[PATIENT LABEL

HealthPoint School Based Health Center

PATIENT REGISTRATION

Last Name/Apellido	**First Name**/Primer nombre	**Middle Name**/Segundo nombre

Social Security Number/Número del Seguro Social	**Birth Date**/Fecha de nacimiento	**Birth Sex**/Sexo natal	**Current Gender**/Sexo actual
		☐ **Male**/Masculino ☐ **Female**/Femenino	☐ **Male**/Masculino ☐ **Female**/Femenino

Gender Identity/Identidad de género

☐ **Additional Gender or Other**/Género adicional u otro
Please specify/Especifique _____

☐ **Choose not to Disclose**/Prefiere no decir
☐ **Female**/Femenino
☐ **Female to Male**/Femenino a masculino

☐ **Gender Queer**/Género queer
☐ **Male**/Masculino
☐ **Male to Female**/Masculino a femenino

Sexual Orientation/Orientación sexual

☐ **Bisexual**
☐ **Choose not to Disclose**/Prefiere no decir
☐ **Don't Know**/No sabe

☐ **Lesbian, Gay Or Homosexual**/ Lesbiana, gay u homosexual
☐ **Straight or Heterosexual**

☐ **Something Else**/Otra
Please specify/Especifica _____

Preferred Pronoun/Pronombre Preferido

☐ **Decline to answer**/Se abstiene de responder
☐ **He, Him, His**/Él, su

☐ **She, Her, Hers**/Ella, su
☐ **They, Them, Theirs**

☐ **Ze, Hir**
☐ **Other**/Otro

Mailing Address/Dirección postal			**Home Address (if different)**/Dirección de la casa (si es distinta)		
City/Ciudad	**State**/Estad	**Zip**/Código postal	**City**/Ciudad	**State**/Esta	**Zip**/Código postal

Marital Status/Estado civil:

☐ **Single**/Soltero(a)
☐ **Married**/Casado(a)
☐ **Partnered**/Vive en pareja
☐ **Widowed**/Viudo(a)
☐ **Divorced**/Divorciado(a)
☐ **Legally Separated**/ Legalmente separado(a)

What is your preferred language?
¿Qué es su idioma de preferencia?
Please specify/Especifique _____

Contact Information/Información de contacto

Patient Phone/Teléfono preferido _____
☐ **Home**/casa ☐ **Cell**/móvil ☐ **Day**/de día

E-mail Address/Correo electrónico: _____

Parent/Guardian Phone/Teléfono secundario _____
☐ **Home**/casa ☐ **Cell**/móvil ☐ **Day**/de día

Preferred Contact/Contacto Preferido:
☐ Phone Call to Cell ☐ Home Phone ☐ Email/Patient Portal ☐ Mail ☐ Day Phone

Answering these questions may help HealthPoint obtain funding for services.
Responder estas preguntas puede ayudar a HealthPoint a obtener fondos para los servicios.

Are you disabled or handicapped?
¿Es discapacitado o minusválido?
☐ **Yes**/Sí ☐ **No**

Are you an immigrant?
¿Es inmigrante?
☐ **Yes**/Sí ☐ **No**

Total number of people in your household (people who live in the same house and depend on the same income)
Número total de personas en su hogar (personas que viven en la misma casa y dependen de los mismos ingresos) _____

Total number of children under 18 in your household
Número total de niños menores de 18 que viven en su hogar _____

Which of the following best describes your household? / ¿Cuál de las siguientes opciones describe mejor su hogar?

☐ **Individual**
☐ **Single Female Head of Household**/Mujer soltera jefa de familia
☐ **Single Male Head of Household**/Hombre soltero jefe de familia
☐ **Two-parent household**/Hogar con dos padres

Are you currently serving in a branch of the military, including the National Guard and Reservists?/¿Sirve actualmente en una rama de las fuerzas armadas, incluida la Guardia Nacional y los reservistas?
☐ **Yes**/Sí ☐ **No**

Are you the family member of a current military member or veteran?/¿Es miembro de la familia de un militar actual o veterano?

☐ **No**
☐ **Yes, spouse or partner**/Sí, cónyuge o pareja
☐ **Yes, child of**/Sí, hijo de
☐ **Yes, other dependent relative**/Sí, otro pariente dependiente

Are you a refugee?
¿Es refugiado?
☐ **Yes**/Sí ☐ **No**

Please complete both sides of this form.
Por favor, complete ambos lados de este formulario.

Are you homeless or in a temporary shelter? ¿Está usted sin hogar o vive en un refugio temporal?

- ☐ **Doubling Up**/Comparto habitación
- ☐ **Not homeless**/Tengo hogar
- ☐ **Other**/Otro
- ☐ **Permanent Supportive Housing**/Vivienda de apoyo permanente
- ☐ **Public Housing**/Vivienda pública
- ☐ **Shelter**/Refugio
- ☐ **Street**/Calle
- ☐ **Transitional**/De transición

At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?
¿En algún momento de los últimos 2 años, ha sido el trabajo agrícola estacional o migrante sido la principal fuente de ingresos suya o de su familia?

- ☐ **No farm work**/No trabajador agrícola
- ☐ **Yes, migrant farm work**/Trabajador agrícola migratorio
- ☐ **Yes, seasonal farm work**/Trabajador agrícola estacional

Do you need an interpreter?
¿Necesita un intérprete?

- ☐ **Yes**/Sí
- ☐ **No**

What is your race or biological family background? (Check all that apply)
¿Cuál es su raza o los antecedentes de su familia biológica? (Marque todo lo que corresponda)

- ☐ **American Indian/Alaskan Native**/Indio americano/Nativo de Alaska
- ☐ **Asian**/Asiático
- ☐ **Black/African American**/Moreno/Afroamericano
- ☐ **Declined to specify**/Se abstiene de especificar
- ☐ **Native Hawaiian**/ Hawaiano nativo
- ☐ **Other Pacific Islander**/Otro Isleño del Pacifico
- ☐ **White**/Blanco

Are you Hispanic or Hispanic-Latino(a)?
¿Es hispano o hispano-latino(a)?

- ☐ **Yes, Hispanic or Hispanic-Latino(a)**/Sí, hispano o hispano-latino(a)
- ☐ **Not Hispanic or Hispanic-Latino(a)**/No es hispano ni hispano-latino(a)

Have you ever been discharged from the uniformed services of the United States?
¿Alguna vez ha sido dado de baja de los servicios uniformados de los Estados Unidos?

- ☐ **Yes**/Sí
- ☐ **No**

What is your Primary Medical Insurance?
¿Cuál es sus Seguro médico primario?

- ☐ **Provider One/DSHS**
- ☐ **Self-Pay**/A pago personal
- ☐ **Other**/Otro
- ☐ **Private Insurance/**Seguro privado

_____

What is your household's monthly gross income?
¿Cuáles son los ingresos mensuales brutos de su hogar?

$ _____ **per month**/al mes

Student ID #/# de Identificación del estudiante	**School/**Escuela

Emergency Contact/Contacto de emergencia **Must be age 18 or older**/Debe tener más de 18 años

Last Name/Apellido	**First Name**/Primer nombre
Phone Number/Teléfono	**Relationship to Patient**/Relación con el paciente

If patient is less than 18:/Si el paciente es menor de 18:

Parent/Guardian's Last Name/Apellido del padre, madre o tutor		**Parent/Guardian's First Name**/Nombre del padre, madre o tutor	
Social Security Number/Número del Seguro Social	**Birth Date**/Fecha de nacimiento	**Birth Sex**/Sexo Natal ☐ **Male**/masculino ☐ **Female**/femenino	**Relationship to Patient/**Relación con el paciente ☐ **Parent**/Padre o madre ☐ **Guardian**/Tutor legal ☐ **Other**/Otro
Mailing Address/Dirección postal			
City/Ciudad	**State**/Estado	**Zip**/Código postal	**Phone**/Teléfono
Medical Insurance Plan:	**Policy #**		**Group #**

I authorize the release of any medical information necessary to process my claims and I authorize payment of medical benefits to the supplier for services described on the claim form/superbill.
I acknowledge that my care at HealthPoint could include visits with both residents and students whose care will be overseen by attending provider or supervisor.
I confirm that the above information is true and correct to the best of my knowledge.

Autorizo que se revele cualquier información médica que sea necesaria para procesar mis reclamaciones y autorizo el pago de prestaciones médicas al proveedor de los servicios descritos en el formulario de reclamación/superfactura (factura detallada). Entiendo que mi cuidado en HealthPoint puede incluir visitas con residentes y estudiantes que serán supervisados por un proveedor o supervisor. Confirmo que la información anterior es verdadera y correcta a mi mejor saber y entender.

Signature of patient or guardian /Firma del paciente o tutor _____ **Date:** /Fecha _____

HealthPoint School-Based Health Center
Consent for Health Services

HealthPoint School-Based Health Centers (SBHC), located on campuses owned by a school district, must have a signed consent from a parent or legal guardian before providing services to the student, except in situations where federal and/or state laws allow the student to access such treatment without parent/guardian consent. If the student is enrolled in school but is not enrolled in the Campus Health Center, he/she can continue to receive School Nurse services. I hereby request and authorize that:

Student Name: _____ Date of birth: _____
First Middle Last MM/DD/YYYY

may receive health care services from HealthPoint staff. Services may include, but are not limited to, routine medical care, naturopathic medical care, mental health counseling, sports physicals, preventive care, evaluation and treatment of acute illness and injuries, medication, nutritional counseling, immunizations, blood studies, ordering and managing of images, and dental screening. Consent is also given for referral for care and, if needed, emergency transportation to other physicians, health care professionals, hospitals, clinics or health care agencies as deemed necessary by the HealthPoint staff. This authorization does not allow services to be provided without the student's consent, unless they are unable to consent.

Additionally, consent is given:
To release a copy of a sports physical or immunization records to the student;

For the SBHC providers to administer over the counter medications (such as ibuprofen, acetaminophen (Tylenol), antacids, etc.) and prescription medications;

To release my child's education records from the school district to the SBHC. Education records include, but are not limited to: student name, school name, attendance history, grades and credits earned, upcoming assignments, missing assignments, test scores, Individual Education Plan (IEP) and documented disciplinary issues. I understand the purpose of sharing these records is to keep my child's health care team informed of his/her academic program and process. SBHC staff will work with the school, the family and the student in order to help the student succeed in school.

For the student named above to receive medical services at any of the HealthPoint medical centers listed below (in order to reduce the need to register again if the child wants to use a non-school based HealthPoint medical center):

HealthPoint Auburn: (253) 735-0166
HealthPoint Bothell: (425) 486-0658
HealthPoint Renton: (425) 226-5536
HealthPoint Auburn North: (253) 351-3900
HealthPoint Renton High: (425) 424-6310
HealthPoint Federal Way: (253) 874-7634
HealthPoint Redmond: (425)882-1697
HealthPoint Tukwila: (206) 439-3289
HealthPoint Tyee: (206) 277-7210
HealthPoint Cynthia A. Green: (206) 839-3540
HealthPoint SeaTac: (206) 277-7200
HealthPoint Kent: (253) 852-2866
HealthPoint Midway: (206) 870-3590
HealthPoint Evergreen: (206)835-2615

PARENT/GUARDIAN, please initial to show that you have received, understand and give consent to each of the following:

_____ **Notice of Privacy Practices: I have received** HealthPoint's Notice of Privacy Practices that describes how my child's health information may be used and shared with other health care providers and how I can access my child's information. They can be found here:
http://www.healthpointchc.org/content/files/NoticeofPrivacyPractices_Eng_8.5x11_2.21.18.pdf
http://www.healthpointchc.org/content/files/NoticeOfPrivacyPractices_SP_12-2013.pdf

_____ **Vaccine Information Statements: I understand** that electronic access to Vaccine Information Statements is at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. The Parent/Guardian is encouraged to review the VIS statements.

_____ **Immunization/Vaccine Records: I give my consent** to HealthPoint to request and receive my child's vaccination records from the school nurse and/or other school staff or the Washington State Immunization Registry.

_____ **Optional:** I give my consent to HealthPoint and its photographer to photograph or record me and/or my children for marketing purposes to show the benefits of SBHCs. I also give HealthPoint the right to use and publish the photographs/videos of me and/or my children.

_____ **For Middle School Students only**: **I give permission** for my student to leave campus in order to attend appointments at the School Based Health Center located on the neighboring high school campus. I understand a pass system and/or escort will be used in order to ensure their return back to class.

In accordance with state and/or federal law, when consent is provided for care, healthcare information is kept confidential. A few exceptions exist. For example:
When permission is given by the patient through a signed release of information.
When the patient indicates risk of imminent harm to self or others.
When the patient has a life-threatening health problem and is under 18 years old.
When there is reason to suspect abuse or neglect.
Certain communicable diseases must be reported to public health authorities.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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

This registration will remain in effect as long as the enrollee is a student in the Highline or Renton school district. The student or guardian may choose to withdraw the consent at any time. Please contact the Clinic Coordinator for more information.

IMPORTANT ADDITIONAL INFORMATION

HealthPoint School-Based Health Centers encourage each student to involve their parents or guardians in health care decisions whenever possible. Under Washington State law, youth may independently access reproductive health care at any age without parent/guardian consent. Also, starting at age 13, youth may independently receive drug and alcohol cessation services and mental health counseling without parent/guardian consent. Starting at age 14, youth may independently receive testing and/or treatment for HIV and STI's. Because youth may independently receive this care, their consent is legally required for release of information about pregnancy and sexually transmitted infections. Consent from students age 13 and over and parent/guardian consent for students age 12 and under is legally required for release of information about alcohol and drug or mental health counseling.

Pediatric Patient Questionnaire

For children 12 months and older

NAME:

DOB:

INTERPRETER NEEDED? ☐ NO ☐ YES, _____

a. Medications/Allergies

List any **allergy(ies)** and **reaction(s)** you have: ☐ NONE _____

List any medications you are currently taking: ☐ NONE

Medicine:	**Dose:**	**How often:**	3.		
1.			4.		
2.			5.		

b. Personal Health History

Have you ever had or are you being treated for any of the following conditions?

ADHD	☐ NO ☐ YES	Eczema	☐ NO ☐ YES	Depression/Anxiety	☐ NO ☐ YES
Food allergies	☐ NO ☐ YES	Broken or dislocated bone	☐ NO ☐ YES	Blood clots	☐ NO ☐ YES
Seasonal allergies	☐ NO ☐ YES	Reflux/GERD	☐ NO ☐ YES	Mental illness	☐ NO ☐ YES
Anemia	☐ NO ☐ YES	Head injury	☐ NO ☐ YES	**Learning/ Developmental delay**	☐ NO ☐ YES
Asthma	☐ NO ☐ YES	Headaches	☐ NO ☐ YES	Autism	☐ NO ☐ YES
Bleeding disorder	☐ NO ☐ YES	Hearing problems	☐ NO ☐ YES	Vision problems	☐ NO ☐ YES
Breathing problems	☐ NO ☐ YES	Ear infection	☐ NO ☐ YES	Snoring at night	☐ NO ☐ YES
Concussion	☐ NO ☐ YES	Prematurity	☐ NO ☐ YES	Other: _____	
Heart Problems	☐ NO ☐ YES	*How early?* _____			
Constipation	☐ NO ☐ YES	Seizures	☐ NO ☐ YES		
Diabetes	☐ NO ☐ YES	Kidney/Urinary tract infection	☐ NO ☐ YES		

When you exercise do you have problems with:

Passing out or feeling like you will pass out	☐ NO ☐ YES
Chest pain or discomfort	☐ NO ☐ YES
Heart skipping beats or racing	☐ NO ☐ YES
Feeling lightheaded or more short of breath than expected	☐ NO ☐ YES
Feeling more tired or short of breath than your friends	☐ NO ☐ YES

Have you ever had surgery:

To remove your tonsils and/or adenoids	☐ NO ☐ YES
To remove your appendix	☐ NO ☐ YES
On your teeth (dental surgery)	☐ NO ☐ YES
To place ear tubes	☐ NO ☐ YES
List any other type of surgeries you had:	☐ NONE

_____

c. Females Only

Have you had a period? ☐ NO ☐ YES

If yes, what age did you start having periods? _____

Please list any problems or concerns about your periods: NONE _____

_____

HealthPoint

d. Family History

Were you adopted ☐ NO ☐ YES

Has anyone in your family ever had *(please provider information for biological parents and siblings only).*

ADD/ADHD	☐ NO ☐ YES	Deafness	☐ NO ☐ YES	**Sudden death**	☐ NO ☐ YES
Asthma	☐ NO ☐ YES	Diabetes	☐ NO ☐ YES	Sickle cell disease	☐ NO ☐ YES
Cancer	☐ NO ☐ YES	High cholesterol	☐ NO ☐ YES	Bleeding disorder	☐ NO ☐ YES
Heart Problems	☐ NO ☐ YES	Strabismus/Lazy eye	☐ NO ☐ YES	Blood clots	☐ NO ☐ YES

1. Has any family member or relative died of heart problems or had unexplained or unexpected sudden death before the age of 50 (including drowning, unexplained car accidents, or sudden infant death syndrome)? ☐ NO ☐ YES
2. Does anyone in your family have a pacemaker, implanted defibrillator, or heart rhythm problem? ☐ NO ☐ YES
3. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? ☐ NO ☐ YES

e. Social History

Tobacco use (including vape): ☐ NO ☐ YES ☐ FORMER Smokers in family: ☐ NO ☐ YES Smoking allowed in the home: ☐ NO ☐ YES

Mother's Name: _____ Birthdate: _____ Age: _____ Living: ☐ NO ☐ YES

Father's Name: _____ Birthdate: _____ Age: _____ Living: ☐ NO ☐ YES

Does child attend Daycare? ☐ NO ☐ YES

Primary residence: ☐ Mother ☐ Father ☐ Other, _____ Secondary residence: ☐ Mother ☐ Father ☐ Other, _____

Mother's occupation: _____ Father's Occupation: _____ # of siblings: _____

Any concerns about relationships with family/friends/other? ☐ NO ☐ YES

Home type: ☐ Apartment ☐ House ☐ Condominium ☐ Mobile Home (trailer)

Do you drink tap water? ☐ NO ☐ YES

Do you use a helmet when you ride your bike, skate, or skateboard? ☐ NO ☐ YES ☐ N/A

Do you use a car seat? ☐ NO ☐ YES ☐ N/A Do you use a seat belt? ☐ NO ☐ YES

Do you have the following at home:

Carbon monoxide detector ☐ NO ☐ YES

Smoke detector ☐ NO ☐ YES

Firearms ☐ NO ☐ YES

How many hours per day do you spend: Playing sports/exercising? ____ Watching Television? ____ On the computer/internet? ____

f. Dental Health

How many times a day do you brush your teeth? _____

How many times a week do you floss your teeth? _____

Have you seen a dentist in the past year? ☐ NO ☐ YES

Thank you for taking the time to tell us about your health history.

HealthPoint

HealthPoint
Your Community Health Center

NOTICE OF PRIVACY PRACTICES

THIS NOTICE EXPLAINS HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND GIVEN OUT. IT ALSO EXPLAINS HOW YOU COULD GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HealthPoint respects your privacy. We understand that your personal health information is very sensitive. We will not give out your information to others unless you tell us to, or unless the law allows or requires us to do so.

We are required by law to keep your protected health information (PHI) private, to give you this Notice, and follow the terms of this Notice. We also have the right to change our practices. If we make changes to this Notice, you will receive the updated Notice upon your next visit. If we change this Notice, we will post the revised notice in the waiting area of our office and on our web site at www.healthpointchc.org.

PHI is any information that includes your personal information, as well as health and billing information. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. USING AND RELEASING PROTECTED HEALTH INFORMATION

A. Without Your Written Permission. We have the right to use and share your health information for the following reasons:

1. Treatment: Information obtained by a nurse, physician, or other member of our health care team, recorded in your medical record, may be used to help decide your future care. We may also share information to others providing you care. This will help them stay informed about your care.

2. Payment: We request payment from your health insurance plan. Health plans need information from us about your medical care. Information shared with health plans may include your diagnoses, procedures performed, or future recommended care.

3. Health Care Operations: We may use and share PHI for our health care operations, such as quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff.

4. Required or Permitted by Law: We may share PHI when we are required or permitted to do so by law. For example, we may release PHI to proper authorities if we believe that you are a possible victim of abuse, neglect, or domestic violence. We may also share PHI necessary to stop a serious threat to the health or safety of you or others. Other releases could include: public health activities; requests from state or federal agencies; law enforcement; court order or other lawful process; approved research; workers' compensation claims; military or national security agencies, coroners, medical examiners, and correctional institutions.

B. Without Your Permission, And You May Object.

1. Fundraising: We may use PHI to contact you in an effort to raise money for our operations. We may also release PHI to a foundation that is related to us so that the foundation may contact you in an effort to raise money for its operations. Any fundraising communications with you will include a description of how you may opt out of receiving any further fundraising communications

2. Family and Other Persons Involved in Your Care. Unless you object, we may share your PHI with a family member, relative, close friend, or any other person you identify is involved in your medical care. We may share information to notify the person of your location general condition or payment related to your care.

3. Disaster Relief Efforts. We may share your protected PHI to a public or private entity authorized by law or its charter to assist in disaster relief efforts for coordinating notification of family members of your location, general condition, or death.

C. Needs Your Written Permission.

1. Psychotherapy Notes. We must get your permission to use or release psychotherapy notes, unless the psychotherapy notes are:
(1) By the creator of the psychotherapy notes for treatment purposes,
(2) For our own training programs in which mental health students, trainees or practitioners learn to improve their counseling skills,
(3) To defend ourselves in a legal proceeding initiated by you,
(4) To a health oversight agency for oversight of the creator of the psychotherapy notes,
(5) To a coroner or medical examiner; or
(6) To prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

2. Minors. We will follow Washington State law when using or sharing PHI of minors. Minors who receive health care services related to HIV/AIDS; STDs, mental health treatment, alcohol/drug testing, and treatment or reproductive health may request that another person receive that information on their behalf. If the minor does not give permission in writing to anyone, we will only release that information to the minor.

3. Marketing Communications: Sale of PHI. We must have your written permission before using or sharing PHI for marketing or the sale of PHI, consistent with the related definitions and exceptions set forth in HIPAA.

Other Uses and Releases. Any requests for information besides those described in this Notice will need your written permission. For example, you will need to sign a permission form before we can send PHI to your life insurance company or to your attorney. You may revoke your permission at any time by providing us with written request.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request to see your medical records and billing records in order to inspect and/or request copies of the records. All requests to view records must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the cost of copying and sending records you request.

B. Right to Alternative Communications. You may request in writing to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to limit PHI we use or share for treatment, payment, or health care operations. You must request limitations in writing addressed to **Michelle A. Matt, HIPAA Privacy Officer**. We are not required to agree to limitations you request, **unless** your request is to limit releasing PHI to a health plan for payment or health care operations and that PHI directly relates to a health care item or service that you or another person or entity on your behalf paid in full.

D. Right to Accounting of Releases. You may request in writing an accounting of releases of PHI made by us in the last six years, subject to certain restrictions and limitations.

E. Right to Request Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to **Michelle Matt, HIPAA Privacy Officer, at (425) 277-1311 ext. 11151** at any time

G. **Right to Receive Notification of a Breach**. We are required to notify you if we discover a breach of your unsecured PHI, according to requirements under federal law.

H. Questions and Complaints. If you have questions about your privacy rights, or are concerned that we have violated your privacy rights, you may contact **Michelle Matt, HIPAA Privacy Officer, at (425) 277-1311 ext. 11151.** You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or with our office.

III. EFFECTIVE DATE

A. Effective Date. This Notice is effective on **September 23, 2013**.