Introduction to the

Pediatric New Patient Packet

Thank you so much for your interest in becoming a new patient at Island Health Care! We are excited to have you join our practice.

Here's a quick description of the forms contained in this packet. The first few forms are required for us to get you in our system and scheduled for your first appointment.

Form 1: Patient Registration (p. 3)	This form includes the basic information that we need to get a patient set up in our system.
Form 2: IHC Consent for Treatment (p. 5)	We need your consent to provide health care services to you at Island Health Care. This form also asks for your health insurance information.
Form 3: Record Sharing with Other Healthcare Providers (p. 6)	This form explains how your information may be shared with other healthcare providers involved in your care.
Form 4: Medical / Surgical / Family History (p. 7)	Understanding your medical, surgical, and family health history helps us provide you with the best possible care tailored to your specific health needs.

The remaining forms are **optional**. Please review the purpose of the forms to decide whether you'd like to fill them out.

Form 5: Island Health Care Sliding Fee Application (p. 9)	Island Health Care provides a sliding fee discount to patients who are income-eligible. Even if you have insurance, you may still be eligible for a sliding fee. To determine if you are eligible for this discount you will need to fill out and sign this application.
Form 6: Proxy Consent to Treat Minors (p. 11)	This allows you to designate individuals other than the minor patient's parent or legal guardian to consent to their medical care and attend appointments with them. This authorization can be given for one specific appointment, for a specific date range, or for one year.
Form 7: Authorization to Treat Unaccompanied Minor (p. 12)	This form allows a minor patient's parent/legal guardian to authorize IHC to see a minor patient between the ages of 14 and 18 even if the parent/legal guardian does not accompany the minor patient to the appointment.
Form 8: Permission to Verbally Discuss Protected Health Information (p. 13)	This form allows Island Health Care to share health/dental information with a designated family member or friend, covering aspects such as clinical data, mental health, consultations, and specific treatments.

Introduction to the

Pediatric New Patient Packet

A copy of our Notice of Privacy Practices is included on pages 14-17 of this packet. On **page 18** you will find the **Notice of Patients' Rights**, which can help you understand your rights as a patient of this Health Center.

Please note that in order to make Island Health Care your primary care provider (PCP), you may need to contact your insurance company to notify them **IN ADVANCE** of your first visit and make any changes.

Please bring this completed packet to the Island Health Care Clinic at 245 Edgartown Vineyard Haven Road. Please also bring the following items if you have them:

- **Photo ID**
- **Insurance card (enter details below)**
- **Vaccination/Immunization Records** (If you can't bring your immunization records in with your paperwork, please make every effort to bring them to the clinic before your first appointment.)

Insurance (e.g., MassHealth, BCBS)	**Subscriber Name**
Subscriber's Relationship to Patient	**Subscriber Date of Birth** (MM/DD/YYYY)
Subscriber Social Security Number (SSN)	**Do you have secondary insurance?** *If yes, please provide information to the front desk* ❑ Yes ❑ No
Subscriber ID Number	

Important Notes:

- After dropping off your completed new patient paperwork, we will contact you in the order your packet was received to schedule your appointment.
- We will make **three attempts** to reach you by phone call and text message. If your voicemail identifies you by name, we will leave a message. **Please notify us promptly if your phone number changes.**
- If we are unable to reach you after three attempts, please call us at 508-939-9358 to schedule.
- **Sign Up for MyChart!** MyChart is IHC's patient portal, powered by Epic. Through the app or website, you and your caregivers can message your care team, request refills, view test results and records, and pay bills. During registration, we'll invite you to create an account—we strongly encourage all patients to do so. Questions? Just ask!

Patient Registration

Medical Record #
For office use only

Island Health Care

We are committed to safeguarding your privacy and ensuring that your personal information is handled with care and respect. Demographic information is used to tailor our services and programs to better meet your individual needs and preferences and will never be used to discriminate against or stigmatize any individual or group.

Legal Name (Print) Last	First	Middle Initial	**Name Used** (if different)
Date of Birth (Month / Day / Year)	**Social Security Number**		

Contact Information

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone ❑ OK to leave voicemail	**Patient Cell Phone** (if 12 or older) ❑ OK to leave voicemail	**Parent Cell Phone** ❑ OK to leave voicemail	Best Number to reach you ❑ Home ❑ Cell
Mailing Address (P.O. Box if you have one)		City	State / Zip Code
Physical Address		City	State / Zip Code
Patient's Email Address (if 12 or older for MyChart access)		**Are you a student?** ❑ Full-time ❑ Part-time ❑ Not a student	
Parent / Guardian 1	Phone	Relationship to Patient	Communications preferences* ❑ Phone ❑ Email ❑ Text ❑ Mail ❑ MyChart
**Select all that apply. By choosing these communication preferences, you are giving Island Health Care permission to contact you using the selected methods.*			
Parent / Guardian 1 Mailing Address		City	State / Zip Code
Parent / Guardian 2	Phone	Relationship to Patient	Communications preferences* ❑ Phone ❑ Email ❑ Text ❑ Mail ❑ MyChart
**Select all that apply. By choosing these communication preferences, you are giving Island Health Care permission to contact you using the selected methods.*			
Parent / Guardian 2 Mailing Address		City	State / Zip Code
In which language do you feel most comfortable reading medical or health care instructions? ❑ English ❑ Português ❑ Other:_____ ❑ Español ❑ ASL ❑ Choose not to disclose		**In which language do you feel most comfortable speaking with your doctor or nurse?** ❑ English ❑ Português ❑ Other:_____ ❑ Español ❑ ASL ❑ Choose not to disclose	
Do you need any language accommodations or support to help us understand each other better? ❑ Yes ❑ No			

Patient Registration

Island Health Care

This information is for demographic purposes only, without personal identifiers and does not affect your care.

1a. What is your annual income?

$ _____

- ☐ No income

1b. How many people does your income support?

_____

2. Veteran status

- ☐ Veteran of U.S. Military
- ☐ Not a veteran of U.S. Military
- ☐ Currently serving
- ☐ Choose not to disclose

3. Do you work in healthcare?

- ☐ Yes
- ☐ No

4. Do you live in congregate housing?

(E.g., nursing home, assisted living facility, etc.)

- ☐ Yes
- ☐ No

5. Race

Check all that apply

- ☐ Alaska Native
- ☐ Black / African American
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian / Chamorro
- ☐ Indian
- ☐ Japanese
- ☐ Korean
- ☐ Native American
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ I don't know/ am not sure of my race
- ☐ I choose not to answer

6. Ethnicity

- ☐ Cuban
- ☐ Mexican, Mexican American, or Chicano/a
- ☐ Puerto Rican
- ☐ Other Hispanic or Latino/a
- ☐ Not Hispanic or Latino/a
- ☐ I don't know/am not sure of my ethnicity
- ☐ I choose not to answer

7a. Are you homeless or unhoused?

- ☐ Yes
- ☐ No

If no, skip to question 8

7b. Housing status

Only answer if you selected "yes" on question 7a

- ☐ Living in transitional housing
- ☐ Doubling up (ex. sharing a single space with others)
- ☐ Living in homeless shelter
- ☐ Living in permanent supportive housing
- ☐ Living in woods / car / camping / street
- ☐ Unknown housing location
- ☐ Other: _____

8. What is your gender?

- ☐ Female
- ☐ Male
- ☐ Agender
- ☐ Gender expansive
- ☐ Gender fluid
- ☐ Gender non-conforming
- ☐ Gender queer
- ☐ Intersex
- ☐ Non-binary
- ☐ Transfeminine
- ☐ Trans female
- ☐ Trans male
- ☐ Transmasculine
- ☐ Two spirit
- ☐ Choose not to answer
- ☐ I'm not sure/ don't know my gender identity
- ☐ My gender identity is not listed

9. What was your sex assigned at birth?

- ☐ Female
- ☐ Male
- ☐ Not recorded on birth certificate
- ☐ Uncertain
- ☐ I choose not to answer
- ☐ Other

10. What is your legal sex?

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ Other

11. Do you think of yourself as:

- ☐ Aromantic
- ☐ Asexual
- ☐ Bisexual
- ☐ Demisexual
- ☐ Gay
- ☐ Lesbian
- ☐ Lesbian or Gay
- ☐ Pansexual
- ☐ Queer
- ☐ Straight / heterosexual
- ☐ Something else
- ☐ Don't know
- ☐ I choose not to answer

12. Marital status

- ☐ N/A - I'm under 18
- ☐ Divorced
- ☐ Domestic partner
- ☐ Legally separated
- ☐ Life partner
- ☐ Married
- ☐ Significant other
- ☐ Single
- ☐ Widowed
- ☐ Other: _____
- ☐ I choose not to answer

13. What are your pronouns?

- ☐ She / her / hers
- ☐ He / him / his
- ☐ They / them / theirs
- ☐ My name
- ☐ I choose not to answer
- ☐ My pronouns are not listed

14a. Are you a seasonal farm worker?

- ☐ Yes
- ☐ No

14b. Farm worker status

- ☐ Migratory agricultural worker during the last 2 yrs
- ☐ Seasonal agricultural worker during the last 2 years
- ☐ Neither

15. Referral source

How did you hear about us?

- ☐ Social Media (ex. Facebook, Instagram)
- ☐ Internet search
- ☐ Friend or family member
- ☐ Health provider
- ☐ Emergency room
- ☐ Newspaper ad or article
- ☐ Outreach worker
- ☐ School
- ☐ Other: _____

Consent for Treatment

1. I _____ (patient name) _____ (date of birth MM/DD/YYYY) give permission for Island Health Care to give me medical treatment.

2. I allow Island Health Care to file for insurance benefits to pay for the care I receive. I understand that:

- Island Health Care will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.*

3. I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

4. I understand:

- I have the right to request a copy of IHC's Patient Bill of Rights and Patient Grievance Resolution process.

5. I have received a copy of IHC's Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Island Health Care has the right to change this Notice at any time. I may obtain a current copy by visiting the Island Health Care website at ihimv.org.

Patient's Signature	**Today's Date**
Parent or Guardian Signature (for children under 18)	**Today's Date**
Full Name (Print)	

**Please ask the front desk about IHC's financial assistance programs if you are worried about the cost of your visit.*

Collaboration/Record Sharing with Other Healthcare Providers Involved in Your Care

Island Health Care

Care Everywhere is a tool that enables the exchange of patient health information across different healthcare organizations and systems, even if they are using different electronic health record (EHR) platforms. The goal of Care Everywhere is to improve patient care by ensuring that a complete picture of the patient's medical history is accessible, regardless of where the patient has previously received care. It also helps reduce errors or delays due to missing or incomplete information. Here's a brief overview of Care Everywhere's functionality:

1. Care Everywhere allows healthcare providers to access and share a patient's health records across different systems. For example, if a patient visits a healthcare facility that uses Epic and then visits a different facility that uses a different EHR system, Care Everywhere helps exchange the relevant health data, ensuring that healthcare providers have comprehensive information to make informed decisions.
2. Through Care Everywhere, clinical data such as medications, allergies, lab results, immunizations, and diagnostic information can be securely shared between different Epic users or between Epic and non-Epic systems. This can improve care coordination, reduce duplicate tests, and support better patient outcomes.
3. Care Everywhere provides alerts to clinicians when a patient's data has been updated or when there are new records from external sources. This ensures that the care team stays informed about any important changes to the patient's health history.

Your Rights and Responsibilities:

- You have the right to refuse consent to the sharing of your health information through Care Everywhere. If you refuse, this applies to your entire electronic health record. If you'd like to refuse consent, please let the front desk know so that they can give you a declination form.
- You have the right to withdraw your consent at any time, and the withdrawal will apply to future information exchanges.
- Withdrawal of consent will not affect the use or disclosure of your health information prior to the withdrawal date.

Epic's Care Everywhere system uses strict security protocols to ensure the privacy and safety of your health information. Only authorized healthcare providers will have access to your data, and all exchanges are governed by healthcare privacy laws, including HIPAA (Health Insurance Portability and Accountability Act).

By signing below, I acknowledge that I understand how my or my dependent/child's health information may be shared through Care Everywhere.

Name of Patient	**Patient's Date of Birth**
Signature of Patient / Guardian	**Today's Date**
Name of Guardian (If signing on the patient's behalf)	**Relationship to Patient** (if signing on patient's behalf)

Medical, Surgical & Family Health History

Island Health Care

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Patient Medical / Surgical History

Past Medical History: Are you being trWeated or have you ever been treated for the following? (Check all that apply.)

❑ ADHD	❑ Eczema	❑ Nerve/Muscle Disease
❑ Allergic Rhinitis	❑ Emphysema	❑ Obesity
❑ Allergies	❑ GERD	❑ Osteoporosis
❑ Anemia	❑ Glaucoma	❑ Pneumonia
❑ Anxiety	❑ Headache	❑ Scoliosis
❑ Arthritis	❑ Hearing Loss	❑ Seizures
❑ Asthma	❑ Heart Murmur	❑ Sickle Cell Anemia
❑ Cancer	❑ Hepatitis	❑ Stroke
❑ Cataracts	❑ HIV/AIDS	❑ Substance Abuse
❑ CHF	❑ Hypertension	❑ Thyroid Disease
❑ Clotting Disorder	❑ Inflammatory Bowel Disease	❑ Tuberculosis
❑ COPD	❑ Jaundice	❑ Ulcers (GI)
❑ Depression	❑ Kidney Disease	❑ UTI
❑ Diabetes Mellitus	❑ Meningitis	❑ Varicella
❑ Eating Disorder	❑ Myocardial Infarction	❑ Vision Problems
OTHER (Please Explain)		

Past Surgical History: (Check all that apply.)

❑ Adenoidectomy	❑ Fracture Surgery	❑ Prostate Surgery
❑ Appendectomy	❑ Gastrostomy	❑ Small Intestine Surgery
❑ Brain Surgery	❑ Heart Surgery	❑ Spine Surgery
❑ CABG	❑ Hernia Repair	❑ Tonsillectomy
❑ Cholecystectomy	❑ Hysterectomy	❑ Umbilical Hernia
❑ Colon Surgery	❑ Joint Replacement	❑ Valve Replacement
❑ Cosmetic Surgery	❑ Lymph Node Biopsy	❑ Vasectomy
❑ Eye Surgery	❑ Mastectomy	❑ VP Shunt
OTHER (Please Explain)		

Medical, Surgical & Family Health History

Island Health Care

Patient Medical / Surgical History

Were you adopted?

❑ Yes ❑ No

Please note the ages and significant health problems for any of these close relatives:

Relative	Age	Significant Health Problem
Mother alive? ❑ Yes ❑ No		
Father alive? ❑ Yes ❑ No		
Sibling alive? **M / F** ❑ Yes ❑ No		
Sibling alive? **M / F** ❑ Yes ❑ No		
Sibling alive? **M / F** ❑ Yes ❑ No		
Sibling alive? **M / F** ❑ Yes ❑ No		
Other relationship alive? **M / F** ❑ Yes ❑ No		

Island Health Care
Sliding Fee Discount Application

How Does the Sliding Fee Scale Work?

As a Federally Qualified Health Center (FQHC), Island Health Care provides a sliding fee discount to patients who are income eligible. Even if you have insurance, you may still be eligible for a sliding fee. To determine if you are eligible for this discount, you must complete this application and sign the self-declaration of income at the bottom of page 2.

If you need help filling out this form or have any questions, please ask the front desk or call us at 508-939-9358 and select option 4.

NOTE: Under federal regulations, in order to provide you with a discount on our services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. Your annual income and your family size will be used to calculate your discount. IHC will reach out to you in June and December each year to verify your income and make sure you are still eligible for the program.

Applicant's Full Name (First, Middle, Last)	**Today's Date**
Mailing Address	**Date of Birth** (MM/DD/YYYY)
City, State, Zip Code	**Primary Phone Number** (best number to reach you)

Island Health Care
Sliding Fee Discount Application

Island Health Care

Number of immediate family members in your household: _____

Name	Date of Birth	Relationship	Employed? FT or PT?*	Annual Income
			❑ Yes ❑ No ❑ FT ❑ PT	
			❑ Yes ❑ No ❑ FT ❑ PT	
			❑ Yes ❑ No ❑ FT ❑ PT	
			❑ Yes ❑ No ❑ FT ❑ PT	
			❑ Yes ❑ No ❑ FT ❑ PT	
TOTAL FAMILY HOUSEHOLD INCOME: (Add the annual income of each household member together)				

* FT = Full time, PT = Part-time

Self-Declaration of Income:

I certify that the information provided is accurate to the best of my knowledge. I understand that I will be asked to update this information twice per year. I understand I am fully responsible for my bill(s) if I do not comply with the above requirements.

Full Name (Print)	**Signature**
Today's Date	

Proxy Consent to Treat Minors

This form may be used to allow an adult other than a parent or legal guardian to serve as a proxy decision maker for routine medical and dental care and services at Island Health Care (IHC). For some families, it may be more convenient to have prior authorization in place that allows routine medical and dental care to be delivered to minors under the care of a proxy decision maker if a parent or legal guardian cannot be present to provide consent or to accompany the minor. If you would like to appoint a proxy decision maker, please review and complete the following form.

Authorization: I hereby appoint the below-named individual as a proxy decision maker to consent to and authorize routine health care, treatment and services for my child(ren) listed below.

Name (Print)	Relationship	Best Phone Number

Routine medical and dental care and interventions may include, but are not limited to: medical evaluation, physical exam, x-rays, lab work (examples include: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, cleaning of minor burns, minor suturing of lacerations, removal of simple cysts, contraceptive care, and incision and drainage of abscesses); dental examination, cleaning, fillings, extractions, and other routine dental procedures. IHC may also give immunizations, allergy shots and intramuscular/intravenous antibiotics pursuant to the consent of the proxy.

I hereby empower and grant the proxy decision maker appointed above permission to consent to and authorize routine medical and dental care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child(ren) listed below, and to receive protected health information directly relevant to and for the purposes of his or her involvement in this care or payment related to this care. More than one child may be listed.

Name of Minor	**Minor's Date of Birth** (MM/DD/YYYY)
Name of Minor 2	**Minor's Date of Birth** (MM/DD/YYYY)
Identify any specific limitations on the kinds of medical and dental services for which this authorization is given (if none, specify "none").	**Limitations**

The authorization is valid for (check one):

- ❑ Today's visit only
- ❑ From _____/_____/_____ to _____/_____/_____ (MM/DD/YYYY)
- ❑ Until revoked in writing by me

I hereby indemnify and hold harmless Island Health, Inc. and all its officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. The individual appointed as proxy (listed above) is permitted to make decisions on consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization.

Full Name (Print)	**Signature**	**Today's Date**

Authorization to Treat Unaccompanied Minor

Island Health Care

Minor patients between the ages of 14 and 18 may be seen by their Island Health Care provider for medical or dental care even if they are not accompanied by a parent, legal guardian, or designated proxy, so long as their parent or legal guardian has completed this form.

Patient's Name (Print)	**Patient's Date of Birth** (MM/DD/YYYY)

I, the undersigned, hereby authorize Island Health Care providers and clinical staff to administer such medical and dental treatment as is necessary for the above-named patient. I hereby certify that I have read and fully understand this authorization.

The authorization is valid for (check one):

- ❑ Today's visit only
- ❑ From _____/_____/_____ to _____/_____/_____ (MM/DD/YYYY)
- ❑ Until revoked in writing by me

By default, this consent will be valid for one year from today's date unless otherwise specified above.

I understand that it is my responsibility to ensure payment for the care and services my minor child receives from Island Health Care. I understand that I will be responsible for the payment of any and all services rendered, whether or not I have verified my care benefits with my insurance company. I hereby indemnify and hold harmless Island Health, Inc. and all its officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization.

Parent or Legal Guardian Name (Print)
Parent or Legal Guardian Signature
Today's Date (Month / Day / Year)

Permission to Verbally Discuss Protected Health Information

Island Health Care

I, _____ (*Your Name*), give my permission for Island Health Care to verbally discuss the information checked below with _____ (*Name of Relative or Friend*). Their phone number is (*optional*) _____.

❑ **All Clinical Information** (includes items below only if checked)

- ❑ STD, STI or HIV results
- ❑ Substance Use Disorder
- ❑ Domestic or sexual violence

❑ **All Financial Information**

❑ **Appointment Information** (includes items below only if checked)

- ❑ Behavioral health appointments
- ❑ Medical appointments
- ❑ Dental appointments

❑ **All Dental Information**

❑ **Mental Health Information** (includes items below only if checked)

- ❑ Treatment details, including:
  - Treatment / aftercare plan
  - Diagnosis & assessment
  - Medications
  - Discharge summary
  - Care team members
- ❑ Progress & program details, including:
  - Program services overview
  - Family service or education plan, goal attainment

Is there anything else we should know? Please be as specific as possible:

I understand that this permission is valid until there is a written revocation.

Patient's Signature	**Today's Date**
Print Name	**Date of Birth**

Notice of Privacy Practices

This notice describes how information about your health and health care may be used and disclosed and how you can get access to this information. Please review it carefully.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. This Notice applies to any services you receive through Island Health Care, including but not limited to, primary care, dental, and behavioral health.	
Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. ○ We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations.
	  ○ We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  ○ We will say "yes" unless a law requires us to share that information.
	• You may make these requests by sending an email to HIM@ihimv.org or calling 508-939-9358 and selecting option 7.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Notice of Privacy Practices

This notice describes how information about your health and health care may be used and disclosed and how you can get access to this information. Please review it carefully.

Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.	
In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.
We typically use or share your health information in the following ways.	

Notice of Privacy Practices

This notice describes how information about your health and health care may be used and disclosed and how you can get access to this information. Please review it carefully.

Treat you	• We can use your health information and share it with other professionals who are treating you. • Example: A doctor treating you for an injury asks another doctor about your overall health condition.
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary. • Example: We use health information about you to manage your treatment and services.
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities. • Example: We give information about you to your health insurance plan so it will pay for your services.
We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html	

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  ○ *Preventing disease*
	  ○ *Helping with product recalls*
	  ○ *Reporting adverse reactions to medications*
	  ○ *Reporting suspected abuse, neglect, or domestic violence*
	  ○ *Preventing or reducing a serious threat to anyone's health or safety*

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Notice of Privacy Practices

This notice describes how information about your health and health care may be used and disclosed and how you can get access to this information. Please review it carefully.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  ○ For workers' compensation claims
	  ○ For law enforcement purposes or with a law enforcement official
	  ○ With health oversight agencies for activities authorized by law
	  ○ For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities	• We are required by law to maintain the privacy and security of your protected health information. • We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. • We must follow the duties and privacy practices described in this notice and give you a copy of it. • We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. • For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html
Changes to the Terms of This Notice	• We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.
This Notice of Privacy Practices applies to the following organizations	Island Health Care Community Health Center 245 Edgartown-Vineyard Haven Road Edgartown MA 02539
HIPAA Privacy Officer	Privacy Officer: Deborah Noble, Chief Clinical Officer Phone: (339) 219-8768 Email: dnoble@ihimv.org

Notice of Patients' Rights

The below is a summary of Massachusetts General Law, Title XVI, Chapter 111, Section 70E, Patients' and Residents' Rights. For a copy of the complete law, ask the receptionist.

As A Patient of this Community Health Center, you have the right to:

1	Choose your doctor or nurse	**12**	Be alone with your doctor or nurse when they treat you
2	Get a bill with a list of charges	**13**	Be treated right away if you might die, even if you don't have insurance or cannot pay
3	Know the names and jobs of the people who take care of you	**14**	Know the facts about any test or treatment before you say yes to it
4	Have your records seen only by your doctor or nurse	**15**	Get copies of bills we send to other places that take care of you
5	Get an answer quickly when you ask something	**16**	Know how your doctor works with the other places that take care of you—including if he or she is paid by them
6	Know how we work with other places to take care of you	**17**	Get copies of bills to or payments from your insurer or health care program
7	Get a copy of our patient rules	**18**	For patients with breast cancer, to be told about all the ways it can be treated
8	Know about free and low-cost health care	**19**	For patients getting breast implants, to be told about all the risks
9	See your records and get a copy of them	**20**	For women having a baby, to know the facts about all the things we may do during labor and birth
10	Say no to having students or observers help take care of you	**21**	Get help with pain
11	Say no to being in research or education projects		

SOURCE: Massachusetts League of Community Health Centers