NASSON Health Care

MAILING ADDRESS
PO Box 72 Sanford, ME 04073

LOCATIONS
15 Oak St Springvale, ME 04083
207 490-6900 PHONE 207 459-2822 FAX
388 Somersworth Rd, N Berwick, ME 03906
207 676-2175

A division of York County
Community Action Corporation

STUDENT ENROLLMENT FORM

Please Print

Child's Full Name _____ Date of Birth ___/___/___ Child's Social Security #_____

Race ☐ American Indian/Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian
☐ Other Pacific Islander ☐ More than one race ☐ White ☐ Other _____

Ethnicity Hispanic or Latino ☐ Yes ☐ No

Sex ☐ Female ☐ Male

Legal Guardian _____Relationship to Patient:_____ Phone _____

Street Address _____ City_____ State _____ Zip Code _____

PO Box _____ City_____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Emergency Contact _____Relationship to patient:_____

Housing Status ☐ Own Home ☐ Rent Home ☐ Public Housing Is Rent Income Based? ☐ Yes ☐ No
☐ Doubling Up ☐ Transitional Housing ☐ Shelter ☐ Streets ☐ Other _____

Confidential Household Income

Parent/Guardian plus Spouse $_____ ☐ Weekly ☐ Monthly ☐ Yearly

Household: List the people who live in the child's household

Last Name	First Name	Middle Initial	Date of Birth	Relationship to Child
_____	_____	_____	___/___/___	_____
_____	_____	_____	___/___/___	_____
_____	_____	_____	___/___/___	_____
_____	_____	_____	___/___/___	_____
_____	_____	_____	___/___/___	_____
_____	_____	_____	___/___/___	_____

Insurance ☐ Yes ☐ No Please provide all copies of your child's insurance cards

Insurance Type ☐ Maine Care ☐ Medicare A ☐ Medicare B ☐ Commercial ☐ Other _____

Name of Insurance _____ Insurance ID# _____ Group #_____

Name of Insurance _____ Insurance ID# _____ Group #_____

Insurance Billing Address_____

CONSENT TO TREAT

- I am personally responsible for providing accurate and current insurance information.
- I authorize my insurance benefits to be paid directly to the physician at York County Community Action Corporation / Nasson Health Care
- I authorize release of all information necessary to secure payments of benefits.
- I understand that I am financially responsible for any remaining balance.
- I am aware of Maine's Minor's Rights to Confidential Health Care as how it pertains to mental health, substance abuse, and reproductive health services. A copy of this law will be mailed to me upon my request.
- I understand that signing this form permits my child to receive all services provided by Nasson Health Care. These services include diagnosis and treatment of acute illnesses, mental health services, and reproductive health services.

I certify that the above information is true and correct to the best of my knowledge.

_____ Date: _____

Patient, Parent or Guardian Signature

Guardian Documentation Received ☐ Yes ☐ No

Does your child have a Primary Care Physician? ☐ Yes ☐ No

Primary Care Physicians Name: _____

Has your child seen a dentist in the past 12 months? ☐ Yes ☐ No

HIPAA NOTICE OF PRIVACY PRACTICES
USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice in effect right now, but we reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a client at the health center, facts about you must be used and disclosed to other parties, for treatment, payment and health care operations. These uses and disclosures require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and or medical records;
- Diseases spread person to person, such as Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS);
- Drug and or alcohol abuse;
- Psychiatric diagnosis and treatment records;
- Laboratory test results;
- Medical history;
- Treatment progress;
- Any other related facts.

We may release the above to:

1. Your insurance company, Medicare, Mainecare (Medicaid), or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment;
2. Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors and state Risk Management;
3. Any hospital, nursing home, or other health care facility where you may have testing done or to which you may be admitted;
4. Any assisted living or personal care facility where you live;
5. Any doctor providing your care;
6. Family members and other people who are part of your plan for service, in such programs as CSHP, EPSDT, home health, hospice, etc.;
7. State and or Federal agencies acting on behalf of programs, Medicare and or Medicaid, including state surveyors or auditors for programs such as CSHP, EPSDT, PCS, WIC, STD/HIV, home health, hospice, etc.;
8. Other health care people to start treatment.

We may contact you to:

1. Provide appointment reminders or news about other health programs we provide;
2. Raise funds or donate items for our business.

We are allowed to use or disclose facts about you without consent in the following situations:

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment;
2. Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation;
3. Where we are required by law to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure is required by law;
5. For certain public health activities, such as reporting births, deaths, injuries, diseases, etc.;
6. Where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to receive abuse, neglect or domestic violence reports;
7. Health care oversight activities;
8. Certain legal administrative proceedings;
9. Certain law enforcement purposes;
10. To coroners, medical examiners and funeral directors in certain situations;
11. For organ, eye or tissue donation purpose;

12. For certain research purposes;
13. To avoid a serious threat to health and safety;
14. For specialized government functions, including military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institution and custodial situations;
15. For Workers' Compensation purposes.
16. For Organized Health Care Arrangement purposes:
    Nasson Health Care is a member of Community Care Partnership of Maine ("CCPM"), an "Organized Health Care Arrangement" focused on improving the health of the communities it serves. The members of CCPM, in collaboration with insurance companies, use population health analytics, utilization review, quality assessment and improvement activities, and other evidence-based strategies to improve your healthcare. Members are mutually accountable for the health of all patients served by CCPM.
    The entities that that make up this Organized Health Care Arrangement include the following community health centers and hospitals:
    - Cary Medical Center
    - DFD Russell Medical Center
    - Fish River Rural Health
    - Greater Portland Health
    - Health Access Network
    - Hometown Health Center
    - Katahdin Valley Health Center
    - Millinocket Regional Hospital
    - Nasson Health Care
    - Penobscot Community Health Care
    - Pines Health Services
    - Sacopee Valley Health Care
    - St. Joseph Healthcare

    CCPM's Organized Health Care Arrangement permits these separate covered entities, including Nasson Health Care, to share PHI with each other as necessary to carry out permissible treatment, payment or health care operations relating to the work of the Organized Health Care Arrangement, unless otherwise limited by law, rule or regulation. The list of entities may be updated to apply to new entities in the future. You can access the most current list at www.ccpmmaine.org/members or call CCPM at 207-992-9200.

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

1. The use of a directory of people served by us (clinic schedules, patient schedules);
2. To a family member, friend or other person you choose who may assist in your care or payment for care.

Other uses and disclosures will be made only with your written approval. That approval may be withdrawn in writing at any time, except in limited situations.

YOUR RIGHTS

You have the right, subject to certain conditions, to:

1. Request restrictions on certain uses and disclosures of facts about you by filling out our Request form. However, we are not required to agree to the requested restrictions.
2. Receive confidential communication of protected health data by giving us another address or means of receiving health data.
3. Inspect and copy protected health data by filling out our request form.
4. Amend protected health data by filling out our form.
5. Receive a list of disclosures made of your protected health data by filling out our request form.
6. Obtain a paper copy of this notice upon request, if you agreed to receive this notice by e-mail, fax, or website.

COMPLAINTS

You may file a complaint with us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation against you for filing a complaint. The complaint must be filed in writing with us and must state the specific incident(s) including the date, what happened and details of the incident. For details about filing a complaint with us, please contact:
Jami Kelly, HIPAA Compliance Officer, at 207-324-5762.

ACKNOWLEDGMENT

I have read this Notice or have had it explained to me. I understand this Notice and have had the chance to ask questions about any matters I do not understand.

Signature Date

PLEASE PRINT NAME

For Staff Use Only

The following good faith efforts were made to obtain acknowledgement:

However, acknowledgement was not obtained because:

Signature: Date: