Telehealth Enrollment Packet

For Faculty

Please Complete All Pages 1 – 7

This enrollment packet is only required to be filled out one time. Each school year you will receive an information update form to fill out, sign, and return. Please be sure to fill out all the required information as well as sign and date all required areas. Thank you for your interest in this program

Luellen Tucker, SBTH Coordinator

Patient Name/Date of Birth

_______________________/_______________

Mitchell County School System Clinic

FACULTY INFORMATION PACKET

Date:_______________ Grade: ___________ Homeroom:__________________________ School year: _________

Patient Information

Name: ____ Primary Language:_________________

Social Security Number:______________________________

Race: African American/Black Asian Caucasian/White Hispanic/Latino Other_________________

Sex: M / F Age______________ Date of Birth______________________

Street Address____ City: ____________________

State: _____ Zip Code:__________ County: _________________ Place of Birth:_________________________

Patient Resides With: ______________________ ***Email Address: ___________________________________

Next of Kin Information

Name: ______________________________ Relationship to Patient:_________________Primary Language:___________

Date of Birth:_________________ Race:_____________Social Security Number:__________________________

Street Address:____

City: ________________________ State:_________ Zip Code: _____________County:__________________

Employer:______________________________ Department:______________________________Title:_______________

Work Number:_______________________________ Extension:_____________

Home Phone:________________________ Cell Phone:____________________ Other:______________________

Notify in Case of Emergencey(other than next of kin)

Name: _______________________________ Relationship to Patient:________________Primary Language: ___________

Street Address: ____

City: ________________________ State: _________ Zip Code: _____________ County: _____________________

Employer: _____________________________ Department:______________________________ Title:_______________

Work Number: _______________________________ Extension:_____________

Home Phone: _______________________ Cell Phone: ____________________ Other:______________________

I hereby voluntarily give my consent to receive telehealth services through Mitchell County School System for the purpose of healthcare service(s) and/or procedure(s). I authorize any physician or designated health/mental health professional working with Mitchell County School System 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 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 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 my 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 my right to withhold or withdraw consent to the telemedicine consultation at any time without effecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I 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. My healthcare provider has discussed the information provided above with me. I have had the opportunity to ask questions about the information presented in this consent and about the telemedicine consultation. All my questions have been answered, and I understand the written information provided above.

Patient Signature____ **Date**_____________

MEDICAL HISTORY

Primary Care Physician:

Name: ___________________________________ Phone Number: ___________________________

Address: ____

Date Last Seen: _______________________

Dentist:

Name: ___________________________________ Phone Number: ___________________________

Address: ____

Date Last Seen: ___________________________

Other Health Care Provider:

Name: ___________________________________ Phone Number: ___________________________

Address: ____

Date Last Seen: ____________________________________

Pharmacy:

Name: ___________________________________ Phone Number: ___________________________

Address: ____

List All Medication Allergies

1)____**2)**____

3)____**4)**____

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

1)_______________________________**2)**_______________________________**3)**_______________________________

4)_______________________________**5)**_______________________________**6)**_______________________________

List All Previous Surgeries

1)____**2)**____

3)____**4)**____

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 Mitchell County School System Clinic needs to be aware of in addressing your care:____

____

●	ENDOCRINE	●	MUSCULOSKELETAL	●	GENITOURINARY
	Swelling under arms or neck		Gout		Frequent urination
	Weakness and tiredness		Pain in fingers or hands		Burning with urination
	Always hungry		Muscle or joint pain		Difficulty starting urination
	Increased thirst		Leg cramps with exercise		Incontinence
	Increased urination		Leg cramps at night		Kidney stones
	Tends to be too hot		Arthritis		Kidney disease
	Tends to be too cold		Swelling in joints	●	**GASTROINTESTINAL**
	Frequent fever and chills		Muscle weakness		Frequent heartburn
	Night sweats	●	**PULMONARY**		Decreased appetite
	Problems going to sleep		Chronic snoring		Frequent nausea or vomiting
	Waking after falling asleep		Persistent cough		Liver disease
	Recent weight gain		Coughing up blood		Jaundice
	Recent weight loss		Tuberculosis/TB(or exposure to)		Difficulty swallowing
	Diabetes		Sleep apnea		Stomach pain
●	**EARS, NOSE, THROAT**		COPD		Change in bowel habits
	Wears glasses or contacts		Asthma		Frequent diarrhea
	Eye drainage	●	**HEMATOLOGICAL**		Frequent constipation
	Blurry vision		Anemia		Incontinence
	Recent changes in vision		Sickle cell disease		Bloody stools
	Deceased hearing		Bleeds or bruises		Rectal pain
	Ear pain		Cancer-Explain type		Hemorrhoids
	Ear drainage		Chemo/radiation exposure		Rectal fissures
	Ringing in ears	●	**NEUROLOGICAL**		Parasites or worms
	Allergies (seasonal)		Frequent headaches		Pancreatitis
	Sinus problems		Migraines	●	**BEHAVIORAL/MENTAL**
	Frequent nose bleeds		Seizures		Nightmares
	Frequent sore throat		Stroke or paralysis		Bed wetting
	Tongue or mouth sores		Memory problems		Eating problems
	Goiter/ thyroid problems		Confusion		Thumb sucking
	Neck pain or lumps		Meningitis		Discipline problems
	Change in sound of voice		Nerve damage to feet/hands		Overactive / hyperactive
	Dental problems	●	**CARDIOVASCULAR**		Overly shy
●	**INFECTIONS**		Chest pain		Sleeping problems
	Hepatitis B		Palpitations or fluttering in chest		Developmental delays
	Hepatitis C		Dizziness / fainting		Learning disabilities
	HIV/ AIDS		Swelling in hands / feet		Depression
			High blood pressure		Anxiety
	Frequent heartburn		High cholesterol		Hears Voices
	Decreased appetite		Shortness of breath with exercise		Angry
	Frequent nausea or vomiting		Heart murmur		Tobacco use
	Liver disease				Alcohol use
	Jaundice				Drug use
	Mental disorder – explain				

		Please explain any other conditions that may not have been listed:____
●	**MALE ONLY**	____
	Weak urine stream	____
	Prostate problems	____
	Lump on testicle	____
	Sexual difficulty	____
	STD – Explain below	______________________________
●	**FEMALE ONLY**	
	Pregnancies (#_____)	
	Miscarriages (#_____)	
	Cesarean Section	
	Hysterectomy	
	High blood pressure while pregnant	
	Gestational diabetes	
	Lump in breast	
	Menstrual problems	
	Sexual difficulty	
	STD – Explain in line below	
●	**OTHERS**	

All medical history provided is true and accurate to the best of my knowledge.

Patient Signature____ **Date** _______________

AUTHORIZATION TO BILL INSURANCE

Please note that Mitchell County School System Clinic **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.**

Primary Insurance Company

Insurance Company____

Name of Person Insured ____

Insured's Birth Date__________________________________

Insured's Social Security Number_________________________

Policy or Member Number____

Group Number____

Secondary Insurance Company

Insurance Company____

Name of Person Insured____

Insured's Birth Date________________ ____________________________

Insured's Social Security Number_________________________ _________

Policy or Member Number____

Group Number____

Responsible Party

Name___________________________ Date of Birth________________________
Social Security Number_______________________________
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.

*Patient 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 so feel free to keep it with you.

I acknowledge receipt of the HIPAA Notice of Privacy Practices from Mitchell County School System. See attached HIPAA form.

Patient Signature___________________________________**Date** _______________

Lab Permission

I give consent for Mitchell County School System healthcare providers to perform lab tests (*urine dips, flu swabs, and strep swabs*) as requested by a licensed physician.

I understand that my insurance carrier will be billed, and any subsequent deductible/balances will be my responsibility.

I understand that the ordering physician will be the only physician to have access to these results unless requested otherwise.

Patient Signature_________________________________**Date**______________

Mitchell County Hospital offers lab services for your convenience. You have the right to use the lab provider of your choice.

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Patient's Name:________________________________

Date of Birth:_______________

Social Security Number:____________________

Address:____

City:______________________State:________Zip Code:____________

The information released will be used for the purpose of:

Primary Healthcare

I, _____________________________, give consent for the healthcare providers of **Mitchell Co. School System** to
Name of patient
release the telehealth medical records of ______________________________ for the purpose of his/her primary care
Name of patient
needs to the following provider.

Name of Office:____

Provider's Name:____

Address:____

City:______________________**State:**________**Zip Code:**__________________

Phone Number:__________________________**Fax Number:**_______________

I expressly and voluntarily authorize the disclosure of (Insert Patient's Name)__________________________'s healthcare information for the purpose stated above. I understand that I may revoke this Authorization, in writing, at any time, except the extent that action has been taken on this Authorization.

Please note the information disclosed pursuant to this request is no longer under the control of the Telehealth Provider and may be subject to disclosure by the recipient.

I understand that I am responsible for any fees associated with this request.

Printed Name of Patient:____

Signature of Patient/Legal Guardian:____

Relationship to Patient:__________________________**Date:**_______________
(if not signed by patient)

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