Telehealth Enrollment Packet

Please Complete All Pages

Please be sure to fill out all information in the packet, signing and dating all required areas. This enrollment packet is only required to be filled out once. Each school year, you will receive a short information update form to complete and return. If you wish to withdraw your child from the Towns County Schools Telehealth, please provide written notice of such request. Thank you for your interest in this program.

Contact person:

Mary Barrett, RN BSN
706-896-4131 ext 2228
mbarrett@townscountyschools.org

Judy Albury, Clinic Staff
706-896-4131 ext 2227

Towns County Schools Telehealth

STUDENT INFORMATION PACKET

Date:_____Grade:_____Homeroom:_____School year:_____

Patient Information

Name:_____

Date of Birth_____ Age_____ Sex: M / F

Street Address_____

City:_____State:_____Zip Code:_____County: _____

Social Security Number:_____Primary Language:_____

Race:

African American/Black Asian Caucasian/White Hispanic/Latino Other_____

Student Resides With:

Both Parents Mother Father Step-Parent Grandparent(s) Other:_____

Mother's/Guardian's Information

Name:_____

Date of Birth:_____Race:_____Social Security Number:_____

Street Address:_____

City:_____State:_____Zip Code:_____County:_____

Employer:_____Work Number/Ext:_____

Home Phone:_____Cell Phone:__Other:_____

Email Address: _____

Father's /Guardian's Information

Name:_____

Date of Birth:_____Race:_____Social Security Number:_____

Street Address: _____

City:_____State:_____Zip Code:_____County: _____

Employer:_____Work Number/Ext: _____

Home Phone:_____Cell Phone:_____Other:_____

Email Address: _____

Person to Notify in Case of Emergency (other than parent/guardian)

Name:_____

Relationship to Patient:_____

Street Address: _____

City:_____State:_____Zip Code: _____

Home Phone:_____Cell Phone:_____Other:_____

Towns County Schools Telehealth

TELEHEALTH CONSENT

I hereby voluntarily give my consent for my child listed below to receive telehealth services through Towns County Schools Telehealth for the purpose of healthcare service(s) and/or procedure(s). I authorize any physician or designated health/mental health professional working with Towns County Schools Telehealth to provide care. I understand that additional consent will be obtained prior to each appointment. I understand that during the telehealth consult, details of my child's medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology. I understand that a physical examination may take place. I understand that a non-medical technician may be present in the telemedicine studio to aid in the video transmission. I understand that video, audio and/or photo recordings may be taken of the patient during the procedure(s) or service(s). I understand that all existing laws regarding access to my child's medical records apply to these telehealth consultations. Not all telecommunications are recorded and stored. Additionally, dissemination of any patient identifiable images or information for telemedicine interactions to researchers or other entities shall not occur without your consent. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during a telemedicine consultation. It is your right to withhold or withdraw consent to the telemedicine consultation at any time without effecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You agree that any dispute arriving from a telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes. I have been advised and understand all potential risks, benefits, and consequences of telemedicine. Your healthcare provider has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented in this consent and about the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in telemedicine consultations for the procedure(s) and/or service(s) described above.

Patient Name:_____ **Date of Birth:**_____

Parent/Guardian Signature_____**Date**_____

Please list any adult(s), other than parents/ guardians, over the age of 18 who has permission to give consent for your child to participate in a telehealth visit if parents/guardians cannot be reached.

1. Name:_____ Relationship to Patient:_____

Home Number:_____ Cell Number:_____ Other:_____

2. Name:_____ Relationship to Patient:_____

Home Number:_____ Cell Number:_____ Other:_____

I hereby voluntarily give my consent for the above listed person(s) to approve a school-based telehealth visit in the event that I cannot be reached. I understand that I may withdraw my consent for any of the above persons at any time by submitting a written statement to the school nurse or telehealth coordinator. I understand that any person(s) listed above will continue to have my consent to approve a telehealth visit until such signed and dated written statement is received.

Parent/Guardian Signature_____**Date**_____

Towns County Schools Telehealth

MEDICAL HISTORY

Name of Primary Care Physician_____

Address_____ Phone Number _____

Name of Dentist_____

Address_____ Phone Number _____

Name of any other Health Care Provider_____

Address_____ Phone Number _____

Name of Pharmacy_____

Address_____ Phone Number_____

List Medication Allergies

1)_____ 2)_____

3)_____ 4)_____

List All Medical Problems (Ex: Asthma, ADD/ADHD, Autism, Hypertension, etc.)

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

List all Previous Surgeries

1)_____ 2)_____

3)_____ 4)_____

Current Medication List (Include dosage and time)

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

Family History (Ex: Hypertension, Cancer, etc.)

Mother_____

Father_____

Please list any religious/personal beliefs that may affect your care: _____

Towns County Schools Telehealth

Medical Form: Mark all that apply

ENDOCRINE

____ Swelling under arms or neck
____ Weakness and tiredness
____ Always hungry
____ Increased thirst
____ Increased urination
____ Tends to be too hot
____ Tends to be too cold
____ Frequent fever and chills
____ Night sweats
____ Problems going to sleep
____ Problems waking up after falling asleep

_____ Recent weight gain
____ Recent weight loss
____ Diabetes
____Other_____

INFECTIONS

____ Chicken pox
____ Hepatitis B
____ Hepatitis C
____ HIV/AIDS
____ Strep Throat
____Other_____

PULMONARY

____ Chronic snoring

____ Persistent cough
____ Coughing up blood
____ TB (or exposure to)
____ Sleep apnea
____ COPD, emphysema or chronic bronchitis
____ Asthma
____ Other_____

NEUROLOGY

____ Frequent headaches
____ Migraines
____ Seizures
____ Stroke or paralysis
____ Memory problems
____ Meningitis
____ Nerve damage to feet/hands
____Other_____

EARS, NOSE & THROAT

____Wears glasses or contacts
____Eye drainage
____Blurry vision
____Recent changes in vision
____Decreased hearing
____Earache or drainage
____Ringing in ears
____Allergies (Seasonal)
____Sinus problems
____Frequent nose bleeds
____Frequent sore throat
____Tongue/mouth sores

____Goiter/thyroid problems
____Neck pain or lumps
____Any change in voice
____Dental problems
____ Other_____

HEMATOLOGY

____Anemia/low blood count
____Sickle cell disease

____Bleeding/bruising easily
____Cancer (type_____)
____ Chemo/Radiation exposure
____Other_____

MUSCULOSKELETAL

____Frequent pain in fingers or hands
____Muscle or joint pain
____Leg camps with exercise
____Leg cramps at night
____Arthritis
____Other_____

GENITOURINARY

____Frequent urination
____ Burning on urination
____Difficulty starting urination
____Incontinence
____Kidney stones
____Kidney disease
____Other_____

CARDIOVASCULAR

____Chest pain
____Heart palpitations
____Dizziness upon standing
____Swelling in feet/hands
____High blood pressure
____High cholesterol
____Fainting spells
____Shortness of breath with exercise
____Heart murmur
____Other

GASTROINTESTINAL

____Frequent heartburn
____Decreased appetite
____Frequent nausea or vomiting
____Liver disease
____ Jaundice or hepatitis

____ Difficulty swallowing
____Stomach pain
____ Recent change in bowel habits
____Frequent diarrhea
____Frequent constipation
____Incontinence
____Bloody stools
____Rectal pain
____ Hemorrhoids

____Rectal fissure
____Parasites or worms
____Pancreatitis
____Other_____

BEHAVIORAL / MENTAL

____Nightmares
____Bedwetting
____Eating problems
____ Thumb sucking
____ Discipline problems
____Overactive/hyperactive
____Shyness/social avoidance
____Sleeping problems
____Developmental delays
____Learning disabilities
____Depression
____Anxiety
____Cries often
____Hears voices
____ Anger
____ Diagnosed behavioral/mental disorder
(Please list_____)

My signature indicates that all medical history is true and accurate to the best of my knowledge.

Parent/Guardian Signature_____ **Date**_____

AUTHORIZATION TO BILL INSURANCE

Please note that Towns County Schools Telehealth is not responsible for billing or for the collection of any associated fees for the services provided. Your insurance will be billed by the physician's office, and you will be responsible for copays, deductibles, or any other charges not covered by your insurance.

Patient's Name_____

Patient's Date of Birth_____Patient's Social Security Number_____

Primary Insurance Company

Insurance Company_____ Person Insured_____

Insured's Date of Birth_____ Insured's Social Security Number_____

Policy or Member Number_____ Group Number_____

Secondary Insurance Company (if applicable)

Insurance Company_____ Person Insured_____

Insured's Date of Birth_____ Insured's Social Security Number_____

Policy or Member Number_____ Group Number_____

Responsible Party

Name_____

Date of Birth_____Employer _____

A COPY OF YOUR INSURANCE CARD IS REQUIRED

Information on this form is protected health information (PHI) and is to be treated as confidential under HIPPA rules, privacy & security. All services are charged directly to the patient or the patient's representative and/or insurance company by the provider. Acknowledgement: I consent to the use of PHI for purposes of treatment, payment and operations. I authorize the entity to use the PHI as needed. I authorize that payment of benefits be made on my behalf directly to the provider. I understand that I am financially responsible for all charges not covered by insurance.

Parent/Guardian Signature_____**Date**_____

HIPAA AND OUR PATIENTS

The HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule became law in 1996. The Office for Civil Rights enforces the HIPAA Privacy Rule, which protects the privacy of identifiable health information. This rule essentially controls the use and disclosure of what is known as Protected Health Information. We are required to provide you with the attached notice. We encourage you to read the information concerning our privacy practices. It is your copy to keep.

I acknowledge receipt of the HIPAA Notice of Privacy Practices from Towns County Schools Telehealth.

Parent/Guardian Signature_____**Date** _____

NOTICE OF INFORMATION PRACTICES

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

Understand your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in education health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assesses ad continually work to improve the care we render and the outcomes we achieve

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

- Ensure its accuracy
- Better understand who, what when, where, and why other may access your health information
- Make more informed decisions when authorizing disclosure to others

Your Heath Information Rights

Although your health record is the physical property of the healthcare practitioner of facility that complied it the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of you information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record as provided in 45 CF 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your heath information by alternative means or at alternative locations
- Revoke your authorization to use or disclosed health information except to the extent that action has already been taken.

Our Responsibilities

This organization is required to:

- maintain the privacy of your health Information
- Provide you with a notice to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable request you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization except as described in this notice.

For More Information or to report a Problem

If you have questions and would like additional information, you may contact the director of health information managed at 367-9841 extension 1530

If you believe your privac6y rights have been violated, you can file a complaint with the director of health information management or with the health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in you record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use our health information for payment.

For example: A bill may be sent to your or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplied used.

We will use your health information for regular health operations.

For Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service to provide.

Business associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and anesthesiology services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriate safeguard your information.

Patient Satisfaction Survey: We may disclose minimal information in order to complete patient satisfaction surveys, which are conducted to improve services provided by the system.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Coroner, medical examiners, and funeral directors: We may disclose health information for the purpose of identifying a deceased person, determining a cause of death, or duties as authorized by law.

Appointments: We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Organ procurement organizations: consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating donation and transplantation.

Marketing: We may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the event authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, disability, or recording vital events such as birth or death.

For example: Information may be disclosed for use in reports of abuse, neglect, or domestic violence or as required by laws that require the reporting of certain types of wounds or other physical injuries. Furthermore, we may disclose information in compliance with requirements of a valid court order, warrant, subpoena, or summons, as well as in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person or about an individual who is or is suspected to a victim of crime.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement:: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, 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.

Effective Date: 04 14 03

UNION GENERAL HOSPITAL, INC.

PRIVACY PRACTICE/CONSENT FORM
(Consent to treatment and authorization to release information and assignment of benefits)

The Towns County Board of Education has joined in partnership with Union General Hospital, Inc. and other primary care providers to develop a comprehensive school-based collaborative healthcare center SBHC (School-based Collaborative Healthcare Center). Medical services will be provided via telehealth and includes diagnosis and treatment of acute illnesses and minor injuries, management of chronic illnesses, management/maintenance of monthly medications, health education/promotion, and referrals to medical subspecialists and community agencies. The primary focus of the center is to provide quality, accessible health care to the children of Towns County, in order to have a positive impact on the children's health, school attendance, and academic performance.

In order for your child to receive services at the health center, this consent form must be completed and proper documentation of insurance obtained.

I hereby voluntarily give my consent for _____ to receive health services at
(Insert child's name)
Union General Hospital SBHC. I further authorize any physician or designated healthcare provider (nurse practitioners, physician assistants, college student interns, etc) working for the clinic to provide such medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of my child's health. Furthermore, I agree to actively participate in the primary health care of my child by accompanying him/her to center appointments as often as possible and attending educational programs developed for parents/guardians.

_____ I authorize release of information from my child's medical record of the family doctor or primary care provider designated by me whenever necessary for his or her care including referrals and/or emergency services.

_____ I give consent to the Union General Hospital SBHC to examine my child's full school record, including attendance and other information that may assist the staff in helping my child.

_____ I authorize Union General Hospital SBHC to release information regarding treatment to third party payers such as Medicaid or other insurers for the purposes of billing or for any other reason in accordance with acceptable medical practice pursuant to the law.

_____ I understand the Union General Hospital SBHC is permitted to disclose protected health information about my child for the purposes of payment, continued care or treatment, and healthcare operations.

_____ If my child's protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS), drug or alcohol abuse and/or mental illness, I hereby give consent to the disclosure of this information by these clinics only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I also understand that I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

_____ I understand that my signing this consent allows the physician and professionals at Union General Hospital SBHC staff to provide comprehensive health services. I also understand that I have the right to withdraw this consent at any time upon written notice to the school and /or clinic staff.

I have read and understand the above information and give permission for my child's care as described. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the school nurse.

_____
Name of Parent or Legal Guardian

_____
Name of Student

_____
Signature of Parent/Legal Guardian

_____
Relationship to Student

Date:_____

Please don't forget to fill out the back side of this page and second attached page.

Authorization to Bill Insurance

Patient's Name: _____

Patient's Birth Date: ___-___-_____ Patient's Social Security # _____-_____-_____

Primary Insurance Company: _____
Name of person insured if patient is a dependent: _____
Insured's Date of Birth: ___-___-_____ Insured's Social Security #: _____-_____-_____
Group #: _____
Policy or Member #: _____
Relationship to Child: _____

Secondary Insurance Company: _____
Group #: _____
Policy or Member #: _____
Relationship to child: _____

Responsible Party:
Name: _____ Date of Birth: _____
Social Security # : _____-_____-_____ Employer: _____

Authorization
The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

1. Grant permission to all physicians, therapists, laboratories, and any other professionals to perform and administer care and treatment of the patient, or designated other qualified health care providers for such services.
2. Grant permission to release any information in connection with any care rendered to the patient to the third party payor/ payers, Medicare, Medicaid, their representatives and/or other physician(s) involved in the patient's care.
3. Grant permission to bill third party payor/payers with benefits paid to be paid directly to the appropriate provider when assignment is accepted.

Letter of Responsibility:
I understand that I am responsible for any unpaid bills not covered by Medicaid, Medicare, and any other private insurance companies. The physicians will not accept any retroactive Medicaid cards on paid accounts. Thus, I will not be entitled to any refunds of Medicaid payments.

_____ _____
(Signature of parent/guardian) (Date)

_____
(Student's Name)

We appreciate you for placing your confidence in us by choosing our staff for your medical needs. Our physicians and staff are dedicated to serving you.

STUDENT INFORMATION PACKET

Date:_____ Grade: _____Homeroom:_____ School year: _____

Patient Information

Name: _____ Social Security Number:_____

Sex: M / F Race:_____ Date of Birth:_____ Age:_____

Street Address:_____

City:_____ State: _____ Zip Code:_____ County: _____

Student Resides With: _____

Child's current primary care provider: _____ Phone#:_____

Mother's/Guardian's Information

Name: _____

Street Address:_____

City: _____ State:_____ Zip Code:_____ County:_____

Employer:_____ Work Number/Extension:_____

Home Phone:_____ Cell Phone:_____ Other:_____

Father's /Guardian's Information

Name: _____

Street Address: _____

City:_____ State:_____ Zip Code:_____ County:_____

Employer: _____ Work Number/Extension:_____

Home Phone:_____ Cell Phone:_____ Other:_____

Person to Notify in Case of Emergency (other than parent/guardian)

Name: _____Relationship to patient: _____

Street Address: _____

City: _____ State:_____ Zip Code:_____ County:_____

Home Phone: _____ Cell Phone: _____ Other: _____

In order for your child to receive services at Union General Hospital SBHC, this consent form must be completed and proper documentation of insurance obtained.

I hereby voluntarily give my consent for my child listed above to receive telehealth services through Union General Hospital SBHC (School-based Collaborative Healthcare Center). I authorize any physician or designated health professional working with Union General Hospital SBHC to provide care. I understand that verbal consent will be obtained prior to each appointment.

**If the patient is seen by any of our providers, and this is not their primary care provider, then a summary of the visit will be forwarded to the patient's primary care provider listed.*

Parent/Guardian Signature: _____ Date: _____