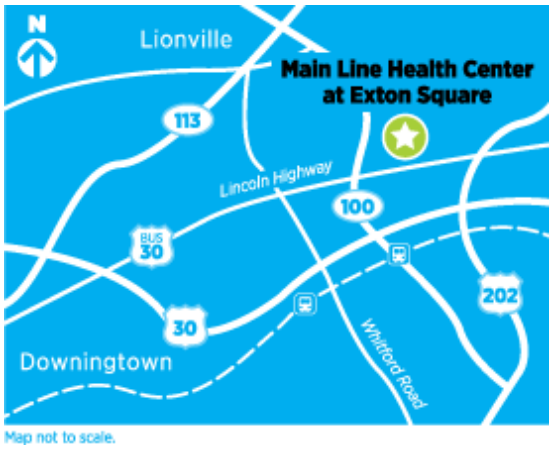
Occupational & Travel Health
484.565.1293

Main Line Health Exton Square

154 Exton Square Parkway
Exton, PA 19341
(Route 30 entrance)



MLH Occupational & Travel Health at Exton Square is located on the first floor of the mall near Macy's with both an interior and exterior entrance. We offer complimentary valet patient parking available Monday-Friday, 8:00am – 6:00 pm. We also have dedicated free parking spots, including spaces for patients with special needs and covered parking on the first floor of the Carriage Garage. As you enter our health center check-in at the registration HUB located in the middle of the facility, for your appointment.

Main Line Health Occupational and Travel Health
Traveler's History Form

Last Name:_____ First Name:_____

DOB: _____ Gender: _____

	Yes	No
High Blood Pressure		
Cardiac conduction defect ,arrhythmia, pacemaker		
Heart disease or Heart Surgery		
Antidepressant or psychiatric medications		
Depression, anxiety, panic attacks		
Diabetes		
Asthma or other Respiratory (lung) disease		
Intestinal problems, heartburn, stomach ulcer		
Psoriasis or other skin disease		
Muscle or bone problems, history of tendon rupture		
History of kidney or liver problems		
Alcohol or drug abuse		
History of altitude illness		
Surgery or hospitalization in past 5 years		
Spleen removal		
History of DVT or clotting problems		
Past Problems with antimalarial medications		

Please explain any yes answers:_____

_____

_____

Current medications, prescribed or over the counter:_____

_____

Allergies: _____

Are you under the care of a physician for any problem not noted above:_____

Is there any additional information you think we should know in anticipation of your trip: _____

Traveler's Signature and Date: _____

Travel Consultant's Notes: _____

Travel Consultant's Name, Signature and Date: _____

Main Line Health Occupational and Travel Health
Pre-Vaccination Questionnaire

Name:_____ Date of Birth: _____

Company Name:_____ Date: _____

Pre-Vaccine Questions

Answer all questions below:	Y	N
1. Acute illness or fever in the past 48 hours?		
2. Any serious reaction after receiving a vaccine?		
3. Ever fainted from an injection or blood draw?		
4. Received any vaccine in the past 4 weeks, including the COVID-19 vaccine? List (include dates)		
5. Allergic reaction to medications (*list below*), food, yeast, eggs, gelatin, latex, or vaccine component?		
6. Allergic reaction to mercury, thimerosal, aluminum, phenoxyethanol, formalin, neomycin, streptomycin, polymixin, chlortetracycline, amphotericin?		
7. History of cancer, leukemia, HIV/AIDS, organ or bone marrow transplant, immune system problem?		
8. In the past 3 months taken cortisone, prednisone, steroids, anticancer drugs, radiation treatments or any medications that weaken the immune system?		
9. In the past year: received transfusion of blood or blood products, taken antiviral drugs or received immune (gamma) globulin?		
10. History of seizure, epilepsy, Guillain Barre, multiple sclerosis, or other brain or nervous system problem?		
11. History of thymus disorder, myasthenia gravis, thymoma, or DiGeorge syndrome?		
12. History of bleeding disorder or taking any anticoagulant medications?		
13. Do you live with someone with AIDS, immune disorder or on chemotherapy?		
14. I understand if I am receiving an MMR, varicella, zoster, typhoid oral or yellow fever vaccine that I should not receive a tuberculosis skin test or QFT tuberculosis test for 6 weeks after the vaccine.		
15: Females only: Are you currently pregnant or breastfeeding? *(note: optimal time for TDAP is 27-36 weeks)*		
16. Females only: I understand if I am receiving an MMR, varicella, typhoid oral or yellow fever vaccine that I understand I must avoid pregnancy for 2 months after receiving the vaccine.		
17. Other: _____		

Please list your allergies:_____

Please list your current medications:_____

Patient Signature:_____ Date: _____

Office Use Only:

Temperature:_____ **Pregnancy Test Results (required for live vaccines and Tdap)** _____

_____ _____

MA/Nurse Name (please print) **MA/Nurse Initials**

Approval to give the following vaccines today:

_____ Provider Signature:_____

_____ Provider Signature:_____

_____ Provider Signature:_____

_____

_____

MLH Occupational and Travel Health
Phone: 484.565.1293

Authorization for Disclosure of Health Information
FROM
Occupational and Travel Health

I hereby authorize **OCCUPATIONAL AND TRAVEL HEALTH** to release medical information from the records of:

Name: _____ Date of Birth: _____

Company Name: _____ Date: _____

Covering the period(s) of care (list applicable dates of treatment:_____
Information to be disclosed (check all applicable items to be released; for a complete chart copy, place a check in all boxes)
☐ Xray Reports Other (please specify):_____

I understand that this will include information relating to (check if applicable to the patient's records):
☐ AIDS/HIV ☐ Psychiatric Care/Treatment ☐ Treatment for Drug or Alcohol use/abuse

This information is to be disclosed to:

_____ (Print Name of Whom is to Receive the Information)

_____ (Print Street Address of Receiver of the Information)

_____ (Print City, State, Zip of Receiver of the Information)

_____ (Print Telephone Number of Receiver of the Information)

For the purpose of (if required):_____

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken to comply with this request. This authorization will automatically expire in six (6) months unless otherwise revoked or indicated to expire on _____ (date not to exceed six months). In accordance with PA state law, I understand that there is a fee for obtaining copies of records, except for copies mailed directly to a healthcare facility or physician. I understand and agree to pay the $20.00 fee charged by Record Reproduction Services. I have been informed this release may take up to two weeks.

_____ _____ _____
(Signature of Patient or Legal Guardian) (Relationship to Patient) (Date)

_____ _____
(Signature of Witness) (Date)

Main Line Health

Acknowledgement of Receipt of Notice of Privacy Notice

By signing below, I acknowledge receipt of the *Notice of Privacy Practices* of Main Line Health ("MLH"). In addition, by signing below, I authorize MLH to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

_____		_____
Signature of Patient	or	Signature or Personal Representative
_____		_____
Patient Name – PRINT		Personal Representative's Name- PRINT
_____		_____
Date / Time		Date / Time
		_____
		Relationship to Patient

Inability to Obtain Acknowledgement

(To be completed only if no signature is obtained).

No acknowledgement of receipt of Privacy Practices was obtained from the patient because:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining the acknowledgement
- □ Other (Please specify):

_____	_____
Signature of MLH Representative	Date / Time

Rev. 07/13

NOTICE OF PRIVACY PRACTICES

I. Who we are

This Notice describes the privacy practices of the Main Line Health System (MLHS) which includes Bryn Mawr, Lankenau and Paoli Hospitals, Bryn Mawr Rehabilitation Hospital, Jefferson Health Ambulance, Main Line HealthCare Physicians, Main Line/Rehabilitation Affiliates, Main Line Clinical Labs and the Home Care Network of the Jefferson Health System.

While treating you, our employees, volunteers, students and health care professionals affiliated with MLHS follow this Notice. In addition, any person involved in your care, entities, sites and locations may share medical information about you with each other for treatment, payment or health care operations as described in this notice.

We are required by law to maintain the privacy of your health information and to provide you with this Notice.

II. Our Duties to Safeguard your Protected Health Information (PHI)

Protected Health Information is any information related to your health care that is shared or maintained in any manner. It includes your insurance information as well. This Notice applies to all of your medical information generated by the health system or any of its entities.
This Notice will tell you about the ways in which we may use and disclose your medical information. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this Notice of our legal duties and privacy practices related to your medical information; and,
- follow the terms of the Notice that is currently in effect.

III. How Main Line Health System May Use and Disclose Medical Information About You – Treatment, Payment and Health Care Operations.

Treatment. We may use and disclose protected health information (PHI) about you in connection with your treatment, for example to diagnose you. In addition, we may contact you to remind you about appointments, give you instructions prior to tests or surgery, or inform you about treatment alternatives or other health related benefits or services. We may also disclose your medical information to other providers, doctors, nurses, technicians, medical students, hospital personnel or other health care facilities involved in your treatment. We may need to communicate this medical information to other health care providers using phone or fax.

Payment. We may use and disclose medical information about you to obtain payment for services we provide to you. For example, we may contact your insurance company to pay for the services you receive, to verify that your insurer will pay for the services, to coordinate benefits or to collect any outstanding accounts.

Health Care Operations. We may use and disclose your PHI for health care operations which include: activities related to evaluating treatment effectiveness, teaching and learning purposes, evaluating the quality of our services, investigating complaints related to service, fundraising activities and marketing activities.

IV. Other Uses and Disclosures of Your PHI for which authorization is not required.

Incapacity or Emergency Circumstances. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure to relatives and/or close friends is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that is directly relevant to the person's involvement with your health care.

Marketing. We may use or disclose Protected Health Information to identify health-related services that may be beneficial to your health, such as notification of a new physician and/or additional services, and then contact you about those services. If you do not wish to receive information of this type, please contact Marketing at:

Main Line HealthCare Marketing Department
2 Industrial Boulevard, Suite 400
Paoli, PA 19301

Public Health Activities. **We may disclose information about you for public health activities including the following:**

- Y **Reporting births or deaths**
- Y To prevent or control disease, injury or disability
- Y To report child abuse or neglect
- Y To report reactions to medications or problems with products
- Y To notify individuals who may have been exposed to a disease or may be at risk for contracting a disease or condition
- Y Reporting information to your employer as required by laws addressing work-related illnesses and injuries or workplace medical surveillance

Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may, in accordance with current Pennsylvania law, disclose your PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

Health Oversight Activities. We may disclose your PHI to a health oversight agency that is responsible for ensuring compliance with rules of government health programs such as Medicare and Medicaid. These oversight activities include, for example, audits, investigations, inspections and licensure.

Legal Proceedings and Law Enforcement. We may disclose your PHI in response to a court order, subpoena, or other lawful process.

Deceased Persons. We may release medical information to a coroner or medical examiner authorized by law to receive such information.

Organ and Tissue Donation. We may disclose your PHI to organizations that obtain organs or tissues for banking and/or transplantation.

Public Safety. We may use or disclose your PHI to prevent or lessen a serious or imminent threat to the safety of a person or the public.

Research. Usually, we will ask for your permission or authorization before using your PHI for research purposes. However, we may use and disclose your PHI without your authorization if Main Line Hospital's Institutional Review Board (IRB) has waived the authorization requirement. An IRB is a committee that oversees and approves research involving human subjects.

Disaster Relief Efforts. We may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Military, National Defense and Security. We may release medical information about you if required for military, national defense and security and other special government functions.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

As Required by Law. We may use and disclose your PHI when required to do so by any other laws not already referenced above.

V. Uses and Disclosures Requiring Your Specific Authorization

Disclosure to Relatives and Close Friends. We may disclose your PHI to a family member, other relative, a close personal friend or any other person if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure.

Highly Confidential Information. **Federal and State laws require special privacy protections for certain highly confidential information about you. This includes PHI that is: 1) maintained in psychotherapy notes; 2) documentation related to mental health or developmental disabilities services; 3) drug and alcohol abuse, prevention, treatment and referral information; 4) information related to HIV status, testing, treatment as well as any information related to the treatment or diagnosis of sexually transmitted diseases; and 5) PHI related to genetic testing. Generally, we must obtain your authorization to release this type of information. However, there are limited circumstances under the law when this information may be released without your consent. For example, certain sexually transmitted diseases must be reported to the Department of Health.**

VI. Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care excluding psychotherapy notes.

You must submit your request in writing to the appropriate Main Line Health office or department. You may be charged a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. You may request that the denial be reviewed. Another licensed health care professional will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. You have the right to request that we amend the PHI we keep about you in your medical and billing records. To request an amendment, your request must be made in writing and submitted to the appropriate Main Line Health office or department. We may deny your request if we believe the information you wish to amend is accurate, current and complete, if the PHI was not created by Main Line Health or if other special circumstances apply.

We will ask your attending physician to review any amendments to the medical record.

Right to an Accounting of Disclosures. You have the right to request a record of all disclosures of your PHI. We are not required to give you an accounting of information we have used or disclosed for treatment, payment or health care operations or information you authorized us to disclose.

To request this list or accounting of disclosures, you must submit your request in writing to the appropriate Main Line Health office or department. Your request may cover any disclosures made in the six years prior to the date of your request. However, we are not required to give you a record of disclosures that occurred before April 14, 2003.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

To request confidential communications, you must make your request in writing to the appropriate Main Line Health office or department. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Revoke Your Authorization. You may revoke your authorization for us to use and disclose your PHI at any time by submitting a request in writing to the appropriate office or department.

VII. Changes to This Notice

We reserve the right to change this notice. Revised Notices will be posted in appropriate locations and on-line at http://www.mainlinehealth.org. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office.

VIII. Complaints

If you believe your privacy rights have been violated, you may file a complaint, in writing, with the Main Line Health Privacy Officer at:

Privacy Officer, Main Line Health

4412 Medical Science Building
The Lankenau Hospital
100 Lancaster Ave., Wynnewood, PA 19096

You may also wish to file a complaint with the Director, Office of Civil Rights of the U. S. Department of Health and Human Services. The Privacy Officer can supply the correct address for the Director.

You will not be penalized for filing a complaint.

IX. Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain a record of the care that we provided to you.

This Notice is effective: April 14, 2003.