Keys AHEC
Health Centers
SCHOOL MEDICAL CENTER

Dear Parent/Guardian,

Keys AHEC is proud to announce the ability to provide a School Primary Care Medical Center at 8 selected Monroe County Public School sites.

The **KEYS AHEC HEALTH CENTERS** will offer basic primary care services that include: school and sport physicals, management of chronic illness and prescriptions. All of these services are provided to children enrolled in Monroe County Public Schools at no-cost. There are no fees or co-pays; however, Keys AHEC may bill insurance companies, where applicable.

All services require parental consent. Should you want your child to receive clinical health services when they are needed, you must sign the **General Consent for Clinical Treatment Form.** Please fill out all sections with the requested information. The General Consent for Clinical Treatment must be signed and dated by the child's parent or legal guardian. If you need help finding a primary care doctor, please let your school health team know and a member of the staff will be happy to assist you.

It is important that you return the completed and signed **General Consent for Clinical Treatment Form** to the child's school or teacher as soon as possible. This will ensure that your child is able to receive services when they are needed and without any delay.

After the school receives the signed **General Consent for Clinical Treatment Form**, your child will be allowed to receive the designated health care services provided by **Keys AHEC HEALTH CENTERS**. Please contact the School Medical Clinic Administrative Office at**: 305-743-7111 x 210** with any questions that you may have.

Sincerely,

Michael Cunningham

Michael Cunningham
CEO Keys AHEC

Florida Keys Area Health Education Center, Inc.
5800 Overseas Hwy, #38-Marathon, FL 33050 PH. 305-743-7111/ FAX 305-743-7709

Keys AHEC
Health Centers

Attention to our Insured Patients

While Keys AHEC Health Centers may bill your insurance company, **there are NO deductibles, coinsurance, copayments, or similar charges or any other out-of-pocket fees required of you as our patient.**

However, on behalf of your insurance company you may receive:

An **explanation of benefits** (commonly referred to as an **EOB** form) which is a statement sent by your health insurance company explaining what medical treatments and/or services were paid for on your behalf.

You may also receive information on your **deductible** which is the amount you would typically have to pay **out-of-pocket** for expenses before your insurance company will cover the remaining costs.

Because Keys AHEC waives all out-of-pocket expenses

YOU ARE NOT RESPONSIBLE FOR THIS OR ANY OTHER FEES.

Keys AHEC
Health Centers

RELEASE OF INFORMATION

I, ___________________________ AUTHORIZE Keys AHEC HEALTH CENTERS to release information regarding treatment to third party payors for the purpose of billing.
By my signature affixed below, I certify that I understand the contents and specifications of this form, which I have read or had read to me.

Parent / Guardian / Patient Signature___________________________**Date:** _____________

GENERAL CONSENT FOR CLINICAL TREATMENT FORM

By signing below, I hereby consent and authorize Keys AHEC's Health Centers, and its medical personnel, to conduct medical clinic services and treatment to the above named Student, including any laboratory tests, or treatment which in their judgment may be deemed necessary.

I understand that the results of medical information obtained while my child receives treatment at the HEALTH CENTER is confidential and will not be disclosed to anyone without my written permission or a court order as required by applicable federal and state laws. I understand Florida laws require Keys AHEC to provide the Department of Health with a report of those individuals diagnosed with communicable diseases. Therefore, I authorize Keys AHEC to report to the Department of Health whenever my child is diagnosed as having a communicable disease. I further understand that my child and/or I will be notified of such a diagnosis. Without written notification to change my preferences related to my child's treatment, I understand that this consent expires on the date that my child is no longer enrolled in the school.

I consent to the use and release of medical information as necessary for treatment, payment, and healthcare operations of Keys AHEC, including the treatment provider, guarantor of accounts, or third party payers for which I have assigned benefits or which may otherwise reimburse for the provision of services, and if requested to my primary care physician or any other healthcare provider for purposes of continuity of care.

Parent / Guardian / Patient Signature___________________________**Date:** _____________

KEYS AHEC HEALTHCENTERS NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Keys AHEC SCHOOL MEDICAL CLINIC Notice of Privacy Practices (see back 3 pages attached)

Parent / Guardian / Patient Signature___________________________**Date:** _____________

GUARDIANS

I, ______________________ am related to the child ____________________ and I am legally authorized to sign this document.

Guardian Signature ____ **Date:**_____________

Keys AHEC
Health Centers

Patient Information/ Información del Paciente/Enfòmasyon sou Pasyan an:

Patient's Name/Nombre del Paciente/Non Pasyan an

Date of Birth/Fecha de Nacimiento/Dat nesan

Sex/Sexo/Sèks: ☐Male/Hombre/Gason ☐Female/Mujer/Fi

Address/Dirección/Adrès

City/Ciudad/Vil

Zip/Código Postal/Kòd Postal

Email/Correo Electronico/Imel

Home Phone/Teléfono de Casa/Telefòn Lakay

Cell Phone/Teléfono Móvil/Telefòn Selilè

Patient's SSN/Numero de Seguro Social del Paciente/SSN Pasyan an

Race/Raza/Ras

School Attending/Escuela a la que Asistio/Lekòl li

Ethnicity/Etnicidad/Etnisite

Primary Language/Idioma Principal/Lang Prensipal

Grade/Grado/Ane

Parent-Guardian Information/Información de los Padres-Guardian/Enfòmasyon sou Paran-Gadyen:

Mother/Madre/Manman

Phone/Teléfono/Telefòn

Father/Padre/Papa

Phone/Teléfono/Telefòn

OR/O/OSWA

Guardian/Guardián/Gadyen Legal

Phone/Teléfono/Telefòn

Emergency Contact/Contacto de Emergencia/Kontak Ijans

Phone/Teléfono/Telefòn

Insurance Information/Informacion del Seguro/Enfòmasyon sou Asirans

Insurance Name/Nombre del Seguro/Non Asirans

☐ Medicaid

Policy #/Politica #/Règleman #

OR
O
OSWA

☐ I have no insurance.
No tengo seguro.
Mwen pa gen asirans.

Group #/Grupo #/Gwoup #

Name of Policy Holder/Nombre del Titular de la Poliza/Non Moun ki gen Asirans

I need assistance in obtaining insurance for my child.
Necesito ayda para obtener un seguro para mi hijo.
Mwen bezwen asistans pou jwenn asirans pou pitit mwen an.

☐ Yes/Sí/Wi ☐ No/Non

Keys AHEC
Health Centers

Patient's Name/Nombre del Paciente/Non Pasyan an ______________________ Date of Birth/Fecha de Nacimiento/Dat Nesan ______________________

Family Doctor Name/Nombre del Médico de Familia/Non Dokte Fanmi a ______________________ OR O OSWA ☐None/Ninguno/Okenn

Medical History/Historial Médico/Istwa Medikal

Current Medications/Medicamentos y Suplementos/Medikaman ak Sipleman: OR O OSWA ☐None/Ninguno/Okenn

____

____

Allergies & Reactions/Alergias y Reacciones/Alèji ak Reyaksyon: OR O OSWA ☐None/Ninguno/Okenn

____

____

Surgeries/Cirugías/Operasyon yo: OR O OSWA ☐None/Ninguno/Okenn

____

____

Hospitalizations/Hospitalizaciones/Entène lopital: OR O OSWA ☐None/Ninguno/Okenn

____

____

Chronic Medical Conditions/Condiciones Médicas Crónicas/Kondisyon Medikal Kwonik:

(Mark all that apply/Marque Todo lo que Corresponda/Make Tout sa ki Aplike)

	Patient Paciente Pasyan	Parent Madre/Padre Paran	Grandparent Abuelo/Abuela Granparan
Alcoholism/Alcoholismo/Tafyatè			
Asthma/Asma/Opresyon			
Cancer/Cáncer/Kansè			
Depression/Depresión/Depresyon			
Diabetes/Dyabèt			
Heart Attack/Infarto de Miocardio/Atak Kè			
Heart Disease/Enfermedad del Corazón/Maladi Kè			
Heart Murmur/Soplo Cardíaco/Kè ki pat bat nòmal			
High Blood Pressure/Alta Presión Sanguinea/Tasyon wo			
High Cholesterol/Colesterol Alto/Kolestewòl wo			
Kidney Disease/Enfermedad del Riñon/Maladi Ren			
Seizures/Convulsiones/Kriz			
Sickle Cell Disease/Enfermedad Drepanocito/Maladi Drépanocytose			
Thyroid Disease/Enfermedad de Tiroides/Maladi Tiwoyid			
Tuberculosis/Tibèkiloz			
Other/Otra/Lòt:______________________			
Other/Otra/Lòt:______________________			

Keys AHEC
Health Centers

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.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- ☐ Reporting abuse of children, adults, or disabled persons
- ☐ Investigations related to a missing child
- ☐ Internal investigations and audits by the department's divisions, bureaus, and offices
- ☐ Investigations and audits by the state's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability
- ☐ Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals
- ☐ District medical examiner investigations
- ☐ Research approved by the department
- ☐ Court orders, warrants, or subpoenas
- ☐ Law enforcement purposes, administrative investigations, and judicial and administrative proceedings

Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Department of Health.

Keys AHEC
Health Centers

INDIVIDUAL RIGHTS

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction. However, in situations where you or someone on your behalf pays for an item or service in full, and you request information concerning said item or service not be disclosed to an insurer, the Department will agree to the requested restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- ☐ Was not created by the department
- ☐ Is ot protected health information
- ☐ Is by law not available for your inspection
- ☐ Is accurate and complete

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- ☐ Disclosures made to you
- ☐ Disclosures to individuals involved with your care
- ☐ Disclosures authorized by you
- ☐ Disclosures made to carry out treatment, payment, and health care operations
- ☐ Disclosures for public health
- ☐ Disclosures for health professional regulatory purposes
- ☐ Disclosures to report abuse of children, adults or disabled
- ☐ Disclosures prior to April 14, 2003

This summary does include disclosures made for:

- ☐ Purposes of research, other than those you authorized in writing
- ☐ Responses to court orders, subpoenas, or warrants

You may request a summary for not more than a 6 year period from the date of your request.
If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.
The Department of Health may mail or call you with health care appointment reminders.

DEPARTMENT OF HEALTH DUTIES

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.
The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at www.myflorida.com and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the:
Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning July 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

REFERENCES

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register* 65, no. 250 (December 28, 2000). "Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. *Federal Register*, Volume 67 (August 14, 2002). HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).