



**FACULTY/STAFF ENROLLMENT & INFORMATION PACKET
FOR NEW PATIENTS ONLY
School Year: 2023-2024**

In which HCSD facility do you work? ___ Mulberry Creek ___ New Mountain Hill ___ Park ___ Pine Ridge
___ Creekside ___ HCCMS ___ HCHS ___ Central Office (*Department:* _____)

PATIENT INFORMATION

Name _____ Date of Birth _____ Age _____
Social Security Number: _____ Sex: ___ M ___ F / Other _____
Home Address: _____ City: _____
State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Email Address: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Other: _____

TELEHEALTH CONSENT

I hereby voluntarily give my consent to receive telehealth services through the Harris County School District's School-Based Telehealth Program via Mercer Medicine for the purpose of healthcare service(s) and/or procedure(s). I authorize any physician or designated health/mental health professional working through the Harris County School District's School-Based Telehealth Program 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 affecting 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 arising from a telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes. Based upon this consent, I have been advised and understand all potential risks, benefits, and consequences of telemedicine. If necessary, I will have the opportunity to ask questions about the information presented in this consent and about the telemedicine consultation. I understand the written information provided above.

Patient Signature _____

Date _____

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN

Name: _____ Phone Number: _____

Address: _____

Date Last Seen: _____

OTHER HEALTHCARE PROVIDER

Name: _____ Phone Number: _____

Address: _____

Date Last Seen: _____

PREFERRED PHARMACY

Name: _____ Phone Number: _____

Address: _____

List All Allergies to Medication(s):

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) _____

Medication List (Include dosage and time):

- | | | |
|----------|---------------|-------------|
| 1) _____ | Dosage: _____ | Time: _____ |
| 2) _____ | Dosage: _____ | Time: _____ |
| 3) _____ | Dosage: _____ | Time: _____ |
| 4) _____ | Dosage: _____ | Time: _____ |
| 5) _____ | Dosage: _____ | Time: _____ |
| 6) _____ | Dosage: _____ | Time: _____ |

Family History (Ex: hypertension, cancer, etc.)

- Mother _____ Medical Issue: _____
Father _____ Medical Issue: _____

Please list any religious/personal beliefs that healthcare providers need to be aware of in addressing your care:

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

Patient Signature _____

Date _____

AUTHORIZATION TO BILL INSURANCE

Please note that the Harris County School District 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 (IF YOU DO NOT HAVE MEDICAL INSURANCE/COVERAGE)

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 HIPAA 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. *See attached HIPAA notice.*

I acknowledge receipt of the HIPAA Notice of Privacy Practices from Harris County School District’s School-Based Telehealth Program via Mercer Medicine.

Patient Signature _____

Date _____

Lab Permission

The Harris County School District’s School-Based Telehealth Program offers lab services via Mercer Medicine’s providers for your convenience.

I give consent for Harris County School District’s School-Based Telehealth Program via Mercer Medicine’s healthcare providers to perform lab tests (*COVID-19 swabs, flu swabs, strep swabs, mononucleosis swabs, and glucose testing*) 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 _____