ADMISSION PROCEDURES FOR THE PLACING WORKER

Referral Procedure

All referrals are screened and approved by our screening team prior to admittance. Woodland Hills must have referral information in order to meet licensing regulations and to better serve the client. A referral may be done by calling the Admissions Coordinator (218-728-7500 ext. 143) or by downloading the referral form from www.woodlandhills.org. Collateral reports are needed and should include: psychological evaluation, diagnostic assessment, disposition report, social history and previous placement discharge reports.

Admissions Packet

All forms must be signed and completed before admittance to Woodland Hills. Please call the Admissions Coordinator (218-728-7500 ext. 143) with any questions. Additional packets may also be downloaded from www.woodlandhills.org.

To be completed by the placing worker:

- ❑ Admissions Form for the Placing Worker
- ❑ For youth who are court ordered court orders are required and should either accompany a youth upon admission or be mailed soon afterward. Court orders should specify which program, length of stay (Chisholm House only), required restitution/community service and any requested special services.
- ❑ For youth who are placed voluntary through the county we need a copy of the Voluntary Placement Agreement signed by his/her parent when applicable.
- ❑ Clothing requirements and personal articles should be provided upon admission. If the family is financially unable to provide for clothing, the referring worker should contact the Admissions Coordinator prior to the youth's admit date.
- ❑ A discharge summary should be provided if the client is coming from another out-of-home placement for continuity of services.

To be completed by the parent/guardian:

- ❑ Admissions Form for the Parent/Guardian
- ❑ Woodland Hills Medical Authorization Form
- ❑ Medical Insurance Form
- ❑ Health History Questionnaire
- ❑ Publicity, Data Sharing and Acknowledgement Form
- ❑ Woodland Hills Receipt of Privacy Practice
- ❑ SMDC General Consent and Authorization
- ❑ SMDC Receipt of Privacy Practice
- ❑ Duluth Public School Annual Health Form
- ❑ Photocopy of both sides of client's health insurance card
- ❑ A minimum of two-week supply of any prescribed medication
- ❑ Parents should keep for their information: Parent Letter, Client Rights, Clothing List, Visitation Guidelines, Directions and Map, Woodland Hills' Privacy Practice, SMDC Letter and Privacy Practice

Special Circumstances

- ❑ Tuition Agreement Form (required for clients from states other than Minnesota.)
- ❑ Woodland Hills reserves the right to request a physician's consent on any client who, for reasons of physical condition, may not be able to participate fully in the program. Admittance into a program will be based on the physician's assessment.

ADMISSIONS FORM FOR THE PLACING WORKER

Client's Identifying Information

Agency Use Only
Youth ID No.:
Agency ID No:
Unit Name:
Admit Date:
Discharge Date:
Type of Discharge:

Client's Full Name

Social Security #

Date of Birth

Placing County

Court File No./Case No.

Client's placement before being admitted to Woodland Hills

If your client is leaving another placement to be placed at Woodland Hills, please provide a discharge summary for continuity of care.

Placement at Woodland Hills

- ❑ Chisholm House – Length of Stay: (specify) 21/14, 30/20, 60/40, 90/60, 120/90
- ❑ Residential Treatment Corrections
- ❑ Residential Treatment Mental Health
- ❑ Semi-Independent Living program (Formerly Community Transition Program)

Judge/Referee

Name

Office Phone No.

Office Street Address

Fax No.

City

State/ZIP

E-mail

Clothing Responsibility

- ❑ If parent, which parent? ________________________
- ❑ If county:
  I, the undersigned, authorize Woodland Hills to spend $ _________________ to make the necessary purchases to meet the initial clothing requirements for my client.

County Representative

Date

Lead Worker

Name	Agency
Office Street Address	Office Phone No.
City State/ZIP	Fax No.
E-mail	Cell No.

Other Professionals Involved with this Client (if not previously shared)

Name	Agency
Office Street Address	Office Phone No.
City State/ZIP	Fax No.
E-mail	Cell No.

Name	Agency
Office Street Address	Office Phone No.
City State/ZIP	Fax No.
E-mail	Cell No.

Name	Agency
Office Street Address	Office Phone No.
City State/ZIP	Fax No.
E-mail	Cell No.

School Contact Information

School youth most recently attended

Name of a school contact person

Street Address

Phone No.

City State/ZIP

Fax No.

Please provide the most recent copy of student's IEP, if applicable.

Request for Copy of the Court Order

Woodland Hills is mandated by the Minnesota Department of Corrections Rule # 2935.5300 and 2960.0070 Subp.3, to obtain a copy of each client's court order for placement within five days of the admit. Please sign below confirming that a copy of the court order is pending, if not already forwarded to Woodland Hills.

Placing Worker's Signature/Title

Date

INTRODUCTION LETTER TO THE PARENT/GUARDIAN

Dear Parent,

Your child will be entering one of the residential programs at Woodland Hills. For 100 years, our agency has helped young people change their lives and prepare for a brighter tomorrow. Our holistic programs serve the complex array of children's needs and promote behavioral, mental and chemical health, and physical well-being. At Woodland Hills, we believe in the potential of every youth we serve, and we strive to help each child find his/her own potential. We will need your help and participation. Please share your concerns with your son's/daughter's case manager once he/she has been admitted, and be prepared for an open dialogue on how we can partner with you in the care of your child. The following overview will provide you information about the program and what to expect. In addition, we need for you to complete all Intake Forms. Below is a checklist for you. **Questions regarding admissions and Woodland Hills in general may be directed to the Admissions Coordinator at 1-800-644-4557, or 218-728-7500 ext. 143.**

- ☐ Admissions Form for the Parent/Guardian
- ☐ Woodland Hills Medical Authorization
- ☐ Health History
- ☐ Insurance Information Form
- ☐ Photocopy of health insurance card (both sides)
- ☐ Two weeks supply of prescribed medications
- ☐ SMDC General Consent and Authorization
- ☐ Acknowledgment of SMDC Privacy Practice
- ☐ Duluth Public School Annual Health
- ☐ Publicity/Data Sharing and Acknowledgement Form
- ☐ Acknowledgment of Woodland Hills Privacy Practice

Clothing and Personal Hygiene

The admissions packet includes a suggested list of clothing and hygiene items your child will need. All clothing should be marked on its tag for identification purposes. Clients do their own laundry and could be working outside at times.

Medical

Each client meets with the nurse (R.N.) for a physical exam. The nurse is also available if medical issues occur during your child's stay. Completing the attached medical forms is critical. Please make sure your child brings at least two-weeks supply of any prescribed medication. We will also need a copy of both sides of his/her medical insurance card. Please include the birth date of the insurer (or parent or guardian, if the student is uninsured). This is required by the Duluth medical, dental and ophthalmology clinics, as well as all pharmacies in order to register your child for these services. **Questions regarding your child's medical care may be directed to Woodland Hills Wellness Center at 218-728-7366**.

There may be times when your child needs care from medical professionals other than Woodland Hills Providers (WH Provider). In this event your child may be transported to a St. Mary's Duluth Clinic Health System (SMDC) facility to receive medical care. If your child requires laboratory work, the specimen will be processed by SMDC laboratory. Enclosed is a SMDC General Consent form. We ask you to sign this form so that, if WH Provider determines that it is appropriate to refer your child to an SMDC facility and/or to the lab for treatment, you have given your consent for the provision of that medical care. It requires two signatures. The first signature, which appears in the middle of the page, reflects your consent for your child to be treated by SMDC health care workers. Your signature at the bottom of the page relates to the privacy of your child's medical information, and reflects your consent for SMDC to release such medical information as indicated in the form. **Questions regarding SMDC's General Consent Form may be directed to SMDC's Supervisor of Registration at 218-786-1221.**

Education

Upon admittance, your child will be enrolled in Woodland Hills Academy, which is part of Duluth Public Schools. The education staff will coordinate with the student's home school district to determine your child's educational needs. Students receive personal attention and are given many opportunities to excel in their education. The school requests you complete their Health History form. **Questions regarding your child's education may be directed to Woodland Hills Academy at 218-728-7492.**

Phone calls and visits

Contact with family is a very important part of each child's placement at Woodland Hills. Clients are allowed two phone calls per week. Visitation is every Sunday between the hours of 1:00 and 4:00 PM or as arranged. Please see the Visitation Guidelines for instructions and directions.

The Case Manager

Soon after your child's placement at Woodland Hills you will be contacted by your child's Case Manager. He/she is responsible for all the services your child will receive and will work with you to develop a treatment plan and transition plan. He/she will be your main contact for progress updates and any concerns you have. The Case Manager will also be available to meet with you monthly during Sunday visitation and at staffings. **You may call your child's Treatment Manager at 218-728-7500 or 800-644-4557.**

Additional Opportunities

Youth in our care are kept busy with a variety of activities, from daily treatment group meetings to school. The groups work around the campus to earn their allowance and visit the store once a week to buy necessities such as hygiene products. The groups also participate in service-learning activities, such as volunteering at nursing homes. On campus, young people have the opportunity to participate in the animal husbandry program featuring llamas, pygmy goats, chickens, rabbits and sheep. Gardening, recreation, sports, cultural programming and after-school enrichment are also available. Additional recreational activities include: low ropes course, field trips, camping/hiking trips, fishing, snowshoeing, and others. Spiritual exploration is also offered on a voluntary basis.

PROGRAM SPECIFIC INFORMATION

Chisholm House

With flexible lengths of stay ranging from 14 to 120 days (40-day minimum for girls), this treatment program focuses on accountability and behavior stabilization. It features behavioral therapy interventions and skill development. For youth in placement beyond 30 days, additional treatment needs are addressed through psycho-educational curriculums and risk assessments.

Residential Treatment Corrections

This program identifies and addresses risk factors, utilizes evidence-based practices and empowers clients to invest in the process of change. Short- and long-term care is delivered in a peer group setting. Based on individual need, medication consultation and psychological services are available. Psycho-educational curriculums focus on interpersonal and social skills, anger management, and non-violence. Our goal is to reduce risk, stabilize behaviors and teach responsibility in order to restore youth successfully back to their community.

Residential Treatment Mental Health

Our mental health program offers a therapeutic living environment to adolescents ages 12-17 who, based on a diagnostic assessment, are in need of residential mental health treatment. Services are delivered under the supervision of an on-site Mental Health Professional and include individual, group and family psychotherapy; as well as skill development groups. The program provides treatment interventions consistent with an individualized treatment plan. The goal of this program is to help clients reduce mental health symptoms so they are better able to cope while in the community, ultimately improving their quality of life.

Semi Independent Living Program

Structured and supervised semi-independent living for adolescents ages 16-20 provides a safe and healthy environment while enhancing skills necessary for successful transition to the community. Services address education, employment and life skills while teaching clients the self-sufficiency required to live independently. As a result, this transition program promotes the development of productivity, independence, self-reliance and personal growth.

ADMISSIONS FORM FOR THE PARENT/GUARDIAN

(If more than one parent needs to complete this form, then please make a copy and return both forms to Woodland Hills.)

Child's Identifying Information

Client's Full Name

Nick Name

Social Security #

Date of Birth

Place of Birth

Race and/or Ethnic Origin – Tribal Affiliation

Religion or Church Affiliation

Primary language

Parent Contact Information

Parent's Name

Home Phone

Street Address

Work Phone

City State/Zip

Cell Phone

☐ **Custodial Parent?**

Email Address

Parent's Name

Home Phone

Street Address

Work Phone

City State/Zip

Cell Phone

☐ **Custodial Parent?**

Email Address

Emergency Contact

Name

Relationship to Child

Home Phone

Work Phone

Cell Phone

Parent Feedback

1. What are your goals for your son/daughter's placement at Woodland Hills?

2. What strengths or positive qualities does your son/daughter possess?

3. What concerns do you have about your son/daughter's placement at Woodland Hills?

4. What is the best time of day and place for the Case Manager to contact you?

Visitation Policy

Parents have the opportunity to visit their son/daughter every Sunday between the hours of 1:00 and 4:00 PM or as arranged. Clients can only receive immediate family for visitation, and no more than six people per visit. Any exceptions to this policy need to be approved by your child's Case Manager in advance. In addition please don't bring the following items into the facility during your visit: food, cell phones, or tobacco products.

Please indicate below the family members you know who will visit your son/daughter during their placement at Woodland Hills.

Name	Relationship to your son/daughter

Socioeconomic Information

Due to funding guidelines, we are occasionally asked to report in general the following information. All data collected will remain confidential and client names are not used in the reporting process. We apologize for any intrusion and thank you for assisting us.

1. **Number of people in youth's family/household: ____**

2. **Youth lives with:**
   Both parents____ Mother only____ Father only____
   Mother & stepfather____ Father & stepmother____ Grandparent____
   Foster parent____ Other ____

3. **What will the total family/household income for all members be at the end of the year? Please check the income range below that corresponds with the number of people living in your household.**

   For example, if there are three people living in your home and the total income for all members is $25,000, you would go to the line that starts with number in household: 3, move right and circle the income box ranging "between $15,900-26,500."

   The following are examples of sources of income which should be included in the totals:
   Employment/wages/tips, Self-employment, Rental property income
   Unemployment compensation, Social security/disability, Pensions and severance
   Retirement, Public assistance/AFDC, Child support/alimony

No. of People in Household	Total Income			
	Less than	Between	Between	More Than
1	$12,350	$12,350-20,600	$20,601-32,950	$32,950
2	$14,100	$14,100-23,550	$23,551-37,700	$37,700
3	$15,900	$15,900-26,500	$26,501-42,400	$42,400
4	$17,650	$17,650-29,450	$29,451-47,100	$47,100
5	$19,050	$19,050-31,800	$31,801-50,850	$50,850
6	$20,450	$20,450-34,150	$34,151-54,650	$54,650
7	$21,900	$21,900-36,500	$36,501-58,400	$58,400
8	$23,300	$23,300-38,850	$38,851-62,150	$62,150

WOODLAND HILLS MEDICAL AUTHORIZATION FORM

I give my consent to Woodland Hills to provide medical services for (son/daughter/ward),

_______________________________________ and ___________________, while he/she is in residence. I give
Child's Name Date of Birth

Woodland Hills complete discretion and authority to determine what sort of medical assistance or treatment is appropriate, and circumstances under which medical attention should be sought. The parent or guardian will be contacted for consultation or permission to act in situations requiring medical services outside of the standard practices of the Wellness Center.

If my child/ward has not received the necessary immunizations prior to placement, or if the immunizations lapse during placement, the Woodland Hills medical staff is authorized to see that he/she receives them. I give my consent for my son/daughter/ward to receive a mantoux test while at Woodland Hills.

I authorize Woodland Hills medical staff to disclose and obtain, oral and written, medical and/or psychological information, to provide medical care. I understand that, when applicable, protected health information (substance abuse, behavioral health, and HIV related information) will be released.

I authorize and assign payment of medical benefits to Woodland Hills. I authorize the release of any medical or other protected health information necessary to process insurance claims submitted on my behalf. I also understand I am financially responsible for whatever portion insurance does not cover including but not limited to insurance deductibles, co-payment amounts and non covered services.

_____________________________________ _______________ _______________

Parent/Guardian signature Date Parent/Guardian's Date of Birth

MEDICAL INSURANCE FORM

Heath Insurance Carrier:

Please provide a photocopy of both sides of the insurance card(s).

Primary Insurance Carrier: ____

Group Number: ________________________ ID#: _________________________

Policyholder Name: ______________________ DOB: ________________________

Policyholder Employer/Group Name: _______________________________________

Is client covered by another insurance Carrier? If yes, please complete the following.

Primary Insurance Carrier: ____

Group Number: ________________________ ID#: _________________________

Policyholder Name: ______________________ DOB: ________________________

Policyholder Employer/Group Name: _______________________________________

Prescription Coverage:

Please provide a photocopy of both sides of the insurance card(s).

Prescription Coverage Carrier: ____

Group Number: ________________________ ID#: _________________________

Rx BIN#: ______________________ PCN#: ________________________

Dental Insurance Coverage:

Please provide a photocopy of both sides of the insurance card(s).

Primary Insurance Carrier: ____

Group Number: ________________________ ID#: _________________________

Policyholder Name: ______________________ DOB: ________________________

Policyholder Employer/Group Name: _______________________________________

Insurance Authorization:

I, (Print Name) ____,

Authorize and assign payment of medical benefits to Woodland Hills. I authorize the release of any medical or other protected health information necessary to process this claim. I also understand that I am financially responsible for whatever portion insurance does not cover including but not limited to insurance deductibles, co-payment amounts and non covered services.

Signature: ______________________________________ Date: ______________

Relationship to Client (Circle One): Parent Legal Guardian

HEALTH HISTORY QUESTIONNAIRE

Date form completed: ___/___/___

Client's name: ____ D.O.B. ___/___/___

Is child under a doctor's care? Yes___ No___ If yes, for what condition?

____

____

____

Name of physician or clinic:

____

____

Street address City, State/Zip Phone

Medications

Drug name	**Dose prescribed**	**Doctor**	**Clinic name and phone number**

1. ____
2. ____
3. ____
4. ____

Allergies

- ❑ Drugs:
- ❑ Latex
- ❑ Food:
- ❑ Bee sting
- ❑ Other:

Childhood Health Conditions/Hospitalizations

- ❑ Meningitis
- ❑ Chicken pox
- ❑ Measles (rubeola)
- ❑ Strep infections or scarlet fever
- ❑ Other:
- ❑ Rheumatic fever
- ❑ Pneumonia
- ❑ German measles (rubella)
- ❑ Frequent ear infections
- ❑ Mumps
- ❑ Diabetes
- ❑ Asthma

Reasons and dates for conditions/hospitalizations:

____

____

____

____

Does your child wear glasses/contacts: Yes ___ No ___

Date of last eye exam: __________________ Doctor: ____

Date of last dental exam: ________________ Doctor: ____

Immunizations: Are they up to date: Yes ___ No ___ If no, explain:

____

____

List any sports or recreation activities that your son/daughter should not participate in due to medical reasons:

____

____

____

____

Has your child had or been treated for any of the following?

Yes	No		Yes	No	
		1. Anemia			16. Chronic diarrhea
		2. Headaches/migraines			17. Recent weight change
		3. Seizures/convulsions			18. Skin changes/rash
		4. Thyroid disease			19. Nose bleeds
		5. Duodenal/gastric or peptic ulcer			20. Sinus problems
		6. Cancer/tumor			21. Sores/bleeding in mouth
		7. Kidney infection			22. Heart murmur/heart disease
		8. Hernia			23. Chest pain
		9. Blood in stool			24. High blood pressure
		10. Back trouble			25. Fainting/dizziness
		11. Lung disease			26. Liver disease/hepatitis
		12. Depression			27. Sexually transmitted disease
		13. Mental illness			28. Night sweats
		14. Broken bones			29. Other:
		15. Chemical dependency			30. Other:

Please explain all "yes" answers from above:

____

____

Has anyone in your immediate family had any of the following?

(If yes, please state the relationship to your child)

- ❑ Diabetes:
- ❑ Heart attack before age 50:
- ❑ High cholesterol or Triglycerides:
- ❑ Tuberculosis:
- ❑ Allergy or asthma:
- ❑ Behavioral or emotional disorder:
- ❑ Hepatitis:
- ❑ Heart trouble:
- ❑ High blood pressure or stroke:
- ❑ Kidney disease:
- ❑ Cancer:
- ❑ Nervous disease:
- ❑ Chemical dependency or alcoholism:
- ❑ Other:

Additional Medical Concerns or Questions for the Nurse

____

____

____

____

____

____

____

PUBLICITY, DATA SHARING AND STUDENT RIGHT'S ACKNOWLEDGEMENT FORM

Client's Name: ______________________________________

Publicity/Community Education Consent

Our agency participates in public relations activities and promotional materials that help us tell our story to the community and donors. Sometimes the story and/or photograph of a Woodland Hills student is the strongest way to explain how Woodland Hills helps and empowers youth to reach their potential. Publicity and community education activities include, but are not limited to, public speaking, interviews and photographs of students participating in an agency activity. At times, certain activities, photos and/or written/verbal statements by students may be considered for the agency's website, promotional materials (printed or video) or media coverage. Clients may only participate in the aforementioned opportunities if their parent/guardian has given the written consent below. The client always has the choice to participate or not. All attempts will be made to show the youth in a positive, productive manner. We adhere to the confidentiality of students and as such, first names are only used in publicity/community education/media activities.

By signing below, you are giving Woodland Hills and your child the consent to participate in publicity/community education/media activities deemed appropriate by Woodland Hills

I give consent for my son/daughter to participate in the publicity opportunities noted above.

____ __________

Parent/Guardian's signature Date

Consent to Participate in Outcome Data Sharing

It is the policy of Woodland Hills to evaluate its programs and services continuously in order to provide the most effective care for youth placed with us. Use of administrative data including aggregate referral and program data obtained on clients at intake and during placement is considered normal business practice and follows all licensing, accreditation and ethical guidelines as well as data privacy. Beyond collecting the aforementioned data, your participation and consent is requested for additional research activities, which further our ability to assess program effectiveness and helps us better serve our clients. These additional research activities include, but are not limited to, collecting data from the appropriate government or placing agencies about offenses and placements incurred following placement at Woodland Hills and general information on the child's progress after leaving Woodland Hills. All information collected is treated as private. This will be assured through the use of identification numbers and reporting of summary results only (names are not used). The information collected is used to improve outcomes, complete funding report requirements and advocate for services for children and families.

I give consent to my son's/daughter's/ward's statistical data to be used for these additional research purposes:

____ __________

Parent/Guardian's signature Date

Client Rights Acknowledgement

A part of this intake packet is a three page document called "Client Rights." These rights are basic to quality childcare and cannot be altered or suspended by staff. Clients and parents/guardians should be acquainted with what to expect from the staff and program at Woodland Hills. Please call the Admissions Coordinator with any questions, at 218-728-7500 x.143.

I have been given a copy of the Client Rights, and I have had the opportunity to ask questions regarding any item(s) I did not understand.

____ __________

Parent/Guardian's signature Date

EFFECTIVE DATE OF THIS NOTICE: 3/1/2004

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

Our Pledge and Legal Duty to Protect Health Information about You

The privacy of your health information is important to us. We are required by federal and state laws to protect the privacy of your health information. We must give you notice of our legal duties and privacy practices concerning your health information, including:

- We must protect information that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care.
- We must notify you about how we protect your health information.
- We must explain how, when and why we use or disclose your health information.
- We may only use or disclose your health information as we have described in this Notice.
- We must abide by the terms of this Notice.

We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all health information that we maintain. We will post a revised Notice in our offices, make copies available to you upon request and post the revised Notice on our website.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

There are a number of purposes for which it may be necessary for us to use or disclose your health information. For some of these purposes, we are required to obtain your consent. In other specific instances, we may be required to obtain your individual authorization. And in a limited number of circumstances, we will be authorized by Law to disclose your health information without your consent or authorization. Following is a description of these uses and disclosures.

A. Uses and Disclosures of Your Health Information for Purposes of Treatment, Payment and Health Care Operations.

- ***Health Care Treatment.*** We may use or disclose health information about you to provide and manage your health care. This may include communicating with other health care providers regarding your treatment and coordinating and managing the delivery of health services with others. For example, we may use or disclose health information about you when you need a prescription, lab work, an x-ray or other health care services.
- ***Appointment Reminders and Other Contacts.*** We may use your health information to contact you with reminders about your appointments, alternative treatments you may want to consider, or other of our services that may be of interest to you.
- ***Payment.*** We may use or disclose your health information to bill and collect payment for the treatment and services provided to you. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.
- ***Health Care Operations.*** We may use or disclose health information about you to allow us to perform business functions. For example, we may use your health information to help us train new staff and conduct quality improvement activities. We may also disclose your information to consultants and other business associates who help us with these functions (for example, billing, computer support and transcription services).
- ***Fundraising.*** As part of our health care operations, we may use or disclose your demographic information and dates of treatment to contact you to raise money for our organization.

Minnesota Patient Consent for Disclosures
For some of the disclosures of health information described above, we are required by Minnesota Laws to obtain a written consent from you, unless the disclosure is authorized by Law.

B. Uses and Disclosures of Your Health Information that Require Your Opportunity to Agree or Object.
In the following instances we will provide you with the opportunity to agree or object to our use or disclosure of your health information:

- ***Persons Involved in Your Care.*** We may, using our best judgment, disclose to a family member, other relative, close personal friend or any other person identified by you, health information relevant to that person's involvement in your care or payment related to your care.
- ***Notification to Others.*** We may, in some instances, disclose health information about you to a family member, a personal representative, or another person responsible for your care, in order to notify such person about your current location or general condition.

C. Uses and Disclosures Authorized by Law.
Under certain circumstances we are authorized by Law to use or disclose your health information without obtaining a consent or authorization from you. These may include when the use or disclosure is:

- ***Required by Law.*** We will disclose your health information when such disclosure is required by federal, state or local laws.
- ***Necessary for public health activities.*** For example, when reporting to public health authorities the exposure to certain communicable diseases or risks of contracting or spreading a disease or condition.
- ***Related to victims of abuse and neglect.*** For example, when reporting suspected victims of abuse or neglect.
- ***For health oversight activities.*** For example, when disclosing health information to a state or federal health oversight agency so that they can appropriately monitor the health care system.
- ***For organ donation purposes.*** For example when disclosing health information to an appropriate organization for the purpose of tissue donation and transplants.
- ***For judicial and administrative proceedings.*** For example, when responding to a request for health information contained in a court order.
- ***For law enforcement purposes.*** For example, when complying with laws that require the reporting of certain types of wounds or injuries.
- ***To a Coroner of Medical Examiner.*** To allow them to carry out their duties.
- ***To avert a serious threat to health or safety.*** For example, when disclosing health information that will help prevent a serious threat to the health or safety of you or another person of the public.
- ***Related to specialized government functions.*** For example, we may disclose health information about you if it relates to military and veterans' activities or national security.
- ***Related to Workers' Compensation***. For example, when reporting health information to entities that provide benefits for work-related injuries and illness.
- ***Related to correctional institutions***. And in other custody situations.

D. Uses and Disclosures of Your Health Information that Require Your Authorization.
Other uses and disclosures of your health information not covered in this Notice will be made only with your written authorization. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect.

YOUR INDIVIDUAL RIGHTS

A. Right to Access and Copy Your Health Information.
You have the right to access and receive a copy or a summary of your health information contained in clinical, billing and other records that we maintain and use to make decisions about you. We ask that your request be made in writing. We may charge a reasonable fee. There might be limited situations in which we may deny your request. Under these situations, we will respond to you in writing, stating why we cannot grant your request and describing your rights to request a review of our denial.

B. Right to Request an Amendment of Your Health Information.
You have the right to request amendments to the health information about you that we maintain and use to make decisions about you. We ask that your request be made in writing and must explain, in as much detail as possible, your reason(s) for the amendment and, when appropriate, provide supporting documentation. Under limited circumstances we may deny your request. If we deny your request, we will respond to you in writing stating the reasons for the denial. You may file a statement of disagreement with us. You may also ask that any future disclosures of the health information under dispute include your requested amendment and our denial to your request.

C. Right to Request Restrictions on Uses and Disclosures of Your Health Information.
You have the right to request that we restrict our use or disclosure of your health information. We ask that your request be made in writing. We are not required to agree to your request for a restriction, and we will notify you of our decision. However, if we do agree, we will comply with our agreement, unless there is an emergency or we are otherwise required to use or disclose the information.

D. Right to Request Confidential Communications.
Periodically, we will contact you by phone, email, postcard reminders, or other means to the location identified in our records with appointment reminders, results of tests or other health information about you. You have the right to request that we communicate with you in a specific way or at a specific location. For example, you may request that we contact you at your work address or phone number or by email. We ask that your request be made in writing. While we are not required to agree with your request, we will make efforts to accommodate reasonable requests.

E. Right to Request and Accounting of Disclosures of Health Information.
You have the right to request a listing of certain disclosures we have made of your health information. We ask that your request be made in writing. You may ask for disclosures made up to six (6) years before the date of your request (not including disclosures made prior to April 14, 2003). We will provide you one accounting in any 12-month period free of charge.

F. Right to Receive a Copy of This Notice.
You have the right to request and receive a paper copy of this Notice at any time. We will make this Notice available in electronic form and post it in our web site.

If you have any questions about these rights or to exercise any of them please contact our Privacy Office listed below.

QUESTIONS OR COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact our Privacy Office. If you are concerned that your privacy rights have been violated, you may file a complaint with our Privacy Office. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Office Contact Information

Address: 4321 Allendale Avenue, Duluth MN 55803

Phone: 218.728.7500 Fax: 218.724.8528 e-mail: www.woodlandhills.org

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

YOUTH'S NAME: ____

This is to acknowledge receipt of a copy of **Woodland Hills'** Notice of Privacy Practice with an effective date of March 1, 2004.

Parent or Guardian's Name: ____

Parent or Guardian's Signature: ____

Date: ___________________

Capacity or Authority of Legal Representative (if applicable)*:_______________________________

*May be requested to provide verification of representative status.

For Office Use Only

We made the following efforts to obtain written acknowledgement of receipt of the Notice of Privacy Practices:

____

____

____

However, acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify):

____

____

____

CLIENT RIGHTS

The following policy establishes Client Rights at Woodland Hills. These rights are basic to quality childcare and cannot be altered or suspended by staff. Clients and parents/guardians should be acquainted with what to expect from the staff and program at Woodland Hills.

1. EQUAL TREATMENT

Right: Clients have the right not to be discriminated against because of age, race, gender, language, sexual orientation, national origin, religion or physical or other disabilities.

Discussion: The law requires that all citizens be treated equally and not discriminated against because of their status. This does not mean that programmatic decisions cannot be based on the particular needs of the individual.

2. RELIGIOUS FREEDOM

Right: Clients have the right to participate in religious activities of their choice, subject to the availability of such activities. Woodland Hills shall not compel clients to participate in any religious activity.

Discussion: Woodland Hills will make a reasonable effort to provide various guest ministers, priests and other religious leaders to attend to the clients.

3. PERSONAL POSSESSIONS

Right: Clients have the right to keep and use personal possessions so long as these possessions do not endanger the safety of staff and clients, disrupt programs and activities, encourage deviant values or appeal to the vulnerability of clients (i.e. weapons and drugs). Under Woodland Hills' group treatment process, personal items are allowed only as defined by the Inventory Intake List.

Discussion: Stereos, radios, televisions, musical instruments, bicycles, jewelry and other large, expensive or potentially disruptive items may be restricted based on considerations of facility safety or order. Upon intake all personal items will be searched to insure safety and security.

4. CONTROL OF CONTRABAND/SEARCHES

Right: During searches the privacy rights of clients are maintained within program guidelines.

Discussion: If contraband is suspected of entering the facility, it is Woodland Hills' policy to conduct searches of clients, program areas and visitors.

5. MAIL AND TELEPHONE

Right: Clients have the right to correspond freely through the mail. Staff may not read incoming or outgoing mail, but may open mail in the client's presence to inspect it for contraband. (This includes packages and other bulk items received by the client.)

Exception: If mail is received from another correctional facility, the client and staff will review the mail together. This mutual review will occur as the mail may put the client in a vulnerable position by people that don't have their best interest at heart.

Discussion: Clients will be provided access to a telephone as described in the Woodland Hills policy and procedure manual on telephone use. Staff will deliver mail and allow telephone usage on the appropriate mail or telephone days. Client telephone days are twice a week or as deemed necessary by the Treatment Team Manager.

6. ACCESS TO ATTORNEYS

Right: Clients have the right to confer with an attorney in private.
Discussion: It is permissible to require visitors who assert that they are attorneys to produce some evidence of the fact, such as a State Bar Membership Card.

7. ACCESS TO COURTS

Right: Clients have the right to request a court review.

Discussion: Clients may request a court review for their referring agent.

8. FREEDOM FROM PUBLIC DISCLOSURE OR REVIEW

Right: Clients shall not be required to make public statements of gratitude to the program or be required to perform or appear at public gatherings. Also, unless a client and his/her parents (or legal guardians) give their written consent, Woodland Hills shall not publicly use reports or pictures in which the client can be identified.

Discussion: On occasion, the media and/or Woodland Hills seek to highlight significant events that occur in the lives of our clients. Clients may only participate in these media or public speaking opportunities if their parent/guardian has given consent. The client always has the choice to participate or not.

9. CONFIDENTIALITY OF RECORDS

Right: Clients have the right to expect that their records will not be released to anyone other than: Woodland Hills treatment staff, to include professional consultants; the juvenile court and probation department; the client's attorney; other persons found by the juvenile court to have a legitimate interest in the records; parents (by written consent).

Discussion: Confidentiality of records is an important concept in juvenile law. Any information, which could, directly or indirectly, identify an individual as a Woodland Hills client, should be disclosed only to authorized persons or agencies. Woodland Hills' staff is expected to follow the Minnesota Data Privacy Act and HIPPA regulations

10. MEDICAL AND DENTAL CARE

Right: Clients have the right to basic and necessary medical and dental care, both routine and emergency.

Discussion: Sick call is permitted four days a week for medical attention and emergency care will be provided. Dental care is provided on an as-needed basis.

11. PROTECTION FROM PHYSICAL AND PSYCHOLOGICAL HARM

Right: Clients have the right to be protected from physical and psychological harm. They have the right to adequate food, clothing and shelter, and shall not be deprived of these in the interest of treatment or discipline. Clients shall not be administered tranquilizers and other drugs in the interest of treatment, discipline or order. Repetitive, purposeless, degrading work is prohibited. Clients have the right to be free from abuse, neglect, inhumane treatment and sexual exploitation.

Discussion: Every Woodland Hills staff member has an affirmative obligation to take every reasonable precaution to protect youth from harm. This includes proper supervision, adhering to safety procedures, following health precautions, etc.

12. VISITORS

Right: Clients have the right to receive visitors, limited only by considerations of facility security and order. Youth have a corresponding right to refuse to receive visitors. They have a right to reasonable communication and visitation with adults outside the facility (which may include a parent, extended family member, sibling, a legal guardian, a case worker, an attorney, a therapist, a physician, a religious advisor, and a case manager in accordance with their case plan).

Discussion: Woodland Hills may place reasonable restrictions on the number of visitors and time and place of visits as necessary to ensure the safe and orderly operation of the program. Limitations on the right to receive visitors shall not be imposed for disciplinary reasons. Visitors who are disorderly, intoxicated or create disturbances may be prohibited from visiting or asked to leave the premises. (Refer to Visitation Guidelines for additional information.)

13. REASONABLE OBSERVANCE OF CULTURAL AND ETHNIC PRACTICE

Right: Clients have the right to reasonable participation and observance of cultural and ethnic practices.

Discussion: Woodland Hills will make reasonable effort to provide cultural activities to clients and allow client participation in cultural/ethnic activities in the community when appropriate.

14. PUBLIC EDUCATION

Right: Clients have the right to a public education.

Discussion: Woodland Hills partners with ISD #709 to provide educational services to Woodland Hills' youth. When appropriate, clients may attend school in the Duluth community. This is determined by education and treatment staff in conjunction with referring agents and parents/guardians.

15. HEALTHY ENVIRONMENT

Right: Clients have the right to a healthy environment based on respect.

Discussion: Woodland Hills' clients have the right to positive and proactive adult guidance, support and supervision. They have the right to courteous and respectful treatment. The have the right to be free from restraint or seclusion except when they are in imminent danger to hurt self or others. Clients also have the right to a reasonable degree of privacy as allowed by the facility. They have the right to daily showering and the use of culturally appropriate hygiene products. They have the right to nutritious and sufficient meals and sufficient clothing and housing. They have the right to live in clean, safe surroundings.

16. TREATMENT PLANNING

Right: Clients have the right to participate in the development of their treatment, case or educational plans.

Discussion: Clients are involved in the development of their treatment plans, case plans and educational plans. Parents/guardians and referring agents are also involved in these plans.

17. GRIEVANCE PROCEDURE (CLIENT)

Right: Woodland Hills' clients have the right to a grievance plan.

If a client has a complaint, suggestion, or wants to express a concern about any aspect of his/her care during their stay in the facility, he/she will put the issue of grievance in writing. Staff will not attempt to influence a client's statements about the facility in the grievance or during the investigation resulting from the grievance. Grievance forms will be provided to the client who wants to file a grievance. Clients can expect a hearing and a response within five business days. The Program Coordinator or Clinical Supervisor will hear the issue of grievance, unless he or she is the one being grieved upon. In that case, the Director of Residential Services will be the hearing officer. If the issue is not resolved, then another administrator (Director of Residential Services, Chief Operations Officer or Chief Executive Officer) will hear the issue. If the issue is not satisfactorily resolved at this level, the client may contact their referring agent or Office of the Ombudsman for further recourse.

18. GRIEVANCE PROCEDURE (PARENT)

Right: Parents' of clients have a right to a grievance plan.

Grievance Plan: If a parent/guardian or legal representative of a client at Woodland Hills would like to make a formal complaint or suggestion, or express a concern about a client's care, they may file a grievance. The grievance should be put in writing and addressed to the Program Coordinator responsible for the client's group. The Program Coordinator would then investigate the grievance and respond to the party that filed it within five (5) working days. If the issue is not resolved to the satisfaction of the parent/guardian or legal representative, the decision may be appealed to the Director of Residential Services or the Chief Operations Officer. He/she would conduct their own investigation and results of that investigation would be given to the concerned party within five (5) working days.

19. OFFICE OF THE OMBUDSMAN

If any client, parent, guardian, staff, referring agency or other concerned person believes that a client's rights have been violated, have been subjected to any physical or sexual abuse or acts of neglect, said party/s may contact the Ombudsman for mental health and lodge a complaint. The complaint must be in writing and signed. The address for the Office of the Ombudsman will be posted in a conspicuous place.

CLOTHING AND PERSONAL HYGENE GUIDELINES

Personal and Hygiene Items

- ❑ Soap
- ❑ Shampoo
- ❑ Toothbrush and Paste
- ❑ Laundry bag
- ❑ Towels (2)
- ❑ Washcloths (2)
- ❑ Deodorant
- ❑ Brush/comb

Recommended Clothing

- ❑ Jeans/pants: 5
- ❑ Shirts: 7 (short- and long-sleeved)
- ❑ Socks: 9 pairs
- ❑ Underwear : 8
- ❑ Underclothing: 2 bras; 2 sport bras
- ❑ Shoes: 2 pairs (tennis shoes preferably)
- ❑ Sleepwear: 1 or 2 sets (sweats, shorts, etc.)
- ❑ Swimwear: 1
- ❑ Shorts: 4
- ❑ Dress shirt: 1
- ❑ Dress pants: 1
- ❑ Dress shoes: 1
- ❑ Bathrobe: 1
- ❑ Shower shoes: 1
- ❑ Slippers: 1
- ❑ Belt: 1
- ❑ Sweat pants: 1
- ❑ Sweat shirts: 2
- ❑ Gym shorts: 1

Seasonal clothing

- ❑ Jacket: Winter coat, spring/fall jacket
- ❑ Winter boots
- ❑ Gloves/mittens
- ❑ Winter hat
- ❑ Thermal underwear

VISITATION GUIDELINES

For the safety and security of clients at Woodland Hills there are guidelines for all visitors. Failure to adhere to the following list could result in termination of the visit that day, and restrict visits in the future. Please see the following pages for directions and a map.

Guidelines:

1. Immediate family is allowed to visit every Sunday between the hours of 1:00 and 4:00 PM or as arranged.
2. No unauthorized visitors will be allowed on the Woodland Hills campus. Visits are restricted to immediate family only, unless the youth's Case Manager and placing worker approved the visit.
3. All items brought in for the client will be inventoried before they are given to the client.
4. Anything that is considered inappropriate will be sent home with the visitors that day. To avoid any problems, families should call and talk to the Case Manager about what items are allowed.
5. Cell phones are not allowed
6. Food is not allowed.
7. Giving money to clients is not allowed. All money will be sent home.
8. Visitors are not to consume alcohol or illegal drugs before or during their visit.
9. Visitors who are suspected of being under the influence of drugs or alcohol will be asked to leave the Woodland Hills campus immediately.
10. Woodland Hills is a tobacco-free campus. Visitors may not use tobacco products at any time on the property or in the building.
11. For security reasons, no weapons are allowed on campus (i.e. firearms, knives, etc.).

DIRECTIONS TO WOODLAND HILLS SITES

To Woodland Hills:

Woodland Hills
4321 Allendale Ave.
Duluth, MN 55803
(218) 728-7500

From Minneapolis-St. Paul:

Take I-35 North to Duluth. Exit on 21st Ave. East (*Please note to not turn off on 21st Ave. West.*). Go up 21st Ave. East for about 7 blocks to Woodland Ave. Stay in right hand lane and turn right on Woodland Ave. and go about 4 miles. Go to the second stop sign (a Piggly Wiggly on right). Go one block further on Woodland Ave., turn left on West Chisholm Street (in front of St. John's School and Church); then right on St. John's Ave. (Woodland Hills is the third building past the Church; the Church being the first, the rectory second, and in the pines is Woodland Hills).

From Eveleth-Virginia via Hwy 53:

Go south on Hwy. 53. Left on Arrowhead Rd. for about 8 miles. Left on Woodland Ave. for about 3 miles. Go to the second stop sign (a Piggly Wiggly on right). Go one block further on Woodland Ave., left in front of St. John's School and Church; then right on St. John's Ave. (Woodland Hills is the third building past the Church; the Church being the first, the rectory second, and in the pines is Woodland Hills).

From Itasca, Beltrami, Polk County areas via Hwy 2:

Take Hwy 2 East, and then go onto Hwy 194 until you reach Hwy 53 South. Then follow the same directions as from Eveleth-Virginia above.

From Two Harbors:

Take Highway 61 onto London Rd. Turn right on 21st Ave. East for about 7 blocks; stay in right hand lane and turn right on Woodland Ave. for about 4 miles. Go to the second stop sign (a Piggly Wiggly on right.) Go one block further on Woodland Ave., left in front of St. John's School and Church; then right on St. John's Ave. (Woodland Hills is the third building past the Church; the Church being the first, the rectory second, and in the pines is Woodland Hills).

From Wisconsin:

Take the Bong or Blatnik Bridge to I-35 North. Then follow the same directions as from Mpls.-St. Paul above.

From Michigan:

Take Hwy. 2 West to Superior, WI. Take the Blatnik Bridge to I-35 North. Then follow the same directions as from Mpls.-St. Paul above.

To Woodland Hills Academy:

Follow the same directions as listed above, except from Woodland Avenue, take a left on West Redwing. Park along the side of the Academy (parallel to West Redwing), inside the fenced area.

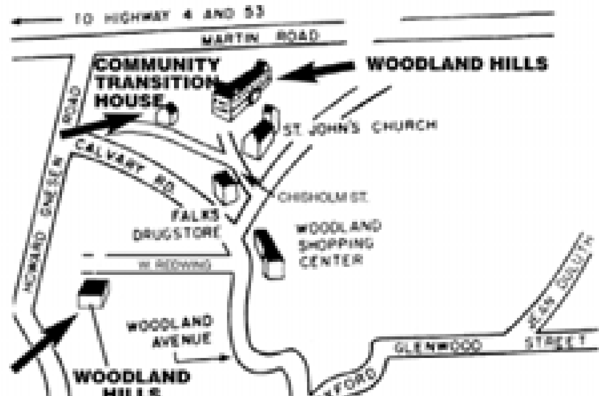
Woodland Hills Academy
110 W. Redwing
Duluth, MN
(218) 728-7418

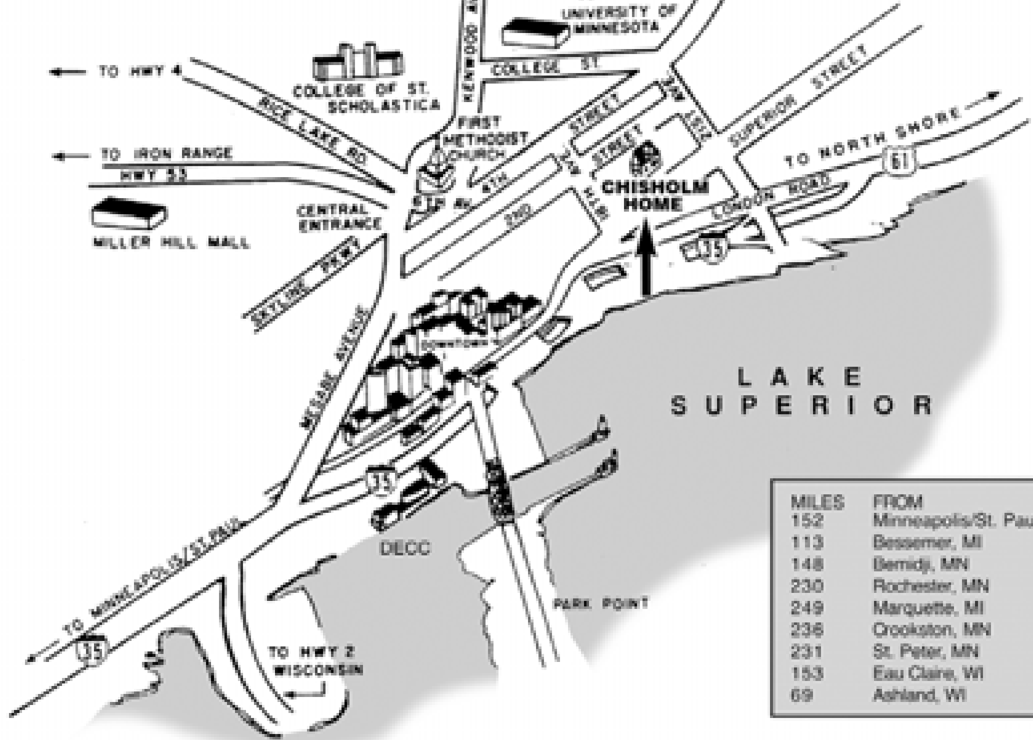
To Transition House (Males):

Follow the same directions as listed above, except from W. Chisholm Street, just after St. John's School and Church you will come to a V. Follow the road to the left, which is W. St. James. The CTP house will be on your right at 4210 W. St. James.

Transition House
(Males)
4210 W. St. James
Duluth, MN 55803
(218) 724-5534

WOODLAND HILLS/DULUTH AREA MAP





MILES	FROM
152	Minneapolis/St. Paul
113	Bessemer, MI
148	Bemidji, MN
230	Rochester, MN
249	Marquette, MI
236	Crookston, MN
231	St. Peter, MN
153	Eau Claire, WI
69	Ashland, WI

ANNUAL HEALTH HISTORY

SCHOOL YEAR ____________

Name____ Male ❒ Female ❒ Birth date ___/___/___ Gr. ______

Address____ City / State___________________________ Zip_________

Parent / Guardian____ Home Phone ________________

Father's Business Phone______________________________ Mother's Business Phone_____________________________

Employer ______________________________ Employer _____________________________

School Previously Attended____________________________________

Within the last year has your child had:

- Any serious illness, operation, hospitalization or serious accidents?
  Yes ❒ No ❒ If YES, please explain ____
- Any allergies or special health problems or unusual health habits?
  Yes ❒ No ❒ If YES, please explain ____
- Is your child on medication at home? Yes ❒ No ❒ If YES, please name the medication and reason.
  ____
- Is your child on medication at school? Yes❒ No ❒ If YES, please name the medication and reason.
  ____
- Drug reaction? Yes ❒ No ❒ if YES, Please indicate ___________________________________
- Had an examination by an eye doctor? Yes ❒ No ❒ Date___/___/___ By Dr: _______________
- Were glasses recommended? Yes ❒ No ❒ Contacts? Yes ❒ No ❒
  Reason: Nearsighted ❒ Farsighted ❒ Other ____________________________________
- Had a physical exam? ❒ Yes ❒ No Date: ___ / ___ / ___ By Doctor: _______________
- Had a dental exam? ❒ Yes ❒ No Date: ___ / ___ / ___ By DDS. ________________
- **Date of immunizations (since last September) - Indicate: day / month / year.**

MMR # 2 ___ / ___ / ___ Td (Adult Tetanus) ___ / ___ / ___ Hepatitis B Series 1. ___ / ___ / ___

Varicella (chicken pox) ___ / ___ / ___ Polio ___ / ___ / ___ 2. ___ / ___ / ___

Other (Type & Dates)__________________________________ 3. ___ / ___ / ___

Has your child had the Chicken Pox disease? Yes ❒ No ❒ if yes please include the date ___ / ___ / ___

List **current** health concerns:____

List **past** health concerns:____

*FOR YOUR INFORMATION: In order for schools to provide continuity of health care, a health record is kept on each child. This record includes immunizations, health history, hearing, vision and scoliosis screenings and chronic and acute illnesses. Pertinent health information will be shared with appropriate school staff.

- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care.

X____ ______________ ______________

Signature of patient, parent of minor, or personal representative *Relationship* *Date*

In order for St. Mary's Duluth Clinic Health System (SMDC) to treat you, we ask you to sign below indicating your consent to treatment:

A. I give my consent to SMDC doctors and healthcare workers to perform exams, treatments, x-rays, lab tests and operations, and to give me medicine that they believe is necessary or helpful to my health.

B. I understand that while I am receiving care, a healthcare worker may accidentally be exposed to my blood or other body fluid. If this rare event occurs, I consent to have my blood tested for blood-borne pathogens, such as Hepatitis B and C, and HIV. I understand that the test results will become part of my medical record and will be released to the exposed healthcare worker and a positive result must be reported to the state by law.

C. I authorize payment from Medicare, Medicaid, insurance and any other funds be paid directly to SMDC for my care and treatment. I understand that it is my responsibility to comply with the requirements of my insurance policies.

D. I agree to pay any charges not covered by insurance, government programs (including Medical Assistance), or other funds. I further agree to pay reasonable attorney fees and all costs of collection in the event my account is turned over to an attorney or collection agency. I understand that it is my responsibility, not SMDC's, to negotiate for payment of a claim that is disputed by the payer.

E. A copy of the Patient Bill of Rights, information on Healthcare Directives, information about how to file a complaint and information on smoking cessation has been made available to me.

F. I request that payment of authorized Medicare benefits be made on my behalf to SMDC for any services furnished me by an SMDC provider and/or in a SMDC facility. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits for related services.

G. I request that payment of authorized MediGap (supplemental insurance) benefits be made on my behalf to SMDC for any services furnished me by an SMDC provider and/or in a SMDC facility. I authorize any holder of medical or other information about me to release to my MediGap carrier any information needed to determine these benefits or benefits for related services.

If I am signing as Authorized Representative of the patient, I am:

☐ Parent of a minor ☐ Court appointed guardian/conservator ☐ Other ______________________
(Please specify relationship to patient)

______________________ ____/____/____ ______________________
Signature (Patient or Authorized Representative) Date Witness (signature by mark must be witnessed)

SMDC respects your right to privacy. Under the following conditions your health information will only be released with your consent:

H. I authorize SMDC to release my medical records to my doctors, other healthcare providers, and anyone else SMDC believes to be involved in my care and treatment. This includes source documents (such as x-rays). This also includes behavioral health and chemical dependency information.

I. I authorize SMDC to release my protected health information to insurance companies, government programs, and other parties responsible for payment of my bill, fraud investigation, and quality improvement. This includes behavioral health and chemical dependency information. SMDC may also release my protected health information to suppliers of medical equipment, special transportation, or other health services so they can request payment from my insurance or other payer. I also authorize SMDC to release my protected health information to organ procurement organizations to facilitate donations.

J. I authorize SMDC to release information from my medical records: as needed by the Federal Drug Administration (FDA) or manufacturers of drugs or medical devices to contact me about defects or recalls; or to emergency service providers involved in my care before and during transport to SMDC, for quality improvement.

K. I authorize SMDC to release information from my medical records and source data as needed to accrediting organizations and to legally authorized agencies to oversee healthcare activities and to physician specialty boards for board certification/re-certification of physicians.

L. I authorize SMDC to release information from my medical records for scientific research to improve patient care. I may object at any time to release of my protected health information for scientific research.

M. I authorize my bill to be combined into one statement that covers all members of my household. Results of tests and treatments will not be included on the bill. I authorize SMDC to discuss bill or payment issues with an adult household member who gives my name, address, date of birth, and either my account number or insurance ID number as well as his or her own name and address.

N. I authorize SMDC to disclose my presence and religious preference to SMDC Chaplains and to clergy of my denomination. I understand that SMDC will ask specific permission before disclosing my presence for behavioral health or chemical dependency services.

O. I agree to the presence of students, observers from other healthcare facilities, healthcare consultants and approved representatives of medical service providers during tests, exams, medical treatments and other services at SMDC. I understand that SMDC will also seek my oral permission to have non-SMDC persons present during any services.

P. I understand that this authorization ends one (1) year from the date signed except for purposes of payment and research.
- I understand that I may revoke this permission at any time by notifying SMDC in writing. No further release will take place after the date notified.
- I understand that other parties may use or disclose health information received from SMDC.
- I understand that SMDC will treat me whether or not I sign this agreement.
- I understand I will receive a copy of this form after I have signed it.
- I understand Wisconsin law gives me the right to inspect and receive a copy of behavioral health and chemical dependency information to be disclosed.

If I am signing as Authorized Representative of the patient, I am:

☐ Parent of a minor ☐ Court appointed guardian/conservator ☐ Other:______________________
(Please specify relationship to patient)

______________________ ____/____/____ ______________________
Signature (Patient or Authorized Representative) Date Witness (signature by mark must be witnessed)

Patient Name:______________________ Medical Record #:______________________

GENERAL CONSENT AND AUTHORIZATION

CON.016 Orig. 7/04; Rev. 7/05, 3/07, 11/07 Original: Medical Record Copy: Patient Stock# 52570

SMDC Health System
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 (Internet copy)

If you have any questions about this notice, please contact: Patient Relations, 400 East Third Street, Duluth, MN 55805; 218-786-3091.

The information privacy practices in this notice will be followed by any health care professional who treats you at any of the SMDC locations and in all departments and units of SMDC, including: St. Mary's Medical Center, St. Mary's Hospital of Superior, Miller-Dwan Medical Center, Polinsky Rehabilitation Center, Pine Medical Center and any Duluth Clinic location.

OUR PLEDGE TO YOU

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care, bill for your care, and comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether made by our staff, volunteers and authorized trainees, or by your personal doctor. (If your personal doctor is not a Duluth Clinic doctor, he or she may have different policies and notices regarding use and disclosure of your health information created in that doctor's office or clinic.) This notice tells you about the ways in which SMDC may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe our obligations regarding the use and disclosure of your health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use health information about you to provide you with health care treatment and services. We may disclose information about you to doctors, nurses, pharmacists, laboratory technicians, and other health care professionals, employees and volunteers at any SMDC department or unit, so they may provide you with the right care. For example, your Duluth Clinic doctor referring you for surgery at St. Mary's Medical Center may need to tell the anesthesiologist about your heart condition, so your anesthesia may be adjusted accordingly. The hospital dietitian may need to know that you have diabetes, so your hospital meals can be planned correctly for you. In addition, with your consent we may provide information about you to others involved in your care, such as a referring physician, an outside specialist, or a family member.

With your consent, SMDC may use and disclose health information about you to obtain payment for the treatment and services you receive from us. For example, we may send billing information to your insurance company or Medicare, or we may tell your insurance company about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. With your consent, we send the guarantor (responsible party for payment) a monthly statement for charges for all patients under that guarantor's account.

SMDC may use and disclose health information about you to support our health care operations. For example, we may use health information to review the treatment and services and to evaluate the performance of our staff in caring for you. We may combine health information about many patients to decide what additional services we should offer. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

If you are admitted and unless you tell us otherwise, we will include your name and location in the hospital, in our patient directory, and make this information available to anyone who asks for you by name. Unless you object, we will also include your religious affiliation and disclose that to a member of the clergy or our chaplain.

We may use and disclose health information to contact you for an appointment reminder, to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you, or to contact you about supporting our fund raising efforts.

Subject to certain requirements, we may use or disclose health information about you without your prior authorization for other reasons:

Research. Under certain circumstances, unless you have objected, we may use and disclose your health information for research purposes. For example, a research project may involve comparing patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the need for research with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process; but we may disclose health information about you to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, so long as the health information they review does not leave our facility. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle procurement or transplantation of organs, eyes or tissues, as necessary, to help them carry out those activities.

Serious Threat to Health or Safety. Under certain circumstances, and as permitted by state law, we may use and disclose health information about you, when necessary, to prevent a serious threat to the health and safety of you, another person or the general public.

Workers' Compensation. If you are seeking workers' compensation for a work-related illness or injury, we may release health information related to your claim, as permitted or authorized by the state Workers' Compensation program.

Public Health Risks. We may disclose health information about you for legally authorized or required public health activities. These may include such things as preventing or controlling disease, injury or disability; reporting births and deaths; reporting child or vulnerable adult abuse or neglect; reporting reactions to medications or problems with products; notifying people of recalls of products they may be using; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities. We may disclose health information to a health oversight agency for legally authorized activities, such as audits, investigations, inspections, and licensure. Through these activities the government monitors the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If there is a lawsuit or dispute, we may release health information about you in response to a subpoena or court or administrative order.

Law Enforcement. We may release health information to law enforcement officials in response to a court order, warrant, or similar process or if otherwise permitted or required by state law. For

example, we may be required to release certain health information if it indicates a crime may have been committed.

Coroners, Health Examiners, and Funeral Directors. We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release certain health information about patients to funeral directors, as necessary, to carry out their duties.
In any other situation not covered by this notice, we will not use or disclose your health information without your written consent or authorization. You may revoke this authorization for any future disclosures by
notifying us in writing.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

By law, we must have your written authorization to use or disclose your health information for any purpose not described in this notice. You have the right to request in writing that you see and get a copy of the health information that we use to make decisions about your care. We may charge a fee for the costs of copying, mailing or other supplies and services associated with your request. If we deny your request to inspect or obtain a copy in certain limited circumstances, you may request that the denial be reviewed. Another licensed health care professional chosen by SMDC will review your request and the denial, and we will comply with the outcome of that review.

If you believe that health information we have about you is incorrect or incomplete, you may make a written request to ask us to amend information. The request should state the reason for the amendment and specific information to be amended. The amendment must be limited to one page. Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously noted.

We may deny your request for an amendment if the request is not in writing or does not state a reason. We may also deny your request if the information to be amended was not created by us (unless the creator of the information is no longer available to amend it), is no longer maintained by us, is not part of the information which you would be permitted to see and copy, or is accurate and complete. We will notify you within 60 days of our response to your request for amendment. If we deny your request, you may submit a statement disagreeing with our denial, or you may direct that your request for amendment and our denial be included with any future disclosures of the information you requested to amend. If you submit a statement of disagreement, we may prepare and provide you with a copy of a written statement of rebuttal, and your statement of disagreement and our rebuttal will be included in subsequent disclosures of the information.

You have the right to make a written request for a list of disclosures we have made of your health information, except for uses and disclosures for treatment, payment, and health care operations, as previously described, and those for which you have authorized disclosure. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. We will not charge you for the first list you request within a 12-month period. Additional requests will be charged according to our cost for producing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will provide you with the list within 60 days of your request, or notify you if we will need additional time, up to a maximum of 30 days to provide it.

You have the right to request a restriction on the health information we use or disclose about you for treatment, payment, or health care operations. There may be risks associated with such restrictions and we may ask you to acknowledge these risks in writing for certain requests you may make. ***We are not required to agree to your request*** **for restrictions** if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If

we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You have the right to request, in writing, but without needing to state a reason, that confidential communications about you be made in an alternative manner or location. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

OUR OBLIGATIONS

We are required by law to maintain the privacy of your health information and to provide you with this notice of our duties and our practices with respect to that health information. We are required by law to abide by the terms of this notice as long as it is in effect.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facilities, indicating its effective date. In addition we will change the notice on our website.

WRITTEN REQUESTS

All written requests or appeals should be submitted to Patient Relations, 400 East Third Street, Duluth, MN 55805; 218-786-3091

COPIES OF NOTICE

You have the right to obtain a paper copy of this notice at any time.

COMPLAINTS

If you are concerned that your privacy rights may have been violated or you disagree with a decision we make about your health information, you may contact our Patient Relations department, 400 East Third Street, Duluth, MN 55805. You may also send a written complaint to the U.S. Department of Health and Human Services. Our Patient Relations/Risk Management office can provide you the address.

Under no circumstances will we ever ask you to waive your rights under this notice or retaliate against you in any manner for filing a complaint.

- -

Please sign below that you have received SMDC's Notice of
Privacy Practices, effective April 14, 2003.

Print Patient Name: ____

Patient/Parent/Guardian/Other signature: ______________________________

Relationship if signed by other than the patient: __________________________

Reason for signature by other than the patient: ___________________________

____

____

Date: ____________________________

FOR OFFICE USE ONLY
By: _______________________ Date: _________________
Site: ______________________ Patient Medical Record #: _______
Patient Date of Birth:_______________ Refused to sign ___
Reason: ____
____
____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NOPP.001 4/03 Patient Label

Attachment A
Acknowledgement of Receipt of NOPP (Pharmacy Use)
Date:___________

Please initial below that you have received SMDC's Notice of Privacy Practices, effective April 14, 2003.