Nimkee
Memorial Wellness Center

2591 S. Leaton Rd.
Mt. Pleasant, MI 48858
Phone: 989.775.4600
Medical Fax: 989.775.4680
Dental Fax: 989.775.4957

Welcome to Nimkee Memorial Wellness Center (NMWC). We're glad you have chosen to register with us. Please fill out the registration forms completely to ensure we have all the necessary information to provide you with the best care possible. If you have any questions, our office is available at (989) 775 – 4670. For more information on our hours of operation, lab hours, Purchased Referred Care (PRC) information, on-call provider number, and other clinical information, please visit http://www.sagchip.org/nimkee. Thank you!

NMWC Business Office requires documentation to determine service eligibility. Patients, parents, guardians, pregnant persons, or eligible college students must submit the appropriate documentation below before services are rendered. You will be contacted once your eligibility has been determined; if you have not been notified within 24 – 48 business hours, please contact our office.

Eligible Service County Area(s): Isabella, Midland, Clare, Missaukee, & Arenac

1. Valid Tribal Membership Enrollment Card:
    a. Saginaw Chippewa Indian Tribal enrollment ID
    b. U.S federally recognized tribal enrollment ID *(residing in service area)* or verification letter

2. SCIT Direct Descendent:
    a. Original birth certificate
    b. Parent(s) SCIT Tribal enrollment ID

3. Social Security Card

4. All Insurance Card(s)

5. Two Residency Verification Documents: *current physical address only*
    a. Driver's License;
    b. State ID;
    c. Voter Registration Card;
    d. Lease Agreement;
    e. Vehicle Title;
    f. Envelope postmarked within the past 90 days. (*Including enrollees 's name)*

6. Newborn Children Only:
    a. Hospital birth certificate
    b. Parent(s) SCIT Tribal enrollment card
    c. Original birth certificate once received to complete registration

7. Pregnant Person: *Required in addition*
    a. Positive pregnancy test verification from OB/GYN

8. College Student: *Required in addition*
    a. Official letter/official transcripts from institute verifying full-time student enrollment

1. Patient Information

_____ _____ _____
(Last Name) (First Name) (MI)

_____/_____/_____ _____ _____
(Date of Birth) (Social Security Number) (Place of Birth)

_____ _____ _____ _____
(Physical Address) (City) (State) (Zip Code)

_____ _____ _____ _____
(Primary Phone) (Secondary Phone) (Work Phone) (E-Mail)

If Minor, child's parent/guardians name: _____

Gender: ☐Female ☐Male ☐Transgender **Ethnicity**: ☐Hispanic ☐Non-Hispanic or Latin

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Race:
☐American Indian/Alaska Native
☐Native Hawaiian/other Pacific Islander
☐Black/African American
☐White/Caucasian
☐Asian
☐Unknown

Preferred Language:
☐English
☐Spanish
☐Other _____
Interpreter Needed: ☐Yes ☐No

Do you have an Advanced Directive? ☐yes ☐no

2. Tribal Affiliation

_____ _____ _____
(Tribe of Membership) (Tribal Enrollment Number) (State where Enrolled)

3. U.S Veteran Status

Are you a U.S Veteran? ☐Yes ☐No

_____ _____ _____
(Service Entry Date) (Service Separation Date) (Vietnam Service)

4. Employment Status

Are you employed? ☐Yes ☐No; ☐Full-time ☐Part-time ☐Retired ☐Student

_____ _____
(Occupation) (Employer Name)

5. Emergency Contact

(First Name)	(Last Name)	(Relationship)	(Phone Number)
(First Name)	(Last Name)	(Relationship)	(Phone Number)

6. Contact Preferences

How would you like NMWC to contact you about your appointments? ☐ Home ☐Cell ☐Email

Would you like communication sent to you via email? (I.e., appointment reminders, updates, etc.) ☐Yes ☐No

Do you have internet access? ☐Yes ☐No What access do you have? ☐Internet ☐Mobile

Insurance Information

PRIMARY INSURANCE

(SUBSCRIBER NAME) (SUBSCRIBER ID #)

(SSN) (DATE OF BIRTH)

(INSURANCE NAME) (INSURANCE PHONE #)

(EFFECTIVE DATE) (TERMINATION DATE)

COVERAGE TYPE:
☐MEDICAL ☐PHARMACY ☐HOSPITAL ☐DME ☐DENTAL

ADDITIONAL POLICY MEMBERS & RELATIONSHIP

Insurance Information

SECONDARY INSURANCE

(SUBSCRIBER NAME) (SUBSCRIBER ID #)

(SSN) (DATE OF BIRTH)

(INSURANCE NAME) (INSURANCE PHONE #)

(EFFECTIVE DATE) (TERMINATION DATE)

COVERAGE TYPE:
☐MEDICAL ☐PHARMACY ☐HOSPITAL ☐DME ☐DENTAL

ADDITIONAL POLICY MEMBERS & RELATIONSHIP

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Insurance Billing Authorization

1. I authorize Nimkee Memorial Wellness Center of the Saginaw Chippewa Indian Tribe to bill my insurance carrier(s) for any and all services rendered by and through their facility.

2. I authorize my insurance carrier(s) to make direct payment to the Nimkee Memorial Wellness Center of the Saginaw Chippewa Indian Tribe for any and all services rendered by and through their facility. I also under- stand that I will not be billed for any services rendered at Nimkee Memorial Wellness Center except for Medical and dental labs.

3. I authorize Nimkee Memorial Wellness Center of the Saginaw Chippewa Indian Tribe to release any and all medical records concerning me to my insurance carrier(s) necessary to determine eligible benefits or the benefits payable for related services.

4. I have read and fully understand that this is a one-time signature authorization form for the Saginaw Chippewa Indian Tribe to authorize billing services to any and all of my insurance carrier(s), current and future.

5. I also understand that I will submit all new insurance information and cards in the event of a change, cancellation, addition, etc. I also understand that in the event of a name change, I will need to renew this form.

6. I have read and agree to the above paragraphs and authorize this implementation by my signature (if minor child) by parent/guardian signature.

Acknowledgment of Authorization

This authorization is to include carriers:

Medicare, Medicaid, Medigap, BC/BS, Railroad Retirement, and other insurance carriers not listed

_____
(Patient Name)

_____ _____
(Patient Signature) (Date)

_____
(Minor Child Name)

_____ _____
(Parent or Guardian Signature) (Date)

_____ _____
(NMWC Registration Staff Signature) (Date)

Saginaw Chippewa Indian Tribe of Michigan

Nimkee Memorial Wellness Center
Summary of Patient Rights & Responsibilities

PATIENT RIGHTS

- **The Right to Service Information.** Patients can access services from the hours of 8:00 a.m. – 5:00 p.m. Please call (989) 775-4600 regarding services available, after hours, and emergency care.
- **The Right to Accurate Information.** Patients are provided, to the degree known, information concerning their diagnosis, evaluation, treatment and prognosis. Patients are also entitled to have their patient information communicated to them in a clear language, or manner that is primarily used by the patient.
- **The Right to Choose.** Patients have the right to a choice of credentialed health care providers (and to know what credentials their provider holds). Patients also have the right to choose another provider (if another provider is available).
- **Being a Full Partner in Health Care Decisions.** Patients have the right to fully participate in all decisions related to their health care except when such participation is considered inadvisable. In this type of situation, patients who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.
- **Care without Discrimination.** Patients have the right to be treated with dignity, consideration, and respectful care from all staff of the Nimkee Memorial Wellness Center (at all times and under all circumstances). Patients must not be discriminated against in the marketing, or enrollment, or in the provision of health care services, consistent with the benefits covered in their policy and/or as required by law.
- **The Right to Privacy**. Patients have the right to communicate with health care providers in confidence and to have the confidentiality of their individually-identifiable health care information protected. Patients also have the right to review and request a copy of their own medical records and request amendments to their records.
- **The Right to Disclosure**. Patient disclosures and records are treated confidentially. Patients are given the opportunity to approve or refuse their release, except when the release is required by law.
- **The Right to Speedy Complaint Resolution.** Patients have the right to file grievances, in writing, regarding his/her care in accordance with the Patient Complaint/Grievance Policy. Nimkee Memorial Wellness Center activities and providers are covered through the Federal Torts Claims Act.
- **Right to an Advance Directive (Living Will, Durable Power of Attorney)**. Patients have a right to obtain and have an advance directive for health care decisions; to have your advance directive (if you have one) included in your medical record; and to have your directive followed to the extent medically appropriate and lawful.

PATIENT RESPONSIBILITIES

- **Appointments.** Please keep all scheduled appointments. If unable to keep the scheduled appointment, notification to the appropriate department is needed at least 24 hours in advance (unless there is as documented emergency).
- **Taking on New Responsibilities -** In a health care system that affords patient rights and protections, you as our patient, must also take greater responsibility for maintaining good health:
- **Late or Missed Appointments.** If you might be late to an appointment, it is important to call as we may not be able to guarantee you will be seen. You may need to be rescheduled for a different time and/or day.
- **Patient Conduct.** Please cooperate with all persons providing your care and treatment, and respect the property, environment and privacy of other patients.
- **Provision of Information.** It is important to provide accurate and complete information regarding your health problems and medical history by answering all questions as truthfully and completely as you can. Also, to inform the health care provider of any medications, including over-the-counter products, dietary supplements, and any allergies or sensitivities.
- **Ask Questions and Follow Instructions.** Please try to understand and follow instructions concerning your treatment and ask questions if you do not understand or need an explanation.
- **Transportation.** Please provide a responsible adult to transport him/her home from the Clinic and remain with him/her for twenty-four (24) hours, if required by his/her provider.
- **Medical Provisions.** It is important to inform your provider about any living will, medical power of attorney, or other directive that could affect your care.
- **Medical Center Charges.** Please be responsible providing payment for treatment and to be cooperative and timely in providing insurance information.
- **Refusal of Treatment/Accepting Consequences.** Please be aware of your responsibility for consequences following a decision to refuse treatment or instructions.
- **Contact Information.** Please provide an accurate contact phone number and address information at each visit.

_____
(Patient Name)

_____ _____
(Patient Signature) (Date)

Nimkee
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Letting your dentist know about any health issues or medications you're currently taking is a great idea. This way, they can tailor your dental treatment to fit your needs and make ensure the best possible care. So, don't hesitate to share any important information with your dentist!

Patient Health Assessment

_____ _____ _____
(Patient Name) (Date of Birth) (Today's Date)

Are you have any pain? ☐Yes ☐No; If yes, please specify _____

Women: ☐Pregnant or trying to get pregnant ☐Nursing ☐Menstrual Problems
Women: Total # of Pregnancies_____ ☐Yes ☐No; Are you currently breastfeeding?

☐Yes ☐No Are you currently under another physician's care?
If yes, complete the Authorization for Use or Disclosure of Protected Health Information Form
(you must sign the authorization with a Nimkee Staff as a witness)
☐Yes ☐No Do you use tobacco?
☐Yes ☐No Do you use controlled substances?
☐Yes ☐No Are you taking any medication, pills, or drugs?
☐Yes ☐No Have you ever been hospitalized or had a major operation? _____

Are you allergic to any of the following? ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Latex

List all other food, drugs, and substances to which you are allergic: _____

_____

List any prescription medications you take:_____

_____

Do you have any other medical concerns you would like us to know about?:_____

_____

Medical & Family History

Patient History, check all that apply now or in the past.

Family History includes mother, father, siblings, & grandparents.

Self	Family	None		Self	Family	None		Self	Family	None	
☐	☐	☐	Anesthetic Reaction	☐	☐	☐	Hepatic Disorder(s)	☐	☐	☐	Renal Disorder(s)
☐	☐	☐	Myocardial Infarction	☐	☐	☐	Hepatitis (A) (B) (C)	☐	☐	☐	Respiratory Disorder
☐	☐	☐	Alzheimer Disease	☐	☐	☐	Jaundice	☐	☐	☐	Asthma
☐	☐	☐	Sickle Cell Anemia	☐	☐	☐	HIV Infection	☐	☐	☐	Tuberculosis
☐	☐	☐	Bleeds Easily	☐	☐	☐	High Blood Pressure	☐	☐	☐	Epilepsy/Seizures
☐	☐	☐	Breast Cancer	☐	☐	☐	Migraine/Headache	☐	☐	☐	Stroke Syndrome
☐	☐	☐	Ovarian Cancer	☐	☐	☐	Osteoarthritis	☐	☐	☐	Drug Abuse
☐	☐	☐	Colon Cancer	☐	☐	☐	Osteoporosis	☐	☐	☐	Sleep Apnea
☐	☐	☐	Coronary Artery Disease	☐	☐	☐	Pancreatitis	☐	☐	☐	Thyroid Disease
☐	☐	☐	Diabetes Mellitus	☐	☐	☐	Psychiatric Disorder(s)	☐	☐	☐	Alcohol Abuse
☐	☐	☐	Glaucoma	☐	☐	☐	Anxiety Disorder(s)	☐	☐	☐	Other_____

Saginaw Chippewa Indian Tribe of Michigan

Health Factors

☐Yes ☐No Do you drink alcohol?
☐Yes ☐No Do you drink 4 or 5 drinks in 1 day?
☐Yes ☐No Have you ever tried cutting down on drinking?
☐Yes ☐No Do you get annoyed when people talk about your drinking?
☐Yes ☐No Do you feel guilty about your drinking?
☐Yes ☐No Have you ever had an “eye-opener” (A drink first thing in the morning?
☐Yes ☐No Is there a smoker in the home?
☐Yes ☐No Do you use smokeless tobacco?
☐Yes ☐No Are you a previous tobacco smoker?
Year Quit_____
☐Yes ☐No Do you use contraception?
Date of last Pap-Smear _____
Date of last Mammogram_____
Date of last Menstrual Period_____

Infants and Children Only:

☐Yes ☐No; Live in or regularly visit a house built before 1950? *(Including daycare, pre-school, and home of friend/relative)*

☐Yes ☐No; Live in or regularly visit a home built before 1978 with recent, ongoing, or planned renovations/remodeling?

☐Yes ☐No; Do you give your child any home or folk remedies?
If yes, explain_____

☐Yes ☐No; Have siblings, housemates, or playmates been followed or treated for lead poising?

☐Yes ☐No; Live near an active lead smelter, battery recycling plant, or other lead industry, or near a heavily traveled highway?

☐Yes ☐No; Live with an adult whose job or hobby involves exposure to lead?

☐Yes ☐No **Measles** *(Rubella)*
☐Yes ☐No **Mumps**
☐Yes ☐No **Varicella** *(Chicken Pox)*
☐Yes ☐No **Rheumatic Fever**
☐Yes ☐No **Heart Disease**
☐Yes ☐No **Leukemia**
☐Yes ☐No **Renal Disease**
☐Yes ☐No **Cancer**
☐Yes ☐No **Neonatal Jaundice**
☐Yes ☐No **Neonatal Feeding Problems**
☐Yes ☐No **Other**:_____

Surgical History:

☐Yes ☐No **Transfusions**
☐Yes ☐No **Adverse reaction to Anesthesia**
☐Yes ☐No **Easy Bruising Tendency**
☐Yes ☐No **Abdominal Aortic Aneurysm Repair**
☐Yes ☐No **Appendectomy**
☐Yes ☐No **Cholecystectomy** *(Gallbladder removal)*
☐Yes ☐No **Colostomy**
☐Yes ☐No **Hernia Repair**
☐Yes ☐No **Pancreatectomy**
☐Yes ☐No **Abdominal Wall Repair**
☐Yes ☐No **Small Bowl Resection**
☐Yes ☐No **Splenectomy**
☐Yes ☐No **Surgical treatment for Ulcer**
☐Yes ☐No **Tonsillectomy**
☐Yes ☐No **Coronary Artery Bypass Grafting**
☐Yes ☐No **Lung Surgery**
☐Yes ☐No **Thyroid Surgery**
☐Yes ☐No **Orthopedic Surgery**
☐Yes ☐No **Implant/Metal Placement/Artificial Joint**
☐Yes ☐No **Breast Reconstruction**
☐Yes ☐No **Cesarean Section Delivery**
☐Yes ☐No **Hysterectomy(Total/Partial)**
☐Yes ☐No **Tubal Ligation**

Nimkee
Memorial Wellness Center

Permission to Treat a Minor without a Parent / Legal Guardian Present

Please be advised that Nimkee Memorial Wellness Center requires parental or legal guardian consent before providing treatment for any non-life-threatening injuries or illnesses. To ensure that your child can receive prompt medical attention, we request that you complete this form, which grants us permission to treat your child if you are unable to accompany them to the clinic. Thank you for your cooperation in ensuring the safety and well-being of your child.

Please Note:

- A parent/legal guardian **MUST** be present for their child's first visit at Nimkee Memorial Wellness Center, Medical and Dental Clinics.
- Minors may not receive immunizations without a parent or guardian present.
- A minor must be at least 16 years of age to receive certain types of treatment in the Medical / Dental Clinic without a parent/legal guardian being present and must bring in a completed "Permission to Treat a Minor" form.
- In certain circumstances, in accordance with Tribal, State, and Federal laws, parent/guardian permission may not be needed for adolescents being seen for concerns of "heightened sensitivity" such as family planning, testing, counseling, and treatment for STI's.

Patient name: _____ Health Record Number:_____

Date of Birth: _____ Today's date: _____

I hereby authorize _____ *(an adult into whose care the minor has been entrusted) to* arrange for and authorize routine and emergency treatment at Nimkee Memorial Wellness Center.

[ ] Please initial here if you are authorizing a minor to seek and consent to treatment without an adult present. This consent applies to certain care, treatment, and procedures defined in the Nimkee Memorial Wellness Center policy for Medical / Dental Care of Minors.

In case of emergency, I can be reached at:

Primary phone:_____Secondary phone:_____

Work phone:_____ Other:_____

Signature: _____Date:_____
Parent/Legal Guardian

Printed Name:_____Relationship to patient:_____

☐ Check here if you would like the authorization to be valid for 1 year

☐ Check here if you would like the authorization to be valid ONLY for the date of the appointment

Notice of Privacy Practices

"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."

Effective date: April 14, 2003

I. Understanding Your Health Record/Information

Each time you visit Nimkee Memorial Wellness Center for services, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your health record, serves as a:

- Plan for your care and treatment. Communication source between the health care professionals.
- Tool with which we can check results and continually work to improve the care we provide.
- Means by which Medicare, Medicaid or private insurance payers can verify the services billed.
- Tool for education of health care professionals.
- Source of information for public health authorities charged with improving the health of the people.
- Potential source of data for medical research, facility planning and marketing (your name or identity would not be used).
- Legal document that describes the care you receive.

Understanding what is in your health record and how the information is used helps you to:

- Ensure its accuracy
- Better understand why others may review your health information
- Make an informed decision when authorizing disclosures

II. Your Health Information Rights

Although your health record is the physical property of the Nimkee Memorial Wellness Center, the information belongs to you.

You have the right to:

- **Inspect and receive a copy your health record**
- **Request a restriction** on certain uses and disclosures of your health information. For example, you could ask that we not disclose the treatment you had to a family member. Nimkee is not required to agree to your request; but if we do, we will comply with your request unless the information is needed to provide you with emergency services.
- **Request a correction/amendment to your health record** if you believe the health information we have about you is incorrect or incomplete.
- **Request confidential communications about your health information.** You can ask that we communicate with you at a location of your choice, e.g., you can ask that we contact you at work instead of at home or vice versa.
- **Receive a listing of the disclosures Nimkee has made** of your health information upon request. This information is maintained for six years.
- **Revoke your written authorization to use or disclose health information**. This does not apply to health information already disclosed or used.
- **Obtain a paper copy of the Nimkee Notice of Privacy Practices** upon request.

III. Nimkee Responsibilities

The Nimkee Memorial Wellness Center is required by law to:

- Maintain the privacy of your health information
- Inform you about our privacy practices regarding health information we collect and maintain about you
- Notify you if we are unable to agree to a requested restriction
-

- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Honor terms of this notice

Nimkee reserves the right to change its privacy practices and to make the new provisions effective for all protected health information it maintains. Nimkee will post any revised Notice of Privacy Practices in the reception areas and other public places of Nimkee as soon as possible after the revision. You may request a copy of the notice.

Nimkee understands that health information about you is personal and is committed to protecting your health information. **Nimkee will not use or disclose your health information without your permission, except as described in this notice and as permitted by the Privacy Act.**

IV. How Nimkee may use and disclose health information about you.

The following categories describe how we may use and disclose health information about you.

A. We will use your health information to provide your treatment.

For example: Your personal information will be recorded in your health record and used to determine the course of treatment for you. Your health care provider will document in your health record her/his instructions to members of your healthcare team. The actions taken and the observations made by the members of your healthcare team will be recorded in your health record so your health care provider will know how you are responding to treatment.

If Nimkee refers you to another health care facility or health care provider, Nimkee will exchange your health information with that health care provider for treatment decisions.

If you are transferred to another facility for further care and treatment, Nimkee will exchange information with that facility to enable them to know the extent of treatment you have received.

Your health care provider(s) may give copies of your health information to others to assist in your treatment.

B. We will use your health information for payment.

For example: If you have private insurance, Medicare, or Medicaid, a bill will be sent to your health plan for payment. The information on or accompanying the bill will include information that identifies you, as well as your diagnosis, procedures, and supplies used for your treatment.

If Nimkee sends you to another health care facility using Purchased Referred Care (PRC), Nimkee will exchange your health information with that provider for health care payment decisions.

C. We will use your health information for health care operations.

For example: We may use your health information to evaluate your care and outcomes. This information will be used to continually improve the quality and effectiveness of the services we provide. This includes health care services provided under Purchased Referred Care (PRC).

- **Business Associates**: Nimkee provides some healthcare services through contracts with business associates. Examples include: emergency room physicians, podiatry medicine, radiology, and laboratory tests. When these services are contracted, Nimkee may release your health information to business associates so that they can perform their job. We require our business associates to safeguard your health information.
- **Notification:** Nimkee may use or disclose information to notify a family member or personal representative about your care in an emergency situation.
- **Communication with Family or personal representative:** Nimkee health providers may disclose your health information to others as directed by you. For example, Nimkee may inform your family members, relatives, close personal friends or any other person you identify. This disclosure of health information is relevant to that person's involvement in providing care or payment for services.
- **Interpreters:** In order to provide you proper care and services, Nimkee may use the services of an interpreter. This may involve disclosing your personal health information.
- **Research:** Nimkee may disclose information for research purposes that has been approved by an Tribal Health Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- **Funeral Directors:** Nimkee may disclose health information to funeral directors as required by law to carry out their duties.
- **Organ Procurement Organizations:** Consistent with applicable laws, Nimkee may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- **Health Promotion:** Nimkee may contact you to provide information about other types of health-related benefits and services that may be of interest to you. Example: We may contact you about the availability of new services for diabetes.
- **Appointment Reminders***:* Nimkee, for example, may contact you with a reminder that you have an appointment for medical care at our facilities.

- **Treatment Alternatives:** Nimkee may recommend possible treatment alternatives and options that may be of interest to you, using your health information. Example: We may refer for acupuncture.
- **Food and Drug Administration (FDA):** Nimkee may disclose to the FDA your health information, if you have experienced adverse events with food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- **Workers Compensation:** Nimkee will disclose health information to workers compensation as required by law.
- **Public Health:** Nimkee will disclose, as required by law, your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, charged with receiving reports of child abuse or neglect, and charged with receiving information of abuse, neglect, or domestic violence. Nimkee may disclose your health information to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- **Correctional Institution:** Should you be an inmate of a correctional institution, Nimkee may disclose to the institution, health information necessary for your health and the health and safety of other individuals.
- **Law Enforcement:** Nimkee may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.
- **Members of the Military:** If you are a member of the military services or U.S. Public Health Service Commissioned Corps, Nimkee may disclose your health information to your military command authorities.
- **Health Oversight Authorities**: Nimkee may disclose health information to health oversight authorities for activities authorized by law. These oversight activities include: investigations, audits, inspections and other actions. These are necessary for the government to monitor the health care system, government programs, and monitor compliance with civil rights laws.

  Federal law makes provision for your health information to be disclosed to an appropriate health oversight agency, public health authority or attorney. This health information may be disclosed, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.
- **Non Violation of this Notice:** Nimkee is not in violation of this Notice or the HIPAA Privacy Rule if any of its employees, business associates or contractors discloses information under the following circumstances:
- **Disclosures by Whistleblowers:** If an Nimkee employee, business associate or contractor in its judgment and in good faith believes that Nimkee has violated or is violating clinical and professional standards that has the potential of endangering patients or members of the public and discloses such information to:
  a. Public Health Authority, Health Oversight Authority, accrediting agencies or any other agency for the purpose of investigating the violation or complaints.
  b. To an attorney on behalf of the workforce member, business associate or contractor or hired by the workforce member, business associate or contractor for the purpose of determining their legal options regarding the suspected violation.
- **Disclosures by Workforce Member Crime Victims:** A Nimkee employee who is a victim of a crime on or off the clinic premises may disclose information about the suspect to law enforcement official provided that:
  a. The information disclosed is about the suspect who committed the criminal act.
  b. The information disclosed is limited to identifying and locating the suspect.

Any other uses and disclosures will be made only with your written authorization, which you may later revoke in writing at any time.

To exercise your rights under this Notice, to ask for more information, or to report a problem

You must contact the Nimkee HIPAA Coordinator in writing at:

C/O HIPAA Coordinator
Nimkee Memorial Wellness Center
2591 South Leaton Road
Mt. Pleasant, MI 48858

If you believe your privacy rights have been violated, you may file a written complaint with the above individual or the Secretary of Health and Human Services, U.S. Department of Health and Human Services, Washington, D.C. 20201. There will be no retaliation for filing a complaint.

Effective Date: April 14, 2003

Acknowledgment of Receipt of

Nimkee Memorial Wellness Center

Notice of Privacy Practices

I hereby acknowledge receipt of the Nimkee Memorial Wellness Center Notice of Privacy Practices at:

Nimkee Memorial Wellness Center

2591 South Leaton

Mt. Pleasant, MI 48858

_____

(Print Patient Name)

_____ _____

(Patient Signature) (Date)

_____ _____

(NMWC Registration Staff Signature) (Date)

For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the Nimkee Notice of Practices because:

_____

_____ _____

(NMWC Registration Staff Signature) (Date)