EFFINGHAM HEALTH TELEMED

TRANSFORMING HEALTHCARE FOR CHILDREN

SAFE • FAST • CONVENIENT

Effingham Health System offers this innovative medical program, where parents may opt-in to use telemedicine to diagnose and treat their sick children while in school. Effingham Health TELEMED will make healthcare for children more convenient and accessible, avoid delays in treatment, and enhance learning by decreasing absenteeism.

Our **award-winning TELEMED program** provides fast, safe, convenient access to healthcare within your child's school. Parents may enroll at the beginning of the school year, or opt-in at any point during the year.

2024-2025 SCHOOL YEAR

The Effingham Health System telemedicine program, in partnership with Effingham County Schools, is available in **ALL PUBLIC ELEMENTARY, MIDDLE & HIGH SCHOOLS.** Effingham Health System is also proud to partner with Global Partnership for Telehealth.

TREATMENT

With the parent's permission, a physician or advanced practitioner from Effingham Health System will perform an assessment and diagnose your child. Our exceptionally trained team will advise on medical treatment and call in any prescriptions for parents to pick up at their pharmacy. **Enrollment occurs at the beginning of each school year, or you may contact your school nurse for more information.**

TECHNOLOGY

Today's telemedicine has evolved to include **cutting-edge medical treatment and innovative technology.** A Bluetooth stethoscope, HD digital exam cameras, and monitors provide a high-definition picture of the patient for the physician, who communicates via live cameras and a computer. A secure connection assures patient privacy.

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School-Based Telemed Frequently Asked Questions

What is School-Based Telemed?
School-Based Telemed uses technology to connect students and school staff with healthcare providers remotely, expanding existing school health services.

What is the goal of the School-Based Telemed Program?
The goal is to keep children healthy, in school, and ready to learn.

Who is eligible for the School-Based Telemed program?
Students and staff at all elementary and middle schools can enroll.

What services are provided by the School-Based Telemed program?
The program offers acute care services, like checking for ear infections and sore throats. Prescriptions can be sent electronically to the familyôs pharmacy if needed.

How do children enroll in the School-Based Telemed program?
Parents need to complete an enrollment packet, which will be sent home on the first day of school and will also be available on the school's website and in the nurseôs office.

How do faculty/staff enroll in the School-Based Telemed program?
Faculty and staff need to complete an enrollment packet, available during pre-planning, on the school's website, and in the nurseôs office.

Is there a cost for the School-Based Telemed Program services?
Medicaid/PeachCare and Private Insurance will be billed. No child will be refused treatment due to inability to pay, and financial assistance is available.

When will health services be available in the School-Based Telemed program?

Medical Services will be provided during the school day with the exception of school closures for the School-Based Telemed program, at all elementary and middle schools

Does a parent have to be present for the Telemed appointment?

Parents are always welcome to attend, but it is not required for acute appointments.

What if the provider orders labs for my child?

If labs are ordered by the provider, you may take your child to the lab at Effingham Hospital, Effingham Family Medicine or any lab you prefer. Strep, and Flu tests may be performed at the school clinic.

Will my child still be seen by the school nurse if I do not participate in the School-Based Telemed program?

Yes. Students will be seen as previously in the school clinic. However, they will not be seen by a provider unless proper forms are completed for the School-Based Telemed program.

Who will be providing the School-Based Telemed Program?

Effingham Health System (EHS) in partnership with Effingham County Board of Education (ECBOE). EHS health care professionals in conjunction with the ECBOE school nurse will provide medical services for School-Based Telemed program.

How will the School-Based Telemed program be monitored?

Monitoring of the Telemed system will be done in accordance with Georgia State guidelines/ regulations and standards of practice for Telemedicine. Protocols will provide guidance on the implementation of the project and to assure compliance with State medical regulations regarding but not limited to HIPAA, FERPA, and medical practice. Confidentiality of medical records will be maintained according to electronic health records standards and regulations.

Who owns the School-Based Telemed program medical records?

Medical records will be maintained by Effingham Health System.

Patient Information School_____

Mr. /Mrs. /Ms.
Last_____First_____ MI_____

Address_____City_____State_____Zip Code_____

Mailing address_____ City_____State_____Zip Code_____

Phone Home_____ Cell_____

Work_____ Ext_____

Date of Birth_____ Male or Female Single/Married/Widowed/Divorced

Social Security No. _____ Employed Y/N Employer _____Full/Part/Retired

Student? Y/N Full Time/Part Time E-mail_____
(Over 18yrs of age only)

Emergency Contact

Last _____ First _____

Relationship_____

Address_____ City _____State_____ Zip Code _____Date of Birth_____

Phone Home_____ Cell_____

Work_____ Ext_____

Guarantor * (Financially responsible person who is signing the attached forms)

Last _____ First _____ MI_____ M/F

Relation_____

Phone No._____Date of Birth_____ Social Security No. _____

Address_____ City_____ State_____ Zip Code _____

Employer_____ Full /Part Phone_____

Address_____City_____ State _____ Zip Code_____

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Insurance Information

Medicare No._____ Part A/A&B /B Medicaid No._____

Wellcare No._____ Amerigroup No._____PeachState No._____

Primary_____ ID No._____ Group No._____

Policy holder_____ Date of Birth_____ Social Security No._____

Address_____City_____State_____

Phone_____

Secondary _____ ID No._____ Group No._____

Policy holder_____ Date of Birth_____ Social Security No._____

Address_____City_____State_____

Phone_____

Self Pay Yes or No if yes, please select one of the following

____ Pay balance in full at the time of service ***or*** ____ Make a payment arrangement prior to being seen

Additional Info

Race Black/African American Hispanic White
Other_____

Ethnicity Hispanic or Non-Hispanic

Pharmacy Used_____ Location_____ Phone_____

Have you ever received care in any of our offices in the past? If so, which one?
_____

How long ago? _____ under what name did you receive care? _____

Accident Information

Is this illness due to an accident? Yes or No

If yes, work or auto accident_____ date of accident_____

Place of
accident_____

If work accident,
Employer_____

Contact person_____ Phone _____

Effingham Health System is a Tobacco Free facility. The use of any tobacco products, e cigarettes or vaping equipment is prohibited on all properties, including parking areas, owned or occupied by Effingham Health System.

Authorization and Consent for Telemedicine Treatment

I hereby voluntarily give my consent for _____ ("Patient") to receive health services at the Effingham County School Based Telehealth Center. I acknowledge and agree that I am the legal guardian with all legal rights to consent on behalf of the Patient for healthcare services.

I understand that the Effingham County School Based Telehealth Center uses telehealth resources to connect Patient with a healthcare provider at Effingham Hospital or the Effingham Hospital owned medical clinics (collectively "Clinic"). I consent to any physician or physician-designated health professional working on behalf of the Clinic to provide such medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of the Patient's health care as determined by the healthcare provider.

I understand that the Clinic may obtain any of the Patient's medical record information from the Patient's doctor or primary care provider designated by me whenever necessary for treatment including referrals and/or emergency services. I further authorize release of written and verbal information pertinent to the Patient's health care from the Effingham County School staff to the physician, school nurse, counselor and administrators whenever necessary for my care.

I understand that the use of the telehealth services are being provided for my convenience and to ensure access to healthcare services at the Effingham School Based Telehealth Center. I understand that as an alternative to consenting to the use of telemedicine services, I could see another provider at his or her office. The benefits of the telemedicine visit are to provide timely access to a healthcare professional at a lower cost. The risks of using telemedicine links is the limitation on the physical assessment of the Patient to the extent additional facts may be obtained through an in-person visit. I understand the risks, benefits and alternatives discussed in this consent and I understand that I may ask any questions regarding the use of telemedicine and any additional risks, benefits and alternatives by contacting the school nurse where Patient is enrolled.

I understand and authorize Effingham County School System to release information for payment for the delivery of healthcare services to third party payers such as Medicaid or other insurers for the purposes of billing and payment for the healthcare services rendered unless I pay for the visit in full at the time of the healthcare visit. Medicaid and other insurers will be billed for services rendered.

I understand that my signing this consent allows the physicians and professionals at Effingham County School Based Telehealth Centers 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 nurse.

I have read and understand the above information and consent to the treatment at the Effingham County School Based Telehealth Centers by the Clinic providers. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the school nurse at the school where my child is enrolled.

_____ _____ _____

Date/Time **Signature** **Patient's Printed Name**

Relationship: _____ Witness:_____

(**Must be signed by Patient or Relative when photograph(s) are obtained)**

FC July 2017

Effingham Health System is a Tobacco Free facility. The use of any tobacco products, e cigarettes or vaping equipment is prohibited on all properties, including parking areas, owned or occupied by Effingham Health System.

Release of Information

_____: Initial I hereby authorize payment of the hospital benefits otherwise payable to me and applicable only to unpaid charges, for this visit directly to this office. I give my permission of this office to release medical information for insurance purposes.

Patient Responsibility

_____: Initial I understand that Effingham Physician Practices will file my insurance as a courtesy, but it is my responsibility to understand my insurance coverage. I understand that I will be responsible for any charges my insurance will not cover.

Consent to be photographed

_____: Initial I understand that photographs or other images may be recorded to document my care, and I consent to this. Effingham Health System will retain the ownership rights to these images. Images will be stored in a secure manner in my medical record. Images that identify me may be used at Effingham Health System only for purposes of treatment, payment or healthcare operations and will not be released and/or used outside the organization for any purpose unless authorized by me or my legal representative.

Prescription (Rx) History Consent

_____: Initial I authorize Effingham Physician Practices to access my prescription history in order to perform accurate medication reconciliation.

Patient's Rights And Responsibilities

I acknowledge that I have been offered a copy of the **PATIENT'S RIGHTS AND RESPONSIBILITIES**, which details my rights as a patient at Effingham Health System (EHS).

Effingham Health System is committed to providing and supporting healthcare excellence to the citizens we serve. Our commitment to patients is reflected in our willingness to provide patient care and services and not be influenced by age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression. Any person who needs emergency treatment at our facility will be treated in accordance with the Emergency Medical Treatment and Labor Act (EMTALA) and be discharged and referred without discrimination."

Let it be known that in any instance Effingham Health System is mentioned, **all** departments and locations of the Health System are included.

_____ _____ _____

Date/Time **Signature** **Patient's Printed Name**

Relationship: _____ Witness:_____

(**Must be signed by Patient or Relative when photograph(s) are obtained)**

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Patient Name: _____ Date of Birth: _____

Medical History – Have you ever had any of the following conditions of diagnoses? Check all that apply.

Allergies	☐ Yes	☐ No		
Anemia	☐ Yes	☐ No		
Anxiety	☐ Yes	☐ No		
Arthritis	☐ Yes	☐ No		
Asthma	☐ Yes	☐ No		
Cancer	☐ Yes	☐ No		
Depression	☐ Yes	☐ No		
Diabetes	☐ Type 1		☐ Type 2	☐ Gestational
GERD	☐ Yes	☐ No		
Heart Disease	☐ Yes	☐ No		
Hypercholesterolemia	☐ Yes	☐ No		
Hypertension	☐ Yes	☐ No		
Seizures	☐ Yes	☐ No		
Stroke	☐ Yes	☐ No		

Other: _____

Surgical History- Have you ever had any of the following surgeries? Check all that apply.

Appendectomy	☐ Yes	☐ No
Cholecystectomy	☐ Yes	☐ No
Eye surgery	☐ Yes	☐ No
Fracture repair	☐ Yes	☐ No
Heart Bypass Surgery	☐ Yes	☐ No
Heart stent	☐ Yes	☐ No
Heart Valve Repair	☐ Yes	☐ No
Hernia Repair	☐ Yes	☐ No
Tonsillectomy	☐ Yes	☐ No

Other: _____

Medications

Medication Name (include all prescriptions, over the counter, and vitamins)	Dose	Frequency	For what?

Patient Name: _____ Date of Birth: _____

Family History

Has your mother had any of the following?
O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Unknown
Has your father had any of the following?
O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Unknown
Has your siblings had any of the following?
O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Unknown
Has your maternal grandfather had any of the following?
O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Unknown
Has your maternal grandmother had any of the following?
O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Unknown
Has your paternal grandfather had any of the following?
O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Unknown
Has your paternal grandmother had any of the following?
O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Unknown
Other family history: _____

Depression Screening – For patients 12 years old and older.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things?
O Not at all O Several days O More than half the days O Nearly every day
Feeling down, depressed, or hopeless?
O Not at all O Several days O More than half the days O Nearly every day
Trouble falling or staying asleep, or sleeping too much?
O Not at all O Several days O More than half the days O Nearly every day
Feeling tired or having little energy?
O Not at all O Several days O More than half the days O Nearly every day
Poor appetite or overeating?
O Not at all O Several days O More than half the days O Nearly every day
Feeling bad about yourself or that you are a failure or have let yourself or your family down?
O Not at all O Several days O More than half the days O Nearly every day
Trouble concentrating on things, such as reading the newspaper or watching television?
O Not at all O Several days O More than half the days O Nearly every day
Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?
O Not at all O Several days O More than half the days O Nearly every day
Thoughts that you would be better off dead or of hurting yourself in some way?
O Not at all O Several days O More than half the days O Nearly every day

Patient Name: _____ Date of Birth: _____

Tobacco Use – For patients 18 years old and older.

Are you a smoker?

O current smoker O former smoker O never smoker O light tobacco smoker
O heavy tobacco smoker

If current smoker, how often do you smoke cigarettes?

O every day O some days O but not every day

If current smoker, how many cigarettes a day do you smoke?

O 5 or less O 6-10 O 11-20 O 21-30 O 31 or more

If current smoker, how soon after you wake up do you smoke your first cigarette?

O within 5 min O 6-30 min O 31-60 min O after 60 min

If current smoker, are you interested in quitting?

O Ready to quit O Thinking about quitting O Not ready to quit O 21-30
O 31 or more

Alcohol Screening – For patients 18 years old and older.

Did you have a drink containing alcohol in the past year?

O Yes O No

How often did you have a drink containing alcohol in the past year?

O never (0 points) O monthly or less (1 point) O 2 to 4 times a month (2 points)
O 2 to 3 times a week (3 points) O 4 or more times a week (4 points)
O 6 or more times a week (4 points)

How many drinks did you have on a typical day when you were drinking in the past year?

O 1 or 2 drinks (0 points) O 1 to 2 drinks (0 points) O 3 or 4 drinks (1 point)
O 5 or 6 drinks (2 points) O 7 to 9 drinks (3 points) O 10 or more drinks (4 points)

How often did you have 6 or more drinks on on occasion in the past year?

O never (0 points) O monthly (2 points) O less than monthly (1 point)
O weekly(3 points) O daily or almost daily (4 points)

Interpretation O Positive O Negative

(The alcohol screening is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive. In women, a score of 3 or more is considered positive.)

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of protected health information. Protected Health Information (PHI) is the use or disclosure about your medical treatment, payment or healthcare operations

PLEASE PRINT BELOW THE PERSON(S) TO WHOM WE MAY DISCUSS YOUR PHI AND RELEASE INFORMATION TO:

1. _____
2. _____
3. _____
4. _____

I wish to be contacted in the following manner (check all that apply)

_____ Home Telephone _____

_____ Cell Phone Number _____

_____Email_____

_____Mail_____

You may leave a message with, discuss my treatment, appointments, release information, or other scheduling that may occur or give information as necessary with the above family, friend or personal representatives. I understand that Effingham Health System will refuse to discuss my information with anyone **not** listed above, except in an emergency. I also understand that this consent does not apply to medical providers for continuity of care.

_____	_____	_____
Patient's Signature and Date	**Patient's Printed Name**	**Date of Birth**

Effingham™ HEALTH SYSTEM