Healthy Children Learn Better

Primary Healthcare Centers make it happen

Fairmount Elementary School
130 Peachtree Street
Fairmount, GA 30139
706-956-2665

Primary Healthcare Centers is excited to partner with Fairmount Elementary School to offer Telemedicine services to students! Telemedicine is a service provided at the school to help take care of the medical needs of students. This service uses a secure video link with the child and school staff on one end and a medical provider from Primary Healthcare Centers on the other. During the visit, a child can receive most of the services they would receive in a doctor's office. Children can be treated for cuts/abrasions, rashes, pink eye, coughs/colds, sore throats, earaches and/or flu-like symptoms. Special equipment gives the medical provider the ability to examine the child's ears, eyes, nose, throat, lungs and skin.

For your child to be able to use this wonderful service the parent or legal guardian must complete and sign the attached forms. Please provide us with a copy of insurance cards. We also offer a sliding fee discount for those who are eligible. If you are approved for this program, charges may be reduced to a lower fee. Please initial that you received the Notice of Privacy Policies and return to the school.

If you have any questions please give us a call!

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I, _____, hereby, voluntarily give my consent for _____ to receive
Parent/Legal Guardian's Name — Child's Legal Name

services at Primary Healthcare Centers. I further authorize any physician or physician designee working for Primary Healthcare Centers to provide medical tests, procedures, and/or treatments for the evaluation and management of my child's care. I agree to actively participate in the care of my child by coming with him or her to appointments as often as possible. I agree to attend educational programs developed for parents and/or guardians. I understand that I have the right to withdraw this consent at any time with written notice to the Centers' director.

<u>This consent to treat is valid for 3 years. However, medical and financial information must be updated annually.</u>

Authorization for release of information:

- Information from my child's record at Primary Healthcare Centers to the family physician or primary care provider whenever it is necessary for care. This would include a referral or emergency care services.
- Written and verbal information that is important to my child's care from the staff of Primary Healthcare Centers. I give consent to Primary Healthcare Center staff to examine my child's full school records. This would include attendance and other information that may assist staff in helping my son/daughter as reasonably necessary to my child's care. I waive any privileges with regard to such disclosure.
- Information regarding treatment to your insurance for the purpose of billing or for any reason that is acceptable medical practice according to the law. Charges for services provided to those with no insurance will be based on a sliding fee scale. No student will be denied services because of inability to pay.
- I authorize disclosure of protected health information for my child. This is for the purpose of payment, continued care or treatment, and healthcare operations. This includes records related to the treatment of any infectious disease (including AIDS), drug and/or alcohol abuse and/or mental illness.
- I authorize regular dental examinations for my child. This may include screenings, photographs, or radiographs. It may also include other methods for the evaluation and management of my child's dental health.
- I authorize vision screenings. This is for the purpose of evaluating visual acuity, and/or the need for eyeglasses, and/or eye disease
- I authorize HIV testing upon request of student/or if advised by the provider.
- I authorize for my child to join in the fitness program coordinated by Primary Healthcare Centers' Health Education Department.
- I authorize vaccination for state required and recommended immunizations. These are according to ACIP and CDC guidelines. They include HPV and Influenza (flu shot).

I have read and understand the above information and give my consent for my child as described. I also understand that I may obtain further information regarding the services offered by Primary Healthcare Centers at 706-956-2665.

_____ Print Name of Parent/Legal Guardian

_____ Print Name of Student

_____ Signature of Parent/legal Guardian

_____ Relationship to Student

____/____/____ Date

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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 for you or your child to take part in telemedicine consultations.
2. WHAT TO EXPECT:
    a. Details of your or your child's medical history, examinations, x-rays and tests will be discussed through the use of video and audio technology.
    b. A physical examination of you or your child may take place.
    c. A non-medical technician may be present to aid with the technology presentation.
    d. Video, audio and/or photo recordings may be taken of you or your child during the consult.
3. MEDICAL INFORMATION AND RECORDS: All laws regarding your or your child's access to medical information and copies of medical records apply to this consultation. Not all telecommunications are recorded and stored. Patient pictures or information from this visit will not be given to researchers or other entities without your consent.
4. CONFIDENTIALITY: All efforts have been made prevent risks of confidentiality associated with the telemedicine consultation. All protections under federal and Georgia state law apply to information received during this consultation.
5. RIGHTS: You may withdraw consent to the telemedicine session at any time. This will not affect your or your child's right to future treatment. This will not cause you or your child to lose any program benefits to which you or your child would be entitled.
6. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Georgia. You agree that Georgia law shall apply to all disputes.
7. RISKS, CONSEQUENCES AND BENEFITS: You have been advised of all the potential risks, consequences, and benefits of telemedicine. Your or your child's healthcare provider has discussed all the above information with you. You have had the opportunity to ask questions about all the information given to you. All your questions have been answered, and you understand all the information on this form.

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

Signature: _____ Date: _____

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

Signature: _____ Date: _____

Please complete all information. Please use student's full legal name. Student's social security number is an important unique identifier which helps us safely maintain accurate records. Please do not leave blanks. If a question does not apply to your child please write decline, unknown, or N/A. You must complete forms using a black or blue ink pen. You must sign and date forms for your child to receive services from Primary Healthcare Centers. It is your responsibility to notify us immediately with any change in address, phone number, or insurance information.

I have received Primary Healthcare Centers' School-Based Healthcare Center Notice of Privacy Practices.

_____
Initials of Parent/Legal Guardian

I understand that I have the right to **opt-out** of any testing or treatment by my signature. I choose to **opt-out** of the following services (please list) _____.

_____ _____ _____/_____/_____
Signature of Parent/Legal Guardian

PATIENT INFORMATON

Patient's Legal Name:_____ Date of Birth:____/____/_____
First Middle Last

Phone Number: (_____) _____-_____ Sex: □Male □ Female Social Security Number: _____-_____-_____

Address:_____City:_____State:_____Zip:_____

How long at address? Yrs_____/Mths_____ Is present housing: □Temporary □Shelter □Group Home □Foster Care

Other: □Rent □Own □Homeless □Doubling-Up Does your family travel by: □Car □Bus □Train □Walk

Birth Country: □USA □Other:_____ Primary Language: □English □Other _____ School: _____

Homeschooled: □Yes □No Remedial/Special Education: □Yes □No Grade:_____ Teacher:_____

Is either parent a Veteran?□Yes □No Is either parent deceased? □Yes □No Is either parent incarcerated?□Yes □No

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

Name:	Relationship:	Age:
1.		
2.		
3.		
4.		
5.		

Please list any additional people in the household on the back of this sheet.

PATIENT'S PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY

Parent's Name:_____ Parent's Name:_____

Address:_____ Address:_____

DOB:____/____/_____ SSN:_____-____-_____ DOB:____/____/_____ SSN:_____-____-_____

Sex: Male or Female Phone#:(____)-_____-_____ Sex: Male or Female Phone#:(____)-_____-_____

MEDICAL INSURANCE

Company Name:_____

ID #:_____ Group #:_____

Claims Address:_____

Name of Insured:_____

Male or Female DOB:_____/_____/_____

Relationship:_____ SSN:_____-_____-_____

Address:_____

Phone #:_____

Who is your PCP?_____

When was your last Well-Child Check?_____

DENTAL INSURANCE

Company Name:_____

ID #:_____ Group #:_____

Claims Address:_____

Name of Insured:_____

Male or Female DOB:_____/_____/_____

Relationship:_____ SSN:_____-_____-_____

Address:_____

Phone #:_____

Who is your dentist?_____

When was your last dental visit?_____

MEDICAL HISTORY

Current Medications: (List all prescription medications, birth control pills, vitamins, herbs, OTC medications, etc.)

_____ _____ _____

_____ _____ _____

Hospitalizations: (List serious illnesses, injuries, and/or operations along with the date of each)

_____ _____ _____

_____ _____ _____

Drug Allergies

Penicillin Aspirin Tetracycline Codeine Hydrocodone Latex Other:_____

YOU	FAMILY	ILLNESS/MED CONDITION	YOU	FAMILY	ILLNESS/MED CONDITION
		Alcohol or Drug Abuse (past or present)			Lung Disease/Tuberculosis
		Anemia/Bleeding Problems			Emphysema
		Cancer/Chemotherapy/Radiation			Yellow Jaundice
		Diabetes			Hereditary Disorders
		Tumor			Phlebitis/Blood Clot
		Depression			Rheumatic Fever
		Eczema/Hives/Rashes			Stroke
		Epilepsy			Suicide Attempt
		Glaucoma/Eye Disease			Thyroid Disease
		Mitral Valve Prolapse			Stomach Ulcer/Gerd
		High Blood Pressure			Sexually Transmitted Disease
		Kidney/Bladder Problems			Liver Disease
		Hepatitis A/B/C/D			Heart Attack/Heart Surgery
		Congenital Heart Defect			Artificial Heart Valve
		Osteoporosis			Severe/Frequent Headaches
		HIV/AIDS			Asthma
		Psychiatric/Mental Health Problems			Please list any others on back

May 2, 2016

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION 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.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice 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, mental health providers or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice 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 practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our practice'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 practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. 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 practice, whether made by practice 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. 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; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation. We may also electronically share your health information.

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 practice. 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. 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. ***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 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. 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 practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the Quality Improvement Director at 706-956-2665 ext 8522. 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 Centers and Notice of Individual Rights.

Patient or Patient's Personal Representative_____ **Date**_____

PRIMARY HEALTHCARE CENTERS

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete the information below and sign your name to verify your permission. Check all that apply:

1. According to Primary Healthcare Centers' policy, test results or medical information will be provided to the patient only or the parent/guardian if the patient is a minor. Please specify below to whom we may release information to other than yourself.

   ____ Myself Only

   ____ Son/Daughter - (specify name) _____

   ____ Husband/Wife - (specify name) _____

   ____ Other (specify name/relationship) _____

2. You may leave messages at:

   ____ Home Answering Machine - (_____) _____-_____

   ____ Cell Phone - (_____) _____-_____

   ____ Work Voicemail - (_____) _____-_____

   ____ Other (please specify) - (_____) _____-_____

3. **If the patient is under 18 years of age, I authorize the following person(s) to bring my child in for treatment and to be given Private Health Information regarding my child while in the office for treatment or to receive PHI, i.e. test results, call backs, appointments, etc. regarding my child via telephone in my absence:

   _____ Relationship to patient _____ Phone#: _____

   _____ Relationship to patient _____ Phone#: _____

   _____ Relationship to patient _____ Phone#: _____

4. I have received a copy of Primary Healthcare Centers' **Notice of Privacy Practices** explaining the uses and disclosures of my health information.

   _____Yes _____No

   Print Patient's Name: _____

   Print Parent's/Legal Guardian's Name: _____

By signing below I confirm that I am the legal guardian of the above mentioned child and the information I have provided for the child is correct. I understand that I am responsible for keeping my child's information current and will notify PHC in writing with any changes of legal guardianship. The above information is correct and I am authorized to sign this form on the child's behalf.

_____ _____

Patient's Signature Date

05/2017

Primary Healthcare Centers – Patient Information Survey

Primary Healthcare Centers is required by certain funding sources to collect specific information on all patients we served. All the information that you provide us is strictly confidential. We **do not** provide patient names or any other type of patient identifying information to these funding sources. Your assistance in this matter is greatly appreciated. Thank you.

Race/Ethnicity: African American Asian Caucasian Hispanic Multi-racial Native American Other (please specify):_____	
Which language are you best served in? English Indian Russian Spanish Other (please specify):_____	
Do you need a translator? YES or NO	Patient Type: MEDICAL DENTAL BOTH
Are you, the patient, on disability? YES or NO	Are you, the patient, a Veteran? YES or NO
Are you, the patient, homeless? YES or NO	If you, the patient, are employed is it seasonal work: YES or NO
If you, the patient, are female, are you the head of household? YES or NO	Family size (number of people living in your household) _____

Family Size (number of people in household)	Income Range (circle one)
If 1 in household, circle in this area →	♦ Less than or equal to $12,060 ♦ $12,061 to $16,039 ♦ $16,040 to $20,019 ♦ $20,020 to $24,120 ♦ $24,121 or greater
If 2 in household, circle in this area →	♦ Less than or equal to $16,240 ♦ $16,241 to $21,599 ♦ $21,600 to $26,958 ♦ $26,959 to $32,480 ♦ $32,481 or greater
If 3 in household, circle in this area →	♦ Less than or equal to $20,420 ♦ $20,421 to $27,158 ♦ $27,159 to $33,897 ♦ $33.898 to $40,840 ♦ $40,841 or greater
If 4 in household, circle in this area →	♦ Less than or equal to $24,600 ♦ $24,601 to $32,718 ♦ $32,719 to $40,836 ♦ $40,837 to $49,200 ♦ $49,201 or greater
If 5 in household, circle in this area →	♦ Less than or equal to $28,780 ♦ $28,781 to $38,277 ♦ $38,278 to $47,774 ♦ $47,775 to $57,560 ♦ $57,561 or greater
If 6 in household, circle in this area →	♦ Less than $32,960 ♦ $32,961 to $43,836 ♦ $43,837 to $54,713 ♦ $54,714 to $65,920 ♦ $65,921 or greater
If 7 in household, circle in this area →	♦ Less than or equal to $37,140 ♦ $37,141 to $49,396 ♦ $49,397 to $61,652 ♦ $61,653 to $74,280 ♦ $74,281 or greater
If 8 or more in household, circle in this area →	♦ Less than or equal to $41,320 ♦ $41,321 to $54,955 ♦ $54,956 to $68,591 ♦ $68,592 to $82,640 ♦ $82,641 or greater

Name of employer of each income earner in the household:

1._____ 2._____

3._____ 4._____