Harris County School District

Telehealth

STUDENT ENROLLMENT & INFORMATION PACKET

FOR NEW PATIENTS ONLY

SCHOOL YEAR: 2023-2024

What school does your child attend? ___Mulberry Creek ___New Mountain Hill ___Park ___Pine Ridge ___ Creekside ___ HCCMS ___ HCHS

Student Information

Name _____ Date of Birth_____ Age_____

Sex: ____M ____F Other_____

Street Address_____

City_____ State _____ Zip Code_____

MOTHER'S/GUARDIAN'S INFORMATION

Name:_____

Date of Birth:_____Social Security Number:_____

Street Address:_____

City:_____ State: _____ Zip Code:_____

Home Phone:_____Cell Phone:_____Other:_____

Email Address: _____

FATHER'S/GUARDIAN'S INFORMATION

Name:_____

Date of Birth:_____Social Security Number:_____

Street Address:_____

City:_____ State: _____ Zip Code:_____

Home Phone:_____Cell Phone:_____Other:_____

Email Address: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY (*OTHER THAN PARENT/GUARDIAN*)

Name: _____ Relationship to Patient:_____

Home Phone:_____Cell Phone:_____Other:_____

TELEHEALTH CONSENT

I hereby voluntarily give my consent for my child listed below 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 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 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 arriving 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.

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

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

Signature of Parent/Guardian_____ **Date**_____

***Other than parents/guardians,* please list any adults over the age of 18 who have 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:_____

3. 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.

Signature of Parent/Guardian_____ **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 child's care:

_____

_____

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

Signature of Parent/Guardian _____ **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.

Signature of Parent/Guardian _____ **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.

Signature of Parent/Guardian _____ **Date** _____

Lab Permission

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.

Signature of Parent/Guardian _____ **Date** _____

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