



**Aunt Martha's Health Center**  
**Patient Registration Form – PEDIATRIC**

NextGen Record # \_\_\_\_\_

PATIENT INFORMATION			
Today's Date	Last Name	First Name	Middle
Date of Birth	Age	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address		City	State    Zip Code
<b>Primary Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		<b>Do you have Advance Directives for Health Care?</b> (i.e., Living Will or Power of Attorney) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not Sure	
<b>Social Security Number:</b> _____		<b>Marital Status:</b> <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Life Partner <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Unknown <input type="checkbox"/> Widowed	
<b>Home Phone Number:</b> (____) _____ May we leave a message at your home phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Contact Preference:</b> <input type="checkbox"/> Home Phone <input type="checkbox"/> Daytime Phone <input type="checkbox"/> Alternate Phone <input type="checkbox"/> No Phone Contact	
<b>Daytime Phone Number:</b> (____) _____ May we leave a message at your daytime phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Alternate Phone Number:</b> (____) _____ May we leave a message at your alternate phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>If the patient is in 8<sup>th</sup> grade or under, please indicate School District # and School Name. If not, indicate N/A.</b> <input type="checkbox"/> 8 <sup>th</sup> grade and under <input type="checkbox"/> N/A School District # _____    School Name: _____			
<b>Is the patient enrolled in Illinois Health Connect?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure (Need clarity from Registration Staff)			
SPECIAL NEEDS / ADDITIONAL DEMOGRAPHIC INFORMATION			
<b>Do you have any of the following impairments?</b> Sight <input type="checkbox"/> No <input type="checkbox"/> Yes Sound <input type="checkbox"/> No <input type="checkbox"/> Yes Verbal <input type="checkbox"/> No <input type="checkbox"/> Yes Recent Trauma <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>Educational Mechanism</b> Verbal instructions given _____ Written instructions given _____	
		<b>Special Religious Concerns</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain: _____	
<b>Homeless Status:</b> <input type="checkbox"/> Not Homeless <input type="checkbox"/> Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Doubling Up <input type="checkbox"/> Street <input type="checkbox"/> Unknown			
<b>Migrant Worker Status:</b> <input type="checkbox"/> Not a farm worker <input type="checkbox"/> Seasonal <input type="checkbox"/> Migrant			
<b>Language Barrier:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>Veteran Status:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Race:</b> <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White		<b>Ethnicity:</b> <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Non Hispanic <input type="checkbox"/> Unknown Ethnicity	
<b>How did you hear about our services? (check all that apply)</b> <input type="checkbox"/> Flyer <input type="checkbox"/> Sign <input type="checkbox"/> Radio <input type="checkbox"/> T.V. <input type="checkbox"/> School <input type="checkbox"/> Health Fair <input type="checkbox"/> Billboards <input type="checkbox"/> Mailing <input type="checkbox"/> Church <input type="checkbox"/> Presentation <input type="checkbox"/> Phone Book <input type="checkbox"/> Family/Friend <input type="checkbox"/> Internet/Website <input type="checkbox"/> Current Patient <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan _____ <input type="checkbox"/> Hospital _____ <input type="checkbox"/> Social Services Agency _____ <input type="checkbox"/> Aunt Martha's Employee _____			

**EMERGENCY CONTACT**

Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_  
 ( )

**RESPONSIBLE PARTY**

Parent/Legal Guardian/Responsible Party: **IF SAME AS PATIENT, please check box**

Mr.  Miss  Mrs.  Ms.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_ Previous Last Name \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Relationship to Pt. \_\_\_\_\_ Gender:  Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
 Primary Phone Number \_\_\_\_\_ Alternate Phone Number \_\_\_\_\_

**INSURANCE INFORMATION**

*Please show your insurance card and picture identification to the receptionist. Income verification is required for all patients, regardless of insurance status.*

Person Responsible for Bill: **IF SAME AS PATIENT, please check box**

Is this person a patient here?  No  Yes Is this person covered by insurance?  No  Yes

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Primary Phone Number \_\_\_\_\_ Alternate Phone Number \_\_\_\_\_

**• PRIMARY INSURANCE**

Please indicate primary insurance:

Medicaid  Medicare  Illinois Health Connect  Harmony / HMO  Private Insurance / PPO  None

Policy Holder's Name \_\_\_\_\_ Policy/Recipient ID # \_\_\_\_\_

\$ \_\_\_\_\_ Patient's Relationship to Policy Holder:  Self  Spouse  Child  Other \_\_\_\_\_

Co-Pay / Deductible \_\_\_\_\_

**• SECONDARY INSURANCE**

Name of Secondary Insurance (if applicable) \_\_\_\_\_ Policy/Recipient ID# \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**INCOME VERIFICATION / HEAD OF HOUSEHOLD FAMILY SIZE / INCOME**

Family Size: \_\_\_\_\_ Family Combined Income: \$ \_\_\_\_\_ Per Week / Month / Year Annualized Income: \$ \_\_\_\_\_

**OFFICE USE ONLY:**Signature Forms

Patient Registration Form is Signed and Dated:  YES  NO  
 Medical Consent/HIPAA is Signed and Dated:  YES  NO

Sliding Fee Forms (Uninsured Patients)

Sliding Fee Application:  YES  NO  N/A  
 Current Income Documentation:  YES  NO  N/A  
 Current Financial Waiver:  YES  NO  N/A  
 Slide has been assigned:  YES  NO  N/A

Income Re-Certify Date: \_\_\_\_\_ Staff Signature: \_\_\_\_\_

**Authorization:** With my signature I certify that all of the information provided on the patient registration forms is correct to the best of my knowledge. I authorize the release of any medical or other pertinent information necessary to process claims pertaining to Aunt Martha's Health Center visits.

X \_\_\_\_\_  
 Signature of Patient / Parent or Legal Guardian

\_\_\_\_\_  
 Date



**AUNT MARTHA'S HEALTH CENTER**  
**Consent for Medical Services**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby consent to receive medical services from Aunt Martha's Health Center. I understand that I may revoke my consent in writing at any time. I also understand that any information regarding my medical history or treatment will remain confidential unless disclosure is required under existing state and federal laws. I consent to the release of my medical history and care to Medicaid, Medicare, Insurance companies, Reviewing and Accreditation Organizations and other Aunt Martha's programs.

_____ Patient Signature	_____ Date
_____ Parent/Guardian/Representative Signature	_____ Date
_____ Staff Witness Signature	_____ Date

---

**Receipt of Advance Directives Information,  
Client's Rights and Responsibilities and Notice of Privacy Practices**

*(Advance Directives does not apply to Pediatric patients)*

By signing below, I acknowledge that Aunt Martha's has provided me with a copy of an *Introduction to Advance Directives, Clients Rights and Responsibilities and Notice of Privacy Practices*. I have received my copies, I have read and understand the information provided to me.

_____ Patient Signature	_____ Date
_____ Parent/Guardian/Representative Signature	_____ Date
_____ Staff Witness Signature	_____ Date.



# PATIENT HEALTH QUESTIONNAIRE

## Nine Symptom Depression Check List (For patients ages 11 and older)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Over the **last two weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way **	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**\*\*If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your doctor or Health Care Clinician. If these kinds of thoughts happen when no one is available, go to a hospital emergency room, or call 911.**

2. If you have checked off **any** problem on this questionnaire so far, how **difficult** have these problems made it for you to work, take care of things at home, or get along with people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

<b>(For Clinic Staff Only)</b>	Add columns: _____ + _____ + _____
<b>Total # of Symptoms:</b> _____	<b>Total Score:</b> _____

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_



## DENTAL HEALTH ASSESSMENT

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

In order for Aunt Martha's to provide you quality health care, we need to know about you. Please answer the following questions honestly. Check the appropriate box for each question.

1. When is the last time you had a dental exam?  
 Less than 6 months ago  
 6 months – 1 ½ years ago  
 More than 1 ½ years ago  
 I don't know
2. When is the last time you had your teeth cleaned?  
 Less than 6 months ago  
 6 months – 1 ½ years ago  
 More than 1 ½ years ago  
 I don't know
3. Do your gums bleed when you brush your teeth?  
 Yes  
 No  
 I don't know
4. Do you have pain in your mouth?  
 Yes  
 No  
 I don't know

---

## ASESORAMIENTO DE SALUD DENTAL

Nombre: \_\_\_\_\_

Fecha de hoy: \_\_\_\_\_

Número de teléfono: \_\_\_\_\_

Fecha de nacimiento: \_\_\_\_\_

Para que Aunt Martha's pueda proveerle calidad en su atención médica, por favor conteste las siguientes preguntas con honestidad. Marque la respuesta para cada pregunta.

1. ¿Cuándo fue la última vez que usted tuvo un examen dental?  
 Menos de 6 meses  
 6 meses – 1 ½ años  
 Mas de 1 ½ años  
 No sé
2. ¿Cuándo fue la última vez que usted tuvo una limpieza de dientes?  
 Menos de 6 meses  
 6 meses – 1 ½ años  
 Mas de 1 ½ años  
 No sé
3. ¿Sus encías sangran cuando se cepilla los dientes?  
 Sí  
 No  
 No sé
4. ¿Tiene usted dolor en la boca?  
 Sí  
 No  
 No sé

### For office use only

Reviewed by: \_\_\_\_\_

Signature

Date

Referred?  Yes  No



## AUNT MARTHA'S HEALTH CENTER PEDIATRIC HEALTH HISTORY FORM

<b>Child's Name</b>		Date	
Child's Previous Doctor/Primary Care Provider		DOB	Age
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		Race	
Allergies/Reactions:			
Mother's Name:	Address:	Phone #:	
Father's Name:	Address:	Phone #:	
Siblings:			
Obstetrician:			
Pregnancy History:			
<b>PRESENT HEALTH CONCERNS</b>	<b>MEDICATIONS/VITAMINS</b>	<b>HERBS/HOME REMEDIES</b>	
<b>BIRTH / DEVELOPMENT / FEEDING</b>			
1. Gestational Age:	Delivered by: <input type="checkbox"/> Vaginal Birth <input type="checkbox"/> Caesarean If caesarean, why:		
2. Birth Weight:	Birth Length:	HC:	
3. Was your child breastfed? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, how long?			
4. Was your child formula fed? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, what type?			
5. Does your child communicate verbally? <input type="checkbox"/> No <input type="checkbox"/> Yes			
<b>FAMILY HISTORY</b>		<b>PATIENT HISTORY</b>	
Does any family member have: (check applicable)		Illnesses / conditions: (check applicable)	
<input type="checkbox"/> Asthma/allergies	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Pertussis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Measles	<input type="checkbox"/> Anemia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Rubella	<input type="checkbox"/> Headaches
<input type="checkbox"/> Cancer	<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Mumps	<input type="checkbox"/> Dental Work
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Infant Deaths	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Vision
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Hearing
<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Seizure	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Immunological Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Heart
<input type="checkbox"/> Seizures	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Kidney / UTI
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Smoker in the home	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Infectious Disease
<input type="checkbox"/> Alcoholism/Drug Abuse	<input type="checkbox"/> Other	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Elevated Lead
<input type="checkbox"/> Mental Illness		<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Other
<b>SOCIAL HISTORY (Please answer C = current, P = past, V = victim, W = witness, B = both, or N/A)</b>			
Suicidal			
Violent Behavior			
Physical Abuse	DCFS Involvement? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Verbal Abuse			
Sexual Abuse			
Assault			
Murder			
<b>Habits</b>	<b>Amount</b>	<b>How often</b>	<b>How long</b>
Tobacco <input type="checkbox"/> No <input type="checkbox"/> Yes			
Alcohol <input type="checkbox"/> No <input type="checkbox"/> Yes			
Drugs <input type="checkbox"/> No <input type="checkbox"/> Yes			
<b>PARENT / LEGAL GUARDIAN</b>			
Do need help with your own basic needs? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## AUNT MARTHA'S HEALTH CENTER CLIENT'S RIGHTS AND RESPONSIBILITIES

---

Aunt Martha's Health Center is dedicated to providing clients with the best possible care to meet their identified needs. To accomplish this, we believe it is critical to include our clients and parents/legal guardians, when applicable, in all decisions that directly impact our team.

It is the duty of Aunt Martha's staff to inform you of your rights and program responsibilities before the commencement of services in a language or method of communication that you will understand. These rights are protected and promoted by agency staff.

---

- You have the right to Confidentiality of information which is governed by the Health Insurance Portability and Accountability Act of 1996 and state law where applicable. Your personal information will be used only as described in the Notice of Privacy Practices, unless written authorization is given to you or your legal guardian, if applicable, except as required by law.
- You have the right to be informed of the nature, availability (including hours which care is available) and goals of all services to which you are otherwise entitled through the agency or other resources.
- You have the right to receive services with adequate and human care in the least restrictive environment.
- You have the right to receive services regardless of age, sex, race, religious belief, ethnic origin, or impairment. However, if you are under the age of 18, your parent or legal guardian's permission is needed, unless you are seeking Family Planning services and you are 12 years of age or older.
- You have the right to be free from abuse, neglect, or exploitation. You will not be subjected to any type of punishment that violates your rights such as corporal punishment, ridicule, humiliation, verbal abuse, or any other means of discipline which would lessen your sense of dignity and value as a person.
- You have the right to view your client record and examine its contents in the presence of a staff member qualified to interpret the file contents. You may request that a statement of clarification be included in your record should you find any discrepancies.
- You or your legal guardian have the right to file a grievance or appeal decisions of the provider up to and including the executive director or comparable position and be informed of the outcome of the petition.
- You or your legal guardian has the right to refuse services, including medications. You will be informed of alternative services available and the risks of such alternatives, if any, as well as the possible consequences of refusal of such services.
- Treatment and/or services will not be denied, reduced, suspended, or terminated for exercising any of your rights.
- You will be made aware of any fees or payment policies that pertain to the services provided. In clinical programs, an inability to pay will not be the sole determining factor in your admission or discharge from any services.
- You have the right and responsibility to be involved in any and all care decisions.
- You have the right to be informed about any financial programs related to your care, treatment, or services.
- You have the responsibility to provide relevant information to clinic staff and to the physician or medical provider to the extent that you are able.
- You have the responsibility to ask questions if you do not understand instructions that are given to you.
- You have the responsibility to accept consequences that may occur as a result of decisions that you make, actions that you take, or inaction.
- You have the responsibility to follow rules and regulations specific to our facility.
- You have the responsibility to show respect to other patients and staff.
- You have the responsibility to make an effort to pay treatment related bills for which you are responsible.

## NOTICE OF PRIVACY PRACTICES

Aunt Martha's Health Center is a covered entity under HIPAA (Health Insurance Portability and Accountability Act). As a covered entity, Aunt Martha's is committed to ensuring that your private health information is treated confidentially. This notice describes instances when your health information may be disclosed (used outside of Aunt Martha's). Other than the disclosures described in this notice, your health information will not be disclosed without your signed authorization.

### Use of Information for Treatment, Payment and Operations

1. In order to provide good medical care to you (treatment), obtain payment for services (payment), and ensure quality and efficiency in our daily functions (operations), there will be times when we must share information outside of this organization:
  - a. An example which may occur under treatment would be calling a physician or hospital to which we are referring you and providing them with information about your condition.
  - b. For payment purposes, we might send information to your insurance company, required in order to process your bill.
  - c. For operations, we might allow your chart to be reviewed by an external reviewer or auditor.
2. In the above instances, your personal health information may be disclosed. Under each of these circumstances, the entities that review your information will be either bound by federal law or otherwise have a responsibility to keep your personal information confidential.
3. Information that we may release under these circumstances would not be limited to and could include information regarding HIV infection, substance abuse, and /or psychiatric illness.
4. You may request restrictions beyond those stated in this notice but our organization is not required to abide by the restrictions requested unless we agree to do so.

### The Right to Inspect and Amend Records

- You have the right to inspect your medical/client record or any other document owned by Aunt Martha's that contains your personal health information with rare exceptions.
- If you believe that any information inspected is inaccurate, you have the right to request that the information be changed so that it is accurate.
- A request to inspect or amend your health information must be in writing. Should you make such a request, it will be evaluated by Aunt Martha's Privacy Officer or designee to determine if the request to inspect your health information and/or the requested change in your health information should be allowed.
- You will be informed of a decision (for inspection or amendment/change of record) within a reasonable period of time.
- If a decision is made to change the information as requested, an effort will be made to inform other entities who may receive inaccurate information.
- However, if it is determined that no change is warranted, you will be informed of this decision as well. You may appeal this decision by resubmitting the request for the change in writing and stating in that request that you are now appealing a previous decision.
- Upon receipt of the second request, the records will be reevaluated by a licensed physician who was not involved in your treatment or in the decision to deny the initial request. The decision at this second level of review will be final.

### Disclosure of Research

- It is possible that your health information might be accessed by a researcher.
- Such access will not be allowed under any circumstances unless the researcher has clearly demonstrated that your health information will be treated confidentially and that protective measures are put in place to ensure that unauthorized access does not occur.
- In these situations, if feasible, you will be contacted and your permission will be asked to allow your information to be utilized for this purpose.
- Whether you allow or don't allow your information to be used, your services at Aunt Martha's will not be affected. Your treatment will in no way be conditioned upon your approval.



- In situations where it is feasible to obtain your approval, your information may still be used (but not in instances where you have requested that your information not be used) provided that the researcher has demonstrated that appropriate steps will be taken to protect your identity, that protective measures are in place to prevent unauthorized access, and that any information pertaining to your identity will be destroyed as early in the research as possible.
- Any disclosure beyond that described above will generally require you to sign an authorization form except under rare and extenuating circumstances.
- Aunt Martha's has formed a Corporate HIPAA Compliance Committee which is responsible for overseeing the implementation of Aunt Martha's HIPAA compliance efforts and ensuring that your personal health information is treated confidentially. Members of this committee, including those who are responsible for investigating complaint, are listed below:
  - Chief Executive Officer      Raul Garza
  - Medical Director              Jennifer Byrd
  - Complaint Recipient         Ernest Gonzalez
- You may submit a complaint verbally or in writing to either the complaint recipient or to this location. If you leave a voicemail message, include your name, patients/client's name and details about the complaint.
- Furthermore, at your discretion, you may complain to any members of the committee listed above. Additionally, if you believe that your rights to privacy have been violated, you have the right to complain to the Secretary of the Department of Health and Human Services in the Office of Civil Rights.
- This privacy notice may be subject to change. If a change should occur, the change will be posted in our waiting area and on our website at the time of implementation or as soon as possible after implementation. You may request a current notice at any time verbally or in writing.