Dear Parent or Guardian,

Camden on Gauley Medical Center, Inc., dba Camden Family Health, is currently offering a range of services at your child's school. These services will be available to all students, staff, and community.

Camden Family Health provides the following services: treatment for acute illnesses; follow-up for long term illnesses; laboratory testing; physical exams, including sports physicals and WV Healthcheck physicals; immunizations; health education; referral services for dental, vision, and other specialists; vision, weight, hearing, and blood pressure screenings; and, behavioral health services.

Camden Family Health will bill private insurances, Medicaid, and WVCHIP for eligible students. Students will not be responsible for payment at the time of service. Parent/Guardian will be billed for copays and/or services not covered by insurance. We do offer a sliding fee program for those who qualify.

If you would like for your child to receive services at the Camden Family Health school-based office, please complete, sign, and return the attached consent form to the school office.

If you have any questions concerning the school-based health program, we would love to hear from you. Please feel free to stop by or call us directly at one of the following numbers:

Webster County High School	304-226-3993
Richwood High School	304-742-3004
Lewis County High School	304-997-8701
Gauley River Elementary School	304-742-1061
Glade Elementary School	304-226-5527
Cherry River Elementary and Richwood Middle Schools	304-846-2588
Panther Creek Elementary School	304-846-2484
Summersville Elementary School	304-872-2178

Also, if you need to reach a provider after normal business hours or when your child's health center is closed, please call 304-226-5725 or 304-872-1663 for assistance.

Thank you,

Camden Family Health
School-Based Health Center Staff

CAMDEN ON GAULEY MEDICAL CENTER, INC
PATIENT RIGHTS AND RESPONSIBILITIES

Each person entering Camden Family Health has the following ***rights***:

- To be treated with respect, consideration, and dignity
- To be provided appropriate privacy of your health records
- To know the names of the people caring for you
- To respect for your cultural, social, spiritual and personal values and beliefs
- To refuse to be included in any research program without limiting medical care or treatment
- To take part in your health care and treatment
- To request and receive information concerning:
    - Their rights
    - Their responsibilities and conduct
    - Services available
    - Provisions for after-hours and emergency care
    - Fees for services
    - Payment policies
    - Advance directives
- To get another opinion about your illness or treatment
- To know about legal reporting requirements

Patients have the following ***responsibilities:***

- To provide your medical provider information about your illness or problems
- To follow the treatment plan prescribed by your provider
- To ask questions about your illness or care
- To inform your provider about any advanced directives that could affect your care
- To accept personal financial responsibility for any charges not covered by your insurance
- To be respectful of all the health care providers, patients and staff

Camden Family Health School-Based Health Care Centers

General Consent for Treatment ~ Assignment of Benefits
Patient Responsibility for Payment

I, the undersigned, being either the patient or the patient's legally authorized representative, do hereby:

GENERAL CONSENT FOR TREATMENT

- Consent to routine medical treatment and/or evaluation, including but not limited to laboratory testing. I agree to all services offered by the School-Based Health Care Center and hereby give my consent for my child to receive services at Camden Family Health School-Based Health Center/s.
- I understand that separate consents will be requested for certain special procedures.
- I authorize the release of any information necessary to process claims and for the insurance company to render payment to Camden Family Health.
- I understand that information may be shared with the school nurse or his/her designee and my primary care physician when pertinent to my child's health and also authorize the school and primary care physician to share information with SBHC when pertinent to my child's health.

ASSIGNMENT OF BENEFITS

- I assign all benefits under any insurance, health benefit plan, Medicare, or Medicaid for payment for medical services rendered by Camden Family Health and further agree to remit payment to Camden Family Health within thirty (30) days of any benefits paid directly to me.

PATIENT RESPONSIBILITY

- I accept financial responsibility for any amount not paid by insurance, other health benefit plans, Medicare, or Medicaid.

REQUIRED FORMS

I have received a copy of the "Notice of Privacy Practices" and understand that it is my responsibility to read the information and ask any questions that I may have. I further understand that current copies are posted in the waiting area and a copy is available on request.

I understand this document remains in effect until my child's date of graduation, unless specifically revoked in writing.

_____ _____
Student Name and Date of Birth Date

_____ _____
Parent Signature Date

_____ _____
Legally Authorized Representative Date
(If parent is unable to consent or if the patient is a minor)

I, _____, **DO NOT,** want my child, _____,
(Parent or Guardian) (Student's Name)
to be seen at the Camden Family Health School-Based Health Care Center/s.

Camden Family Health
Insurance Information

****Please provide a copy of the card if possible****

_____ _____

Student's Name (as it appears on insurance card) Date

Private Insurance Information

Insured Parent/Legal Guardian:_____

Birthdate of Card Holder: _____ Social Security Number of Card Holder: _____

Address (if different from child):_____

Place of Employment:_____

Insurance Company and Complete Address: _____

_____

Insurance Company Phone Number: _____

Group Number: _____ Insurance ID Number:_____

From (month/year): _____ To (month/year): _____

Medicaid Information

Please Circle or Write in your child's carrier: (Ex: Molina, Unicare, Aetna Better Health, etc.)

_____

Medicaid ID Number: _____

PCP/HMO Provider: _____ Provider Phone Number: _____

West Virginia Children's Health Insurance Program (WVCHIP)

Name listed on card: _____ Birthdate of card holder: _____

ID Number on card: _____ Group Number: _____

From (month/year): _____ To (month/year): _____

Please list any additional information on your insurance card.

_____

You may send a copy of your card at any time by mail, fax, or drop off.

Camden Family Health
School-Based Health Centers
Parent/Guardian Consent Form

Please read and complete this form so your child can use the School-Based Health Center.

If you want your child to receive health services, please read this form carefully, complete the questions and sign the attached signature sheets.

Name of Student: _____
(Please list child's name as it appears on birth certificate)

_____
Parent/Guardian (Please Print) Relationship to child Date

_____
Mailing Address City State Zip Code

_____ _____ _____
Home Phone Number Work Phone Number Other Phone Number (Cell)

_____
Parent/Guardian (Please Print) Relationship to child Date

_____
Mailing Address City State Zip Code

_____ _____ _____
Home Phone Number Work Phone Number Other Phone Number (Cell)

Student's Birth Date: ___/___/_____ Grade: ____ Social Security Number: _____-____-_____
(It is very important that we have this number)

Sex (Circle): Male Female Race (Circle): White Black Other:_____

Please list an alternate contact: _____ Relationship to Child: _____

Alternate Contact's Phone Number:_____

By signing the attached signature sheet, I authorize my child to be seen at the SBHC. I agree to all services offered by school-based health center and hereby give my consent for my child to receive health services at Camden Family Health School-Based Health Center, operated by Camden on Gauley Medical Center, Inc. I authorize release of information necessary to process insurance claims and I authorize payment of medical benefits to the health care center. I understand that I am responsible for any charges incurred by my child. I understand that information may be shared with the school nurse and/or his/her designee and my primary care physician when pertinent to my child's health and also authorize the school nurse and/or his/her designee and primary care physician to share information with Camden Family Health when pertinent to my child's health. I understand that this consent will be valid until my child leaves school or until I provide the Camden Family Health staff with written directions otherwise.

Children Will Not Be Seen Without Written Consent
Except as permitted by law

Camden Family Health Student Health History Form

Student's Name _____ Current Grade _____ Date _____

The following information will help the healthcare provider evaluate your child's health. Please answer to the best of your knowledge.

Does your child have a family doctor or pediatrician? Yes:____ No:____. If yes, please list your medical provider's Name:_____When did your child have his/her last ***complete*** physical exam?_____

What is your preferred pharmacy for your child? _____
(Pharmacy Name and Location)

____My child has not had a physical exam within the last year. If time allows, I would like my child to get a physical exam during this school year. I understand that I will be notified of the date and time the physical will be given. Afterwards, I will receive a letter explaining the findings and recommendations.

Allergies

Is your child allergic to any medications? Yes____ No____ If Yes, what medications?

Does your child have any other allergies? (Such as foods, pollens, insect bites, etc.) Yes____ No____
If Yes, What?_____

Medications

List any Medication your child is currently taking and the reason for which the medication was given.

Medication/Dose	Reason	How long taking medication

Please check any of the following health conditions that your child has:

___Anemia	___Depressed or overly nervous	___Allergies	___Toothaches
___Asthma	___Frequent Illness	___Hypertension	___Other
___Diabetes	___Scoliosis	___Bladder Infection	Please Explain:_____
___Headaches/Migraines	___Seizure Disorder	___Serious Injuries	_____
___Emotional Disorders	___Stomach or Intestinal Disorders		

Please let us know if your child has other important health issues that we should know about:

Dental

How often does your child go to the dentist? At least once a year:___ Only with toothaches:___ Never:___
When was your child's last dental exam?_____ Name of Dentist:_____

Additional Information

In the past year, have there been any changes in your family such as:

___Marriage	___Serious Illness	___Change in School	___Moved to a new home
___Separation	___Loss of job	___Births	___Divorce
___Deaths	___Other:_____		

*****Please attach a copy of your child's Immunization Record*****

_____ _____
Parent/Guardian Signature Date

Version 3/mdr

CAMDEN FAMILY HEALTH
NOTICE OF PRIVACY PRACTICES

This Notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. For purposes of this Notice, "we" means and includes Camden Family Health. This Notice 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 PHI

Your PHI may be used and disclosed by your physician, our office staff and others outside of our offices who are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice. Following are examples of the types of uses and disclosures of your PHI that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. We will also disclose PHI to other physicians who may be treating you. For example, your PHI 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. In addition, we may disclose your PHI from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your PHI will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose your PHI in order to support the business activities of your physician's practice. We will share your PHI with third party "business associates" that perform various activities (for example, billing services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI. We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your PHI to the extent required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your PHI as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

Uses and Disclosures of PHI Based upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you for so long as we maintain the PHI. You may obtain your medical record and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records. Under 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 laboratory results that are subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for 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 your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

You may have the right to have your physician amend your PHI. This means you may request an amendment of PHI about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. 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 PHI. This right applies to disclosures for purposes other than treatment, payment or health care operations. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

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 electronically.

West Virginia law places more stringent restrictions than federal law on the disclosure of certain kinds of medical information. The following information in this paragraph applies to uses and disclosures for all the purposes described above: Generally speaking, but with several exceptions listed in the applicable West Virginia statutes, West Virginia law requires either your written authorization or a court order, for disclosure of information about your mental healthcare or about HIV or AIDS testing of you. West Virginia law requires that before performing an abortion for a minor, a physician intending to perform the abortion must notify the minor's parent or legal guardian if they can be found, but, under some circumstances, a minor may get a court order forbidding such disclosure. Under West Virginia law, both parents (divorces or separated) of a child will have equal access to the child's records, except as limited by court order or other West Virginia law. The parent objecting to the release of records to the other parent has the duty to provide us with a court order prohibiting the release. Under West Virginia law, a physician may, at the request of a minor patient, withhold from the patient's parents or legal guardian information about venereal disease treatment, birth control, pre-natal care, or drug rehabilitation treatment of the minor. Under West Virginia law, physician may, at the request of a minor patient whom the physician believes to be a "mature minor" capable of making his or her own healthcare decisions, withhold medical information about the minor from the minor's parents or legal guardian and may follow the minor's instructions about disclosure or non-disclosure of the mature minor's medical information. For any medical information the use or disclosure of which is more stringently restricted by West Virginia law than by federal law, we will abide by the more stringent restrictions imposed by West Virginia law.

3. 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 Officer of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer 304-226-5725 for further information about the complaint process.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.