Dear parents:

Alivio Medical Center, in partnership with Little Village High School, opened a Health Clinic at Little Village High School. The Health Center is certified Federally Qualified Clinic offering full medical services to students at Little Village, their families, and surrounding communities.

In order to be seen at the clinic, your child must have a consent form on file. Please complete the information at the bottom of the page. If you do want your child to be seen at clinic, Alivio will give your child forms to be filled out by parent and returned to Clinic.

Below are some questions that you may have regarding the Alivio Health Clinic at Little Village High School:

I have insurance. Should I sign my child up for the clinic?
Yes. Alivio accepts all forms of insurance. Students enrolled at Alivio Health Clinic at Little Village High School can be treated under the same terms as they would be at their regular clinic.

I don’t have insurance. Can I sign my child up for the clinic?
Yes. All children in the State of Illinois from birth to 19 are eligible for medical coverage through All Kids Program. For your convenience Alivio has resources to help apply for Medicaid. Additionally, Alivio offers affordable care through sliding scale fees based on income.

If I already have a doctor, should I sign my child up for the clinic?
Yes. You do not need to change your doctor. For students with public aid insurance, there will be no penalty for being seen by doctors at the Alivio Health Clinic at Little Village High School. The benefit: in case of emergency. Students enrolled at the clinic can be treated immediately without the delay or costs of urgent care.

What are the benefits of enrolling my child at the Alivio Clinic at Little Village?

EMERGENCIES- Immediate treatment
CONVENIENCE- Students can make appointments and be seen during the day without having to leave the school building.
PHYSICALS/IMMUNIZATIONS- Complete all health requirements.

To take full advantage of these services at the Alivio clinic at Little Village High School, please fill out a consent form and return it to your child’s school. For any additional questions of any information, please call Alivio Medical Center at 773-535-4291.

Thank you,

Principals of Little Village High School and Alivio Medical Center Staff.

☐ No thank you. I do not want my child to receive services from the Alivio health clinic at Little Village High School
☐ Yes thank you. I want my child to receive services from the Alivio health clinic at Little Village High School.

Student Name: ____________________________ School: Multicultural Arts
Social Justice
Infinity
World Language

Parent/Guardian Signature: ____________________________ Date: __/__/__
Alivio Medical Center at
Little Village Lawndale High School
Consent Form

Consent to receive services offered at Little Village Lawndale High School, a site of Alivio Medical Center, and to complete confidential questionnaires is given for the family member named below. I have been informed and understand the scope of services to be provided to the student/patient. I further understand that confidentiality between the student and Alivio Medical Center at Little Village Lawndale High School Center’s professionals will be ensued in specific areas designated by the law and will not to be discussed with the parent/guardian unless the student agrees.

I authorize the results of school physicals and immunizations to be released to the Chicago Public Schools. I also authorize the Little Village Lawndale High School to release medical records including any physicals and immunizations to Alivio Medical Center at Little Village Lawndale High School.

I authorize the Alivio Medical Center at Little Village Lawndale High School to release information regarding my child’s treatment to third-party payers’ or others for purposes of billing, program management and evaluation in accordance with federal and state law and regulations regarding confidentiality.

I release the Board of Education of the City of Chicago and its members, officers, employees, agents and representatives from any and all claims, suits, actions, liabilities, legal cost and attorney’s fees arising from the operation of, or any services rendered by the Alivio Medical Center at Little Village Lawndale High School including those based upon the ordinary negligence of the Health Center and its staff.

Student/Patient name: ___________________________ Date of Birth: __________

Student/Patient’s food or medication allergies: □ Yes □ No

If yes, please list allergies: __________________________________________

Parent/Guardian Name: __________________________________________

Parent/Guardian Signature: ___________________________ Date: __________

Witness: ___________________________ Date: __________

Note under Illinois law:
An adolescent 12 years old or above may consent for care related to pregnancy, birth control, or sexually transmitted diseases. (325 ILCS10/1 410 ILCS 2 10/4)
An adolescent 18 years old or above, or emancipated by law, may give his/her own consent for medical care. (750 ILCS 30/1 et seq.)

Adult Patients Only

Patient Signature: ___________________________ Date: __________
PERSONAL INFORMATION
Patient Name: __________________________ Phone #: __________________________

Last First Middle
Address: __________________________ Community Area: __________________________
Street City Zip Code

Date of Birth: __________________________ Place of Birth: __________________________ SS #: __________________________

LVLHS: School (choose one) Multicultural Arts / Social Justice / Infinity / World Language

Sex: [ ] MALE [ ] FEMALE

Grade: ( ) Freshmen ( ) Sophomore ( ) Junior ( ) Senior
Ethnic Background: [ ] Asian [ ] Afro-American [ ] Mexican [ ] Puerto Rican [ ] Hispanic [ ] Caucasian

Parents Name and Address:
Name: __________________________ Phone #: __________________________

Last First Middle
Address: __________________________ Street City Zip Code

D.O.B.: __________________________ Relationship: __________________________

Employment Information For Responsible Billing Party (Patient/Parent/Guardian)
Employer Name: __________________________ Phone #: __________________________

Address: __________________________ Street City Zip Code

Dept.: __________________________

Patient Insurance Information (List all policies covering the patient and present insurance cards to the receptionist)

1. Medicaid Patients
   Case ID Number: __________________________ Recipient ID Number: __________________________
   Type of Medicaid Coverage [ ] GA [ ] Spend-Down [ ] TPL [ ] QMB [ ] HMO

2. Commercial/Medical Insurance
   Primary Insurance: __________________________ [ ] PPO [ ] HMO [ ] Other
   Address: __________________________ Group #: __________________________
   Insurance ID #: __________________________ Relationship to Patient [ ] Self [ ] Spouse [ ] Child [ ] Other

3. No Insurance: __________________________

EMERGENCY CONTACT for a relative and/or Parents work number
1. Name: __________________________ Phone #(Home): __________________________

   Last First Middle Phone #(Work): __________________________
   Address: __________________________ Relationship: __________________________
   Street City Zip Code

2. Name: __________________________ Phone #(Home): __________________________

   Last First Middle Phone #(Work): __________________________
   Address: __________________________ Relationship: __________________________
   Street City Zip Code
HEALTH CARE CONSENT

You have the right to accept or refuse any medical treatment. You have the right to choose what options are best for you.

I, ____________________________, hereby consent to medical screening and medical examination to determine my current health status, other medical evaluations, diagnostic procedures, routine care, and medical treatments that the medical and professional staff of the clinic may deem necessary, advisable, or appropriate.

Medical information will be kept in a confidential medical record.

I authorize disclosure of my medical records to a hospital, if hospitalization is deemed necessary, advisable, or appropriate and to reporting agencies for purposes of disease surveillance and control.

__________________________________________________________
Signature of Patient

__________________________________________________________
Signature of Witness

Date
Fecha

Fecha

FORMA DE CONSENTIMIENTO MEDICO

Usted tiene el derecho de aceptar o negarse a cualquier tratamiento médico.
Usted tiene el derecho de elegir cuales opciones son mejor para usted.

Yo, ____________________________, por el presente consiento o autorizo a una evaluación o examen médico para determinar mi estado de salud presente. También consiento a cualquier otra evaluación o procedimiento médico, cuidado rutinario, y tratamiento médico que el personal médico de la clínica considere necesario, aconsejable o apropiado.

Los informes médicos que se obtengan serán mantenidos en un expediente médico, confidencial.

Yo autorizo la divulgación de mi historial médico a cualquier hospital en caso de que hospitalización sea necesaria o recomendada y para la vigilancia y control de enfermedades.

__________________________________________________________
Firma de Paciente

__________________________________________________________
Firma de Testigo

Fecha
Fecha
Acknowledgement of Receipt of Notice of Privacy Practices
(Filed in Patient’s medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Patient name: ___________________________ Date of birth: _______________

(Please print)

Signed: ___________________________ Date: ___________________________

Relationship (if not signed by patient): ___________________________

I wish to place the following restrictions on disclosure of my health information:

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Internal use Only
If patient/patient’s representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (data and time): ___________________________

By (name and title): ___________________________

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Reconocimiento De Recibo De La Declaración De Privacidad
(Ser archivado en el registro médico del paciente)

He sido presentado con una copia de la Declaración De Privacidad, detallar como mi información de salud se puede usar y puede ser revelada como permitido bajo la ley federal y estatal, y resumir mis derechos con respecto a mi información de la salud.

Nombre de paciente: ___________________________ Fecha de nacimiento: _______________

(Favor De Imprimir)

Firma: ___________________________ Fecha: ___________________________

La relación (si no es firmado por el/la Paciente): ___________________________

Deseo poner las siguientes restricciones de la información de mi salud:

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Uso Interno Solamente
Si el paciente/representante del paciente rechaza firmar el reconocimiento, documenta la fecha y el tiempo fueron presentadas al paciente y firma abajo.

Presentando en (fecha y tiempo): ___________________________

Por (nombre y título): ___________________________
CONSENT TO OBTAIN MEDICATION HISTORY

Alivio Medical Center is now utilizing electronic medical records and we need to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several sources, including your pharmacy and your health insurance.

An accurate medication history is very important to help us treat you and to avoid potentially dangerous drug interactions. By signing this consent form you give us permission to collect, and give your pharmacy and your health insurance permission to give us information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your electronic medical record, should your provider feel it is important to your medical care.

This medication history is a useful guide, but it may not be complete. Some pharmacies do not make drug history available to us, and the drug history might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to tell us about any errors in your medication history. (Please choose one option below)

________ I give permission for Alivio Medical Center to obtain my medication history from my pharmacy, my health insurance and my other healthcare providers.

________ I DO NOT give permission for Alivio Medical Center to obtain my medication history from my pharmacy, my health insurance nor my other healthcare providers.

Print Patient Name

Patients Date of Birth

Signature of Patient or Guardian

Relationship to Patient

Date

Preferred Pharmacy

Provider:
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.

This Notice of Privacy Practices 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. It 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.

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed for the purpose of providing health care services to you, to pay your health care bills, to support the operation of our practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you or your protected health information 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.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, we may provide your protected health information to your health plan to obtain payment for services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to run our practice, improve your care, and contact you when necessary. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Uses and Disclosures Which Do Not Require Your Authorization: We may use or disclose your protected health information in the following situations without your authorization: as required by law; for certain public health and safety issues, including the reporting of reportable communicable diseases; and suspected abuse, neglect, or domestic violence; in response to a court or administrative order or subpoena; to coroners, funeral directors, or medical examiners upon the death of an individual; to organ or tissue procurement organizations; for worker’s compensation claims, law enforcement and special government functions, such as national security and health oversight purposes. We can also share your information for certain health research. We may disclose your protected health information to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the federal privacy laws.

Uses and Disclosures to Individuals Involved in Your Care or Payment for Your Care: If family members, relatives, or friends are helping to care for you or pay for your medical costs, we may release protected health information to them unless you object. This information will be limited to that necessary to pay for your care or to care for you. We also may provide your protected health information to a disaster relief organization to allow your family to be notified about your condition and whereabouts in a disaster. In an emergency situation where you may not be able to object, we may share your information if we believe it is in your best interest. We also may share your information when necessary to lessen a serious and imminent threat to health or safety.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke such authorization at any time in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization. Uses and disclosures of your psychotherapy notes, if any, uses a
disclosures of your protected health information for marketing purposes, and disclosures that constitute a sale of your protected health information only will be made with your written authorization, unless otherwise permitted or required by law, as described in this Notice.

We may contact you to raise funds for our organization and you have the right to opt out of receiving fundraising communications.

**Your Rights:** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** 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 protected health information that is subject to a law that prohibits such access. We may charge a reasonable, cost-based fee for copying or postage. You may not remove our records from the premises. If we maintain your information electronically, we can provide you with the protected health information in a mutually agreeable readable electronic form and format upon your request.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or payment for 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.

We are not required to agree to a restriction in all circumstances, but we will agree to a restriction for disclosures to a health plan if (1) the disclosure is for the purpose of carrying out payment or health care operations and (2) the protected health information pertains solely to a health care item or service for which you, or a person other than the health plan on your behalf, has paid us in full. If we agree to a restriction on the use or disclosure of your protected health information, we must comply with such restriction, other than in an emergency or certain other circumstances permitted or required by law.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate all reasonable requests.

**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 alternatively i.e., electronically.

**You may have the right to request an amendment of your protected health information.** If we deny your request for amendment, you may 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 protected health information.** We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures. We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**You have the right to be notified of a breach.** We are required by law to notify you following a breach that may have compromised the privacy or security of your unsecured protected health information.

**You have the right to choose someone to act for you.** If you have given someone medical power or attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we will take any action.

We are required to abide by the terms of this Notice currently in effect. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw notice.

**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.) of your complaint. You may file a complaint with us by notifying our privacy contact (Kevin Laguardia 773-254-1400) of your complaint. We will not retaliate against you for filing a complaint.