professionals when they need a higher level of care than their school nurse can provide. As a parent/guardian, you'll even have access to join the visit through your computer or phone if you desire. The provider will work with the school nurse to perform basic labs and write prescriptions if necessary, and will follow up with your child's primary care doctor after the visit to communicate what care was provided and arrange follow-up appointments if necessary.

For each visit to the clinic, your insurance will be billed for a primary care visit (not an urgent care visit) even though the bill will have a First Assist Urgent Care logo on it. However, if you don't want to use your insurance, there will be a $49 fee for a clinic visit. Keep in mind: If you have insurance and pay this $49 fee, your insurance will not be billed, so this fee will not count toward your deductible.

Enclosed in this packet, you'll find additional information explaining the clinic and how you and your child can participate.

We hope you enjoy and take part in this clinic. If you have any questions, please don't hesitate to call Linda Snodgrass, the practice administrator of the school-based program, at 423-946-0482.

Sincerely,

Lisa Carter, CEO
Niswonger Children's Hospital

# FREQUENTLY ASKED QUESTIONS

It is our pleasure to introduce you to the school-based clinic, developed in partnership with Mountain States Medical Group ("MSMG"). Using telemedicine technology, our goal is to provide quality health care to staff and students in the convenience of the school setting.

## GENERAL INFORMATION

**How does the school-based clinic work?**
With the help of telemedicine technology, an off-site provider can receive information related to a patient's medical condition. The provider can also view images of the patient's throat/mouth, ears, eyes, skin rashes, and so forth through interactive audio and visual technology. This model enables students to access health care services in a timely and convenient manner, reducing time away from school or work. Typically, a nurse will be present with the student on-site, while the doctor will be off-site.

**What services will the school-based clinic offer?**
The school-based clinics offer primary care services to students and staff, including the following:

- Fever
- Sore Throat
- Allergy Symptoms
- Ear Pain
- Nausea
- Abdominal Pain
- Skin Irritation
- Inflammation
- Limb Sprains
- Chronic Illness
- UTI

**What if I/my child do not have insurance?**

- A $49 flat rate fee will be billed for the consultation if you do not have medical insurance. Your school can also work to secure enrollment in the state health insurance plan (TennCare) if your child qualifies.
- If the nurse and/or doctor determine that additional health care services would be necessary or beneficial, they may provide a referral or recommendation for follow-up care.

**When is the school-based clinic open?**

- The clinic will be open Monday – Friday, during normal school hours.

**Which practitioners are participating?**

- All providers are employed by Mountain States Medical Group First Assist Urgent Care

**How do I enroll my child?**

- Complete, sign, and return all of the forms in this packet.
- Include a photocopy of your insurance card with the completed forms.
- Please copy the front and back of card.

# FREQUENTLY ASKED QUESTIONS

## TELEMEDICINE VISIT DETAILS

**Do I have to be present for the telemedicine visit?**
No, you do not have to be present. But you are welcome and encouraged to attend the visit. The nurse will attempt to contact you and invite you to join by phone or video technology. If the nurse is unable to reach you in a timely manner and you have already completed the proper paperwork, we will proceed with the telemedicine visit and provide you with a summary of the visit upon your request.

**Will my child be alone during the visit?**
No. The school nurse will be in the room to assist the off-site physician with his assessment. Others may also be present to help operate the telemedicine equipment.

**Can I view the telemedicine visit?**
At the time of the visit, you can be sent a link. You can join the video call from a computer or your phone if you have the APP downloaded

**Will my child be able to stay at school after a telemedicine visit?**
It depends on the child's medical condition, symptoms, and whether he/she is well enough to remain at school. By providing health care services in a timely manner, we aim to help students miss fewer days at school (due to earlier treatment) and to save parents time off work as well.

**How soon do I know what the eMD consult recommendations were?**
The provider will follow up with the guardian/parent after the call. There will also be a faxed copy sent to the primary care if this was indicated on the paperwork. If you participate in the call, it can all be discussed at that time.

**How am I notified of the office visit results, prescriptions, doctor's notes, and so forth?**

- Prescriptions will be e-prescribed to your preferred pharmacy.
- If applicable, a doctor's note will be sent to the appropriate school office.
- The school nurse will be available to answer your questions and/or provide you with a written summary of the visit, upon your request. You may also receive a follow-up letter or statement.

**What are the provider's credentials?**
The providers are Physician Assistants, Nurse Practitioners, or Physicians

**Can I opt out of the visit and still have my child see a school nurse?**
Yes, all you have to do is to not complete the consent form. However, if your child becomes sick and needs a telemedicine visit, this visit cannot be performed without a consent form and insurance information.

**What happens if my child needs further treatment?**
The provider will make a clinical decision as to what further treatment is needed and communicate that information to the school nurse and a guardian/parent.

PERF LINE

**Consent for Care and Treatment**

Mountain States Medical Group (**"MSMG"**) has partnered with your school to develop collaborative school-based healthcare clinics. Our goal is to provide quality health care to staff and students in the convenience of the school setting. We aim to positively affect students' health, school attendance, and academic performance. For more information, please refer to our "Frequently Asked Questions" or contact the school nurse at your child's school.

**In order for your child to receive health care services at the school-based clinic, you must consent to the following and complete/sign this form where indicated.**

- I give my consent for MSMG, its physician(s), and other health care providers (**"Providers"**) to examine (student's name) _____ and to provide care and treatment, which may include the evaluation, diagnosis, consultation, and treatment of my child's medical condition using advanced telecommunications technology (**"Telemedicine Services"**).
- I understand that if my child requires Telemedicine Services, reasonable attempts will be made to contact me and invite me to join the medical visit by phone or video technology. If I cannot be reached in a timely manner, I understand and give consent for my child to be seen by Providers in my absence and to provide me with a summary of the visit upon my request.
- I understand that Telemedicine Services may include audio, video, or other electronic media and Providers may: (1) be located off-site; (2) examine my child face-to-face via telemedicine technology and/or review health information transmitted via telemedicine technology; and (3) rely on information provided by my child and/or other on-site health care professionals.
- I understand and agree that Providers shall not be held liable for factors beyond their control (such as technology failures, incomplete or inaccurate data provided by others, or distortions of images due to electronic transmission). I understand that reasonable steps will be taken to protect the confidentiality of patient data, but the security of electronic information cannot be guaranteed.
- I understand that other individuals may be present during the visit to operate telemedicine equipment and technology, and I consent and authorize audio/video recording or photography to be taken in order to provide the Telemedicine Services to my child. These recordings or photographs may become part of my child's medical record.
- I understand that if a Provider believes that further health care services are required or would benefit my child, a referral or recommendation for follow-up care may be made.

*I have read this form or had it read to me, and I understand its contents. By signing below, I affirm that: (1) I agree to all of the statements above, and (2) I authorize Telemedicine Services to be provided to my child during the _____ school year.*

_____ _____

Signature of Parent or Legal Guardian Date

**Assignment & Authorization To Bill Insurance**

**In order for your child to receive health care services at the school-based clinic, you must consent to the following and complete/sign this form where indicated.**

- I authorize and grant to MSMG permission to bill my insurance company or other applicable third-party payor(s) for health care services provided to my child. I also authorize direct payment from my insurance company to MSMG for the health care services provided to my child.
- I assign and convey directly to MSMG my rights under the applicable insurance and/or benefit policies, so that MSMG may obtain payment for health care services provided to my child. I assign to MSMG: (1) the right to claim payment for goods and services provided to my child by MSMG; (2) the right to any settlements or legal remedies; and (3) the option (but not the obligation) to appeal or pursue any denied or delayed claims.
- I authorize MSMG to release information – which relates to the health care services provided to my child – to my insurance company, applicable third-party payor(s), and/or their representatives. I also authorize my insurance plan and other applicable third-party payor(s) to release information to MSMG regarding benefits, coverage, and settlement information.
- I understand and agree that I am fully responsible for any unpaid bills not covered by my insurance policy, including co-payments, deductibles, and/or other out-of-pocket costs, in accordance with MSMG's fee schedule. If I do not have insurance coverage, I understand that I will be billed directly for MSMG's services to my child. I agree to promptly pay any such out-of-pocket amounts for the health care services provided by MSMG to my child.

*I have read this form or had it read to me, and I understand its contents. By signing below, I affirm that I understand, acknowledge, and agree to all of the statements above.*

_____ _____

Signature of Parent or Legal Guardian Date

_____

Printed Name of Parent or Legal Guardian

PERF LINE

MOUNTAIN STATES MEDICAL GROUP

*Medical Record / CI #:* _____

*Patient Name:* _____

*Date of Birth:* _____

# REGISTRATION CONSENTS AND ACKNOWLEDGEMENTS



## PRIVACY ACKNOWLEDGEMENT

1. May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results?* ❑ Yes ❑ No
   If no, is there another number at which we may try to reach you? _____
2. May we mail to the address you provided information regarding your appointment or test results?
   ❑ Yes ❑ No If no, is there another address at which we may send you information?
   _____
3. Do you wish us to share health information regarding you with a family member or friend?
   ❑ Yes ❑ No If yes, please provide name of person(s). _____
4. May we contact you via e-mail with information about our practice, educational programs and general health information?
   ❑ Yes ❑ No If yes, I understand that email transmissions may not be secure and will not be used for the purpose of communicating my personal health information.

**NOTE:** To protect your information, we reserve the right to use professional judgment and discretion when communicating information/test results which may be "sensitive" in nature.

❑ I acknowledge I have received a copy of Mountain States Medical Group's "Notice of Privacy Practices for Protected Health Information," which describes how MSMG uses and discloses health information.

## REFERRALS FOR SERVICES

This practice is an affiliate of Mountain States Health Alliance (MSHA). MSHA is committed to Bringing Loving Care to Health Care and exists to identify and respond to health needs of individuals and communities in our region and in attaining their highest possible level of health. Consistent with the MSHA-wide mission and shared values of our employed physicians, our physician employees agree to refer their patients to providers, practitioners and suppliers within the MSHA system whenever their patients need medical services not available at this practice and whenever such referral is in the individual patient's best interest, not contrary to the patient's express choice and not inconsistent with the requirements of the patient's insurance.

## MEDICARE AND MEDICAID INFORMATION

I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare/Medicaid claim. I further certify that I have provided any required information concerning any other liability for medical practice charges in order to complete the Medicare Secondary Payor (MSP) form. I request that payment of authorized benefits be made on my behalf. I authorize Mountain states Medical Group to secure information from the Department of Human Services regarding my qualification for Medicaid.



PERF LINE

MOUNTAIN STATES MEDICAL GROUP

*Medical Record / CI #:* _____

*Patient Name:* _____

*Date of Birth:* _____

# REGISTRATION CONSENTS AND ACKNOWLEDGEMENTS



**BY SIGNING AND DATING THIS ATTACHED SPACE, I ACKNOWLEDGE NOTICE AND RECEIPT OF THE ABOVE INFORMATION PRIOR TO TREATMENT.**

**Patient / authorized Representative signature** _____ Date _____ Time _____
If Authorized Representative, relationship to Patient: _____

**If person other than patient is responsible for payment:**

**Guarantor signature _____ Date _____ Time _____**

**Witness signature _____ Date _____ Time _____**

PERF LINE

PERF LINE

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# Health Questionnaire

*Instructions for Parents: Please complete this form on your child's behalf, and attach a copy of your insurance card.*

## GENERAL HEALTH

Does your child have any known allergies (foods, medications, etc.)? Yes ☐ No ☐
List all known allergies: _____
_____

Does your child have any Physical Disabilities? Yes ☐ No ☐
If yes, please explain: _____
_____
_____

Is your child currently being treated for any health problems? Yes ☐ No ☐
Specify who is providing the treatment:
If yes, explain: _____
_____

Does your child take daily medications? Yes ☐ No ☐

Please list all medications, the dosage, and when given:

| Name of Medication | Dosage | When Given | Name of Medication | Dosage | When Given |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

## FAMILY HISTORY

(Mother-M, Father-F, Brother-B, Sister-Sis, Son-S, Daughter-D, Grandmother-GM, Grandfather-GF, Aunt-A, Uncle-U)
Please specify who has or had any disease listed below, by using the abbreviations above.
If none, please check the box at the bottom of this section.

| | WHO | | WHO |
|---|---|---|---|
| Asthma | _____ | Heart Trouble | _____ |
| Allergies | _____ | High Blood Pressure | _____ |
| Birth Defects | _____ | Kidney/Bladder Problems | _____ |
| Blood Disorders/Anemia | _____ | Lung Diseases | _____ |
| Cancer | _____ | Tuberculosis | _____ |
| Tumors | _____ | Seizure | _____ |
| Cystic Fibrosis | _____ | Developmental Disability | _____ |
| Diabetes (Before Age 40) | _____ | Muscle Disease/Weakness | _____ |
| Early Childhood Death | _____ | Death Under Age 50 | _____ |
| Ear/Eye Disorders | _____ | | |

Not applicable. There is no family history of the above diseases. ☐

**Do you, your child, or anyone in the home:**

| | YES | NO |
|---|---|---|
| SMOKE | ☐ | ☐ |

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NISWONGER Children's HOSPITAL

## MEDICAL HISTORY

Please specify if your child has or had any condition listed below.

| Conditions | YES | NO |
|---|---|---|
| Allergies | ☐ | ☐ |
| Allergic to drugs | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Kidney/Urinary Tract Problems | ☐ | ☐ |
| Problems Walking | ☐ | ☐ |
| Other Respiratory Problems | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Shortness of breath during exercise | ☐ | ☐ |
| Stomach Ulcers | ☐ | ☐ |
| Skin Rashes | ☐ | ☐ |
| Abdominal Pain | ☐ | ☐ |
| Constipation/Diarrhea | ☐ | ☐ |
| Serious Digestive Problems | ☐ | ☐ |
| Chicken Pox Age ____ | ☐ | ☐ |
| Ear Problem | ☐ | ☐ |
| Ear Infections | ☐ | ☐ |
| Hearing Aid | ☐ | ☐ |
| Eye Problem | ☐ | ☐ |
| Ear Infections | ☐ | ☐ |
| Hearing Aid | ☐ | ☐ |
| Eye Problem | ☐ | ☐ |
| Wears Glasses | ☐ | ☐ |
| Musculo-Skeletal Problems | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ |
| Physical/Sexual Abuse | ☐ | ☐ |
| Hemophilia | ☐ | ☐ |
| Fainting Spells/Knocked Out | ☐ | ☐ |
| Frequent Sore Throat | ☐ | ☐ |
| Headaches | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Heart Problems | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Thyroid Problems | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Hepatitis | ☐ | ☐ |
| Injuries (Major) | ☐ | ☐ |
| Broken Bones | ☐ | ☐ |

| Behavior History | YES | NO |
|---|---|---|
| Nightmares | ☐ | ☐ |
| Bedwetting | ☐ | ☐ |
| Eating Problems | ☐ | ☐ |
| Thumb Sucking | ☐ | ☐ |
| Discipline Problems | ☐ | ☐ |
| Overactive/Hyperactive | ☐ | ☐ |
| Shy | ☐ | ☐ |
| Sleeping Problems | ☐ | ☐ |
| Slow Development | ☐ | ☐ |
| Learning Disability | ☐ | ☐ |
| Smoker | ☐ | ☐ |
| Former Smoker | ☐ | ☐ |
| Alcohol | ☐ | ☐ |
| Inhalant Abuse | ☐ | ☐ |
| Other Drugs | ☐ | ☐ |
| Depression | ☐ | ☐ |
| Other Behavioral Problems | ☐ | ☐ |
| Other Mental Problems | ☐ | ☐ |

| Other Medical History | YES | NO |
|---|---|---|
| Frequent Colds | ☐ | ☐ |
| Lung Problems | ☐ | ☐ |
| Meningitis | ☐ | ☐ |
| Menstruation Started Age ____ | ☐ | ☐ |
| Menstrual Problems | ☐ | ☐ |
| Premature Birth Weight | ☐ | ☐ |
| Obese/Overweight | ☐ | ☐ |
| Underweight | ☐ | ☐ |
| Serious Acne | ☐ | ☐ |
| Speech Problem | ☐ | ☐ |
| Pregnant | ☐ | ☐ |
| Sickle Cell Disease | ☐ | ☐ |
| Sickle Cell Trait | ☐ | ☐ |
| Other Blood Disorders | ☐ | ☐ |
| Seizures/Epilepsy | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| AIDS/HIV | ☐ | ☐ |
| HPV | ☐ | ☐ |

Explain any **Condition(s)** marked "YES".

**PLEASE REMEMBER TO ATTACH A COPY OF YOUR PHOTO ID & YOUR INSURANCE CARD (Front & Back).**

PERF LINE

NISWONGER Children's HOSPITAL

# Patient Information Form

*Instructions for Parents: Please complete this form on behalf of your child.*

## PATIENT INFORMATION

Child's Name (Last Name, First Name, Middle Name):_____

Date of Birth (Month/Day/Year): _____ / _____ / _____ Male: (☐) Female: (☐) SSN #:_____- _____- _____

Child's Street Address: _____

Child Lives With (Check All That Apply): ☐ Mother ☐ Father ☐ Guardian/Other: _____ Phone #: _____

Preferred Pharmacy Name:_____ Preferred Pharmacy Street Address: _____

Preferred Pharmacy Phone: _____ City, State, Zip: _____

School Name: _____ School District: _____

Pediatrician/Primary Care Provider: _____ Physician/Primary Care Provider Phone/Fax #: _____

Is the Patient Covered by Medicare or Medicaid: ☐ YES ☐ NO

Race/Ethnicity (Please select appropriate group):

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Other

☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ Latino / Hispanic ☐ Decline to Answer

## PARENT/GUARDIAN INFORMATION

**Mother's/Guardian's Name:** _____ **Father's/Guardian's Name:**_____

Primary Phone: _____ Alternate Phone: _____ Primary Phone: _____ Alternate Phone: _____

Employer: _____ Work Phone: _____ Employer: _____ Work Phone: _____

Date of Birth: _____ Email: _____ Date of Birth: _____ Email: _____

**EMERGENCY CONTACT - In case of an emergency, who should we contact?**

Name: _____ Relationship:_____ Phone: _____

**Mountain States Medical Group may disclose *Medical* and *Billing* information to this contact: ☐ YES ☐ NO**

## INSURANCE INFORMATION

Is your child covered by insurance? ☐ YES ☐ NO

Person(s) Responsible for Bill: ☐ Mother ☐ Father ☐ Other:_____ Street Address: _____

Primary Phone Number: _____ Cell Phone Number:_____

**PRIMARY INSURANCE**

Policy Holder: ☐ Child ☐ Mother ☐ Father ☐ Other: _____ Date of Birth: _____

Insurance Name: _____ Insurance Phone #: _____

Insurance ID#:_____ Insurance Group #: _____

**SECONDARY INSURANCE**

Policy Holder: ☐ Child ☐ Mother ☐ Father ☐ Other: _____ Date of Birth: _____

Insurance Name:_____ Insurance Phone #: _____

Insurance ID# _____ Insurance Group #:_____

**I certify that the information contained on this form is true and correct. Furthermore, I understand that it is my responsibility and duty to inform Mountain States Medical Group if any information on this form changes in the future.**

_____

Printed Name of Parent/Legal Guardian Signature Date

PERF LINE

Back of Form
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PERF LINE

# 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.*

## WHO WILL FOLLOW THIS NOTICE:

This notice summarizes the privacy practices of members of Mountain States Health Alliance's ("MSHA's") Affiliated Covered Entity (ACE), which are health care facilities and other health care entities that are under MSHA's common ownership or control and share privacy policies and procedures.

These include, but are not limited to, the health care components of:
Abingdon Physician Partners, Blue Ridge Medical Management Corporation, Community Home Care, Inc., Dickenson Community Hospital, Emmaus Community Healthcare, LLC., Franklin Woods Community Hospital, Indian Path Medical Center, Johnson City Medical Center, Johnson County Community Hospital, Johnston Memorial Hospital, Inc., Mediserve Medical Equipment of Kingsport, Inc., Norton Community Hospital, Norton Community Physicians Services, LLC., Russell County Community Hospital, Smyth County Community Hospital, Sycamore Shoals Hospital, Unicoi County Memorial Hospital, Wilson Pharmacy, Inc., and Woodridge Hospital.

As the members of MSHA's ACE may change over time, you can go online to our website at www.MountainStatesHealth.com for a current list of members of Mountain States Health Alliance's ACE.

This notice applies to all departments, units, all healthcare professionals and others who may be involved directly or indirectly in your care at MSHA entities such as employees, physicians, allied health professionals such as physician assistants and nurse practitioners, residents, students, volunteers, business associates and others affiliated with MSHA. We may share your health information with each other for purposes described in this notice, including for our joint healthcare operations activities.

## OUR PLEDGE TO YOU:

We understand that your health information is personal, and we are committed to protecting its privacy. We are required by law to:

- Maintain the privacy of your health information
- Give you this notice of our legal duties and privacy practices regarding your health information
- Follow the terms of our Notice of Privacy Practices that are currently in effect; and
- Notify you following a breach that compromises the privacy or security of your health 1nformat1on

# NOTICE OF PRIVACY PRACTICES

## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

### RIGHT TO INSPECT AND COPY:

You have the right to request to inspect and obtain a copy of the health information that may be used to make decisions about your care or payment. To inspect and obtain a copy of your health information, you must submit your request in writing to the healthcare entity. There may be fees for the costs of copying, mailing or other supplies associated with your request.

### RIGHT TO AMEND:

If you feel that health information we have about you is incorrect, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the healthcare entity. We may deny your request under certain circumstances. You will be informed of the decision regarding any request for amendment of your health information and, if we deny your request for amendment, we will provide you with information regarding your right to respond to that decision.

### RIGHT TO AN ACCOUNTING OF DISCLOSURES:

You have the right to request a list of certain disclosures we make of your health information covering up to six years. We will include all disclosures except those for treatment, payment, health care operations, and certain other disclosures (such as those you asked us to make). To request this list of disclosures, you must submit your request in writing to the healthcare provider or facility. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list but will notify you of the cost involved and offer you the chance to withdraw or modify your request before any costs are incurred.

### RIGHT TO REQUEST RESTRICTIONS:

You have the right to request a restriction on the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to a request for restrictions, other than a request that we not disclose information to a health plan for payment or health care operations where the request relates only to a health care item or service for which we have been paid in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the healthcare provider or facility. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your health plan.

# NOTICE OF PRIVACY PRACTICES

## CONFIDENTIAL COMMUNICATIONS:

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. Your request must specify how or where you wish to be contacted and be submitted in writing. We will accommodate reasonable requests.

## RIGHT TO A PAPER COPY OF THIS NOTICE:

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may also obtain a copy of this notice at our website, www.MountainStatesHealth.com.

## HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

The following describes different ways that MSHA entities may use and disclose health information that identifies you.

## TREATMENT:

We may use health information to treat you or provide you with healthcare services. For example, we may tell your primary care physician about the care we provided you or give health information to a specialist to provide you with additional services.

## PAYMENT:

We may use and disclose health information so that we or others may bill or receive payment from you, an insurance company or a third party for the treatment and services you receive. For example, we may give your health plan information about your treatment so that they will pay for such treatment.

## HEALTHCARE OPERATIONS:

We may use and disclose health information for healthcare operations and administrative purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may share information with doctors, nurses, medical students, and other personnel for learning purposes.

## HEALTH INFORMATION EXCHANGE:

MSHA participates in one or more electronic health information exchange networks. Through these health information exchanges, your information will be electronically available to other health care providers and other entities. These entities can access your MSHA health information for your treatment or other permitted purposes. If you have questions about MSHA's involvement in electronic health information exchange, please contact our Privacy Officer in the Corporate Compliance Department at 423-302-3345 or the MSHA AlertLine at 1-800-535-9057.

# NOTICE OF PRIVACY PRACTICES

## FUNDRAISING ACTIVITIES:

We may disclose certain limited health information to our Foundation so that they may contact you regarding fundraising activities. You have the right to notify the Foundation at 423-302-3131 to request to not receive fundraising information.

## FACILITY DIRECTORY:

We may list your information in our facility directory, unless you ask us not to.

## INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE:

If you do not object, we may disclose relevant health information to a family member, friend, or other person involved in your medical care or who helps pay for your care. We may also disclose health information to a personal representative, who is a person who has legal authority to make healthcare decisions on your behalf.

## BUSINESS ASSOCIATES:

We may disclose health information to our business associates who perform functions on our behalf or provide us with services, if the information is necessary for such functions or services.

## RESEARCH:

Under certain circumstances, we may use and disclose health information for research purposes.

## OTHER PURPOSES:

We may use or disclose health information about you for other reasons:

- In a disaster relief situation
- To a school when proof of immunization is required for attendance, with your permission
- When required by international, federal, state or local law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law
- To avert a serious threat to health or safety of the public or another person
- For special government functions such as military, national security, and presidential protective services.
- In response to a court or administrative order, subpoena or other lawful process
- To a law enforcement official for law enforcement purposes
- To report child or elder abuse or neglect or domestic violence
- If you are an inmate, to a correctional institution
- To an organ donation bank or to facilitate organ or tissue donation
- To workers' compensation or similar programs for work-related injuries or illness
- For public health activities such as to prevent or control disease, injury or disability; to report births and deaths; to notify a person who may have been exposed or who may be at risk of spreading a disease
- To health oversight agencies for activities authorized by law
- To a coroner/medical examiner to identify a deceased person or determine cause of death
- To funeral directors to carry out their duties

# NOTICE OF PRIVACY PRACTICES

## OTHER USES OF MEDICAL INFORMATION:

Uses and disclosures of health information that are not discussed by this notice or required by law will only be made with your written permission. Your written authorization will typically be required for most uses and disclosures of psychotherapy notes, most uses and disclosures for marketing and most arrangements involving the sale of health information. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time.

## CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS:

If you receive alcohol or drug abuse treatment services at Woodridge Hospital, federal law and regulations provide additional privacy protection to information about these services. Generally, we may not identify that you receive services at Woodridge Hospital, or disclose any information identifying you as an alcohol or drug abuser unless:

1. You consent in writing:
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation

Violation of the Federal law and regulations governing the confidentiality of alcohol and drug abuse treatment records is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations governing alcohol and drug abuse treatment records do not protect:

- Any information about a crime committed by a patient either at the treatment program or against any person who works for the program, or about any threat to commit such a crime.
- Any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations governing the privacy of alcohol and drug abuse treatment records.)

## CHANGES TO THIS NOTICE:

We reserve the right to change this notice and the revised or changed notice will be effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at each MSHA covered entity. The effective date is noted on the first page.

## COMPLAINTS:

- If you have questions, would like additional information or believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Privacy Officer in the Corporate Compliance  Department at 423-302-3345 or the MSHA AlertLine at 1-800-535-9057. There will be no retaliation against you for filing a complaint.

# NOTES

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