Dear Parents/Guardians,

It is my pleasure to introduce you to Decatur County TeleHealth. Our primary focus is to provide quality, accessible health care to the children and staff of Decatur County Schools.

What is Decatur County TeleHealth?

- Decatur County TeleHealth is a comprehensive Adult & Pediatric Primary Care service currently located at Jones Wheat (JWE) and West Bainbridge (WBE) Elementary Schools in collaboration with the providers of Memorial Hospital and Manor.
- Only students and staff at the above mentioned schools can be served at this time.

What services will Decatur County TeleHealth Offer?

- Care for acute illnesses (i.e., sore throat, earache, colds, rashes, eye infections)
- Minor injuries (i.e., scrapes and muscle strains)
- Management and ongoing care of existing medical conditions (i.e., asthma, sickle cell)
- Monthly medication management/medication maintenance
- Professional counseling in regard to nutrition and personal hygiene
- Mental health, substance abuse and family centered case management

How do I enroll my child with Decatur County TeleHealth?

- Contact the Decatur County TeleHealth Coordinator at your child's school.
- Fill out the health questionnaire and consent forms.
- Give a front and back copy of your insurance card to Decatur County TeleHealth.

What if my child is enrolled with Medicaid, Wellcare, PeachState or Amerigroup?

Decatur County TeleHealth is a part of several insurance plans including the Medicaid system Georgia Better Health Care, WellCare, PeachState for Kids and Amerigroup. Medicaid and PeachState only allows up to 5 out-of-network visits per year. If you wish for Decatur County of Georgia to become your child's medical home, he/she must be enrolled with the Medical Providers at Memorial Pediatrics. You can call GBHC at 1-866-211-0950 and ask them to assign your child to Memorial Pediatrics.

What if my child is enrolled with a private insurance plan?

For private insurance, please contact Decatur County TeleHealth with a copy of your insurance card front and back in order to verify if you can use your insurance for this type of care at the school site.

What if my child does not have health insurance?

If you do not have Medicaid or any type of insurance, please call Decatur County TeleHealth at (229) 248-2218 for JWE or (229) 248-2821 for WBE, depending on the school your child attends. You may be eligible for free or low-cost insurance offered through the State of Georgia. *Without proper insurance coverage benefits, you will be financially responsible for the services rendered.*

When is Decatur County TeleHealth open?

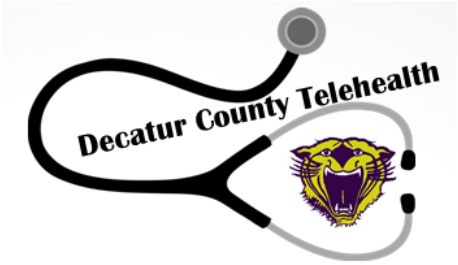
- Monday-Friday, during school hours.
- For after hours service, children will need to be seen at Memorial Pediatrics or at their primary medical office.

Does a parent/guardian have to be present?

- Parents/guardians are strongly encouraged to be present when a child is being treated.
- If a parent/guardian cannot be present, the child will still be treated. Someone from the clinic will make contact with the parent/guardian to inform them of what happened during the appointment.
- Parents/guardians are expected to follow up with Decatur County TeleHealth with any questions about the child's appointment.

We are excited to offer these services to you this year. Please contact the Telemedicine School Nurse for Jones Wheat Elementary School, Bonnie Provence at (229) 248-2218, bprovence@dcboe.com or West Bainbridge Elementary School, Becky Loyd at (229) 248-2821, bloyd@dcboe.com with any questions you may have.

Thank you!



PRIVACY PRACTICE/CONSENT FORM

(Consent to treatment, transportation and authorization to release information and assignment of benefits)

In order for your child to receive services at the health center, this consent must be completed and proper documentation of insurance obtained.

I hereby voluntarily give my consent for _____ to receive health services at the Decatur County TeleHealth. I further authorize any physician or designated health professional working for the clinic to provide such medical tests, procedures and treatments as are reasonably necessary or advisable for the medical evaluation and management of my child's health care. Furthermore, I agree to actively participate in the primary health care of my child by accompanying him/her to center appointments as often as possible and attending educational programs developed for parents/guardians.

I authorize release of information from my son or daughter's medical record of the family doctor or primary care provider designated by me whenever necessary for his or her care including referrals and /or emergency services.

I authorize release of written and verbal information pertinent to my child's health care from the Decatur County TeleHealth whenever necessary for his or her care. I further give consent to the Decatur County TeleHealth staff to examine my son or daughter's full school record, including attendance and other information that may assist the staff in helping my son or daughter.

I authorize Decatur County TeleHealth to release information regarding treatment to third party payers such as Medicaid or other insurers for the purposes of billing or for any other reason in accordance with acceptable medical practice pursuant to the law. Medicaid and other insurers will be billed for services rendered.

Charges for services rendered to students not insured and as HMO insured patients choosing to use our services out of network will be based on a sliding fee scale.

I understand the Decatur County TeleHealth is permitted to disclose protected health information about my child for the purposes of payment, continued care or treatment and healthcare operations.

If my child's protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS), drug or alcohol abuse and or mental illness, I hereby give consent to the disclosure of this information by these clinics only as reasonably necessary to accomplish the purposes described above and I waive any privileges with regards to such disclosure. I also understand that I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

I understand that my signing this consent allows the physician and professionals at Decatur County TeleHealth staff 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 clinic director.

I have read and understand the above information and give permission for my child's care as described.

_____ **Name of Parent or Legal Guardian**

_____ **Name of Student**

_____ **Signature of Parent or Legal Guardian**

_____ **Relationship to Student**

Date: _____

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DATA COLLECTION AUTHORIZATION

REASON FOR DATA COLLECTION: Evaluation and Research of impact of school based health clinics on student outcomes.

Decatur County TeleHealth is part of a research body that is attempting to determine the impact that school-based health clinics have on the success of students. Decatur County TeleHealth is primarily funded by grants. These grants require certain information to be shared so that the administrators of the grant can see a snapshot of the population of people that are being served. Because Decatur County TeleHealth is a health clinic, your health information may be used or disclosed as required by law and it may be shared with a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability and /or conducting public health surveillance, investigations or interventions. The privacy of your medical record is important to us and are protected by law just as they would be in a clinic or hospital settings. We want to tell you about a law that protects your medical record. The law is called the Health Insurance Portability and Accountability Act or HIPAA for short. Under HIPAA, your personal health information that identifies you receives greater protection.

The Researchers and Regulators may use or disclose the following health information about you: Health and school records; answers to surveys.

Other Items You Should Know: Decatur County Schools and the Decatur County TeleHealth are required by HIPPA to protect your health information.

Revoking your Authorization*:* You do not have to sign this Authorization. In addition, if you sign this Authorization, you may change your mind at any time and revoke (take back) this Authorization. If you want to revoke this Authorization, you must write to one of the addresses below, depending on the school your child attends:

Bonnie Provence, School Nurse
Jones Wheat Elementary School
1401 East Shotwell Street
Bainbridge, GA 39819

Becky Loyd, School Nurse
West Bainbridge Middle School
915 Zorn Road
Bainbridge, GA 39817

If you revoke your Authorization, the clinic will not collect any more health information that identifies you, but they may use or disclose information that you already gave them in order to notify any of the other Researchers that you have revoked your authorization; to maintain the integrity or reliability of the Research Study and to comply with any law that they are required to obey.

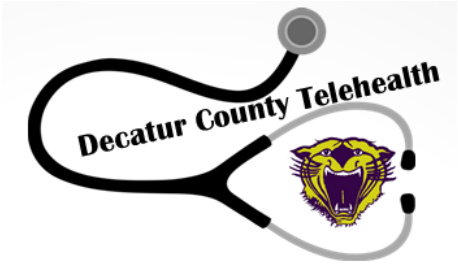
Expiration Date*:* There is no defined expiration date. This is an on-going evaluation of clinic outcomes.

Your participation in this research study allows us to bring more funds into our school based health clinic to serve you and your children. Thank you for participating!

_____ _____
Student's Name **Date**

_____ _____
Parent/Guardian's Signature **Relationship to Study Subject**

_____ _____
Signature of Decatur TeleHealth Staff **Date**



AUTHORIZATION TO BILL INSURANCE

Patient's Name: _____

Patient's Date of Birth: _____/_____/_____ Patient's Social Security #: _____-_____-_____

Primary Insurance Company: _____

Name of Person Insured: _____

Insured's Date of Birth: _____/_____/_____ Insured's Social Security #: _____-_____-_____

Policy or Member #: _____ Group #: _____

Responsible Party:

Name: _____ Employer: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Authorization

The undersigned patient or authorized individual acting on behalf of the patient understands and agrees as follows:

1. Grant permission to all Medical Providers at Memorial Pediatrics, therapists, laboratories and any other professionals to perform and administer care and treatment of the patient or designated other qualified health care provider for such services.
2. Grant permission to release to the third party payer (or payers), Medicare, Medicaid, their representatives and/or other physician(s) involved in the patient's care, any information in connection with any care rendered to patient.
3. Grant permission to bill third party payer or (payers) with benefits paid directly to the appropriate provider when assignment is accepted.

Letter of Responsibility:

I understand that I am responsible for any unpaid bills not covered by Medicaid, Medicare and any other private insurance companies. The Medical Providers will not accept any retroactive Medicaid cards on paid accounts. Thus, I will not be entitled to any refund Medicaid payments.

_____ _____

Signature of Parent/Guardian **Date**

_____

Student's Name

We appreciate you for placing your confidence in us by choosing our staff for your medical needs. Our Medical Providers and Staff are dedicated to serving you.

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INTAKE FORM

Please complete all information on this intake form. You must **COMPLETE USING INK** then sign and date it in order for your child to receive services from Decatur County TeleHealth. It is your responsibility to notify us immediately of any changes in address, phone numbers, insurance or health information.

Today's Date: _____

Student's Name: _____ _____ _____
Last *First* *Middle*

Child's Birth Date: _____/_____/_____ **Age**: _____ **Primary Language**: English Spanish Other

Social Security Number: _____-_____-_____ **Sex**: Male Female **Race**: Black White Hispanic Asian Multiracial Other

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Cell Phone**: _____ **Other**: _____

Is Present Housing: Permanent Temporary Shelter None Unstable Foster Care Other

School: _____ **Teacher**: _____ **Grade**: _____ **Remedial/Special Education** __Yes __No

Name of Parent(s)/Legal Guardian:
_____

Lives with: Both Parents Mother Father Grandparent Other (name and relationship): _____

Does child have regular contact with: Mother ___Yes ___No Father ___Yes ___No

Mother/Guardian's Employer: _____ **Father/Guardian's Employer**: _____

Primary Language of Mother:___English ___ Spanish ___Other **Primary Language of Father**:___English ___Spanish ___Other

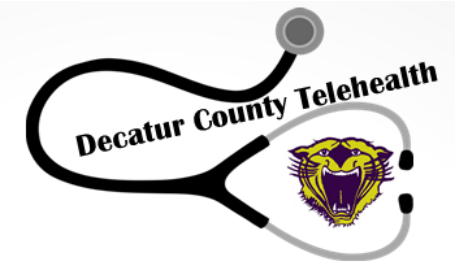
Who lives with the student: Please list everyone who lives in the home.

NAME	RELATIONSHIP	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the name and contact information of a person (or person) we can contact if parents cannot be reached.

Emergency Name & Number _____ **Relationship to Student** _____

Emergency Name & Number _____ **Relationship to Student** _____



PHYSICIAN INFORMATION

Does your child have a primary care physician? YES NO

Name of Physician: _____
Address: _____
Telephone: _____
Last Date Seen: _____

Does your child see a medical specialist? YES NO

Name of Specialist: _____
Address: _____
Telephone: _____
Last Date Seen: _____

Does your child see a mental health provider/therapist? YES NO

Name of Specialist: _____
Address: _____
Telephone: _____
Last Date Seen: _____

Does your child have a dentist? YES NO

Name of Specialist: _____
Address: _____
Telephone: _____
Last Date Seen: _____

Has your child seen a doctor in the last year? ____Yes ____No
If yes, how many times? 1 time 2 times 3times 4 or more times
Where? _____

Why? _____

Has your child used a Hospital Emergency Room in the last year? ____Yes ____No
If yes, how many times? 1 time 2 times 3times 4 or more times
Where? _____

Why? _____

Was your child in the hospital overnight in the last year? ____Yes ____No
Where? _____

Why? _____

How Long? _____

Pharmacy
Which pharmacy do you prefer to use? _____ Phone: (_____)_____-_____

Religious/Personal Beliefs
Are there any religious beliefs or medical considerations Decatur County TeleHealth needs to be aware of? ____ Yes ____ No
If "yes", please explain:
_____
_____
_____

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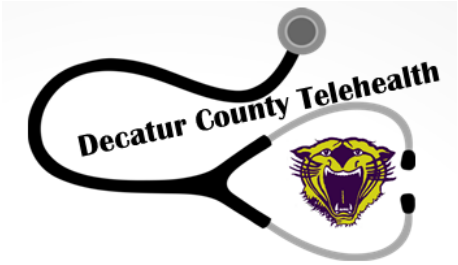

HEALTH QUESTIONAIRE

Does your child have any known allergies (food, medications, etc)? ____ Yes ____No
List all known allergies:
_____
_____

Does your child have any Physical Disabilities? ____ Yes ____No
If yes, please explain: _____
_____

Is your child currently being treated for any health or mental health problems? ____ Yes ____ No
Specify who is providing the treatment: _____
If yes, please explain: _____
_____

Does your child receive daily medications? ____Yes ____ No
Please list all medications, the dosage and when given:

Name of Medication	Dosage	When Given	Name of Medication	Dosage	When Given
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Will your child need to take prescribed medications during school hours? _____ Yes _____No
If yes, what medication will be given at school? _____

Since all students enrolled in Decatur County TeleHealth will be seen by the school nurse, you will need to sign the school's clinic permission form. Have you signed this form? _____Yes _____ No

FAMILY HISTORY

(Mother- M, Father- F, Brother- B, Sister- S, Grandmother- GM, Grandfather- GF, Aunt- A, Uncle- U,)
Please specify who <u>has</u> or <u>had</u> any disease listed below by using abbreviations above.

	WHO		WHO
Asthma	_____	Heart Trouble	_____
Allergies	_____	High Blood Pressure	_____
Birth Defects	_____	Kidney/Bladder Problems	_____
Blood Disorders/Anemia	_____	Lung Diseases	_____
Cancer	_____	Tuberculosis	_____
Tumors	_____	Seizures	_____
Cystic Fibrosis	_____	Mental Retardation/Illness	_____
Diabetes (before 40)	_____	Muscle Disease/Weakness	_____
Early Childhood Death	_____	Death Under Age 50	_____
Ear/Eye Disorders	_____		

There is no family history of the above diseases: _____

Does the student or anyone in the home:

Smoke	**____ Yes ____ NO**	**Who? _____**	**Relationship to Student: _____**
Drink Alcohol	**____ Yes ____ NO**	**Who? _____**	**Relationship to Student: _____**
Use Drugs	**____ Yes ____ NO**	**Who? _____**	**Relationship to Student: _____**
Chew Tobacco	**____ Yes ____ NO**	**Who? _____**	**Relationship to Student: _____**

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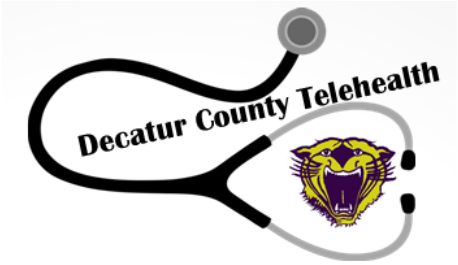

CHILD'S MEDICAL HISTORY

Please specify if your child has or had any disease listed below.

Allergies		Frequent Colds	____Yes ____No
Allergic to drugs		Lung Problems	____Yes ____No
Anemia	___Yes ___No	Meningitis	____Yes ____No
Kidney/Urinary Tract Problems	___Yes ___No	Menstruation Started Age __	____Yes ____No
Problems Walking	___Yes ___No	Menstruation Problems	____Yes ____No
Other Respiratory Problems	___Yes ___No	Premature Birth Weight _____	____Yes ____No
Asthma	___Yes ___No	Obese/ Overweight	____Yes ____No
-Shortness of breath during exercise	___Yes ___No	Underweight	____Yes ____No
Stomach Ulcers	___Yes ___No	Pregnant	____Yes ____No
Skin Rashes	___Yes ___No	Serious Acne	____Yes ____No
Abdominal Pain	___Yes ___No	Sickle Cell Disease	____Yes ____No
Constipation/Diarrhea	___Yes ___No	Sickle Cell Trait	____Yes ____No
Serious Digestive Problems	___Yes ___No	Other Blood Disorders	____Yes ____No
Chicken Pox Age _____	___Yes ___No	Seizures/Epilepsy	____Yes ____No
Ear Problem	___Yes ___No	Speech Problem	____Yes ____No
Ear Infections	___Yes ___No	Tuberculosis	____Yes ____No
Hearing Aid	___Yes ___No	Cancer	____Yes ____No
Eye Problem	___Yes ___No	AIDS/HIV	____Yes ____No
Wear Glasses	___Yes ___No	Other_____	___Yes ____No
Musculo-Skeletal Problems	___Yes ___No		
Rheumatic Fever	___ Yes ___No		
Physical/Sexual Abuse	___ Yes ___No		
Hemophilia	___ Yes ___No		
Fainting Spells/Knocked Out	___ Yes ___No		
Frequent Sore Throat	___ Yes ___No		
Headaches	___ Yes ___No		
Heart Murmur	___ Yes ___No		
Heart Problems	___ Yes ___No		
High Blood Pressure	___ Yes ___No		
Thyroid Problems	___ Yes ___No		
Diabetes	___ Yes ___No		
Hepatitis	___ Yes ___No		
Injuries (major)	___ Yes ___No		
Broken Bones	___ Yes ___No		

***** Explain any illnesses marked "Yes":**

_____

_____

_____

_____

***** Please explain any area marked "Yes":**

_____

_____

_____

_____

BEHAVIOR HISTORY

Nightmares	___ Yes ___No
Bedwetting	___ Yes ___No
Eating Problems	___ Yes ___No
Thumb Sucking	___ Yes ___No
Discipline Problems	___ Yes ___No
Overactive/Hyperactive	___ Yes ___No
Shy	___ Yes ___No
Sleeping Problems	___ Yes ___No
Slow Development	___ Yes ___No
Learning Disability	___ Yes ___No
Smoker	___ Yes ___No
Alcohol	___ Yes ___No
Inhalants	___ Yes ___No
Other Drug	___ Yes ___No
Depression	___ Yes ___No
Other _____	___ Yes ___No

***** Please list any present concerns you have about your child's behavior or mental health:**

_____

_____

_____

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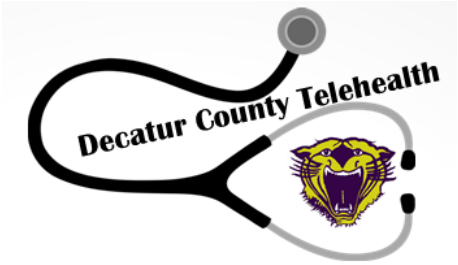
DENTAL HISTORY

Does your child have dental problems? ____ Yes ____ No
How often are your child's teeth brushed? ____ Occasionally ____ Once a Day ____ Twice Daily ____ Other
Has your child had a toothache recently? ____ Yes ____ No
Has your child had any injury to the teeth or jaws? ____ Yes ____ No
When was your child's last dental visit? _____
Does your child have a finger or thumb sucking habit? ____ Yes ____ No
Generally speaking, what has been your child's experience with a dentist? ____ Good ____ Bad ____ Very Bad ____ No Experience

If you have any other medical concerns, please list and describe in the space available below.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____



Please remember to attach a front and back copy of your insurance and prescription card.

Thank you for placing your confidence in us by choosing our staff for your medical needs.

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TELEMEDICINE PATIENT CONSENT/REFUSAL FORM

Patient Name: _____

Date of Birth: _____/_____/_____

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) and/or service(s)
   _____

2. **NATURE OF TELEMEDICINE CONSULT:** During the telemedicine consultation:
   a. Details of your medical history, examinations, x-rays and test will be discussed with other health professionals through the use of interactive video, audio and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
   d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s).

3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.

4. **CONFIDENTIALITY:** 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 this telemedicine consultation.

5. **RIGHTS:** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care of treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. **DISPUTES:** You agree that any dispute arriving from the telemedicine consult will be resolved in Georgia and that Georgia law shall apply to all disputes.

7. **RISKS, CONSEQUENCES & BENEFITS:** You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered and you understand the written information provided above.

I agree to participate in a telemedicine consultation for the procedure(s) described above.

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

_____
Date

I understand that all charges will be my responsibility and will be billed to my insurance if applicable. I will be financially responsible for any amounts not covered by my insurance carrier.

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

_____
Date

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