

## SCHOOL-BASED TELEHEALTH CONSENT FORM

All students receive basic first aid treatment while at school. However, in order for students to initiate a telehealth visit, parents/guardians must:

1. Fill out applicable legal/payment/insurance information
2. Select a telehealth provider
3. Sign the opt-in waiver & telehealth consent below once per school year, **AND**
4. Give verbal consent at the time of visit.

### A – PATIENT/STUDENT LEGAL & DEMOGRAPHIC INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Preferred Pronouns (optional): \_\_\_\_ he/him \_\_\_\_ she/her \_\_\_\_ they/them

Race (optional):

\_\_\_\_ White \_\_\_\_ Black or African American \_\_\_\_ American Indian or Alaska Native

\_\_\_\_ Asian \_\_\_\_ Native Hawaiian or Other Pacifica Islander

Ethnicity (optional):

\_\_\_\_ Not Hispanic/Not Latino \_\_\_\_ Hispanic/Latino

Student's Full Address:

Street Name & Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

### B – GUARANTOR'S LEGAL & DEMOGRAPHIC INFORMATION (Financially Responsible Party)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Preferred Pronouns (optional): \_\_\_\_ he/him \_\_\_\_ she/her \_\_\_\_ they/them

Telephone Number: \_\_\_\_\_

Guarantor's Full Address (if different from the student's):

Street Name & Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

### C – PAYMENT/INSURANCE

Telehealth providers may bill you for telehealth appointments. Parents/Guardians may elect billing preference. Any associated billing for insured patients is the responsibility of the patient, NOT the District or school. Patients with financial needs can request financial aid below.

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**Please choose ONE:**

- Please bill my student's/the patient's medical insurance:**

Insurance Company: \_\_\_\_\_

Plan Name (if applicable): \_\_\_\_\_

Payer ID (If applicable): \_\_\_\_\_

Primary Subscriber Name: \_\_\_\_\_

Primary Subscriber's Full Address (if different from the student's):

Street Name & Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Primary Subscriber DOB: \_\_\_/\_\_\_/\_\_\_\_\_

Primary Subscriber's Preferred Pronouns (optional): \_\_\_ he/him \_\_\_ she/her \_\_\_ they/them

Primary Subscriber Insurance ID #: \_\_\_\_\_

Patient's relationship to subscriber: \_\_\_\_\_

- I do not have insurance, but I am able to pay for telehealth visit. Visit will be billed to guarantor listed above. (Visits cost up to \$69.00)**
- I am concerned about ability to pay and would like to be considered for financial assistance.**

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**D – PREFERRED PHARMACY**

If the provider determines prescription treatment is necessary, a prescription will be sent to the pharmacy below. The parent/guardian is responsible for picking up and administering the first dose of medication at home.

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

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**F – PATIENT AGREEMENT**

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- I certify the above information is true and correct to the best of my knowledge and belief.
- I understand the school-based health clinic will attempt to contact me when my student seeks assistance in the clinic beyond typical first aid care and a visit will not be initiated without consent by a parent/guardian at the time of service.
- I understand medication may be administered by Unlicensed Assistive Personnel or trained school volunteers under the direction of a nurse.
- If selected above, I give consent for my student to receive health services which may include physical examination, treatment for chronic and acute health problems, health education, and limited diagnostic tests (e.g. throat cultures, urine dip, etc.). Telehealth visits may result in photos or recordings taken during the exam. These photos and videos may be shared with consulting providers during telehealth visits. These photos and recordings will be deleted from the device after the telehealth visit and no permanent record will be stored by (school district).
- I understand that school personnel will not have access to any medical records, and the results of all examinations and counseling are strictly confidential. I agree that patient records may be shared with the Utah Department of Health and any telehealth provider or consulting physicians as necessary.
- If my student has a communicable disease, I give consent to the (School District) Health Services Department School Clinic to share medical information with the student's school.
- I understand that if it is deemed necessary to send my student home during school hours for medical reasons, he/she will need to be picked up from the school within 45 minutes of notification from the school office.
- Services rendered by a telehealth medical provider may be billed. I will be responsible for amount not covered by my insurance company. Financial assistance may be available for families without health insurance or financial hardship through chosen providers. (School District) is not responsible for any financial cost incurred during a telehealth visit.
- I understand that I can withdraw my consent to have my student treated at the (School District) Telehealth Clinic at any time by written documentation delivered to the clinic staff.

Printed Name of Parent/Legal Guardian: \_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Interpreter Name(If Applicable): \_\_\_\_\_ Agency: \_\_\_\_\_

## Consent and Conditions of Service – School Based Connect Care

As the patient, or as the personal representative of the patient (in either case, the "Patient"), I consent to the terms and conditions of this agreement. By signing below, I intend that the following terms apply to all healthcare services received by the Patient from providers employed or contracted by IHC Health Services, Inc. ("Intermountain Healthcare" or "Intermountain") and provided through the Connect Care platform. The terms "I," "my," and "you" in this agreement refer to the patient and to his or her authorized agent or legal representative.

### Consent to healthcare services

1. **I consent to healthcare services through the Connect Care Service provided by Intermountain.** This includes services I receive provided by Intermountain employees, medical staff, and independent contractors for any visits provided during the school year. Healthcare services include all healthcare and related medical, surgical, diagnostic, and therapeutic services, the implementing of physician orders, and all tests, studies, treatments and procedures ordered and performed in the good faith belief that they are either medically necessary or otherwise appropriate for me under the circumstances.

I understand that:

- All healthcare services come with some risk, sometimes even the risk of serious harm. I accept this risk in the hope of a good result.
- No promise has been made to me concerning a final result, outcome, or cure.
- Healthcare provider training may occur during my care. Any care provided by a trainee will be under the supervision of my doctor or healthcare team.
- I can change my mind or refuse care. If I do, I must tell my healthcare team as soon as possible.

### Privacy of my setting

2. I understand that I may access the Connect Care Service through a mobile application (which is part of the Connect Care Service) or through an approved web browser using a phone, device, computer, kiosk, or other equipment that may be located in a variety of settings. By proceeding to use the Connect Care Service, I understand and agree that:
  - I determine my expectation of privacy and security in choosing my setting.
  - I am responsible to make sure I am comfortable with the privacy and security of my setting regardless of how I access the Connect Care Service or who owns the equipment through which the service is provided.
  - If I am not comfortable sharing certain information in my setting, I will not share that information.
  - If I choose to share information in a setting that is not private or secure, I do so at my own risk.
  - Neither Intermountain Healthcare nor any other third party is liable for information that I choose to disclose or not to disclose based on my setting.

### My protected health information

3. **Intermountain will keep medical records about me confidential**, as required by state and federal laws. I have been offered a copy of Intermountain's Notice of Privacy Practices, which describes how medical information about me may be used and shared and my rights including how I can get access to this information. It may be revised from time to time, and I may ask to see a copy at any time.
4. I consent for my health information to be accessed by anyone at Intermountain needing it for treatment, payment, or healthcare operations, without further approval from me.

### Consent for TeleHealth Services

5. I understand the Connect Care is a telehealth service. In using this telehealth service, I understand that:
  - I will be allowed to select my providers treating me through Connect Care to the extent possible.
  - Intermountain safeguards medical information about me used in telehealth services, and only uses and shares this information as described in Intermountain's Notice of Privacy Practices.
  - The technology used to deliver telehealth services meets industry security and privacy standards.
  - This technology could fail resulting in lost information and potential exposure of my health information notwithstanding the security measures in place.

### Financial Assistance

6. I understand that **I can apply for financial assistance** through Intermountain's Financial Assistance Policy.

### Insurance and government payments

7. **I consent for Intermountain to file for insurance benefits** to pay for my care.
  - I transfer to Intermountain (and to any other healthcare provider for whom Intermountain bills) the benefits of any insurance policy or other arrangement that may pay for my care.
  - I consent for Intermountain (and anyone it may assign as my legal representative) to negotiate claims with any insurance company or other payer to obtain payment for services provided to me.
  - I consent for Intermountain to deposit any money received against the charges of the facility (and of any other healthcare provider for whom Intermountain bills).

8. I attest that **any information I have used to apply for government benefits is correct**. This includes Medicare, Medicaid, Tricare, or any other government program.
- I consent for Intermountain (or anyone else with medical information needed to process a claim for payment) to share it with government program administrators or any other payer.
  - I request these payers to make payments for all these services directly to Intermountain.

**What I am responsible to pay**

9. I, as the patient or as a person signing for the patient who is otherwise legally responsible to pay for the care of the patient (the "Responsible Party"), agree to pay for the following charges:
- **All amounts owed for healthcare services I receive from Intermountain**, as determined by Intermountain or an independent contractor.
  - **My share of the costs**, including all co-payments, deductibles, and co-insurances that apply.
  - **All charges for non-covered services**.
  - **Interest on unpaid balances** that are more than 30 days past due or are sent by Intermountain or an independent contractor for collection.
  - A service charge of \$20.00 for any check or form of payment that returns unpaid.
  - All costs and attorney fees (if used) Intermountain or an independent contractor incurs if either refers my overdue bill for collection.
  - If I am the Responsible Party, **I hereby consent to credit bureau inquiries** for Intermountain Healthcare's or the independent contractor's business needs, including any account management companies and debt collectors.
10. I agree that any overpayment I make will be applied to any other accounts with Intermountain owed by me with any excess being refunded to the proper party in accordance with Intermountain policy.

**Consent for Text, Digital, and Email Communications**

11. **I hereby consent to receiving text, digital, and email communications** (including auto-dialed, artificial, and pre-recorded messages and calls) to my cellular phone number, email address, and any other telephone numbers provided during any interaction, agreement or communication with the Intermountain Healthcare system, the independent contractor, or their affiliates, agents and contractors. I acknowledge that text and email communications are not a secure method of communication and accept the risk that my information may be intercepted and read by a third party.

**Changes to this consent**

12. If I make changes to this consent document, they are not valid.

**By signing below, I understand and agree to the following:**

- a. I have had the opportunity to read this agreement, or have it read to me, and I understand what I am agreeing to.
- b. I have had the opportunity to ask questions regarding this agreement and I have received satisfactory answers to all my questions.
- c. I can ask for and get a copy of this agreement.
- d. This document will remain in effect unless I revoke it in writing.

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I have received or been offered a copy of Intermountain Healthcare's Notice of Privacy Practices.

Date: \_\_\_\_\_ Initials: \_\_\_\_\_

Date:	Patient or Authorized Representative Signature	Representative Name (print name)
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Language services, free of charge, are available upon request \* Se proveen servicios de interpretación gratis. Hable con un empleado para solicitarlo \* 我們將根據您的需求提供免費的口譯服務。請找尋工作人員協助