HAWAI'I KEIKI
Healthy and Ready to Learn

UH Mānoa Nursing with Hawai'i Department of Education

NURSING
UNIVERSITY of HAWAI'I at MĀNOA

www.nursing.hawaii.edu/hawaiikeiki

2019-2020

Dear Parents/Guardians,

Did you know that Barbers Point Elementary School has added a Nurse to your school health room to work with the School Health Assistant (SHA) in supporting your child's health and education? Barbers Point Elementary School is staffed with a Hawai'i Keiki advanced practice registered nurse (APRN). When your child is sick at school, this APRN can treat your child and decide—if your child needs to go home or can stay in school.

The APRN can:

* Care for your child's allergies, asthma, and other medical conditions.
* Give your child medication when needed.
* Offer advice about health topics to you and your children.

Why is this important? Because keeping your child in school keeps them in class, which keeps them learning.

There's no cost to you for any services your child may receive. However, we need your insurance information in case we need to bill them for certain services. Students without health insurance can still get care from the APRN at no cost.

But before a Hawai'i Keiki APRN can care for your child, we need your permission. Please review the enclosed consent form, sign it, and return it to Maria Pineda, APRN.

Remember that a Hawaii Keiki APRN doesn't replace the care your child gets from the doctor or clinic. Also, even though you've signed the consent form, we won't treat or give medications to your child without talking to a parent or guardian first.

If you have any questions about the consent form or the Hawai'i Keiki APRN, please contact Maria Pineda.

Thank you for keeping your child healthy and learning.

Maria Pineda *APRN*	(808) 861-6834 mpineda@ucera.org	**Office Hours** School days 8am-2pm

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What is a School Nurse Practitioner?

Nurse Practitioners (NP) have advanced education and are licensed by the State of Hawaii to provide high-quality health care services with parental consent.

Available Health Services

- Diagnosing and treating common pediatric illnesses or injuries
- Prescribing medication and other treatments
- Performing check-up exams
- Working with health care providers to manage your child's care
- Preventing and controlling communicable disease and other health problems

Hawaii Keiki School Health Program
Parental Consent Form

Hawaii DOE School District

University Clinical, Education & Research Associates
677 Ala Moana Boulevard, Suite 1003 • Honolulu, HI 96813-4100 • phone: (808) 469-4900 • fax: (808) 536-7315

Office Use Only

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Sex: ❑ Male ❑ Female Grade _____
Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian
❑ Asian/Pacific Islander ❑ Other _____

Student Mailing Address:_____

_____

_____ _____ _____
City State Zip Code

Who is the student's regular doctor or nurse practitioner?
Name: _____
Telephone: _____
Address: _____
_____

PARENT/GUARDIAN INFORMATION

Mother
Last Name: _____First Name: _____

Home: _____Cell: _____ Work:_____

Father
Last Name: _____ First Name: _____

Home: _____Cell: _____ Work:_____

Legal Guardian *If Applicable*
Last Name: _____First Name: _____
Home: _____Cell: _____ Work:_____
Relationship of legal guardian to student
❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Additional Emergency Contact
Name: _____
Relationship to Student: _____
Home: _____Cell: _____ Work:_____

INSURANCE INFORMATION

Does your child have Medicaid?
❑ No ❑ Yes: Medicaid # _____

Does your child have Quest?
❑ No ❑ Yes: Quest # _____

Which Plan?
❑ Alohacare Quest ❑ Ohana Quest
❑ HMSA Quest ❑ United Health Care Quest
❑ Kaiser Quest

Does your child have coverage through your employer or any other type of health insurance?
❑ No ❑ Yes: Health Plan: _____
Member ID/Group Number: _____
Subscriber Date of Birth: _____/_____/_____
Month Day Year

If your child does not have health insurance, would you like someone to contact you to enroll into health insurance?
❑ No ❑ Yes What is the best time to contact you? _____

PARENTAL CONSENT FOR SCHOOL HEALTH SERVICES

I have read and understand the services listed on the next page (School Health Services) and my signature provides consent for my child to receive services provided by the Hawaii Keiki School Health Program.

NOTE: By law, parental consent may not be required for the provision of certain health care services, including but not limited to the application of first aid treatment, the provision of services where the health of the student appears to be endangered, and certain treatment and services as set forth under Chapter 577A of the Hawaii Revised Statutes. Parental consent is not required for students who are 18 years or older or for students who are parents or legally emancipated.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PARENTAL CONSENT FOR RELEASE OF HEALTH RECORDS/INFORMATION

I have read and understand this consent for the release of health records and information as described on page 2 of this form.
My signature indicates my consent to the release health records and information as specified.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

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SCHOOL HEALTH SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of the Hawaii Keiki School Health Program, as part of the school health program approved by the State of Hawaii Department of Education and University of Hawaii School of Nursing and Dental Hygiene. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. Hawaii Keiki school health services may include, but are not limited to:

1. Screening for vision (including eye glasses), hearing, asthma, obesity, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including screening, evaluation, diagnosis, treatment, and referrals.
6. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, & HIV, as age appropriate.
7. Referrals for service not provided at the Hawaii Keiki School Health Center.
8. Annual health questionnaire/survey.

HAWAII KEIKI AND STATE OF HAWAII DEPARTMENT OF EDUCATION
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH RECORDS/INFORMATION
PARENTAL CONSENT FOR RELEASE OF HEALTH RECORDS/INFORMATION UNDER FERPA

My signature on the reverse side of this form (on page 1) authorizes release of my child's health records/information by the State of Hawaii Department of Education as described in the paragraph below. Such records/information may be protected from release by federal and state laws, including the Family Educational Rights and Privacy Act (FERPA), which protects the privacy of students' educational records, including health records/information in some instances.

By signing this consent, I am authorizing my child's Hawaii Keiki School Health Program-related health records and information to be released by the State of Hawaii Department of Education to the following parties for the purposes of providing medical treatment to my child, allowing providers providing services to my child to obtain payment for such services, and allowing certain other administrative activities relating to the provision of care:

- The University of Hawaii
- UCERA (the non-profit organization that provides Hawaii Keiki services in conjunction with the University of Hawaii)
- Any third party health care providers providing services to my child under the Hawaii Keiki School Health Program or through referrals from the Hawaii Keiki School Health Program
- Any third party payers who may pay or reimburse providers for health care treatment or services

Student: First Name_____ Last Name_____ Date of Birth_____

UCERA

University Clinical, Education & Research Associates
677 Ala Moana Boulevard, Suite 1003 • Honolulu, H/96813-4100 • phone: (808) 469-4900 • fax: (808) 536-7315

1. Consent for Treatment

I wish to receive medical care and treatment at University Clinical, Education & Research Associates (UCERA). Accordingly, I consent to the procedures that may be performed during this office visit, including emergency treatment. I authorize consent to any of the following: imaging, laboratory procedures, other diagnostic procedures, medical or surgical treatment, or other clinical services that my physician, physician assistant, or nurse practitioner believes are advisable to evaluate or treat me, and to other services rendered under the general and special instructions of my physician.

I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that this office has not made any guarantees to me as to the results of treatments or examinations. I am also aware that I should ask my physician any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

2. Disclosure of Information for Payment Purposes

I understand that my medical information will be sent to my insurance carrier for billing purposes for any treatment I may receive at this office including treatment for Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnoses, and/or drug, alcohol or other substance abuse.

I understand that according to law, I may choose to pay out-of-pocket for certain services if I do not want my health information regarding those services to be provided to my insurance company. I agree to notify this office of my wishes regarding payment before these services are provided. I also understand that if I fail to pay in full for the services, the information will be sent to my insurance company.

3. Information to Other Providers

I understand that this facility may share my information electronically or on paper with other providers in the course of my treatment, for making arrangements for my continuing care, or upon request when seeking care from other providers. If I prefer that this medical facility not use or share my information, I may submit a written request for consideration per this facility's Notice of Privacy Practices.

4. Financial Agreement

I understand that I will receive a bill from UCERA. I understand and agree to pay all charges for services rendered and that I am obligated to pay for services in accordance with the regular rates and terms of UCERA. UCERA has a right to charge a Late Payment Fee and for a Returned Check Fee.

If I choose to pay all charges myself, I will notify this office prior to receiving services.

Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts, whether or not the account is referred to a collection agency.

5. Medicare Coverage

I certify that the information I have given in applying for payment under Medicare is correct. I authorize the Social Security Administration to release information about my Medicare effective dates and Medicare claim number to UCERA. I authorize any holder of medical or related information about me to release any information needed to process this or a related Medicare claim to the Social Security Administration or its intermediaries. I request that payment of benefits be made on my behalf to UCERA for any services provided in this office.

6. Assignment of Benefits

I hereby authorize assignment of the medical insurance benefits I am due to UCERA for application to bills for medical services and supplies received. I further authorize UCERA to receive direct payment from all such benefit payments. I agree to remain responsible and liable for payments of all amounts due UCERA and not received from my insurance carrier(s). I understand UCERA is submitting claims on my behalf as a courtesy. I shall not revoke this assignment for any reason.

7. Patient's Rights and Responsibilities

My signature below confirms that I have received the information on my Rights and Responsibilities as a patient and I have received a copy of this facility's NOTICE OF PRIVACY PRACTICES.

MINORS OR INCAPACITATED PERSONS- The patient is (please check & complete):

- ☐ A minor _____ years of age.
- ☐ Incapacitated and unable to sign for the following reason(s):_____

I have read this consent, received a copy of this facility's Notice of Privacy Practices, and am the patient or the patient's duly authorized representative. On my own behalf (or on behalf of the patient), I accept and agree to be bound by all of these TERMS AND CONDITIONS OF SERVICE.

_____ _____ _____

Patient or Representative's Signature Print Name Date

REPRESENTATIVE: Please describe your authority to act on behalf of the patient:_____

UCERA

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NOTICE OF PRIVACY PRACTICES

Effective Date of Revised Notice: September 23, 2013

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

Each time you are seen by one of UCERA's providers in a hospital, faculty practice clinic, doctor's office, nursing home or other facility, a record of your visit is made. This record contains information about your symptoms, examinations, test results, medications you take, your allergies and the plan for your care. We refer to this information as your health or medical record. It is an essential part of the healthcare we provide for you. Your health record contains personal health information and there are state and federal laws to protect the privacy of your health information.

This health information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your Protected Health Information. We are required by law to maintain the privacy of Protected Health Information and to provide you with notice of our legal duties and privacy practices with respect to Protected Health Information. We are required to abide by the terms of this Notice of Privacy Practices.

To promote continuity and consistency of care, our providers at affiliated hospitals participate in an integrated health record system. This means that information created in the course of caring for you may reside in the integrated record and may be available to other providers participating in the integrated record system who are involved with your care. These other providers may not be UCERA providers and are legally separate and responsible for their own acts.

Additionally, UCERA physicians and providers are using an electronic health record (EHR) software that allows us to comply with Federal laws while also allowing us to gain access to shared medical records and share medical records with other providers and partners in our EHR network(s). The EHR network(s) assure that all participating providers are adhering to strict levels of confidentiality regarding all patient records.

USES AND DISCLOSURES OF HEALTH INFORMATION

We will use your information for:

1. Treatment. The physicians, nurses and clinical staff involved in your care will document information in your record about your examination and the care planned for you. We may disclose your health information to other health care providers for treatment purposes.

   For example, we may disclose your Protected Health Information to doctors, nurses, and other health care personnel or providers to coordinate the different care you need, such as prescriptions, lab work, and X-rays. We may also permit disclosure of your electronic health record via electronic transfer to other facilities and providers for treatment purposes. We also may disclose your Protected Health Information to other people who provide services that are part of your care, such as a hospice or home care agency. We participate in one or more Health Information Exchanges ("HIE"). Your health information and basic identifying information regarding your visits to our facilities

maybe shared with the HIEs for the purposes of diagnosis and treatment. Other providers participating in these HIEs may access this information as part of your treatment.

We may also use health information about you to call or send a letter to remind you about an upcoming appointment, to follow up with diagnostic test results, or to provide you with information about other treatments and care that could benefit your health.

2. Payment. A bill will be sent to you or your insurance. We may include information that identifies you, as well as your diagnoses, procedures, healthcare providers and supplies used. We also may contact your insurance company to determine if they will pay for your medical care as part of their certification process. We may also disclose your health information to third parties for collection of payment.

3. Health care operations. UCERA physicians, nurses, managers and staff may look at your health information to assess the care and results in your case and others like yours. UCERA is a faculty practice plan affiliated with the University of Hawaii's John A. Burns School of Medicine, so we may use your information in the process of educating and training students and resident physicians. Additionally, we may use or disclose, as needed, your Protected Health Information in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities.

You have the right to request a restriction on the above uses and disclosures of your protected health information for treatment, payment and health care operations; however, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. We may, however, also end the agreement at any time after informing you of such.

OTHER PERMITTED DISCLOSURES

Business Associates

Some services in our organization are provided through contracts with business associates. To protect your health information, however, we require the business associate to protect your information.

Communication with Others Involved in Your Care

We may disclose to a family member, or other relative, close personal friend or any other person you identify, health information directly relevant to that person's involvement in your care or payment related to your care.

The disclosure will only be done if you agree, or are silent when given the opportunity to disagree, or we believe, based on the circumstances and our professional judgment that you do not object. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

If you are incapacitated or in an emergency circumstance, we may disclose to a family member, or other relative, close personal friend, or any other person accompanying you, health information directly relevant to that person's involvement in your care or payment related to your care.

Disaster Relief

We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Research

Under certain circumstances, we may use and disclose health information about you from your medical record for research purposes. All research projects, however, are subject to a special approval process designed to protect the privacy of your health information.

Childhood Immunizations

We may disclose a student's immunization records to schools required to obtain proof of immunization prior to admitting the student as long as we obtain verbal authorization from the student or the student's legal representative.

Required by Law (Without Authorization)

Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government audits or investigations (such as the Department of Health and Human Services);
- Required by Court Order;
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Examples of these types of disclosures include, but are not limited to:

Food and Drug Administration	Public Health or legal authorities charged with disease prevention and health oversight agencies
Correctional institutions	Workers Compensation Agents
Organ and Tissue Donation Organizations	Military Command Authorities
Funeral Directors, Coroners and Medical Examiners	National Security and Intelligence Agencies
Protective services for the President and others	Law enforcement as required by law or in accordance with a valid subpoena

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Release of psychotherapy and psychiatry notes;
2. Uses and disclosures of Protected Health Information for marketing purposes;
3. Subsidized treatment communication; and
4. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer, and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

PATIENT RIGHTS

You have the right to:

- Inspect and obtain a copy of your health record other than psychotherapy/psychiatric notes, information compiled in anticipation of or for use in civil, criminal, or administrative proceedings, or certain information that is governed by the Clinical Laboratory Improvement Act. To arrange for access to your records, or to receive a copy of your records, you should submit a written request to UCERA at the address on the top of this page. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
    - **Right to an Electronic Copy of Electronic Health Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic health record.

- Request an amendment of your health records if you feel a portion of your health records that we created is incorrect or incomplete. We are not required to agree to your request.
- Obtain an accounting of disclosures of your Protected Health Information. However, the following disclosures will not be accounted for: (i) disclosures made more than six years before your request, (ii) disclosures made for the purpose of carrying out treatment, payment or health care operations, (iii) disclosures made to you, (iv) disclosures of information maintained in our patient directory, or disclosures made to persons involved in your care, or for the purpose of notifying your family or friends about your whereabouts, (v)disclosures for national security or intelligence purposes, (vi) disclosures to correctional institutions or law enforcement officials who had you in custody at the time of disclosure, (vii) disclosures made pursuant to an authorization signed by you, (viii) disclosures that are part of a limited data set, (ix) disclosures that are incidental to another permissible use or disclosure, or (x) disclosures made to a health oversight agency or law enforcement official, but only if the agency or official asks us not to account to you for such disclosures and only for the limited period of time covered by that request. The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person's address (if known), and a brief description of the information disclosed and the purpose of the disclosure. We may charge you a reasonable fee for this accounting.
- Request communication of your health information in a certain way or at a certain location. For example, you can ask that we contact you by mail and not by telephone, or that we contact you at a specific telephone number, or that we use an alternative address for billing purposes, or that we not leave messages on certain answering machines.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Request a restriction on the information disclosed to your health plan if you pay for related items or services, out-of-pocket and in full (or in other words, you have requested that we not bill your health plan), at the time the services are provided. We will honor this request.

Our duties are to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect about you through this notice;
- Abide by the terms of the notice currently in effect;
- Notify you if we are unable to agree to a requested restriction;
- Notify you immediately if we receive information that there has been a breach involving your health information;
- Follow reasonable requests you make to communicate with you as you instruct, for example, contact you at a certain telephone number or address; and

- Provide you a paper copy of this notice of privacy practices upon request. You may also obtain a copy of this notice from our website at www.ucera.org.

To exercise any of these rights, your request must be in writing and mailed to UCERA at the address at the top of this page.

Despite your general right to access your Protected Health Information, access may be denied in some limited circumstances. For example, access may be denied if you are an inmate at a correctional institution or if you are a participant in a research program that is still in progress. Access to information that was obtained from someone other than a health care provider under a promise of confidentiality can be denied if allowing you access would reasonably be likely to reveal the source of the information. The decision to deny access under these circumstances is final and not subject to review. In addition, access may be denied if (i) access to the information in question is reasonably likely to endanger the life and physical safety of you or anyone else, (ii) the information makes the reference to another person and your access would reasonably be likely to cause harm to that person, or (iii) you are the personal representative of another individual and a licensed health care professional determines that your access to the information would cause substantial harm to the patient or another individual. If access is denied for these reasons, you have the right to have the decision reviewed by a health care professional who did not participate in the original decision. If access is ultimately denied, the reasons for that denial will be provided to you in writing.

UCERA reserves the right to change this Notice of Privacy Practices and its policies and procedures for privacy practices at any time and to make the changes effective for all protected health information created or received prior to the new effective date and then currently maintained by the practice location. The revised Notice will be posted on our website and in waiting rooms or patient lobbies and reasonable efforts will be made to advise you of the change(s) in the Notice, policies and procedures at your next service visit. You may also obtain a copy of the revised Notice upon request.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have any questions about your rights or duties or our practices and procedures regarding protected health information, please call UCERA's Customer Service department at (808)469-4900.

If you believe your privacy rights have been or are being violated, you may complain to UCERA at: UCERA Privacy Officer, 677 Ala Moana Blvd., Suite 1001, Honolulu, Hawaii 96813. You may also file a complaint with the Secretary of the Department of Health and Human Services. Complaints to the Secretary must be filed in writing on paper or electronically and must be made within 180 days of when you became aware of, or should have been aware of, the incident giving rise to your complaints. By law, you will not be penalized for filing a complaint.