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Seattle World School Teen Health Center

Dear Parents or Guardians of Seattle World School students:

Your child can now receive health care right at school!

There is a School-Based Health Center located in the building and available to all students of the Seattle World School. The Health Center is sponsored by **International Community Health Services (ICHS)** and its partner **Neighborhood House**, with additional funding from the City of Seattle's **Families and Education Levy**. Medical and mental health professionals from ICHS provide services and consultations; additional health center staff include health educators, patient navigators, and a clinic care coordinator who all work together to provide a variety of services to support your child's health, wellbeing, and academic success.

The services that the health center offers your child include (but are not limited to):

- Quality care on-site by a Licensed Medical or Mental Health Provider
- Appointments during and after school
- Physical exams and health assessments (including sports physicals and other routine exams)
- Immunizations and medications
- Diagnosis and treatment of illness and injuries
- Assessment and counseling related to mental health
- Nutrition consultations
- Reproductive health care
- Preventive health care including health education activities
- A healthcare home, including coordination of additional care at other clinics with the same services
- Referrals to other healthcare providers
- Dental exams, x-rays and cleanings

Each student must provide full parental consent in order to receive comprehensive services. Parental consent requires completion of the attached registration form and the signature from the student's legal guardian. Public insurance plans, such as Medicaid, generally cover the entire fee for your student's services at the health center. However, if you have private insurance your plan may not cover the entire cost of care and insurance rules may require that ICHS bill for some out-of-pocket expenses. However, no students will be denied services because of the inability to pay.

We are proud to be able to provide high quality school-based healthcare to students. We believe this is a unique opportunity for students to learn how to care for their health. Join us in this effort!

Please complete and sign the attached consent form and return it to the Seattle World School Teen Health Center. Feel free to stop in and meet the clinic staff or call if you have questions about the clinic and its services!

Please sign consent on other side

Seattle World School Teen Health Center
1700 E Union St. Seattle, WA 98122 206-332-7160

ICHS International Community HEALTH SERVICES

Neighborhood House
Strong Families. Strong Communities. Since 1906.

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ICHS School-Based Health Centers
Consent for Health Services

School-based health centers located in Seattle Public Schools must have a signed consent from a parent or legal guardian before providing services to youth, except in situations where federal and/or state laws allow youth to access such treatment without parent/guardian consent. If the youth is enrolled in school but is not enrolled in a School-Based Health Center (SBHC), they can continue to receive school nurse services.

I hereby request and authorize that:

Print Youth's Name:_____ _____
First Name Middle Initial Last Name Birthdate

School:_____ **Graduation year:**_____

receive healthcare services available from and deemed necessary by the staff of the SBHC . These services include, but are not limited to, mental health counseling, routine medical exams, dental services (including exams, x-rays, and cleanings), sports physicals, well-teen care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs and x-rays. Consent is also given for referral of care and if needed, emergency transportation to other providers, healthcare professionals, hospitals, clinics, or healthcare agencies as deemed necessary by the Center and its staff. This authorization does not allow services to be rendered without the youth's consent unless they are unable to provide consent.

When consent is provided for care, all information is kept confidential, except in the following circumstances:

1. The client gives permission through a signed release of information
2. If they indicates a risk of imminent harm to self and others.
3. They have a life threatening health problem and are under the age of 18 years.
4. There is a reason to suspect abuse or neglect.
5. Certain communicable diseases must be reported to public health authorities.

Consent is given to share necessary information with the healthcare providers at the SBHC, including exchange of information between the mental health therapist, medical provider and the School Nurse, for the purpose of providing the best care for the above-named student. To facilitate coordination of care, the student's School Based Health Center medical record will be accessible to International Community Health Services staff at the SBHC.

Students may also receive medical services independently at one of ICHS' medical clinics. Consent is given for services to be received at any ICHS medical and dental clinics. To schedule appointments or get more information, please call 206-788-3700.

Consent for services is authorized for the length of time the youth is enrolled in Seattle World School. I may choose to withdraw the consent at any time by writing to the Health Center.

Student Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Name/Relationship of Legally Responsible Guardian (print):_____

FOR YOUR INFORMATION

Under Washington State law, youth may independently access reproductive health care at any age without parent/guardian consent (RCW 3.02.100(1 and 2)). They may independently receive drug and alcohol services and mental health counseling from age thirteen (RCW 70.96A.095, RCW 70.96A.0097, RCW 71.34.530, and RCW 71.34.500) and care for STDs from age fourteen (RCW 70.24.110) without parent/guardian consent. The School-Based Health Center encourages each youth to involve their parents or guardians in healthcare decisions whenever possible.

If necessary, the SBHC will inform youth of options of and assist youth in accessing outside care. The SBHC will assist the youth in discussing these situations with parents/guardians.

Youth's consent is legally required for release of information about the following kinds of diagnoses and treatment: pregnancy, sexually transmitted diseases (including HIV/AIDS testing), and alcohol and drug or mental health counseling.

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Community Based Organization
Parent/Guardian Consent Form
2016-2017 Approval

Public Health – Seattle & King County
School-Based Partnerships Program
401 5th Ave #1000 Seattle, WA 98104
206.263.8350

Seattle World School Teen Health Center
International Community Health Services (ICHS)
1700 E Union St. Seattle, WA 98122
206.971.0810

Consent to Release of Education Records under the Family Education Rights and Privacy Act (FERPA)

I consent to the release of my child's education records from the Seattle School District to the above listed agencies. I understand that education records include, but are not limited to:

1. Student name, DOB, and contact information
2. Student Demographics: including Special Education status and 504 Status and race/ethnicity
3. Attendance History
4. Discipline History
5. Coursework and grades History
6. Test Scores History
7. Enrollment History
8. Assignment Grades
9. Upcoming & Missed Assignments

This release includes permission for agency staff to access my child's academic records using an automated data feed through Seattle Public Schools.

I understand that the purpose of sharing these records with the above-mentioned entities is to keep my child's school-based health center medical and/or mental health provider informed of his/her academic program and progress. In collaboration with Public Health - Seattle & King County, International Community Health Services staff will work with my child and/or his/her school in an effort to improve my child's success at school. The University of Washington Department of Psychiatry and Behavioral Science will only be granted access to the above educational records for the purpose of maintaining a secure database to store the data. I acknowledge that I may revoke this consent by sending a written notification to the Seattle School District's School & Community Partnership Department, MS: 32-159 P.O. Box 34165 Seattle, WA 98124.

This Release of Information will make the above-listed educational records, which includes historical student data, available to agency staff from the date of consenting signature until December 31, 2017. I consent to Seattle School District releasing information to the above listed agencies (please print clearly):

Parent/Guardian Signature (if youth is 17 or younger): _____

Parent/Guardian Printed Name: _____

Student's Signature (if youth is 18 or older): _____

Today's Date: _____

_____ _____

PRINT **Student's Name** (First and Last name) Student **Date of Birth**

_____ _____

Student **School District ID # Student's School

***Student ID # can be found on student ASB card, report card, official school mailing, or by contacting your student's school*

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Seattle World School Teen Health Center- Student Health History Form

Student Name:_____ Date of Birth:_____ Language: _____

Please check the box if the student or any of their family members (list relationship of relative) has ever had any of these conditions:

CONDITION	STUDENT	RELATIVE	CONDITION	STUDENT	RELATIVE
Alcoholism			Hypertension		
Asthma			Learning Difficulties		
Bladder/Kidney Problems			Mental, emotional, and/or social problems		
Bleeding Problem or Anemia			Seizures		
Bowel Problems			Sickle Cell		
Broken Bones			Skin Rash		
Cancer			Stomach Problems		
Dental Problems			Stroke		
Diabetes			Suicide		
Headaches			Thalassemia		
Heart Condition			Thyroid Condition		
Hepatitis			Tuberculosis		
HIV/AIDS			Others		

Surgery/Hospitalizations: _____

Current Medications: _____

Allergies to: Food _____ Medications: _____Vaccination: _____

Are your students' immunizations up-to-date? _____yes _____no _____unsure

If the student is an immigrant/refugee, when and with whom did they come to the US?

_____

Who does the student live with? _____

Are you worried about the student in regards to any of the following issues?

CONCERN	Yes	No	CONCERN	Yes	No
Alcohol or drugs			General Health		
Chewing Tobacco			Moodiness		
Diet/Weight			Progress in school		
Communication			Riding with others under the influence		
Discipline			Self-esteem		
Driving under the influence			Sexual health/behavior		
Friends/relationships			Smoking cigarettes		

When was the student's last medical exam? _____

Have they had a dental exam in the past year? _____yes _____no

Patient/Parent/Guardian Signature: _____Date: _____

ICHS International Community HEALTH SERVICES

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Patient Rights and Responsibilities

PATIENT RIGHTS

You have the right to:

- Choose a health care provider that provides you with quality care.
- Receive care in a safe, private, and respectful setting by knowledgeable personnel.
- Receive services in a manner that respects your language, culture and beliefs.
- Receive information about your care and treatment in terms you can understand.
- Receive services without discrimination based on race, color, sex, marital status, sexual orientation, age, creed, religion, ancestry, gender identity, genetic information, use of service animals, national origin, veteran status, citizenship status, or the presence of any sensory, mental or physical disability or the ability to pay.
- Receive information about ICHS hours, providers, services, fees and payment policies in a language that is easy for you to understand.
- Be notified if your care involves the training of healthcare providers.
- Privacy of your healthcare information except as required by law or insurance company contracts.
- Read and receive copies of your medical records within a reasonable amount of time.
- Know that when an emergency occurs and you are transferred to another facility, a responsible person/family member will be notified.
- Request assistance with information on advance directives for your healthcare.
- Be notified in advance to allow you to choose whether or not you would like to participate in experimental clinical research studies.
- Respectfully express dissatisfaction with the care you receive through a patient complaint/grievance policy.

PATIENT RESPONSIBILITIES

You have the following responsibilities:

- Ask questions if you do not understand what you are being told.
- Tell us everything you know about your health history, current health, and any changes in your health.
- Tell us about all medications, herbs, supplements, and over the counter (OTC) medications you may be taking.
- Participate in your care by making decisions, following directions and accepting responsibility for your choices.
- Follow the treatment plan agreed upon with your provider. This includes following instructions of other health care professionals as they carry out the orders of the provider.
- Choose a family member or other person to represent you if you are unable to make your own health care decisions.
- Treat other patients, visitors, volunteers and ICHS staff and property with courtesy and respect.
- Arrive on time for all appointments and let us know in advance you are unable to keep an appointment.
- Provide accurate information for processing any insurance coverage, and to pay any co-payments, co-insurance amounts, and deductibles as requested in a timely manner.
- Inform your provider about any existing advance directive or medical power of attorney.
- Conduct yourself in an appropriate manner while receiving services from ICHS staff or at ICHS facilities and events. Failure to follow instructions from ICHS staff, comply with policies and treatment agreements, or when refusal of treatment prevents the delivery of safe and appropriate care, the relationship with the patient may be terminated with notice.

_____ _____

Patient's Signature/Print Name Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

To comply with the Health Insurance Portability and Accountability Act (HIPAA), Privacy Regulation, ICHS is required to provide you our Notice of Privacy Practices. This is to inform you that we keep a record of the health care services we provide you. You may ask to see or request for a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. For more information, please contact our Medical Records departments at:

Bellevue Clinic	(425) 373-3012
Holly Park Clinic	(206) 788-3541
International District Clinic	(206) 788-3712
Shoreline Clinic	(206) 533-2641

This form will be retained in your medical record.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Printed name of patient Patient's date of birth

_____ _____
Signature of patient or authorized representative (if patient is under 18) Date

_____ _____
Printed name if signed on behalf of patient Relationship to patient

Notation

A copy has been given to patient or authorized representative.

ICHS International Community HEALTH SERVICES

Notice of Privacy Practices
(Effective September, 2013)

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 maintain the privacy of protected health information and to provide you with notice of our legal duties and our privacy practices with respect to that information. We are required to abide by the terms of the Notice of Privacy Practices currently in effect, but we reserve the right to change these terms at any time. Any changes will be effective immediately and will be available to you on our website (www.ichs.com).

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

For Treatment. We may use or disclose your protected health information to provide you with medical treatment. We may disclose your protected health information to doctors, nurses or other members of our health care team who are involved in your care. For example, your physician may need to consult with specialists about your care. Your protect health information would be shared with them to help understand your health care needs.

For Payment. We may use or disclose your protected health information so that the treatment and services you receive at International Community Health Services ("ICHS" or "we") may be billed to you, an insurance company or third party. For example, we may need to give your health plan information about surgery you received so that your health plan will pay us or reimburse you for the surgery. We will not disclose your protected health information to third party payers without your authorization unless allowed to do so by law. You have a right to request the restriction of the disclosure of your protected health information to a health plan 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, and we are required to agree to such request.

For Health Care Operations. We may use and disclose your protected health information about you for health care operations. These uses and disclosures are necessary to make sure that all of our patients receive quality care. For example, we may use health information to assess the quality of the health care services provided to you or to evaluate the performance of our staff.

OTHER ALLOWABLE USES OF YOUR PROTECTED HEALTH INFORMATION WITHOUT REQUIRING YOUR PRIOR AUTHORIZATION

Business Associates. There are some services provided at ICHS through contracts with business associates. Examples include laboratory, external auditors, outside attorneys and others. Whenever an arrangement between a business associate and ICHS involves the use or disclosure of your protected health information, we will have a written agreement that will protect the privacy of your protected health information.

Communication to Entity Assisting with Disaster Relief. We may disclose your protected health information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or health care services at ICHS.

Treatment Alternatives. We may use your protected health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Research. Under certain circumstances, ICHS may use and disclose population health information for medical research purposes. In most circumstances, we will ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are. Before we use or disclose health information for research, the project will have been approved through this research approval process. In most circumstances, we will ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are. We may, however, disclose health information about you to people preparing to conduct a research project as long as the health information does not leave ICHS.

As Required By Law. We will disclose your protected health information 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 your protected health information when necessary to prevent a serious threat to your health or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to prevent the threat.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health 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 your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health. As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Health Oversight Activities. We may disclose your protected health 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 laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process;
- 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;
- About criminal conduct at ICHS;
- 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 disclose your protected health 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 health information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may disclose your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

CERTAIN USES AND DISCLOSURES REQUIRING AUTHORIZATION

Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, disclosures that constitute a sale of protected health information, and other uses and disclosures of protected health information not covered by this Notice will be made only with your written permission. If you provide ICHS with permission to use or disclose your protected health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Communication with Family and Friends. We may share your protected health information with family members or friends who are involved in your care and/or payment for your care if you tell us that we can do so, or if you do not object to sharing of this information. We may also share relevant information with these persons if, using our professional judgment, we believe that you do not object.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Although your health record is the property of ICHS, your protected health information belongs to you. You have the following rights regarding your protected health information:

Right to this Notice. You have a right to a paper copy of this Notice. You may ask us to give you a copy at any time. You may also obtain a copy of this Notice at our website: **www.ichs.com**.

Right to Inspect and Copy. You have a right to inspect and receive a copy of certain health care information pertaining to you including billing records. You must submit your request in writing to the:

International Community Health Services
Attn: Health Center Manager
PO Box 3007, Seattle WA 98114-3007

If you request a copy of such protected health information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health record, you may request that the denial be reviewed. We will comply with the outcome of the review.

Right to Request Amendment. You have a right to ask that your protected health information be amended by giving a written request to our Health Center Manager.. We have the right to deny this request under certain circumstances. You may write a statement of disagreement if your request is denied. This statement of disagreement will be stored in your health record, and included with any release of your records.

Right to an Accounting of Disclosures. You have the right to receive an accounting of disclosures. This is a record of certain disclosures we made of your protected health information in accordance with law.

You must submit your request in writing to the Health Center Manager. We may charge you for the costs of providing the record. 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. The Health Center Manager can be reached at the following address:

International Community Health Services
Attn: Health Center Manager
PO Box 3007, Seattle WA 98114-3007

Right to Request Restriction. You have a right to ask us to restrict certain uses and disclosures of your protected health information. For example, you may request that we limit the protected health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose your protected health information about a surgery you had to a family member or friend. You must submit your request in writing to the Health Center Manager. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse; however, we are not required to agree to a requested restriction.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a specific way or location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must submit your request in writing to the Health Center Manager. We will not ask you for the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of Breach – You have a right to be notified following a breach of unsecured protected health information.

Complaints

If you believe your privacy rights have been violated, you may contact the ICHS Compliance Officer at 206.788.3658 or submit your complaint in writing to the ICHS Compliance Officer at PO Box 3007; Seattle, WA 98114-3007.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

The quality of your care will not be jeopardized nor will you be subject to any retaliation for filing a complaint.

If you have any questions about this notice please contact the ICHS Compliance Officer at 206.788.3658.