North Olympic Healthcare NETWORK

North Olympic Healthcare Network
240 West Front Street | Suite A
Port Angeles, WA 98362-2609
(360) 452-7891 P | (360) 452-8087 F

What is the NOHN Mobile Health Clinic?

Some students may not have access to healthcare due to lack of insurance, transportation, time, financial resources, a primary care provider, or knowledge about healthcare needs. North Olympic Healthcare Network (NOHN) has partnered with the Port Angeles School District and Peninsula College to reduce these barriers and improve access to care by deploying a Mobile Health Clinic (MHC) to locations where these barriers are present.

Will my information be shared?

North Olympic Healthcare Network (NOHN) keeps a record of the healthcare services provided to you. We use your health information primarily for the purposes of treatment, payment, and healthcare operations. We will not disclose your protected health information to others or for other purposes unless you direct us to do so, or unless the law authorizes or compels us.

What are my privacy rights?

You have the right to a copy of your health record and to be informed about how your health information is protected. You can obtain a full version of the Notice of Privacy Practices (NPP) from NOHN by contacting us at 360-912-6770 or via email at MHC@nohn-pa.org. Additionally, the NPP is available at the Mobile Health Clinic location or in our downtown clinic locations.

More information on our website https://www.nohn-pa.org/for-patients/privacy-practices/

For minor patients: *An Acknowledgment of the Notice of Privacy Practices must be signed by the patient's parent, guardian, or authorized representative prior to receiving services. Patients aged 18 or older can sign for themselves.*

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative
- I have received a copy of the Notice of Privacy Practices for North Olympic Healthcare Network
- I understand that I may contact the person named in the Notice if I have questions about the contents of the Notice.

____ ______________________
Signature of patient/parent/legal guardian Date

____
Description of relationship to patient

TO BE COMPLETED BY STAFF

(If applicable)

Staff member sought but unable to obtain an acknowledgment form the patient or the patient's personal representative for the following reason(s):

☐ Patient/personal representative refused to sign form

Reason for refusal as stated by patient:

____

____

Signature of staff member ____________________________________ Date ___________________

MOBILE HEALTH CLINIC – REGISTRATION FORM

North Olympic Healthcare NETWORK

Please complete entire form. Incomplete forms may result in delay or denial of service.

Student (Patient) Information

Legal Name ______________________________

Preferred Name ______________________________

School/Site ____________________ Grade ________

Date of Birth ______________________________

Student's Identifying Gender ______________________

Student (Patient) Sexual Orientation ________________

Student (Patient) Race ______________________

Student (Patient) Ethnicity ____________________

Address ______________________________

City ______________ State ________ Zip ________

Phone #: Cell ______________ Home ____________

May we call and/or **text** you for scheduling and appointment reminders? ☐ Yes ☐ No If no, who should we contact?

Name ______________________________

Phone # ________________ Relationship ________

Emergency / Billing / Other Information

Emergency Contact Name ______________________

Phone # ________________ Relationship ________

Billing Contact Name__________________________

Phone # ________________ Relationship ________

Date of Birth ______________ SS # ____________

Address ______________________________

City ____________ State ________ Zip ________

Student's (Patient's) Doctor ____________________

Housing Situation – *I have steady housing:* ☐ Yes ☐ No

If no, please describe: ________________________

Student (Patient) lives with: (Check all that apply.)

☐ Mother ☐ Father ☐ Legal Guardian
☐ Grandparent(s) ☐ Foster Parent(s) ☐ Emancipated Minor
☐ Other ______________________________

In the past 2 years, has **seasonal/migratory farm work** been your or your family's main source of income? ☐ Yes ☐ No

REQUEST TO DISCLOSE PHI / PERSONAL HEALTH INFORMATION (Scheduling info only): To better coordinate your care, NOHN requests your consent to release limited, scheduling-related medical and behavioral health information to school/site staff:
I, ____________________ (DOB) ________ authorize and give permission for my protected health information to be shared with school/site staff to coordinate my care. Only information necessary to facilitate scheduling and communications about appointments is authorized. This release may include office staff, counselors, nurses, teachers, and school navigators.
I understand that I may amend or revoke this at any time in writing and that the changes or revocation will take effect immediately upon a written request.

______________________________ ____________
Signature of Patient or Authorizing Representative **Date**

Insurance Information:

Does student have health insurance? ☐ Yes ☐ No

Insurance Plan / Company ______________________

Policy Number ______________________________

Group Number ______________________________

Subscriber Name ______________________________

Subscriber Date of Birth ________________________

Subscriber's Relationship to Patient ________________

Services Sought: ☐ Medical ☐ Behavioral Health ☐ Dental ☐ Vision

Fees and Billing: No one will be denied service due to inability to pay, but the following information is required so we can bill your insurance or determine if you qualify for a sliding fee discount. If you do not wish to provide the information, we will bill you at full fee for service.

Sliding Fee Program: If the student does not have insurance and does not qualify for Apple Health, we can provide sliding fees for certain services. ***Please complete below.***

Gross Annual Household Income $__________________

Number of Family Members in Your Household __________

To schedule or if you have any questions, please reach out to us via phone, text or email at (360) 912-6770 or MHC@nohn-pa.org.

Please complete the Consent Form on the next page. →

MOBILE HEALTH CLINIC – CONSENT FORM

Please complete entire form. Incomplete forms may result in delay or denial of service.

I give permission to North Olympic Healthcare Network (NOHN) to perform such medical and therapeutic procedures as may be professionally necessary or advisable to my (or my child's) health screening, diagnosis, and treatment.

I understand that a patient record will exist for each student and that I am responsible for medical expenses that may occur. **The NOHN Mobile Health Clinic is not a free service.** NOHN will bill your insurance company. Anything not paid by the insurance company will be billed to you.

In the case of medical health services, NOHN MUST have a signed Consent Form from a parent or legal guardian before health services are provided to youth.

I understand that the following types of services may be offered through the NOHN Mobile Health Clinic:

- Mental health services
- Routine physical exams, including sports physicals
- Diagnosis and treatment of acute and chronic illness
- Referral for health care services that cannot be provided on the mobile unit
- Dental screenings
- Laboratory tests
- Health education, counseling, and/or wellness promotion
- Immunizations
- Reproductive health services, like counseling, education, exams, and referrals
- Vision screenings

According to law, MINORS may provide their **own** consent for substance abuse treatment and mental health care services at the age of 13 or older. MINORS may provide their **own** consent for reproductive health care at any age. If necessary, NOHN will inform youth of options for outside care and will assist youth in discussing these issues with parents/guardians.

When a student consents for his/her own care, all information is kept confidential and cannot be released except in the following circumstances when it can be confidentially shared:

- If a student shows signs of risk of suicidal behavior.
- If a student has a life-threatening health problem and is under 18 years old.
- If the student gives us permission through a signed release of information.
- If student plans to do serious bodily harm to someone else.
- If there is reason to suspect abuse or neglect. This may include any sexual contact with a minor (people under 18 years old) by a person older than 18 **or** where this is a three- or more-year difference in ages.

Please Note: The student's consent is LEGALLY required for release of information about the following: pregnancy, sexually transmitted disease (including HIV/AIDS testing), substance abuse treatment, and/or mental health counseling.

______________________	______________________	______________
Student's Signature	PRINT Student's Name	Date
______________________	______________________	______________
Parent / Guardian Signature	PRINT Parent / Guardian Name	Date

Relationship to Student: ___________________

Do you need your services to be confidential? ☐ Yes ☐ No

If yes, a PASD or NOHN Navigator will contact you. You can choose to start or stop confidential services at any time.

If you are a student and want to learn more about Confidential Care, including what options are available for you, please reach out to your PASD Family Navigator, nurse, teacher, or counselor.

To schedule or if you have any questions, please reach out to us via phone, text or email at (360) 912-6770 or MHC@nohn-pa.org.

Please complete the Registration Form on the next page. →