Teen Health Center
Roseburg High School
400 W Harvard Avenue
Roseburg, Oregon 97470
Phone 541-492-2055
Fax 541-440-8266

Roseburg High School 541-492-2055
Aviva Health 541-672-9596

The Teen Health Center at Roseburg High School has operated as a School Based Health Center by Aviva Health since September 2005.

What is a School Based Health Center?

A School Based Health Center is a primary care medical office that is located in a school. Like a medical office anywhere else, we offer many health and medical services to students. The Teen Health Center at Roseburg High School is a branch of Aviva Health of Roseburg, Oregon. The main office of Aviva Health is located at 150 Kenneth Ford Drive, Roseburg, Oregon. Aviva Health has an agreement with Roseburg High School to provide medical services at Roseburg High School that is regulated by the School-Based Health Center Program of the State of Oregon.

Who works at the Teen Health Center at Roseburg High School?

Staff will include a Nurse Practitioner (NP), a Registered Nurse (RN), and a Receptionist. The Nurse Practitioner will treat most common health conditions, write prescriptions, order laboratory tests and x-rays, and perform common office procedures. All Teen Health Center staff is supervised by and has the support of Aviva Health physicians, other NPs, and medical director.

What services are offered?

We can take care of most of your student's health care needs at the Teen Health Center. If there is an emergency or service we do not provide, we contact 911 or make a referral to another provider. If the student has a primary care provider locally, we attempt to coordinate with that provider. If desired, the student may be referred to a physician at Aviva Health. When the Teen Health Center is not open or staff is unavailable, school personnel will follow Roseburg High School guidelines for all emergency situations.

A short list of services offered at the Teen Health Center:	
• Wellness and how to maintain it • Physical examinations, routine and sports, by appointment • Immunizations and flu shots • Screening tests such as anemia, diabetes, infections • Diagnosis and treatment most common health problems • Referrals to other health care providers • Disease Prevention	• Vision and blood pressure screening • Tobacco prevention and cessation • HIV/AIDS prevention education, testing, and counseling • Drug and alcohol prevention • Nutrition education and weight management • Diagnosis and treatment of minor injuries • Urgent Care

What about appointments?

Appointments are encouraged whenever possible. A parent may call and make an appointment, or your student is welcome to come by and schedule an appointment. Walk-ins will be taken as time allows. Hours will be posted on the Teen Health Center door.

What about confidentiality?

Our health services and records are private and confidential as required by law. Health records are the property of Aviva Health and will not become a part of your student's school record. Access to the student's records by others is allowed only with written permission as required by law.

Like other health care providers, the Roseburg High School Teen Health Center follows the guidelines of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA regulates how medical information may be used and disclosed and how you can get access to this information. We are required to give you a copy of our Notice of Privacy Practices and have you sign the Notice of Privacy Practices Receipt, which is included in your registration packet of information, as with any other medical office.

What about parental consent?
Written consent packets are available at registration and throughout the year at the Teen Health Center, The Teen Health Center complies with Oregon State Law regarding parental consent for providing services for students under the age of 18. If a student presents for care and the Teen Health Center does not have a written consent on file, an attempt to contact parent or guardian will be made by phone.

Parent/Student Health Center Communication
Students are encouraged to discuss Teen Health Center visits with their parents. When medication is prescribed, parents are notified by phone and a written report with instructions will be sent home. If you have questions, you may reach the Teen Health Center at 541-492-2055.

Please read and sign the consent packet. This consent packet will be valid for as long as the student is in this high school, unless you terminate it in writing. New consent packets will be available at registration in August. If you do not want your student to be seen at the Teen Health Center, please mark "NO" in the space provided on the informed consent form. This will prevent you from being bothered further by permission requests.

Please call us at Roseburg High School Teen Health Center at 541-492-2055, if you have any questions or concerns.

What about costs and billing?

Billing for services at the Teen Health Center will be completed as it would in any other medical facility. Your health insurance, if any, will be billed.

If you have a commercial or private insurance, Aviva Health will bill the insurance. If you have not met your deductible, you will receive a statement for the copay and the remainder of the amount of today's visit; that payment will be applied to your deductible. The student never has to pay a copay or any money out of pocket at the School-Based Health Center.

If you cannot afford the total bill, you may apply for the Aviva Health sliding scale which is a significant percentage off the original price. The sliding scale is determined by how many people are in your household and your income for the last 30 days. **No student will be turned away due to inability to pay.**

What are the benefits of being an established patient of Aviva Health?
Aviva Health is a Federally Qualified Health Center whose mission is to serve and assist people in Douglas County who have limited access to health care by caring for the community on a personal level. Aviva Health does accept all forms of private and public insurance.

Besides making available primary health care services at Roseburg High School, a student and his or her family may receive several benefits from being established with Aviva Health:

- Sliding Scale discounts for care based upon family income.
- Health care coverage with established providers after school hours, on weekends, and during the summer
- Pharmacy discount program that may save up to 50% on prescription costs
- Discounts on the costs of laboratory and x-ray procedures
- Dental clinic also available

If requested, an Application for Reduced Charges is available.

Aviva Health does not intend to replace the care of any medical provider that the student or student's family may be already established with. Where insurance requires a primary care provider's authorization, that provider will be contacted before treating a patient. All primary care providers will be notified of any significant findings or developments in a student's care.

Please obtain the student health packet at the Teen Health Center booth at registration or in the Teen Health Center Office.

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Please Print Clearly

STUDENT INFORMATION

Student Last Name	First Name	Middle Initial	Preferred Name	Date of Birth	Age

Address	City	State	Zip Code

Gender ☐ Male ☐ Female		Home Phone	May we leave a message? ☐ yes ☐ no
		Cell Phone	May we leave a message? ☐ yes ☐ no
		Alternate	May we leave a message? ☐ yes ☐ no

Responsible Party	First	Middle Initial	Last	DOB
Relationship		Phone Number		

Do you have a regular medical provider? ☐ yes ☐ no	**Regular Provider** Name
Allergies Allergies to Medicines? ☐ yes ☐ no If yes, to what medicine and what is the reaction to it?	Address
	City State Zip Code
	Phone

Student Status	**Primary Language**	**Primary Race**	
☐ Full time ☐ Part time Grade _____	☐ English ☐ Spanish ☐ German ☐ Sign Language ☐ Other _____ Do you need an interpreter? ☐ yes ☐ no	☐ American or Alaskan Native ☐ Asian _____ ☐ African American (Black) ☐ Caucasian (White) ☐ Hispanic/Latino ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other _____	

Emergency Contact People

Name First	Last	Relationship	Phone	Cell Phone	Work Phone

Parent/Guardian Information

Last First Name	Relationship	Address	Date of Birth	Phone

By marking yes to special confidentiality, you are stating that if your partner/spouse or parent/guardian were to receive from this clinic a bill for or phone call about your appointment today, you would worry about your safety? Special Confidentiality is not pertaining to your medical records. No Yes

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Informed Consent and Consent for Services

PARENT CONSENT REQUIRED

Please Print Clearly

Student Last Name	First Name	Middle Initial	Date of Birth

The Parent/Guardian/Patient response on this form will be the basis on which your child may or may not have access to the Roseburg High School Teen Health Center. Your signed response will remain in effect for as long as your student is enrolled at Roseburg High School or until revoked in writing and delivered to the Teen Health Center. Failure to sign and return this form will result in the student being denied access to the Teen Health Center with the exception of potentially life or function threatening medical emergencies. PLEASE SIGN AND RETURN.

Parent/Guardian/Patient Signature	Date
(Daytime) person to contact in case of emergency	Phone number:
Relationship to Patient	

Unless you ask us NOT to, we may treat your student with over-the counter medications if there is a minor ailment. **Parent/guardian will be contacted** by telephone or via written summary note if prescription medications or laboratory tests/x-rays are indicated.

Privacy and authorization to give consent for treatment: According to Oregon Law (ORS 109.610, ORS 109.640, ORS 109.675), a student age 15 may give consent for any medical or surgical treatment; age 14 may give consent for mental health treatment; and a student of any age may give consent for treatment of sexually transmitted disease and birth control. The Federal Health Insurance Portability and Accountability Act (HIPAA) may restrict a parent/guardian's access to a student's medical records without permission by the student. State law requires students to be advised of resources for services requested but not available at Teen Health Center. For further information, please ask to speak to the clinic nurse practitioner or the school clinic coordinator at Aviva Health.

Services that are provided to students may be billable. However, services will not be withheld due to inability to pay.

The School-Based Health Center may ask students aged 12 to 19 years who visit to answer an anonymous survey after your visit. The survey asks about the satisfaction and the experience of the student in the SBHC and other general questions about their state of physical and mental health. Students can refuse to participate in the survey and this will not affect your ability to receive health care in the SBHC. To view a copy of the survey, please go to the link "SBHC data requirements" at http://healthoregon.org/sbhc. If you have any questions about the survey, please contact the State Office of the SBHC program in sbhc.program@state.or.us

_____ YES I consent to health care services offered by the Roseburg High School Teen Health Center for the above-named student. I understand that this consent is valid as long as my student is enrolled at Roseburg High School, unless terminated in writing.

_____ NO I do not give my consent to services offered.

Date	Parent/Guardian Signature

Date	Patient Signature

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Insurance and Payment Information

Please Print Clearly

Student Last Name	First Name	Middle Initial	Date of Birth

Services that are provided to students may be billable. However, services will not be withheld due to inability to pay.

A copy of your insurance card(s) is(are) needed if you have insurance. Please attach a copy – front and back – with this consent packet. Please include the policy holder's name and date of birth on the copy of the card.

☑ Please check which type of insurance you have

☐ Private Insurance ☐ Oregon Health Plan ☐ Medicare ☐ Other ☐ None

INSURANCE CARD

A copy of your insurance card is needed if you have health insurance. Please send it to us via one of these options:

- Please attach a copy of your insurance card/s – front and back – with this packet. Include the policy holder's name and date of birth on the copy.
- You may fax a copy of the card/s – front and back - to 541-440-8266. Include the policy holder's name and date of birth on the copy.
- You may bring the card/s into the Teen Health Center and we will make a copy for the student's file. Include the policy holder's name and date of birth.

All information provided to Aviva Health Teen Health Center at Roseburg High School is treated as privileged and confidential for your protection, we will not discuss your billing account with other individuals without your permission.

If you do not have health insurance for your student and would like information about the Oregon Health Plan, the Teen Health Center has OHP application packets available for your convenience. We can also contact the Aviva Health Outreach & Enrollment Specialist to make an appointment with you at the Teen Health Center office or at the Aviva Health main clinic office across from Costco to assist you in completing the application and send it electronically to the Oregon Health Authority OHP Processing Center for you. The Oregon Health Authority OHP will notify you regarding your benefit coverage and information typically within 45 days.

SLIDING SCALE DISCOUNT INFORMATION

Patients of Aviva Health may apply for a discount that is based upon family income and household size. The discounts apply to all charges for services from Aviva Health. Also, Mercy Medical Center allows the same discount for laboratory and x-ray services. So, the savings can be considerable.

If requested, an Application for Reduced Charges is available.

AVIVA HEALTH

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The following information is needed to assist the clinic in securing funds. Your cooperation is appreciated. All information disclosed in this section is reported anonymously. Please circle the correct amount or check the box if income is above all amounts.

☐ **Choose not to provide my financial information.**

Number of Persons in Household	1	2	3	4	5	6
Household Income is Less Than	1,012	1,372	1,732	2,092	2,452	2,812
Household Income is Less Than	1,518	2,058	2,263	2,598	3,138	3,678
Household Income is Less Than	2,023	2,743	3,463	4,183	4,903	5,623
Income is Above all amounts	☐	☐	☐	☐	☐	☐

Has the patient ever been in the military? Yes No **Has the patient ever been seen at the VA?** Yes No

US Citizenship: By Birth Permanent Resident/Alien Student Visa Other

Race: Black White Asian American Indian Pacific Islander Hawaiian Other

Ethnicity: Hispanic Non-Hispanic Choose not to disclose

Language Spoken: _____ **Do you need a translator?** Yes No

Is the patient: a single parent? Yes No **Homeless?** Yes No **Resident of public housing?** Yes No

Gender Identity: Male Female Transgender Male Transgender Female Other Choose not to disclose

Sexual Orientation: Straight Lesbian/Gay Bisexual Other Don't know Choose not to disclose

The undersigned patient or individual acting on the behalf of the patient agrees as follows:

1. Authority is granted to Aviva Health to render needed treatment to the above-named patient.
2. I authorize Aviva Health to release needed treatment to the above-named patient.
3. I authorize payment of medical benefits to Aviva Health for services rendered.
4. I understand that I am responsible for all charges incurred through Aviva Health.

I request that payment under the medical Insurance program be made to the provider named above on any bills for services furnished to me during the effective period of this authorization and I authorize the above-named provider to release to the Social Security Administration any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original. If it becomes necessary to effect collection of my account the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and court costs.

I have read the above and agree to the terms provided.

Signature of applicant: _____ **Date**: _____

Signature of Parent/Guardian: _____**Date:** _____

Staff initials: _____ **Date:** _____

Receipt of Notice of Privacy Practices Written Acknowledgement

I, _____ have received a copy of Aviva Health's notice of Privacy Practices.

_____

(Signature of patient or legal guardian) (Printed patient or legal guardian)

Date:_____

For Internal Purposes Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

-Individual refused to sign.

-Communication barriers prohibited obtaining acknowledgement.

-An emergency situation prevents us from obtaining acknowledgement.

-Other (please specify):_____

NOTICE OF PRIVACY PRACTICES

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

If you have any questions about this notice, please contact the Compliance Officer at 541-672-9596. Revision Date: April 17, 2018

YOUR MEDICAL INFORMATION. We create and maintain electronic medical records for each of our patients. Our office also participates in an electronic health records exchange (HIE) with area health care providers. This secure, electronic exchange enables each provider you see who participates in the exchange to access and update your health records. This will allow for faster access, better coordination of care and assist providers and public health officials in making more informed decisions. This notice applies to all of the records of your care maintained by this office, and to our employees and healthcare professionals entering information in your record. Other physicians or health care providers that you use may have different policies or notices regarding the use and disclosure of your medical information; however, all providers participating in the secure network have agreed to adopt policies and notices similar to this one. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to (1) make sure that medical information that identifies you is kept private; (2) give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) follow the terms of the notice that is currently in effect. You may opt out and prevent searching of your health information available through the health information exchange by completing and submitting an Opt-Out form to Aviva Health.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. "Use" is what we do with your information in this office. "Disclose" means sharing your information with others outside this office. All of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, office staff or other medical personnel who are involved in your care. As noted above, in an effort to provide you with the highest quality of coordinated care, we will place your records on a secure, electronic network that enables other participating providers you see to access and update your health records.
- **For Payment**. We may use and disclose medical information about you as reasonably necessary in billing and collecting from you, an insurance company or a responsible third party.
- **For Health Care Operations**. We may use and disclose medical information about you as reasonably necessary to run the office and make sure our patients receive quality care.
- **Appointment Reminders**. We may contact you as a reminder that you have an appointment.
- **Treatment Alternatives**. We may tell you about treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services**. We may tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in a hospital. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **Research**. Under certain circumstances, we may use and disclose medical information about you for research purposes.
- **As Required by Law**. We will disclose medical information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threatened harm.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation**. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans**. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation**. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks**. We may disclose medical information about you for public health activities. These activities generally include the prevention or control disease, injury or disability; reporting of births and deaths, child abuse or neglect, reactions to medications or problems with products; and notification of people of recalls of products they may be using, a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition, the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make the last disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law.
- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena.
- **Law Enforcement**. We may release medical information if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons or similar process; (2) about a death we believe may be the result of criminal conduct; (3) about criminal

conduct at the office; or (4) in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

▪ **Coroners, Medical Examiners and Funeral Directors**. We may release your medical information to a coroner or medical examiner.
▪ **National Security and Intelligence Activities**. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
▪ **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU. You have the following rights regarding medical information we maintain about you:

▪ **Right to Inspect and Copy**. With limited exceptions, you have the right to inspect and copy medical information that may be used to make decisions about your care. You must submit your request in writing to the Privacy Officer. If you request a copy of the 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 very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We will select a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

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

To request an amendment, complete and submit an AMENDMENT REQUEST form to the Privacy Officer.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not (1) created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the medical information kept by or for the office; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.

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

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

▪ **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the REQUEST FOR LIMITATION AND RESTRICTION OF PROTECTED HEALTH INFORMATION to the Compliance Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

▪ **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

To request confidential communications, you may complete and submit the PATIENT'S REQUEST TO LIMIT CONFIDENTIAL COMMUNICATIONS to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

▪ **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office. The summary will contain, in the top right-hand corner the effective date. You are entitled to a copy of the current notice in effect.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact the Privacy Officer. You will not be penalized for filing a complaint.

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