PACKER HEALTH CLINIC

ELEMENTARY STUDENT INFORMATION SHEET

Date_____ Grade_____ Homeroom_____

Patient Information

Name _____ Social Security Number_____

Sex: M / F Race_____ Date of Birth_____ Age_____

Street Address_____

City_____ State _____ Zip Code_____ County _____

Student Resides With _____

Mother's/Guardian's Information

Name _____

Street Address_____

City _____ State_____ Zip Code_____ County_____

Employer_____ Work Number/Extension_____

Home Phone_____ Cell Phone_____ Other_____

Father's /Guardian's Information

Name _____

Street Address _____

City_____ State_____ Zip Code_____ County_____

Employer _____ Work Number/Extension_____

Home Phone_____ Cell Phone_____ Other_____

Person to Notify in Case of Emergency (other than patient)

Name _____Relationship to patient_____

Street Address _____

City_____ State_____ Zip Code_____ County_____

Home Phone_____ Cell Phone_____ Other_____

In order for your child to receive services at the Packer Health clinics, this consent form must be completed and proper documentation of insurance obtained.

I hereby voluntarily give my consent for _____ to receive services through Packer Telehealth clinics. I authorize any physician or designated health/mental health professional working for the Packer Telehealth clinics to provide care.

Parent/Guardian Signature_____ Date_____

TELEHEALTH CONSENT

I hereby voluntarily give my consent for my child listed below to receive telehealth services through Packer Health Clinic for the purpose of healthcare service(s) and/or procedure(s). I authorize any physician or designated health/mental health professional working with Packer Health Clinic to provide care. I understand that verbal consent will be obtained prior to each appointment. I understand that during the telehealth consult, details of my child's medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology. I understand that a physical examination may take place. I understand that a non-medical technician may be present in the telemedicine studio to aid in the video transmission. I understand that video, audio and/or photo recordings may be taken of the patient during the procedure(s) or service(s). I understand that all existing laws regarding access to my child's medical records apply to these telehealth consultations. Not all telecommunications are recorded and stored. Additionally, dissemination of any patient identifiable images or information for telemedicine interactions to researchers or other entities shall not occur without your consent. 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 a telemedicine consultation. It is your right to withhold or withdraw consent to the telemedicine consultation at any time without effecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You agree that any dispute arriving from a telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes. I have been advised and understand all potential risks, benefits, and consequences of telemedicine. Your healthcare provider has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented in this consent and about the telemedicine consultation. All your questions have been answered, and you understand the written information provided above. I agree to participate in telemedicine consultations for the procedure(s) and/or service(s) described above.

Patient Name:_____ **Date of Birth:**_____

Parent/Guardian Signature_____ **Date**_____

Please list any adult(s), other than parents/ guardians, over the age of 18 who has permission to give consent for your child to participate in a telehealth visit if parents/guardians cannot be reached.

1. Name:_____ Relationship to Patient:_____

Home Number:_____ Cell Number:_____ Other:_____

2. Name:_____ Relationship to Patient:_____

Home Number:_____ Cell Number:_____ Other:_____

3. Name:_____ Relationship to Patient:_____

Home Number:_____ Cell Number:_____ Other:_____

I hereby voluntarily give my consent for the above listed person(s) to approve a school-based telehealth visit in the event that I cannot be reached. I understand that I may withdraw my consent for any of the above persons at any time by submitting a written statement to the school nurse or telehealth coordinator. I understand that any person(s) listed above will continue to have my consent to approve a telehealth visit until such signed and dated written statement is received.

Parent/Guardian Signature_____ **Date**_____

MEDICAL HISTORY

Name of Primary Care Physician _____

Address _____

Phone Number _____ Date Last Seen _____

Name of Dentist _____

Address _____

Phone Number _____ Date Last Seen _____

Name of any other Health Care Provider _____

Address _____

Phone Number _____ Date Last Seen _____

Name of Pharmacy _____

Address _____

Phone Number _____

List Medication Allergies _____

_____

List all Medical Problems _____

_____

_____

List all Previous Surgeries _____

Family History **Mother** _____

Father _____

Medication List (Include dosage and time) _____

_____

_____

Are there any religious/personal beliefs that the Packer Health clinics need to be aware of in addressing your child's care? If yes, please explain _____

_____

MEDICAL HISTORY CONTINUED

PLEASE MARK ALL THAT APPLY

ENDOCRINE

____ Swelling under arms or neck
____ Weakness and tiredness
____ Always hungry
____ Increased thirst
____ Increased urination
____ Tends to be too hot
____ Tends to be too cold
____ Frequent fever and chills
____ Night sweats
____ Problems going to sleep
____ Problems waking up after falling asleep
____ Recent weight gain
____ Recent weight loss
____ Diabetes
____Other_____

INFECTIONS

____ Chicken pox
____ Hepatitis B
____ Hepatitis C
____ HIV/AIDS
____ Strep Throat
____Other_____

PULMONARY

____ Chronic snoring
____ Persistent cough
____ Coughing up blood
____ TB (or exposure to)
____ Sleep apnea
____ COPD, emphysema or chronic bronchitis
____ Asthma
____ Other_____

NEUROLOGY

____ Frequent headaches
____ Migraines
____ Seizures
____ Stroke or paralysis
____ Memory problems
____ Meningitis
____ Nerve damage to feet/hands
____Other_____

EARS, NOSE & THROAT

____ Wears glasses or contacts
____ Eye drainage
____ Blurry vision
____ Recent changes in vision
____ Decreased hearing
____ Earache or drainage
____ Ringing in ears
____ Allergies (Seasonal)
____ Sinus problems
____ Frequent nose bleeds
____ Frequent sore throat
____ Tongue/mouth sores
____ Goiter/thyroid problems
____ Neck pain or lumps
____ Any change in voice
____ Dental problems
____ Other_____

HEMATOLOGY

____ Anemia/low blood count
____ Sickle cell disease

____ Bleeding/bruising easily
____ Cancer (Please list_____)
____ Chemo/Radiation exposure
____Other_____

MUSCULOSKELETAL

____ Frequent pain in fingers or hands
____ Muscle or joint pain
____ Leg camps with exercise
____ Leg cramps at night
____ Arthritis
____Other_____

GENITOURINARY

____ Frequent urination
____ Burning on urination
____ Difficulty starting urination
____ Incontinence
____ Kidney stones
____ Kidney disease
____ Other_____

CARDIOVASCULAR

____ Chest pain
____ Heart palpitations
____ Dizziness upon standing
____ Swelling in feet/hands
____High blood pressure
____ High cholesterol
____ Fainting spells
____ Shortness of breath with exercise
____Heart murmur
____Other_____

GASTROINTESTINAL

____ Frequent heartburn
____ Decreased appetite
____Frequent nausea or vomiting
____ Liver disease
____ Jaundice or hepatitis
____ Difficulty swallowing
____ Stomach pain
____ Recent change in bowel habits
____ Frequent diarrhea
____ Frequent constipation
____Incontinence
____ Bloody stools
____ Rectal pain
____ Hemorrhoids
____ Rectal fissure
____ Parasites or worms
____ Pancreatitis
____Other_____

BEHAVIORAL / MENTAL

____ Nightmares
____ Bedwetting
____ Eating problems
____ Thumb sucking
____ Discipline problems
____ Overactive/hyperactive
____ Shyness/social avoidance
____ Sleeping problems
____ Developmental delays
____ Learning disabilities
____ Depression
____ Anxiety
____ Cries often
____ Feels sad
____ Hears voices
____ Anger
____ Diagnosed behavioral/mental disorder (Please list_____)
____ Other

My signature indicates that all medical history is true and accurate to the best of my knowledge.

Patient/Parent/Guardian Signature_____ Date _____

AUTHORIZATION TO BILL INSURANCE

Please note that Packer Health Clinic is not responsible for billing or for the collection of any associated fees for the services provided. Your insurance will be billed by the physician's office, and you will be responsible for copays, deductibles, or any other charges not covered by your insurance.

Patient's Name_____

Patient's Birth Date_____ Patient's Social Security Number _____

Primary Insurance Company _____

Name of person insured _____

Insured's Birth Date _____ Insured's Social Security Number_____

Group Number_____

Policy or Member Number _____

Secondary Insurance Company _____

Name of person insured _____

Insured's Birth Date _____ Insured's Social Security Number_____

Group Number _____

Policy or Member Number_____

Responsible Party

Name_____ Date of Birth_____

Social Security Number _____ Employer _____

A COPY OF YOUR INSURANCE CARD IS REQUIRED

Information on this form is protected health information (PHI) and is to be treated as confidential under HIPPA rules, privacy & security. All services are charged directly to the patient or the patient's representative and/or insurance company by the provider. Acknowledgement: I consent to the use of PHI for purposes of treatment, payment and operations. I authorize the entity to use the PHI as needed. I authorize that payment of benefits be made on my behalf directly to the provider. I understand that I am financially responsible for all charges not covered by insurance including copays. If my child has Medicaid, I also am aware that there are only five visits allowed outside of my listed medical provider.

Patient/Parent/Guardian Signature_____ Date_____

HIPAA AND OUR PATIENTS

The HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule became law in 1996. The Office for Civil Rights enforces the HIPAA Privacy Rule, which protects the privacy of identifiable health information. This rule essentially controls the use and disclosure of what is known as Protected Health Information. We are required to provide you with the attached notice. We encourage you to read the information concerning our privacy practices. It is your copy so feel free to keep it with you.

I acknowledge receipt of the HIPAA Notice of Privacy Practices from the Packer Health Clinic.

Patient/Parent/Guardian Signature_____ Date_____

Notice of Privacy Practices

When it comes to your health information, you have certain rights.
Get an electronic or paper copy of your medical records
• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record
• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
• We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communications
• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will say “yes” to all reasonable requests.
Ask us to limit what we use or share
• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.
Get a list of those with whom we’ve shared information
• You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice
• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you
• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
• We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated
• You can complain if you feel we have violated your rights by contacting us using the information on page 1.
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hippa/complaints/.
• We will not retaliate against you for filing a complaint.
You have the right to:
• Get a copy of your paper or electronic medical record
• Correct your paper or electronic medical record
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we’ ve shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated
You have some choices in the way that we use and share information as we:
• Tell family and friends about your condition
• Provide disaster relief
• Include you in a hospital directory
• Provide mental health care
• Market our services and sell your information
• Raise funds
We may use and share your information as we:
• Treat you
• Run our organization
• Bill for your services
• Help with public health and safety issues
• Do research
• Comply with the law
• Respond to organ and tissue donation requests
• Work with a medical examiner or funeral director
• Address workers’ compensation, law enforcement, and other government requests
• Respond to lawsuits and legal actions
For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
• Share information with your family, close friends, or others involved in your care
• Share information in a disaster relief situation
• Include your information in a hospital directory
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:
• Marketing purposes

• Sale of your information
• Most sharing of psychotherapy notes
In the case of fundraising:
• We may contact you for fundraising efforts, but you can tell us not to contact you again.
How do we typically use or share your health information? We typically use or share your health information in the following ways.
Treat you
• We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
Run our organization
• We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
Bill for your services
• We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.
How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. • We can share health information about you for certain situations such as:
• Preventing disease
• Helping with product recalls
• Reporting adverse reactions to medications
• Reporting suspected abuse, neglect, or domestic violence
• Preventing or reducing a serious threat to anyone's health or safety
• We can use or share your information for health research.
• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services
• We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities:
• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
• We do not use or disclose health information for any reason not included in our privacy policy without your authorization.

This Notice of Privacy Practices applies to the following organizations:

Packer Health Clinic
To report a violation, you may contact the Privacy Officer below:

Suzanne Sumner, RN, BSN
Colquitt County School Nurse Coordinator
229•890•6194
Suzanne.sumner@colquitt.k12.ga.us