ADVANCED NEUROPSYCHOLOGY AND PEDIATRIC PSYCHOLOGY SERVICES
Pediatric Evaluation Form

Pediatric Neuropsychology| Pediatric Psychology | Child/Adolescent Psychiatry

This form will be part of the patient's permanent medical record. You can skip questions that you do not want to answer. Your doctor will talk about the information in this form when you meet.

Patient's First and Last Name:______________________________

Patient's Preferred Name while at appointments here: ______________________________

Patient's Preferred Pronouns (circle all that apply):
She/her/hers He/him/his They/Theirs Other (please specify):

Date of Birth: ____________ Patient's Age: ______________

Name of Person(s) Completing Form: ______________________________

Relationship to Patient: ☐Self ☐ Parent ☐ Caseworker ☐Guardian ☐ Other (Specify): ________

Who Referred the Patient?______________________________

Why was the Patient Referred (what question needs to be answered or what is help needed for?):

____

PREGNANCY, DELIVERY & DEVELOPMENTAL HISTORY

☐ If you do not have information about the patient's health and development during their first 5 years of life, please check here and skip to the next section (Patient's Health History):

Please check if the patient's birth mother had any of the following events or experiences while pregnant with the patient:

☐ Prenatal Health Care or Check-ups ☐ Medical Concerns ☐ Mental Health Concerns
☐ Physical Injury ☐ Exposure to Toxins or substances ☐ Medication Use
☐ X-rays

Age of the patient's birth mother when the patient was born: ____________
How many weeks had the patient's birth mother been pregnant when the patient was born? _________
Were there any problems while giving birth to the patient? ☐ Yes ☐ No
Were there any health problems for the patient after birth? ☐ Yes ☐ No

Birth weight of patient: _____lbs. ______oz.
Did the patient leave the hospital at the same time that their birth mother did? ☐ Yes ☐ No
Did the patient gain weight as expected? ☐ Yes ☐ No
Did the patient have colic? ☐ Yes ☐ No
Did the patient have any problems feeding? ☐ Yes ☐ No
Were there any concerns with the patient's development? ☐ Yes ☐ No

How was the patient fed from 0-6 months (check all that apply)? ☐ Breast fed ☐ Formula Fed

When could the patient regularly do the activities listed below (please record the age):

	Years	Months
Smile at people	_______	_______
Crawl	_______	_______
Sit on own (without support)	_______	_______
Stand on own (without support)	_______	_______
Walk	_______	_______
Speak single words	_______	_______
Speak 2-3 word sentences	_______	_______
Stay dry during the day (urine only)	_______	_______
Stay dry at night (urine only)	_______	_______
Become toilet trained for bowel movements	_______	_______

Please circle the word that best describes the patient as a young child (less than 5yo):

Sensitivity to touch, taste, and/or smell:	Low	In the Middle	High
Followed a regular sleep & eating routine/schedule:	With Difficulty	In the Middle	Easily
Shifted from one activity to the next:	With Difficulty	In the Middle	Easily
Got comfortable in new situations and with new people:	Slow	In the Middle	Fast
Level of interest in new things (e.g. curiosity, exploration)	Low	In the Middle	High
Showed intense positive emotions (e.g. excited)	Rarely	In the Middle	Often
Showed intense negative emotions (e.g., frustrated, sad)	Rarely	In the Middle	Often
Level of energy	Low	In the Middle	High
Level of affection (cuddliness) the patient showed others	Low	In the Middle	High
Easily soothed or comforted	Rarely	In the Middle	Often

I would like to share more information on the topics in this section when we meet: ☐ Yes ☐ No

Patient's Health History

Patient's Primary Care Doctor: ____

Phone number:____

Address:____

Does the patient see medical specialists (e.g., neurology, endocrinology, cardiology, etc)? ☐ Yes ☐ No

Has the patient had any serious illnesses or injuries (e.g., needed surgery, an emergency room visit, a hospital stay, &/or many doctors appointments)? ☐ Yes ☐ No

Please check all that apply to the patient now or in the past:

☐ Asthma	☐ Eye problems	☐ Bowel problem	☐ Bladder problem	☐ Food allergy
☐ Genetic condition	☐ Ear aches	☐ Sickle Cell Anemia	☐ Physical disability	☐ Medication allergy
☐ Headaches	☐ Stomach aches	☐ Stroke	☐ Cerebral Palsy	☐ Diabetes
☐ Cancer	☐ Eating/Feeding problems		☐ Immune System Problem	
☐ Heart/Cardiac Issue	☐ Seizures/blackouts/epilepsy		☐ Brain Injury (unconscious, bleed, etc.)	

Has hearing been tested? ☐ Yes ☐ No When ________ Results__________________

Has vision been tested? ☐ Yes ☐ No When ________ Results__________________

Does the patient have any of the following now:

Speech/language problems?	☐ Yes	☐ No
Motor problems (e.g., hands feet/legs)?	☐ Yes	☐ No
Vision problems/glasses?	☐ Yes	☐ No
Hearing problems/hearing aids?	☐ Yes	☐ No

Please list all medications, supplements, and vitamins the patient is **currently** taking:

Medication/Supplement/ Vitamin	Dose	Reason Given	Prescriber/provider

Please list all medications the patient has taken **in the past**:

Medication	Child's Age	Reason Given	Prescriber/provider

Please check all of the mental health treatments that the patient has in place right now:

☐ None
☐ Not Available/Unknown
☐ Psychotherapy/counseling
☐ Medication(s)
☐ Inpatient psychiatric hospitalization
☐ Day treatment program
☐ Residential treatment
☐ Substance-use treatment
☐ Eating disorder treatment
☐ Case management
☐ Treatment related to foster care
☐ Treatment related to probation
☐ Family therapy
☐ Group therapy
☐ Court-mandated treatment
☐ School-based counseling
☐ Neuropsychological evaluation
☐ Psychiatric evaluation

Please check all of the mental health treatments that the patient had in the past:

☐ None
☐ Not Available/Unknown
☐ Psychotherapy/counseling
☐ Medication(s)
☐ Inpatient psychiatric hospitalization
☐ Day treatment program
☐ Residential treatment
☐ Substance-use treatment
☐ Eating disorder treatment
☐ Case management
☐ Treatment related to foster care
☐ Treatment related to probation
☐ Family therapy
☐ Group therapy
☐ Court-mandated treatment
☐ School-based counseling
☐ Neuropsychological evaluation
☐ Psychiatric evaluation

Please check all services that the patient or family had:

	Current	Past (not now)
Child Protective Services (CPS)	☐	☐
Office-Based (not through school) Physical Therapy	☐	☐
Office-Based (not through school) Occupational Therapy	☐	☐
Office-Based (not through school) Speech Therapy	☐	☐
Respite Care	☐	☐

I would like to share more information on the topics in this section when we meet: ☐ Yes ☐ No

FAMILY MEMBER HEALTH HISTORY

Family members include people related by blood and by family unions. Examples: birth family members, step family members, and adoptive and foster family members who the patient lives with now.

Please check all of the items below that apply to family members of the patient (names are not needed):

☐ Not Available
☐ Eating Disorder
☐ Tics/Tourette's
☐ Bipolar Disorder
☐ Anxiety
☐ Criminal activity or Legal Problems
☐ Chronic Pain
☐ Physical Disability
☐ Suicide Attempt
☐ Post Traumatic Stress Disorder
☐ ADHD
☐ Autism
☐ Depression
☐ Obsessions/Compulsions
☐ Special Education
☐ Substance Abuse
☐ Developmental/Learning Disabilities
☐ Schizophrenia
☐ Mental health treatment
☐ Stress-Related Physical Symptoms
☐ Chronic Medical Condition
☐ Other

There is detailed information I would like to share in-person on this topic: ☐ Yes ☐ No

SOCIAL HISTORY

Race and/or Ethnic Heritage: ________________ Primary language spoken in the home: ________________

Please check all who have legal custody of the patient:

☐ Birth Mother ☐ Birth Father ☐ Other Family Member: ______________________
☐ Adoptive parent(s) ☐ Foster parent(s) ☐ Ward of the State of Michigan

If the patient lives in more than one home, please note how much time is spent in each home:

____

Please list all individuals currently living in the patient's home(s):

Name	Age	Gender	Relationship

The patient has parents or siblings that do not live in their home(s)? ☐ Yes ☐ No
The patient is having a hard time getting along with people in their home(s)? ☐ Yes ☐ No
The patient is a parent of their own child(ren)? ☐ Yes ☐ No
There are weapons in the patient's home(s)? ☐ Yes ☐ No
There any family issues or changes that might be hard for the patient right now? ☐ Yes ☐ No

Please check all that apply to the patient's relationships with other people under 18 years old:

☐ Many friends ☐ School-only friends ☐ Online-only friends (never met)
☐ Close friends ☐ Friends mostly with younger children ☐ Friends mostly with older children
☐ No friends ☐ Friends mostly with family members ☐ Acquaintances/Associates
☐ Not interested in friends ☐ Hard to make friends ☐ Hard to keep friends
☐ Bullied ☐ Bullies others ☐ Conflict and disagreements
☐ Rejected by others

Older Children (12+ years only)

The patient is :

Dating:	☐ Yes	☐ No	☐ Not now, but in the past	☐ Unknown
Sexually Active:	☐ Yes	☐ No	☐ Not now, but in the past	☐ Unknown
Using Nicotine/Tobacco:	☐ Yes	☐ No	☐ Not now, but in the past	☐ Unknown
Using Alcohol:	☐ Yes	☐ No	☐ Not now, but in the past	☐ Unknown
Using Marijuana:	☐ Yes	☐ No	☐ Not now, but in the past	☐ Unknown
Using illicit drugs: (e.g., prescription pills that are not theirs, cocaine, heroin, etc.)	☐ Yes	☐ No	☐ Not now, but in the past	☐ Unknown
Engaged in activities with a risk for harm:	☐ Yes	☐ No	☐ Not now, but in the past	☐ Unknown
Involved with the legal system:	☐ Yes	☐ No	☐ Not now, but in the past	☐ Unknown
Employed:	☐ Yes	☐ No	☐ Not now, but in the past	☐ Unknown
Driving independently:	☐ Yes	☐ No	☐ Not now, but in the past	☐ Unknown
Taking medication(s) without supervision:	☐ Yes	☐ No	☐ Not now, but in the past	☐ Unknown

There is detailed information I would like to share in-person on this topic: ☐ Yes ☐ No

There are aspects of the patient's identity (racial, ethnic, religious, cultural, social, sexual, gender, etc.) that I would like to share in-person: ☐ Yes ☐ No

Stressful Life Events History

Please check all of the items below that apply to the patient ever in their life:

☐ Abuse ☐ Neglect ☐ Witness to Violence ☐ Traumatic event
☐ Human Trafficking
☐ Act(s) of violence or injustice based on their race, gender, sexual orientation, religious beliefs, ability status, or another part of their cultural identity
☐ None

There is detailed information I would like to share in-person on this topic: ☐ Yes ☐ No

Educational History

The patient is currently enrolled in school. If summer, the patient will be enrolled in school in the fall:
☐ Yes ☐ No ☐ Unsure

If "No", what was the last grade the patient completed: ____________________
If "Yes", what grade are they currently in/recently finish: ____________________

The patient's current school is:
☐ Public ☐ Charter ☐ Private ☐ Homeschool ☐ Early/Middle College ☐ Other

School Name/address:
____
____
____
____

Contact Person at School: ____

Please check all early programs that the patient had to support their development:

	Current	Past (not now)
Early On	☐	☐
Early Head Start	☐	☐
Head Start	☐	☐
Preschool	☐	☐
Daycare	☐	☐

The patient was held back in school? ☐ Yes ☐ No If yes, what grade(s)____________

Please check all items that are problems for the patient?
☐ Reading ☐ Math ☐ Attending school ☐ Following the rules
☐ Spelling ☐ Paying attention ☐ Tests ☐ Writing
☐ Finishing assignments ☐ Sitting still/quietly ☐ Getting along with others
☐ Learning new information (all subjects) ☐ Detention(s)/Suspension(s)/Expulsion(s)
☐ Talking in class ☐ Nurse/Office visits often ☐ Complaints of health problems

Has the patient been tested by the school to see what gets in the way of them doing better? ☐ Yes ☐ No
Does the child get any extra help, support, services, or therapies in school? ☐ Yes ☐ No
Does the patient have an IEP (Individualized Education Plan) or 504 Plan? ☐ Yes ☐ No
Any changes in the patient's grades or behavior in school lately? ☐ Yes ☐ No

There is detailed information I would like to share in-person on this topic: ☐ Yes ☐ No

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The information that I reported in this form is true to the best of my knowledge.

______________________________________ ____________________
Signature Date

Thank You!

Advanced Neuropsychology & Pediatric Psychology Services
HIPAA DISCLOSURE AUTHORIZATION FORM

Full Name (Patient)____

I hereby authorize the **disclosure or receipt** of my child's academic records, including, but not limited to: Individualized Education Plans, educational testing, grades and other records or information from:

____Or:____

(Name of Individual) (School District)

Address:____

Phone:_______________________________________ Fax:______________________________________

<u>For the purposes of consultation and/or evaluation and/or treatment.</u>

- I understand that I may inspect or copy the information described by this authorization except as prohibited by law.

- I understand that, at any time, I may revoke (take back) this authorization, when the office receiving this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

- I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.

- I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting confidentiality.

- I understand that uses of this authorization other than specified above, may include disclosures required for my treatment, or payment of services, including results given to a referring physician, health or auto insurance company or parent/guardian.

- I understand this may include information about communicable disease and/or serious communicable disease and/or infections as defined by Michigan stature and Department of Public Health rules, which include Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), venereal disease and tuberculosis if any; alcohol and/or drug abuse information protected under the 42 Code of the Federal regulations, Part 2, if any; psychiatric or psychological records, if any; social work records, if any; including communications made by me to a social worker/psychologist.

Date Signed:_____________________________

Signature of Patient(if 18 or older) or Representative____

Authority or Relationship to Patient, if Representative____

Expiration Date: This authorization will expire on:_____________________________

(If no date or event is stated, the expiration date will be six months from the date of this authorization. COPY PROVIDED: The subject of this authorization shall receive a copy of this authorization, when signed.)

Revised 5-3-21

Advanced Neuropsychology & Pediatric Psychology Services

FEE AGREEMENT

I am aware of the charges for treatment services and accept financial responsibility for services rendered by agreeing to:

Authorize billing to my insurance company if contracted with Hurley Medical Center. I understand that I am liable and responsible for any deductibles and coinsurance payments **at the time of service**. If my coverage changes, lapses, or does not provide for my treatment, I will promptly notify the clinic and I will be responsible for payment of services not covered by my insurance. Hurley Medical Center will submit claims for payment.

Pay all fees personally at the time of service*, at the rate of $ ______** per individual full session of the published rate of service.

* Master medical and non-contracted private insurance patients will be issued a receipt by the billing department that can be submitted to your insurance carrier for reimbursement.

** ____
____

I will be expected to keep scheduled appointments and will be financially liable for the full charge amount for missed appointments if I do not notify the clinic in advance (24 hours).

Insurance Company: ______________________ Program: ____________________
Co-pay: ______________________________ Deductible: __________________
Number of visits allowed per year: _____________

A 1% interest fee per month will apply to all unpaid patient balances after 60 days and every 30 days thereafter.

I have read and understand the above rights and responsibilities, and agree to the terms of this fee agreement.

Client: ____________________________________ Date: __________________

Parent/Guardian: ______________________________ Date: __________________
(*if appropriate*)

Staff Witness: ________________________________ Date: __________________

Advanced Neuropsychology and Pediatric Psychology Services

CLIENT RIGHTS

We at Advanced Neuropsychology & Pediatric Associates are committed to treating all our clients with dignity and respect. In keeping with this commitment, we want you to know that you have the following specific rights:

1. To be protected from physical, sexual and other abuse; if mistreated in any way, you may seek help from the Clinical Director;
2. To have the risks associated with the use of any medications and/or procedures explained to you in terms that you understand;
3. To refuse the use of any potentially hazardous medications and/or procedures without your written consent;
4. To request the opinion of a consultant at personal expense or to request and be given information concerning significant alternatives for care and treatment;
5. To have prepared and kept current a complete record of your condition and treatment as allowed by law;
6. To have your treatment record and all information about you kept confidential in accordance with relevant laws and professional ethics;
7. To privileged communication with those who examine and treat you; information that you provide may not be disclosed unless you agree in writing to its disclosure unless required by specific law or court decisions;
8. To refuse to be photographed or recorded on film or tape unless you give written consent;
9. To be informed about any proposed change and the reason for change in clinical staff responsibility for you or any transfer of your case inside our outside the clinic;
10. To understand the clinic's responsibility when you refuse to participate in a given type of treatment;
11. To review and understand the rules and regulations of the clinic applicable to your conduct;
12. To report any violations of your rights as they are given here;
13. To receive assistance through the Clinical Director or a person designated by the Clinical Director in protecting the rights guaranteed to you and in seeking action if your rights are violated.

Signature of Patient or
Representative____Date____________

Authority or Relationship to Individual, if Representative______________________________

Hurley Medical Center
Advanced Neuropsychology and Pediatric Psychology Services
Appointment Expectations

Therapy works best when patients and families come on-time to all scheduled appointments. All patients under 14 years old must have a parent or guardian on-site during the appointment. Your provider may also require a parent or guardian be present even if the patient is older than age 14. Therapy appointments are usually weekly to biweekly. Your provider will notify you how often your visits need to be in order to be helpful for you.

If you cannot attend an appointment please call 810-262-2320 to cancel at least 24 hours prior to the appointment time.

Policy for late arrivals and missed appointments:

- If you arrive more than 15 minutes after the scheduled appointment time, the appointment will be considered missed.
- If you don't show up for a scheduled appointment and fail to call to cancel the appointment more than 24 hours in advance, the appointment will be considered missed.
- After one missed appointment, the appointment policy will be reviewed with you
- After two missed appointments, you may be charged a missed appointment fee of $40 which is not covered by insurance and must be paid before another visit may be scheduled.
- Missed appointments must be rescheduled within a month of the last attended appointment to continue in treatment.

Please notify us if at any time during therapy you are no longer able to attend regularly so we can help find the best solution for you. We reserve the right to cease providing services for any of the following reasons:

- Three missed appointments in close proximity of time
- Three appointments cancelled less than 24 hours before the scheduled appointment time
- Missed or cancelled appointments that are not rescheduled within one month of the last attended appointment
- Many missed appointments or non-regular appointment attendance.

If we stop seeing you for therapy services, you will be given contact information for other providers in the area.

My signature indicates I have read the appointment policy, had my questions answered, and I agree to follow the policy. I was provided a copy of the policy if I so requested.

____ ____________________

Patient/Parent or Guardian of Minor Patient Date Patient Name Printed

____

Witness Date

Revised 2-12-21

ADVANCED NEUROPSYCHOLOGY AND PEDIATRIC PSYCHOLOGY SERVICES:

INFORMED CONSENT FOR TELEHEALTH

This informed consent for telehealth contains important information about receiving services using the telephone or videoconferencing. When you sign this document, it will mean that you agree to telehealth services. All other issues related to informed consent are included in the standard informed consent form.

Benefits and Risks of Telehealth

Telehealth refers to providing services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telehealth is that the patient and provider can engage in services without being in the same physical location. This can be helpful if the patient and provider cannot meet in person. In some situations it is also more convenient and takes less time. Telehealth, however, requires that the patient and provider learn how to use technology for this purpose. Although there are benefits of telehealth, there are some differences between in-person services and telehealth, as well as some risks. For example:

Risks to confidentiality. Because telehealth visits take place outside of the provider's private office, there is potential for other people to overhear visits if you are not in a private place during the visit. Your provider will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for the visit where you will not be interrupted. It is also important for you to protect the privacy of our visit on your cell phone or other device. You should participate in services only while in a room or area where other people are not present and cannot overhear the conversation.

Issues related to technology. There are many ways that technology issues might impact telehealth. For example, technology may stop working during a visit, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

Crisis management and intervention. Usually, we will not engage in telehealth with patients who are currently in a crisis situation or requiring high levels of support and intervention. Before starting telehealth, we will develop an emergency response plan to address possible situations that may come up during our telehealth work.

Effectiveness. For the types of services offered via telehealth at Advanced Neuropsychology and Pediatric Psychology Services, most research shows that telehealth is about as effective as in-person services. However, some providers believe

room. Call Advanced Neuropsychology and Pediatric Psychology Services at 810.262.2320 after you have called or obtained emergency services.

If the visit is interrupted and you are not having an emergency, disconnect from the visit. I will wait two (2) minutes and then re-contact you via the telehealth platform on which we agreed to conduct the visit (Google Meet or the telephone). If you do not receive a call back within two (2) minutes, then call Advanced Neuropsychology and Pediatric Psychology Services at 810.262.2320.

If there is a technological failure and we are unable to resume the connection, you will only be charged for the amount of actual visit time.

Fees

The same fee rates will apply for telehealth as apply for in-person services. However, insurance or other managed care providers may not cover visits that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic visits, you will be solely responsible for the entire fee of the visit. Please contact your insurance company before engaging in telehealth visits in order to determine whether these visits will be covered.

Records

The telehealth visits shall not be recorded in any way. We will maintain a record of our visit in the same way we maintain records of in-person visits in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent for services at Advanced Neuropsychology and Pediatric Psychology Services. It does not amend any of the terms of that agreement.

Your signature below indicates agreement with telehealth terms and conditions.

____________________________ ____________________________

Patient/Guardian Date

____

Patient/Guardian Printed Name

Clinical Excellence. Service to People.

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.

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be information about healthcare we provide to you or payment for healthcare provided to you. It may also be information about your past, present, or future medical condition.

We are also required by law to provide you with this Notice of Privacy Practices (NPP) explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for *all* medical information that we maintain. If we make changes to the Notice, we will:

- Post in our waiting area that a new Notice is in effect, with copies of the full NPP available for pick up.
- Have copies of the new Notice available on our website, www.hurleymc.com, or upon request. You can also contact our Privacy Officer (contact information below) to obtain a copy of our current Notice.

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you.
- Explain your rights with respect to medical information about you.
- Describe how and where you may file a privacy-related complaint.

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you can mail questions to, or contact, our Privacy Officer at the address listed below.

Privacy Officer
Hurley Medical Center
One Hurley Plaza
Flint, MI 48503
810-262-9890

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records related to your care, which are maintained by Hurley Medical Center, whether electronic or paper and whether made by hospital personnel, your personal doctor, a consulting or other treating doctor, a diagnostic facility, or any Hurley Medical Center facility or support personnel. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

We use and disclose medical information about patients every day. This section of our Notice explains in some detail how we may use and disclose medical information about you in order to provide healthcare, obtain payment for that healthcare, and operate our business efficiently.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed; however, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the hospital may also share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, and x-rays. We also may provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this hospital.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the hospital so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for hospital operations. These uses and disclosures are necessary to run the hospital and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many hospital patients to decide what additional services the hospital should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other hospital personnel for review and learning purposes. We may also combine the medical information we have with medical information from other hospitals to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Fundraising Activities. We may use protected health information about you to contact you in an effort to raise money for the hospital and its operations. We may disclose protected health information to a foundation related to the hospital so that the foundation may contact you in raising money for the hospital. We only would release contact information, such as your name, address, other contact information, such as, phone number, age, gender, date of birth, other demographic information, health insurance status, department of service information, treating physician information, outcome information, and the dates you received treatment or services at the hospital. If you do not want the hospital to contact you for fundraising efforts, you must notify the Hurley Foundation by calling **810-262-9667**, or e-mail to **rwarmbo1@hurleymc.com** advising that you want to opt-out.

Hospital Directory. We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (good, fair, serious, critical) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a minister, priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. Should you wish to not be included in the Hospital Directory, you must inform the Registration Clerk, who will in turn provide you with the necessary objection form for your completion and signature. In the event there is a problem, you may contact the Privacy Officer.

Patient Satisfaction Surveys. We may conduct patient satisfaction surveys by mail, e-mail or telephone to understand how we can improve our services to patients and their families. We may disclose protected health information to a patient satisfaction research organization who is our business associate. They may contact you on our behalf for the purpose of understanding how we can improve our services. For example: A patient may receive an e-mail after discharge from a patient satisfaction research organization asking for ratings and comments regarding the services provided.

Disaster Relief. We may use or disclose protected health information to federal, state, or local government agencies engaged in disaster relief activities, as well as to private disaster relief or disaster assistance organizations (such as the Red Cross) to allow them to carry out their responsibilities in a specific disaster situation. This is so these organizations can help family, friends, or caregivers locate an individual affected by a disaster and inform them of the individual's general health condition or to help individuals obtain necessary medical care for injuries or health conditions caused by a disaster.

Individuals Involved in your Care or Payment for your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the hospital. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you 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 medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical 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 medical information they review does not leave the hospital. We will almost always ask for your specific permission if the researcher will record your name, address or other information that reveals who you are, or will be involved in your care at the hospital.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Community Health Record. In order to enhance patient care, Hurley Medical Center works to make information in its electronic health record available to providers who may care for you in other settings. This means that some providers who are not employees of Hurley Medical Center may have access to your electronic health record. This information will only be shared in a safe, secure manner and all providers are required to adhere to state and federal privacy laws, including HIPAA.

Health Information Exchange (HIE). Hurley Medical Center, along with other health care providers, participate in HIEs that allow patient information to be shared electronically. HIEs give your health care providers who participate immediate electronic access to your pertinent medical information necessary for treatment, payment and operations. If you do not opt-out of the HIE, your information will be made available through the HIE to your authorized participating providers in accordance with this Notice of Privacy Practices and the law. If you opt-out of the HIE, your protected health information will continue to be used in accordance with this HIPAA Notice and the law, but will not be made electronically available through the HIE. To opt-out of the Health Information Exchange, please contact Michigan Health Connect at: 877-269-7860, or e-mail info@michiganhealthconnect.org, or visit their website www.michiganhealthconnect.org, to obtain the necessary form(s).

SPECIAL SITUATIONS

Organ and Tissue Donation. We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Public Health Activities. We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- Public health investigation or surveillance;
- To notify a person who may have been exposed to a disease or may be at risk for contacting or spreading a disease; or
- To the FDA, with respect to and FDA-regulated product or activities related to the quality, safety or effectiveness of such FDA-regulated product or activity;
- To an employer, about an individual who is a member of the workforce of the employer, if the health care information being disclosed is provided at the request of the employer regarding findings concerning a work-related illness or injury or a work-related medical surveillance and the employer needs such information to comply with its legal requirements(i.e., MIOSHA), provided the patient is either notified at the time of treatment or treatment is provided at the work site;
- To a school, about an individual who is a student or prospective student regarding proof of immunization(s), if the school is

required by law to have such proof prior to admitting the student and we obtain and document the agreement from the parent, guardian or person acting in loco parentis or, if the student is emancipated or an adult, the student; or
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights law.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a Court or Administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:
- In response to a Court order, subpoena, warrant, summons or similar process;
- Certain information, in order to, identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- As required by law regarding wounds, other injuries, assaults and other violent acts;
- In response to an administrative request(including the Secretary of HHS, or designee) or similar process authorized by law, provided that it is relevant and material, specific and limited in scope to what is reasonably needed and only if de-identified information cannot reasonably be used;
- About criminal conduct at the hospital, and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state to conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Authorizations. Other than the uses and disclosures described above, we will not use or disclose medical information about you without the "authorization" – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization or fill out an Authorization Revocation Form. Authorization Revocation Forms are available from our Privacy Officer. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

The following uses and disclosures of medical information about you will only be made with your authorization (signed permission):

- Uses and disclosures for marketing purposes.
- Uses and disclosures that constitute the sales of medical information about you.
- Most uses and disclosures of psychotherapy notes.
- Any other uses and disclosures not described in this Notice.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to: Health Information Services, Hurley Medical Center, One Hurley Plaza, Flint, MI 48503, 810-262-9214. If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer (see page 1 for contact information). In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the hospital;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). 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. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Requests Restrictions. You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations for Hurley Medical Center information that involves scheduled/elective procedures. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

- Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operations (and is not for purposes of carrying out treatment); and,
- The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.;
- The disclosure has not already been made.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restriction(s).
It is your responsibility to notify subsequent providers/suppliers of any restriction requests and secure their agreement(e.g., pharmacists, a medical equipment provider, your physician's office, etc.)

Right to Notification if a Breach of Your Medical Information Occurs. You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

- A brief description of what happened;
- A description of the health information that was involved;

- Recommended steps you can take to protect yourself from harm;
- What steps we are taking in response to the breach; and,
- Contact procedures so you can obtain further information.

Right to Request an Alternative Method of Contact. You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you can make that request at the time of your registration as a patient, or provide us with a request in writing. You may write us a letter or fill out an Alternative Contact Request Form. Alternative Contact Request Forms are available from our Privacy Officer. Changes to the alternative method of contact will be made within two (2) business days of the receipt of the request.

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.hurleymc.com or by contacting the Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of a summary of the current notice in the hospital. The notice will contain the effective date at the bottom of each page. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Hurley Medical Center's Privacy Officer or with the Secretary of the Department of Health and Human Services.

We will not take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint with us please mail to the Privacy Officer at the following address:

Privacy Officer
Hurley Medical Center
One Hurley Plaza
Flint, MI 48503
810-262-9220

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.D. 20201

Toll-Free Phone: 1-877-696-6775

Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Email: OCRComplaint@hhs,gov

OTHER USES OF MEDICAL INFORMATON

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.