Parent(s) and/or Guardian(s):

East Georgia Healthcare Center offers healthcare services at your child's school through our school-based clinic. The clinic gives your child an opportunity to be evaluated by a licensed healthcare provider without having to miss a great deal of class time. Parents and/or guardians do not need to be present during the visit, but a signed consent form is required for examinations & treatment. We will notify and obtain verbal consent from parents or guardians before each visit if they are not present. After each visit, you will be contacted again to review the examination and address any questions you may have. To ensure timely service, please keep your contact information up to date. Full summaries of the visit will be sent through our secure patient portal.

Description of Services

A sliding fee scale is offered for patients without insurance, however, if you do have insurance this will be billed at the time services are provided to your child. Any co-pays or deductibles for students will be billed to the parent or guardian by mail.

The following services are provided:

- Preventative medicine services such as Well Child Physicals
- Same day sick visits
- Sports physicals, vaccinations, prescriptions, lab testing, referrals, and follow up care
- Administration of medication for health problems as appropriate
- Chronic condition and medication management
- Mental health counseling

Staff Contact Information & Health Center Hours

East Georgia Healthcare Center strives to provide exceptional care for your children and family. If you have any questions, please feel free to contact us at **(478) 494-9926.**

Hours of Operation and Service Locations

We are open daily following the school calendar.

Twin City Elementary
Monday & Tuesday 8:00am-4:15pm

Emanuel County Institute
Wednesday - Friday 8:00am-4:15pm

Jenkins County Schools
Monday - Friday 8:30am - 2:30pm

Langston Chapel Schools
Monday - Friday 8:00am – 4:00pm

Treutlen County Schools
Monday 8:00 am-6:00 pm
Tuesday - Thursday 8:00 am-5:00 pm
Friday 8:00 am-3:30 pm
Closed Daily for Lunch 12:00pm-1:00pm

Swainsboro Elementary School
Monday 8:00am-4:00pm
Tuesday 8:00am-4:00pm
Wednesday 8:00am-5:00pm
Thursday 8:00am-4:00pm
Friday 8:00am-3:30pm

*Please keep this page for reference

ENROLLMENT & CONSENT FORM

East Georgia Healthcare Center

Phone (478) 494-9926

STUDENT INFORMATION

Student Name: _____School of Attendance:_____ Grade: _____

Address: _____ Birth date: _____

City/State/Zip: _____

Student SS#: _____ Email: _____Cell:_____

☐ **I have completed the demographic update on the Patient Portal or have visited the clinic to complete the necessary forms as instructed for services with East Georgia Healthcare Center.*

PARENT / GUARDIAN INFORMATION

Father: _____ Phone (H)_____ (W)_____ (C) _____Email _____

Mother: _____Phone (H)_____ (W)_____ (C) _____E-mail_____

Guardian: _____Phone (H)_____ (W)_____ (C) _____E-mail_____

Alternate Contact:

Relationship to the child _____

Name_____Phone (H)_____ (W)_____ (C) _____E-mail_____

Alternate Contact:

Relationship to the child_____

Name_____Phone (H)_____ (W)_____ (C) _____E-mail_____

CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

I, the parent/guardian of said student, give consent for my child to receive services at the school-based health center. I understand that this consent form is valid for the duration of my child's education in a public school system served by EGHC or until I provide the healthcare center staff with written directions otherwise.

All healthcare information is confidential. By signing the consent form, you are giving the healthcare center, school nurse, and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing purposes.

Confidentiality between the student, parents, and the health center is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions. I am the legal guardian of the above-named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above-named child will be shared between the medical provider and the alternative contact.

_____ _____

Signature of Parent / Legal Guardian Date

east georgia healthcare center

PATIENT INFORMATION

Patient's Full Name: _____ Date of Birth: _____ SSN: ___ - ___ - _____

Mailing Address: _____
City State Zip Code

Physical Address: _____
City State Zip Code

Home Phone: _____ Cell Phone: _____ **Preferred Pharmacy:** _____

I would like to receive appointment reminders and/or test results by (Circle One of Each) Cell or Home Text or Voice

Preferred Number (Circle One): Home Cell Other Email:

Race (Check all that apply): White Black/African American Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian
American Indian/Alaska Native Native Hawaiian Other Pacific Islander Guamanian or Chamorro Samoan Choose not to disclose

Ethnic Background (Check all that apply): Non-Hispanic/Latino Cuban Mexican Mexican American Chicano/a
Puerto Rican Another Hispanic/Latino/Spanish Origin _____ Choose not to disclose

Preferred Language: (Circle One): English Spanish Other (please specify)

Gender at Birth (Circle One): Male Female Unknown

Housing Status: Homeless? [ ] Yes [ ] No Resident of Public Housing? [ ] Yes [ ] No

Student Status: (Circle One): Full-Time Part-Time Not a student Are you a veteran? [ ] Yes [ ] No Disabled? [ ] Yes [} No

Marital Status (Circle One): Single Married Divorced Separated Widowed

GUARANTOR INFORMATION

If other than Mother or Father, please provide a copy of custody paperwork.
We consider the person completing this form to be financially responsible for patient.

Person Completing This Form (Circle One): Self Mother Father Legal Guardian Other (specify):

Name: _____ Date of Birth: _____ SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____

Employment Status:(Circle all that apply) Full-Time Part-Time Not Employed Self-Employed Retired Military-Active Military-Reserve

Annual Household Income: **[ ] $15,960 or less [ ] $15,961 - $23,940 [ ] $23,941 – $31,920 [ ] $31,921 or more**

1. **Have you or anyone in your family performed any type of farm work in the last two (2) years?** [ ] Yes [ ] No
2. **If yes to #1, have you or a member of your family ever moved somewhere to do farm work?** [ ] Yes (migrant) [ ] No (seasonal)
3. **If yes to #1, have you or anyone in your family stopped migrating to work in agriculture because of a disability or age?** [ ] Yes [ ] No

Emergency Contact Information

Name: _____ Relationship to Patient _____

Mailing Address: _____ City _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone _____ Email _____

Insurance Information

Choose all that apply: [ ] I am uninsured [ ] I am insured [ ] I have private insurance [ ] I have Medicaid [ ] I have Medicare

I don't have insurance and I would like information about affordable insurance options and enrollment [ ] Yes [ ] No

Primary Insurance Company: _____ ID# _____ Policy Holder Name: _____

Secondary Insurance Company: _____ ID# _____ Policy Holder Name: _____

Payment is expected at the time of service. If you have insurance, we will file your claim as a courtesy; however, your insurance policy is a contract between you and your insurance company, not between EGHC and the insurance company. If your insurance does not pay all or part of your claim, you, the patient, will be billed for the remaining balance and are responsible for ensuring payment is made.

Patients without insurance are responsible for paying in full at the time of service.

By signing below, you authorize EGHC to submit claims to your insurance company (if applicable) and acknowledge that you are financially responsible for any remaining balance.

Are you interested in applying for our sliding fee discount program?

YES	NO	Currently enrolled

_____ _____

Patient or Responsible Party's Signature **Date**

HIPAA – Authorization of Protected Health Information

I_____ give permission for the following person(s) to participate in the
(Patient/Parent's/Guardian's Name if under 18)

care of _____ while treated by the staff of East Georgia Healthcare Center.
(Patient's Name)

I authorize the following person(s) to accompany the patient to the office, to participate in their medical care to be provided in the office, to pick up prescriptions for the patient, and/or access patient record(s) if they're unable to do so personally. A picture ID will be required.

Patient's Date of Birth _____

Name/Relationship/Phone number	Allowed to accompany patient (and make medical decisions if patient is a minor):	Allowed to pick up prescriptions:	Allowed to access **ALL** patient records:	Allowed to access all patients records excluding mental/behavioral health and/or Substance Use Disorder (SUD)
	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No

*****If there are specific encounters or record types you wish to remain confidential please discuss that with your provider or nurse.*****

Prescription delivery: I authorize EGHC pharmacy to deliver my/my dependent's prescription medication as requested. Home_____ Work _____ EGHC Clinic_____

_____ _____

Patient /Parent's /Guardian's Signature Date Signed

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION INCLUDING ANY SUBSTANCE USE DISORDER RECORDS ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Center may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Center or the hospital. For example, we may disclose medical information about you to people outside the Center who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Center and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Center personnel for review and learning purposes. For example, we may review your record to assist with our quality improvement efforts.

NOTE: Use and disclosures described above as they relate to Substance Use Disorder ("SUD") records require your specific consent at the bottom of this form before we can utilize them for treatment, payment or healthcare operation purposes ("TPO"). You can sign one form to permit all future uses and disclosure for TPO purposes, or you can restrict your consent to each individual disclosure. Examples of how your SUD information is used or disclosed upon our consent is consistent with the examples set out above. You should be informed that the requirement for your consent for TPO is specific to us. Once any SUD records are released to another HIPAA covered entity or business associate, they are permitted to redisclose records in accordance with HIPAA regulations.

For Appointment and Health Reminders. We may contact you by telephone, text or email to remind you of your scheduled appointments or recommended services.

WHO WILL FOLLOW THIS NOTICE. This notice describes our Center's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Center personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Center. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Center, whether made by Center personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Current law permits us to include any SUD records in your treatment record with other treatment therapies. **Other ways we may use or disclose your protected healthcare information include appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; and others; public health risks; and worker's compensation.

**Other than releasing SUD records to a coroner or medical director without specific consent and to public health authorities, provided that the records disclosed are de-identified according to standards established in the HIPAA Privacy Rule, your written consent is required for the other types of disclosure mentioned above, i.e., research, fundraising, avert a serious threat to health or safety except in emergency situations, law enforcement, military and veterans, national security and intelligence activities, organ and tissue donations; and other public health risks and workers' compensation. Any SUD records may not be used as records and testimony in civil, criminal, administrative and legislative proceedings absent your written consent.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny *your* request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Center. To request an amendment, your request must be made in writing and submitted to the Privacy Officer, and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations (SUD records require your specific written consent)You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Except as to SUD treatment, ***we are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Center For any SUD related treatment, you must provide your written consent to be included in fundraising activities.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full. Disclosure of SUD records to a health plan require your written consent.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing, and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you (for SUD disclosures, your request can include the prior three years). To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Center's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Center or with the Secretary of the Department of Health and Human Services. To file a complaint with the Center, contact Tracy Mason, Privacy Officer, (478) 237-6262 x 01204 215 N. Coleman Dr., Swainsboro, GA 30401. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient/Parent's/Guardian's Signature **Date Signed**