ChristianaCare

Baltz Elementary School-Based Health Center

1500 Spruce Avenue
Wilmington, DE 19805
Phone: (302) 651-2696 Fax: (302) 651-2697

Dear Parents/Guardians:

The School-Based Health Center (SBHC) is a partnership between ChristianaCare Health Services and Red Clay School District. This letter is an invitation to sign up your child in the SBHC.

Health care is provided in the SBHC at your child's school by a Physician or Nurse Practitioner/Physician Assistant and a Licensed Clinical Social Worker/Licensed Professional Counselor of Mental Health, and Registered Dietician.

To sign up your child in the SBHC, you need to provide the following:

- **Up-to-date insurance information** is required if your child is insured. (Note: No co-pay, co-insurance or deductible will be charged). If you do not have insurance, we will provide healthcare services while we work with you to obtain coverage.
- **A completed Consent Form** (included in this packet).
- A completed **Student Registration Form** and **Health History Form** (included in this packet)

The completed enrollment/registration forms should be returned to the SBHC as soon as possible.

SBHC services offered:

- Physicals
- Health screenings
- Immunizations
- Diagnosis and treatment of minor illnesses and injuries
- Counseling (individual, family and group)
- Crisis intervention and suicide prevention
- Health education/risk reduction
- Nutrition Counseling

Please know that your child's pediatrician or family doctor will still be your child's main doctor. The SBHC does not take the place of your child's pediatrician or family doctor, and SBHC doctors and nurses will work with your child's main doctor to care for your child. The SBHC offers services that may add to the care provided by your main doctor. When appropriate, and with your permission, we will try to share medical information with your child's doctor to prevent any duplication of health care services, and to take good care of your child. If your child does not have a doctor, we can help you find one.

We hope that you will register your child in the SBHC. Then, together with you and your child's primary doctor, we can work towards keeping your child healthy and in school. Please encourage your child's pediatrician or family doctor to call the SBHC with questions. **If you have questions or need more information, please call the SBHC at (302) 651-2696.**

10. ***I understand*** that a telehealth visit is not the same as an in-person visit because I will not be in the same room with my provider. I understand that I will not be treated through telehealth unless my condition supports the use of this technology as my provider will not be able to perform some aspects of a full physical examination.

11. ***I understand*** that digital communication technology may include, but not be limited to real time two-way audio, video, or other telecommunications or electronic communications, including remote patient monitoring, secure video conferencing, and/or secure texting with my care team.

12. ***I understand*** that there are benefits to utilizing telehealth services, which include, but are not limited to, convenient medical evaluation and management. I also understand that there are risks involved in receiving treatment through telehealth, which include, but are not limited to interruption in the audio/video connection that may result in the visit being postponed until a later time and/or performed through an alternate method, and, in rare cases, unauthorized access to my confidential information. In the event of a technical failure, I understand that I should immediately contact my provider's office, or, if it is an emergency, dial 911.

13. ***I understand*** that laws protecting the confidentiality of my medical information also apply to telehealth and that ChristianaCare uses security protocols to help protect my privacy and ensure my confidential communications are sent only to the intended care team member(s).

14. ***I understand*** that ChristianaCare will not record the video or audio of my telehealth visit without my consent at the time of the recording.

15. ***I consent*** to have ChristianaCare obtain health information from me and provide health care services to me through telehealth communications when and where my provider or qualified member of my care team determines it is appropriate and necessary.

16. ***I understand*** that I may refuse or stop participation in telehealth services and request alternate services, such as an in-person visit, at any time.

By signing below, I certify that I am the parent or legal guardian of the student named above and have read the above consent statements about services offered at my student's School-Based Health Center and voluntarily agree to have my student participate. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from the services/treatment.

Print Name of Parent/Legal Guardian: _____
Signature of Parent/Legal Guardian:_____
Date: _____

ChristianaCare

Christiana Care Health System School-Based Health Center
Patient Registration Form

Patient (Student) Information – Please Print (*in pen*)

School
Baltz Elementary School

Grade: Pre-K K 1 2 3 4 5

Patient's Last Name:	**First:**	**Middle:**

Identified Sex: ☐ **Male** ☐ **Female** ☐ **Transgender Male** ☐ **Transgender Female** ☐ **Decline to Answer**

Address: **Zip Code**	**City**	**State**	**Birthdate:**

Race (please circle all that apply): Caucasian/White Black/African American Asian/Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native Undetermined Other	**Ethnicity** (please circle): Hispanic/Latino Arabic Non-hispanic/latino/arabic
Primary Care Physician (Family Doctor) **Name:**_____ **Phone Number:** _____	**In case of an emergency contact:** _____ **Relationship to patient:**_____ **Phone #:**_____

Parental/Legal Guardian Information

Mother's Full Legal Name:	**Date of Birth:**	
Address:	Home Phone#:	
Parent Email Address:	Cell Phone#:	
Employer Name & Address:	Work Phone#:	
Father's Full Legal Name:	**Date of Birth:**	Home Phone#:
Address:	Cell Phone#:	
Employer Name & Address:	Work Phone#:	
Legal Guardian Name (if not mother or father): **Relationship to Student**	**Date of Birth:**	Home Phone#:
Address:	Cell Phone#:	
Employer Name & Address:	Work Phone#:	

► Insurance Information (REQUIRED) – *Send in a Copy Front and Back of Insurance Card*

Source of payment for care, please check off one of the following: _____**No Insurance** _____**Medicaid Provider:** _____ **Medicaid Number:** _____ _____**Commercial Insurance :** _____ **Policy Number:** _____ **Subscriber Name:** _____ **Relationship to Student:** _____ **Subscriber Birthdate:** _____ **Delaware Healthy Children Program**	***Secondary Insurance Information:*** ____**Medicaid Provider:** _____ **Medicaid Number:** _____ ____**Commercial Insurance:** _____ **Policy Number:** _____ **Subscriber Name:** _____ **Relationship to Student:** _____ **Subscriber Birthdate:** _____

ChristianaCare

Christianacare-

Privacy Office
4000 NeXUS orive,Avenue North-suite NW3-tOO,
Wilmillgton, DE 19803
Telephone NO.: 302 23-4468, rax NO.: 302-425-2,175

Ejfettive Date: September 23i 2013
Last RevisedDat.e:September 27, 2021

HIPAA Notice of Privacy Practices (NPP): Please Review It carefully!

ThisSummary NPP*or* Noticeis aboutYoor Information, Your Rights, and Our Responsibilities. It describes how your information may be used and disclosed by ChristianaCare, and how you can get accessto it. ChristianaCare ta.kes our patients' privacy seriously. We knowthat your medical information is verypersonal We do our bestto protect the privacy of yourmedical infonnation. We will onty use a.nd disclose the minimum necessary informationfor the intended purpose and as required by law. Youcanaskfor a COPY of our detailed NPP *or* accessit on our website www.christian acare.org/privacy

Our Responsibilities	To serveyou, we createandreceive personal information aboutyour health. This information is caned Protected Health information (PHI), and it comesfrom you, yourphysicians. hospitals, a.nd other healthca.re service providersinvotved in yourcare. For members of the ChristianaCareHealth & Welfare Benefits Plan {benefitsplan). PHI may come from youremployer, otherinsurers, Health Maintenance Organizations {HM Os) or third-party administrators {TPAs), as applka.ble. Your PHI can be in oral, written, or electronic format. We are required bylaw to: • maintain the privacy and security of your PHI. • enter intoa Business Associate Agreement with third parties who participate in your treatment, payment, and oor health careoperations that requires the business associate to protect the privacy and security of PHI. • notifyyou promptly if we determine inappropriate use orISclosure ofyour PHI has occurred that compromises the privacy or security of your information. • use and disdoseyourinformation, asdescribed in this Notice. unless you tell us we cannot in writing. If you cha.nge your mind at any time, you must tellus in writing. • follow the duties and privacy practices described in this Noticeand giveyou a copy of it.
Who will fofkrw this Notice?	• All OiristianaCareorganizations, facilities, a.nd medical practices • Anydoctor, health care professional, or other person caringfor you • All peoplewho wortforChristiana Care • All OiristianaCare volunteers • Anybusiness associateneeding health information, so they can provideservices forChristianaCare
We maystore thefoUowinc information about you:	**Your Information** The information we may storeincludes, but is not limited to: • Clinical Data: Diagnoses/Conditions, La.b Resutts, Medications, Other Treatment Information • Demographic Data: AIJdressfr.p Code, Dateof Birth, Driver'sLicense, Name, Social Security Number, Other Identifiers • Financial Data: Claims Information, Credit Card/Bank Account Number, Other Financial Information, Name, and Driver's LicenseInformation
We may use and disdose your information for purposesof:	**O' Uses an Disdosures** This section desaibes how we may use and giveout medical information a.boot you. Although this list d'Jes not contai'Ie,myp::assbiity, all of-the waysthatweareallowed to use and *OW* out i11fu 11ebCA1without your permission will fall within one of the categories listed in this section. We may use and disdoseyour information for the followingsituations, including, but not limited to: • Helping to manage the health caretreatment yooreceive • Coordinating your care among various health care providers • Collecting standardized assessment information to completea Home Health Assessment on admission • Billing for your health services and managing our health careoperations • Conducting research