



## School Based Health Center Enrollment Packet

Hello BlueJays!

We welcome you and your child to be part of our PrimaryPlus-Ripley School Based Health Center. It offers students, parents, teachers, faculty, and the entire community (care for all ages) access to primary care services. PrimaryPlus is a Federally Qualified Health Center with over nine service locations including nearby Maysville, KY, and just recently we added the pediatric team of Kid Care to our medical family. Our PrimaryPlus-Ripley office will operate year-round and during the school year we are readily available to care for your child(ren) during school hours (upon completion of this packet). Parents/Guardians are always welcome at the appointments but are not required to be present as long as **THIS PACKET IS FULLY COMPLETED and RETURNED.**

**How the School-Based Health Center Works:** Once the student's completed consent and history are received (which are enclosed in this packet), we can begin caring for your child for approved services. You will be notified of your child's appointment and contacted by phone providing information on his/her visit. If the parent/guardian has signed consents and not reachable via phone to discuss the appointment, PrimaryPlus-Ripley will provide a care visit summary to send home to the parent regarding the child's visit.

**Already a patient of the PrimaryPlus health system:** If you are already a patient of PrimaryPlus' health network **we ask that you still complete this packet.** PrimaryPlus-Ripley is a school-based health center and some of the packet information varies from our standard patient packet.

**Note on Transportation:** The Health Center is based on the Catherine Street side of RULH Elementary School. Children who are not at the Elementary School (i.e. Middle and High students) **will not** be transported to the health center. The school system has worked with PrimaryPlus-Ripley to coordinate care with the school nurse to utilize a TeleHealth system to medically evaluate your child without them having to leave their school. Children located in the Elementary school will be brought into the Health Center.

Please feel free to contact the PrimaryPlus-Ripley team at 937-744-4343 if you have any questions. Our office hours are Monday through Friday 8 am to 5 pm. At the end of this packet, you will find an INFO Sheet that will hopefully answer any questions that you may have on how our school-based program will work. You can also learn more about the PrimaryPlus organization, our services, our locations, our team and more at [www.primaryplus.net](http://www.primaryplus.net).

This packet includes:

- Care Statement (will need to be returned to school)
- Patient Registration (will need to be returned to school)
- Insurance & Financial Information (will need to be returned to school)
- Privacy, Acknowledgement and Authorization (will need to be returned to school)
- Health History—2 pages (will need to be returned to school)
- Consent to Treat (will need to be returned to school)
- About our School-Based Health Center (Parent/Guardian to Keep for Reference)
- HIPAA Privacy Information (Parent/Guardian to Keep for Reference)

**PLEASE RETURN COMPLETED PACKET  
TO THE SCHOOL NO LATER THAN  
FRIDAY, August 28<sup>th</sup>!**

PrimaryPlus will give away a \$100 GIFT CARD to 3 lucky RULH students that return completed signed consents. We will also award 3 lucky classrooms (one at each school) a PIZZA party for the classroom with the most returned PrimaryPlus-Ripley packets.



**PATIENT REGISTRATION**

Today's Date: / /

**PLEASE COMPLETE AND RETURN THIS PAGE**

PATIENT INFORMATION				
Student Last Name:	Student Legal First Name:	Middle Name	Preferred Name:	Students Birth Date: / /
Legal Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone:		Cell Phone:	
Students Social Security #: - -	Email Address: <b>Note: Read about our Patient Portal in the INFO SHEET Section of this Packet!</b>			
Mailing Address:		City:	State:	Zip:
Mailing Address of Responsible Payor—if different from above		City:	State:	Zip:
Do you speak and understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No  Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Other: _____	Students Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Students Assigned sex at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Unknown	Homeless Status: Do you consider yourself homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No  Veteran Status: <input type="checkbox"/> Veteran <input type="checkbox"/> Non-veteran	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other: _____	Students Sexual Orientation: <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to disclose	Students Preferred Pronouns: <input type="checkbox"/> He/Him <input type="checkbox"/> She/Her <input type="checkbox"/> They/Them <input type="checkbox"/> Other: _____	Public Housing: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Other: _____	Students Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other: _____	Agricultural Status: <input type="checkbox"/> Non-Agricultural <input type="checkbox"/> Employed Year- Around <input type="checkbox"/> Seasonal <input type="checkbox"/> Migrant <input type="checkbox"/> Retired Farmer	Preferred Pharmacy:	
Parent/ Guardian Contact Information				
Parent/Guardian Full Name:		Relationship to Student:		
Home Phone #:		Cell/ Alternate #:		
Parent/Guardian Employer/Occupation:		Day/ Work Phone #:		
Emergency Contact Information				
Emergency Contact Name:		Relationship to Student:		Contact #:

**Insurance & Financial Information**

PLEASE COMPLETE AND RETURN THIS PAGE

Today's Date: / /	Student's Last Name:	Student's First Name:	Student's Date of Birth: / /
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Responsible Party (For example: Parent/Guardian who is responsible for insurance and/or payment)		
Last Name:	First Name:	MI:
Social Security #:	Birth Date: / /	Relationship to Student:

**Insurance Type (Please Mark All that Applies):**

- Private Insurance  
  Medicare  
  Medicaid  
  Self Pay (No Insurance Coverage)

Primary Insurance:	Policy #:	Group #:	Policy Holder:
			Policy Holders Relationship to Student:
Secondary Insurance:	Policy #:	Group #:	Policy Holder:
			Policy Holders Relationship to Student:
Tertiary Insurance:	Policy #:	Group #:	Policy Holder:
			Policy Holders Relationship to Student:

**\*\*\*PrimaryPlus-Ripley asks that you please include a copy of your child's insurance card(s) when returning this completed packet, if possible.\*\*\***

**PrimaryPlus-Sliding Fee Program:**

PrimaryPlus offers a Sliding Fee Program that provides up to a 75% discount on most services (50% on dental services). This program is available to all patients--uninsured or underinsured. If you or your child has no insurance coverage or your health insurance plans have a high deductible, you may qualify for this program. Eligibility is based on household income and family size. Applications can be printed at [www.primaryplus.net/about/forms](http://www.primaryplus.net/about/forms) or can be picked up at our PrimaryPlus-Ripley location. Call 937-744-4343 for more information.

- I hereby assign my insurance benefits to be paid directly to the healthcare provider and assure that the information above is correct.
- I also acknowledge that I have read and understand about PrimaryPlus' sliding fee program.
- I authorize PrimaryPlus to release medical information required to process my child's insurance claim.

X Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Note: Patient/Student Signature is ONLY allowed if 18 or OLDER

Today's Date: / /	Student's Last Name:	Student's First Name:	Student's Date of Birth: / /
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**Acknowledgement of Receipt of Privacy Practices**

We are required to give each patient a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign below on this form to acknowledge receipt of this notice which is enclosed in this packet (Pages 12-13).

*Please answer the following questions so that we can contact you in the most efficient way possible:*

- May we leave a message at home or on your cell regarding your child's care?  YES  NO
- May we leave a message at your work for you to call our office regarding your child's care?  YES  NO
- May we send text reminders about your child's appointment to the cell number provided?  YES  NO
- May we send/receive clinical information from health care providers participating in your care?  YES  NO

PrimaryPlus is happy to share records of your child's visit with their pediatrician or regular primary care provider. If you wish us to share that information, please include the providers name and contact information below.

**Medical Providers Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

*Note: If your student is a patient at any of our PrimaryPlus locations including PrimaryPlus-Kid Care (Dr. Michael Coleman & Dr. Casey Keeton)—his/her records will be viewable in our Electronic Health Records system.*

**List below any person/persons authorized by you to discuss/receive/access your medical information:**

- | Last Name: | First Name: | Relationship to Student: |
|------------|-------------|--------------------------|
| 1) _____   | _____       | _____                    |
| 2) _____   | _____       | _____                    |
| 3) _____   | _____       | _____                    |

*By signing below, I authorize PrimaryPlus to use/disclose my health information in a manner consistent with that stated in the Notice of Privacy Practices that I have received.*

Student/Patients Name (Please Print): \_\_\_\_\_

Parent/Guardians Name (Please Print): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Parent/Guardians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: Patient/Student Signature is ONLY allowed if 18 or OLDER

# HEALTH HISTORY

PLEASE COMPLETE AND RETURN THIS PAGE

Today's Date: / /	Student's Last Name:	Student's First Name:	Student's Date of Birth: / /
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**Has the student had OR currently have any of the following problems, please mark Yes or No? Also, please check YES, if there is a Family History.**

Problem	Yes	No	Family History Yes	Problem	Yes	No	Family History Yes	Problem	Yes	No	Family History Yes
Asthma/ Wheezing				Eye Trauma				Seizure Disorder			
Allergy (Hay Fever)				Fainting w/ Exercise				Sickle Cell			
Allergy (Food)				Glaucoma				Sinus Issues			
Allergy (Pet)				Frequent Headaches				Sleep Apnea			
ADHD/ ADD				Hearing Loss				Snoring			
Anemia				Heart Disease				Frequent Sore Throat			
Anaphylactic Reaction				Heart Murmur				Speech Issues			
Acne				Kidney Disease/ Issues				Spinal Curvature			
Alcohol/ Drug Abuse				High Blood Pressure				Frequent Stomachache			
Behavior Issues				HIV/ AIDS				Stroke			
Bleeding Disorder				Hives				Suicide Attempts			
Bowel Movements				Hyperactivity				Testicle not in Sac			
Broken Bones				Joint Problems				Toothache			
Cancer				Lazy Eye				Tuberculosis			
Cataract				Lead Poisoning				Twitching Eyelid			
Chicken Pox				Learning Problems				Underweight			
Chronic Ear Infection				Leukemia				Urinary Tract Infections			
High Cholesterol				Light Sensitivity				Vaginal Discharge			
Concussion				Lumps Groin/ Breast				Watery Eyes			
Constipation				Mental Illness				Other:			
Depression				Migraines							
Diabetes				Muscle Problems							
Diarrhea				Nervous Twitch/ Tics							
Dizzy/ Lightheaded				Frequent Nose Bleeds							
Dry/ Burning Eyes				Nightmares							
Eczema/ Skin Infection				Obesity							
Eye Strain				Rheumatic Fever							

# HEALTH HISTORY CONTINUED

PLEASE COMPLETE AND RETURN THIS PAGE

Today's Date: / /	Student's Last Name:	Student's First Name:	Student's Date of Birth: / /
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Please Mark Yes or No to the following and provide details of care if available.

Medical/ Dental/ Eye History	Yes	No	Comments
Date of last well child exam:			Date of exam:  Providers Name:
Do they take any medications currently?			
Have they previously taken medications?			
Are they allergic to any medications?			
Have they ever been pregnant?			# of Pregnancies:  # of Living Children:
Any previous surgeries?			
Any previous head injuries?			
Any developmental delays?			
Immunizations up to date?			
Other medical concerns?			
Has your child had a dental exam within the last 6 months?			Preferred dentist:
Has your child had an eye exam within the past year?			
Do they wear glasses?			
Any other information we should be aware of?			

Home History	Yes	No	Comments
Does anyone in the home smoke?			
Has your child been a victim of abuse or bullied?			
Has your child seen someone abused?			
Do they get enough to eat?			
Is there a gun in the home?			
School History	Yes	No	Comments
Are there any learning problems/ disabilities?			
Are they in special classes or have IEP?			

*I have reviewed the health history form provided by PrimaryPlus and have disclosed all my child's known health history to-date. PrimaryPlus encourages you to alert us if anything regarding your child's health should change throughout the year.*

\_\_\_\_\_  
Parent or Guardian Signature                      Parent or Guardian Printed Name                      Date

**CONSENT TO TREAT**

PLEASE COMPLETE AND RETURN THIS PAGE

Today's Date: / /	Student's Last Name:	Student's First Name:	Student's Date of Birth: / /
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Physicians of: Lewis County Primary Care Center, Inc./ DBA PrimaryPlus

- I, \_\_\_\_\_ (parent/guardian) acting on behalf of \_\_\_\_\_ (student/patient) who is suffering from a condition requiring medical, podiatric and/or dental care. I agree to allow this care to be received. It may include routine diagnostic and medical treatment that the attending physician(s) or others of the health center medical staff consider necessary. Services could include treatment for illness or injury including over the counter medications or necessary prescriptions, well child exams, appropriate immunizations, and appropriate behavioral evaluations--unless emergency services are needed.
- I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me about the result of examination or treatment in this health center.
- I understand that:
  - Normally, except under emergency or extraordinary circumstances, no important procedures are performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician or other health professionals to the patient's satisfaction.
  - Each patient has the right to agree or refuse to agree to any proposed procedure or therapeutic course; and
  - No patient will be involved in any research or experimental procedure without his or her full knowledge and agreement.
- I realize that there are medical, nursing and other health care personnel at this health center who are still in training. I understand that they may be present during my care unless I request them not to be present.
- This form has been fully explained to me, and I am satisfied, and I understand its content and significance.
- Once the student's completed consent and history are received, PrimaryPlus can begin caring for your child for approved services during school hours. Attempts will be made to notify the parent/guardian of your child's appointment and to see if they wish to attend the visit. If no contact is made and all consents are in place, PrimaryPlus will continue the appointment as needed and contact the parent with follow-up information following the appointment including sending home a copy of the care summary.

Parent/Guardians Name (Please Print): \_\_\_\_\_

Parent/Guardians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: Patient/Student Signature is ONLY allowed if 18 or OLDER

**I HEREBY CONSENT FOR THE FOLLOWING PERSON/PERSONS TO BRING MY UNDERAGED CHILD TO LEWIS COUNTY PRIMARY CARE CENTER, INC FOR TREATMENT. (Please list name and relationship to child).**

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

x \_\_\_\_\_

Parent or Legal Guardian Signature

\_\_\_\_\_

Date



# The following pages are for you to keep for your records!



## ABOUT OUR SCHOOL BASED HEALTH CENTER

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

### ABOUT PrimaryPlus

Our PrimaryPlus-Ripley team is excited to have the opportunity to share in the health of your family this school year. Our NEW school-based health center which is located at RULH Elementary, opened in the spring and we are so grateful for the warm welcome we have received from the community. Our healthcare team is ready for the 2020-21 school year and thrilled to share our mission with you and your child(ren). Below we have included some information about PrimaryPlus and how our school-based health center will be able to best serve you!

PrimaryPlus is a non-profit, Federally Qualified Health Center that serves the Northeastern Kentucky and the Southern Ohio region with nine family health centers including nearby Maysville, KY and the NEW Ripley location. Our mission is centered around providing Quality, Advanced, Affordable Healthcare for the entire family. In Spring 2020, we were fortunate to add the pediatric office of Kid Care featuring Michael Coleman, MD & Casey Keeton, MD to our medical family. In addition to our primary care and pediatric services, we also offer women’s health, dental, counseling, dermatology and pharmacy services as part of our healthcare network. It is our continued goal to keep care accessible and affordable for all. To learn more about Primary Plus visit [primaryplus.net](http://primaryplus.net) or LIKE us on Facebook @PrimaryPlus2.

**THE PRIMARYPLUS-RIPLEY TEAM.** PrimaryPlus-Ripley features the care of Family Health Nurse Practitioner, Carissa Kirk, APRN. Carissa is a RULH graduate and is also a parent to students in the RULH School System. She loves the kids of this school system and is excited to have the opportunity to nurture and care for them. PrimaryPlus-Ripley also employs a Licensed Practical Nurse and Certified Medical Assistant which are both familiar with this school district and have students here, as well. Plus, we have established a great partnership with the school nurse and RULH administration, which have been so instrumental in making this school-based health center successful.

### SCHOOL HEALTH & COMMUNITY HEALTH: Our Mission to Serve

**Community Health:** Our school-based health center serves dual purposes...1) to provide care for the school-age population and faculty during school hours and 2) to serve the entire community—children, parents, grandparents, aunts, uncles and everyone in between. All ages are welcome to use our PrimaryPlus-Ripley office. We offer a public entrance on the Catherine Street side of the elementary school for community access. Appointments can be made by calling 937-744-4343. PrimaryPlus accepts most commercial insurances, OH Medicaid (Caresource & Molina), Medicare and offers a sliding fee scale that can provide up to a 75% discount on care for those that are uninsured or underinsured.

**School Health:** From the school health side of things, we have established a great working relationship with the RULH staff and school nurse. **PrimaryPlus-Ripley School Based Health Center Information Forms and Consents MUST be signed by the parent/guardian for the child to utilize the health center during school hours.** See *How the School-Based Health Center Works on the Next Page!*

**How the School-Based Health Center Works:**

Your child can be seen by our Family Health Nurse Practitioner during school hours (parent can choose to be present if they wish). Parents can also call to schedule an appointment for themselves or their child when needed.

- If the child presents sick symptoms at school, the school nurse would first assess the child, contact that parent, and if all consents are in place and the parent/guardian agrees to the child being seen, the nurse will then work with PrimaryPlus to get the child an appointment with the school based health center.
- Students that attend the elementary school would be walked over for care since PrimaryPlus-Ripley is located inside RULH Elementary. Students of the Middle & High School will utilize a TeleHealth System for the student to be seen and treated (students **will not** be transported).
- **It is important to stress... to allow your child access to be seen by the PrimaryPlus-Ripley care team, you must complete the forms in the Back to School packet.**
- Parents will be contacted by the healthcare provider to discuss a treatment plan for the child, any necessary prescriptions will be provided.
- PrimaryPlus is also working on a system where the parent/guardian could utilize a telehealth system to call in for the appointment, to be present with the child during the visit—more details to follow in early fall.

**ALREADY A PRIMARYPLUS PATIENT?** If you are already a PrimaryPlus patient, GREAT, we are happy to be able to continue to serve you! We will still need you to fill out the consent forms provided in the school packet, there are some additional information and signatures needed to be able to treat your child(ren) while at school. However, the great news is—if your child has been seen at a PrimaryPlus location, our Ripley team will have access to those medical records, as PrimaryPlus' Electronic Medical Records is all connected. This includes records for PrimaryPlus-Kid Care featuring Dr. Coleman & Dr. Keeton, as they are now part of our healthcare network. **Important Note:** *PrimaryPlus believes in being a team...so our Ripley site is not designed to take you away from your "routine" care provider but to serve as an additional outlet of care offering the same quality service and hopefully an added touch of convenience. Our medical team, whether based at Ripley or Maysville, will work together to BEST SERVE YOUR FAMILY!*

**NOT A PATIENT OF PRIMARYPLUS?** If you currently have healthcare providers outside of the PrimaryPlus network, your child is still welcome to utilize our school-based health center services—consent forms will need to be completed. We wish to stress we do not wish to take the place of your child's regular pediatrician or primary care provider if there is one already established—we value and respect our fellow healthcare providers. PrimaryPlus-Ripley is here to be an added outlet for care if you should need us. Of course, if you or your child does not have an established medical provider, we welcome you to be part of our family of patients, having a medical home is very important. Note: If you would like your child to use the PrimaryPlus-Ripley School Based Health Center, we are happy to share his/her record of care with his/her established healthcare provider, please be sure to indicate this on the PRIVACY, ACKNOWLEDGEMENT & AUTHORIZATION page of the packet.

**SERVICES AVAILABLE at PRIMARYPLUS-RIPLEY.** Our Ripley location is a primary care site just like so many of our other PrimaryPlus locations. We can care for the entire family for well and sick visits including well child examinations, immunizations, colds, flu, stomach issues, high blood pressure, diabetes, other chronic health, rashes, etc. Plus, we have extended services within our Maysville office such as dental, mental health, dermatology, etc. that we welcome you to utilize.

**Continued on next Page...**

**HOW TO PROVIDE CONSENT FOR CARE.** In order, for your child to be seen by our PrimaryPlus-Ripley School Based Health Center, you must complete the forms that are enclosed. Forms will need to be completed in their entirety including signatures, insurance information, emergency contacts, etc. Forms can also be picked up at the PrimaryPlus-Ripley Health Center. Once this packet is completed, your child can begin being cared for during school hours.

**PAYMENT & INSURANCE:** PrimaryPlus-Ripley will bill the necessary insurance or party for the health center visits. If your insurance has a co-pay the parent/guardian will receive a statement via mail. **IF YOU HAVE NO INSURANCE COVERAGE:** PrimaryPlus offers a Sliding Fee Program that provides up to a 75% discount on most services (50% on dental services). This program is available to all patients--uninsured or underinsured. If you or your child has no insurance coverage or your health insurance plans have a high deductible, you may qualify for this program. Eligibility is based on household income and family size. Applications can be printed at [www.primaryplus.net/about/forms](http://www.primaryplus.net/about/forms) or can be picked up at our PrimaryPlus-Ripley location. Call 937-744-4343 for more information.

**CONTACTS FOR SCHEDULING:** If you have questions feel free to call the PrimaryPlus-Ripley office at 937-744-4343.

**OFFICE HOURS:** PrimaryPlus-Ripley is open Monday-Friday 8 AM to 5 PM.

**PATIENT PORTAL:** PrimaryPlus offers an online portal to be able to view the care summaries of you or your child's visit, PLUS you can also send messages to our medical team, pay your bill online, view lab results, update demographic information, etc. If you would like to register your child for a patient portal, please include an email address on the PATIENT REGISTRATION page of this packet. We will then send you a link to your email to register for the account. After setting up the account, you can access the Patient Portal 24/7 at [www.primaryplus.net](http://www.primaryplus.net). There is a **+PatientPortal** button in the top right-hand corner of the website to access it.

**ALREADY HAVE A PRIMARYPLUS PORTAL ACCOUNT:** If you already have a portal account with PrimaryPlus, you can easily add your child to your portal. In the top right hand side of your screen is your name/photo--click here on your name/photo and then select **Family Access** and it will walk you through the process of adding your child, repeat if you have multiple children. Note: If you are doing this from a mobile device, make sure you are in Full Site View (which can be selected at the bottom of the page). Once adding your children, you will be able to switch between your own personal account and/or your child(ren) under the Profile tab in the top right hand corner OR if on a mobile device, scroll to the bottom of the page to change names.

**AGE RESTRICTIONS:** You will have full viewing rights on your child until the age of 18. Once the child has turned 18, you will only be able to view his/her billing information. Any child over the age of 18, that wishes to still have his/her parents granted medical chart access would need to sign an additional consent form in person.

**COVID-19 RESPONSE:** Please know our team is taking the COVID-19 response very seriously; we have systems in place in all our offices for the added protection of our patients including your child. Our PrimaryPlus-Ripley site is ensuring limited exposure, adhering to social distancing, providing limited waiting room usage, increased sanitizing, conducting proper screenings and our staff are required to wear masks at all times.

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*Please note that the school-based health center is completely optional. School nursing and emergency services will still be provided as always whether you consent to the school-based health center or not.*

*This consent packet will remain in effect for the 2020-2021 school year. You may revoke this consent for treatment at any time by providing PrimaryPlus-Ripley with a written notice that states you wish to have your child removed from the care of the school-based health center. Also, please notify us at the number below and in writing for any changes in guardianship.*

*Please keep this program description for your records. Please let us know if there is anything keeping you from enrolling your child. If you have any questions or need help with the application, please call PrimaryPlus-Ripley at 937-744-4343.*

**Thank you for the opportunity to care for your family!**

# HIPAA Notice of Privacy Practices

PLEASE KEEP THIS PAGE FOR YOUR RECORDS



**LEWIS COUNTY PRIMARY CARE CENTER, INC. dba PrimaryPlus**  
211 KY 59, PO Box 550 Vanceburg, KY 41179 (606) 796-3029

## **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### **1. Uses and Disclosures of Protected Health Information**

#### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and  
**(Continued on Next Page)**

Disclosures. Under the law, we must make disclosures to you and when requirements of Section of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### **Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under the federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for the notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

**You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number 606-796-3029.