



Main Line HealthCare
Occupational & Travel Health
Main Line Health Center at 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	Exton:	484-565-1293	610-903-1084 (f)
Occupational and Travel Health Centers	Lankenau:	484-476-2881	484-476-2158 (f)

Welcome to the OCCUPATIONAL AND TRAVEL HEALTH CENTERS

Travel Health advises the traveler of the required (those required for entry into a country according to international regulations) and recommended immunization for the control and preventive of infectious diseases. This information is prepared according to your personal medical situation, timetable, and destinations, in accordance with the latest information available from the Center for Disease Control (CDC).

Consultation appointments are made to discuss all necessary immunizations and information needed for travel. Appointments are scheduled with a travel consultant who is a physician or physician assistant trained in the Travel Health field.

REACTIONS TO IMMUNIZATIONS:

You will receive specific information about your prescription medicine and immunization. If you find that you have any additional questions about a possible reaction or related health concern, please call us at the office number where you were treated (see top of page). For emergencies after hours please contact either your personal physician or a hospital Emergency Department, **(Paoli Emergency Department is 484-565-1043, Bryn Mawr Emergency Department is 484-337-3582)**. Please advise Travel Medicine of any reaction as soon as possible, even if an Emergency Department or your personal physicians took care of you, so we can document your file.

INSURANCE:

We will require payment at the time of service by cash, check, or credit card. We cannot bill your insurance company, since this is a preventive service, not a treatment for illness or injury. Consequently, there is no diagnosis that we can provide. While we are a part of the Jefferson Health System, Travel Health does not have a contract or agreement with any insurance company, be it Medicare, Blue Cross/Blue Shield, Aetna, etc. For this reason, we cannot accept payment from your personal insurance company. The bill will be your responsibility. We can generate a receipt that lists CPT codes for the procedures, but you are responsible for any insurance-related paperwork.

There will be a \$40.00 fee charged for all returned checks.

DISCLAIMER:

There is no guarantee that the vaccine(s) and/or medications(s) that you may receive will be effective in preventing and/or treating diseases. Local and systemic reactions are possible (including rare cases of death from anaphylaxis). In recommending the vaccine(s)/medication(s), we believe that the benefits outweigh the risks. In accepting the vaccine(s)/medication(s), you also believe this. In signing below, you are accepting that there is no guarantee of vaccine/medication effectiveness and that there is the possibility of significant side effects (even, rarely, death).

Patient Name and Signature

Date

Occupational/Travel Health Witness Name and Signature

Date

(This is completed for each new trip and is page 3 of the travel packet which is stapled together.)

(The protocol becomes pages 4 and 5 of travel packet)

Main Line HealthCare Occupational and Travel Health

First Name _____ Last Name _____ Date ____ m

Social Security _____ - _____ - _____ Date of Birth _____ Male ____ Female ____

Address _____

Home Phone _____ Cell _____

Work Phone _____ Email _____

(please circle preferred method of contact)

Emergency contact name and phone _____

Date of Departure _____ Return Date _____

Current Itinerary: Please give ALL countries including stopovers in the order to be visited

Destination: Circle all that apply: Urban Rural Remote High Altitude Beach

Purpose of trip : (circle all that apply)

Vacation

Medical Care

Business

Study Abroad

Adoption

Volunteer

Visiting Friends/Relatives

Business

Missionary

Other

Accommodations: (circle all that apply)

Hotel

Camping

Rental Home/Apt

Hostel

Cruise Ship/Boat

Other

Private Home

Planned Activities: (circle all that apply)

Biking

Hiking

Swimming

Rafting

Baoting

Climbing/Trekking

Contact with Animals

Caving

Construction

Scuba

Health Care Work

Visiting Schools, hospitals, orphanages

How did you learn about our travel clinic? _____
r4

Travel Consultant Notes: _____

Travel Consultant _____ Date _____

Cinician _____ Date _____

Main Line HealthCare Occupational and Travel Health Medical History

Last Name _____ First Name _____ Birth Date _____

	Yes	No
High Blood Pressure		
Cardiac conduction defect, arrhythmia, pacemaker		
Heart disease or Surgery		
Antidepressant or psychiatric medication use		
Depression, anxiety, panic attacks		
Diabetes		
Asthma or other Respiratory(lung) disease		
Intestinal problems, heartburn, stomach ulcer		
Psoriasis (skin disease)		
Muscle or bone problems, history 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		
Problems with anti-malarial medications		

Please explain any yes answers _____

Do you have any chronic health problems for which you take medication on a regular basis or under the care of a physician for any health problem not noted above? Yes ____ No ____

If yes, please explain _____

Please tell us any additional information that you believe is important for us to know as you prepare for your current trip: _____

Have you purchased evacuation insurance? Yes ____ No ____ Unsure ____

Traveler's signature _____ Relationship if minor _____ Date _____

Office Use Only:

Travel Consultant _____ Date _____

Clinician _____ Date _____

Main Line HealthCare Occupational and Travel Health Centers
Pre Vaccination Questionnaire

Last Name _____

First Name _____

DOB _____

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?		
5. Allergic reaction to medications, 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. Are you pregnant or breastfeeding? Any possibility of pregnancy in the next 2 months?		
14. Do you live with someone with AIDS, immune disorder or on chemotherapy?		

Please list any medication allergies: _____

Please list current medications: _____

Date: _____ **Patient Signature:** _____

Office Use Only:

Date: _____ **Vital Signs:** BP _____ **Pulse** _____ **Temp** _____

Review of any positive answers to above:

MD, PA or NP Name/Signature/Date _____

Second vaccination:

Date: _____ **Patient to initial here if no significant health conditions and/or new medications since last visit** _____

Vital Signs: BP _____ **Pulse** _____ **Temp** _____

MD, PA or NP Name/Signature/Date _____

Third vaccination:

Date: _____ **Patient to initial here if no significant health conditions and/or new medications since last visit** _____

Vital Signs: BP _____ **Pulse** _____ **Temp** _____

MD, PA or NP Name/Signature/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:**

- **Reporting births or deaths**
- To prevent or control disease, injury or disability
- To report child abuse or neglect
- To report reactions to medications or problems with products
- To notify individuals who may have been exposed to a disease or may be at risk for contracting a disease or condition
- 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.