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 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.

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:

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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** ____________