Coffee TeleHealth

School-Based Collaborative HealthCare Center

Dear Parents/Guardians,

It is my pleasure to introduce you to Coffee TeleHealth – School-Based Collaborative HealthCare Center. The primary focus of the center is to provide quality, accessible health care to the children and staff of Coffee County Schools.

What is Coffee TeleHealth?

- Coffee TeleHealth is a comprehensive Adult & Pediatric Primary Care site located at all elementary schools, CMS, GWCFC & CHS.
- Only students and staff at the above mentioned schools can be served at this time.

What services will Coffee 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 Coffee TeleHealth?

- Contact the Coffee TeleHealth Coordinator at (912) 389-6832.
- Fill out the health questionnaire and consent forms.
- Give a copy of your insurance card to Coffee TeleHealth.

What if my child is enrolled with Medicaid, WellCare or PeachState?
Coffee TeleHealth is a part of several insurance plans including the Medicaid system Georgia Better Health Care, WellCare, and PeachState for kids. Medicaid or PeachState only allows up to 5 out-of-network visit each year. If you wish for Coffee TeleHealth to become your child's medical home, child must be enrolled with Dr. Brian Griner or Dr. Keith Childers. You can call GBHC at 1-866-211-0950 and ask them to assign you to Dr. Keith Childers of Douglas or Dr. Brian Griner of Valdosta.

What if my child is enrolled with a private insurance plan?
For private insurance, please contact Coffee TeleHealth with a copy of your insurance card front and back in order to verify if you can use your card at the school site.

What if my child does not have health insurance?
If you do not have Medicaid or any other type of insurance, please call Coffee TeleHealth Coordinator at (912)-389-6832 or Department of Family and Children Services at 912-389-4286. You may be eligible for free or low-cost insurance offered through the State of Georgia. Without proper documentation of insurance, you may be financially responsible for services rendered.

When is Coffee TeleHealth open?

- Monday-Friday, during school hours
- For after hours service, children will need to be seen at a local emergency room or urgent care facility.

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 appointment.
- Parents/guardians are expected to follow up with Coffee TeleHealth with any questions about the child's appointment.

We are excited to offer these services to you this year. Please contact Telemedicine Coordinator at (912) 389-6832 with any questions you may have.

Thank you

Coffee TeleHealth

School-Based Collaborative HealthCare Center

PRIVACY PRACTICE/CONSENT FORM

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

The Coffee County Board of Education has joined in partnership with Emory University's Urban Health Program. Pediatricians, General Practitioners, and Behavioral Health Providers to develop this comprehensive school-based collaborative healthcare center. The staff is comprised of pediatricians, mid-level providers (nurse practitioner, physician assistant), nurses, social workers, and interns from the local colleges and universities. Our services include onsite and telemedicine diagnosis and treatment of acute illnesses and minor injuries, management of chronic illnesses, management/maintenance of monthly medications, routine health physicals, counseling, health education/promotion, and referrals to medical subspecialists and community agencies. The primary focus of the center is to provide quality, accessible health care to the children of Coffee TeleHealth-School-Based Collaborative HealthCare Center, in order to have a positive impact on the children's health, school attendance, and academic performance.

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

I hereby voluntarily give my consent for _____ to receive health services at the
(insert child's name)
Coffee TeleHealth - School-Based Collaborative HealthCare Center. I further authorize any physician or designated health/mental health professional (nurse practitioners, physician assistants, college student interns, etc) 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 or mental 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 Coffee TeleHealth – School-Based Collabortive HealthCare Center whenever necessary for his or her care. I further give consent to the Coffee TeleHealth – School-Based Collaborative HealthCare Center 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 Coffee TeleHealth – School-Based Collaborative HealthCare Center 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. No students will be denied services because of inability to pay.

I understand the Coffee TeleHealth - School-Based Collaborative HealthCare Center 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 regard 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 Coffee TeleHealth - School-Based Collaborative HealthCare Center 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. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the clinic at (912) 389-6832.

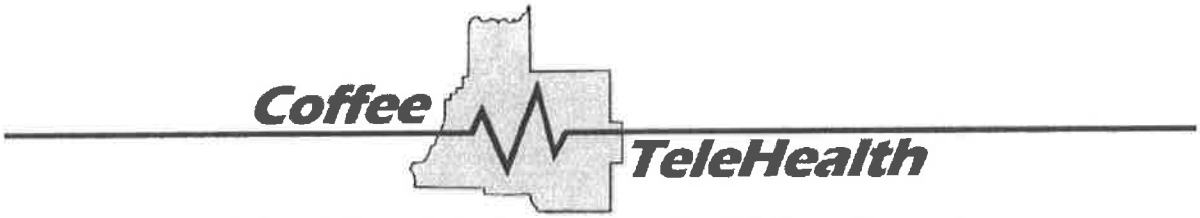
_____
Name of Parent or Legal Guardian

_____
Name of Student

_____
Signature of Parent/Legal Guardian

_____
Relationship to Student

Date: _____



School-Based Collaborative HealthCare Center

DATA COLLECTION AUTHORIZATION

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

Coffee TeleHealth - School-Based Collaborative HealthCare Center is part of a research body who is attempting to determine the impact that school-based health clinics have on the success of students. Coffee TeleHealth - School-Based Collaborative HealthCare Center is funded by grants. All grants require certain information to be shared so that the administrators of the grant can see a snapshot the population of people that are being served. Because Coffee TeleHealth - School-Based Collaborative HealthCare Center 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. 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: Coffee County Schools and the Coffee TeleHealth - School-Based Collaborative HealthCare Center Project are required by HIPAA to protect your health information.

Revoking your Authorization: You do not have to sign this Authorization. In addition, if you sign this Authorization, later, 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:

Kathy Cole, R.N., 1311 South Peterson Avenue, Douglas, Georgia 31533.

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.

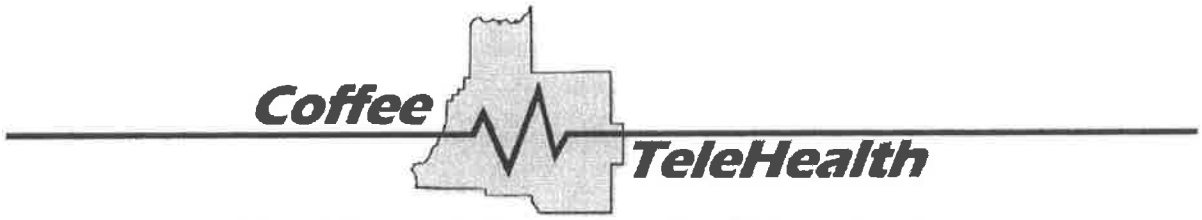
Your participation in this research study allows us to bring more funds into our school based health clinic to serve you and your children. Thank you for participating!

Student's Name: _____ Date: _____

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

_____ Date: _____

Signature of Coffee TeleHealth staff



School-Based Collaborative HealthCare Center

Authorization to Bill Insurance

Patient's Name: _____

Patient's Birth Date: ___-___-_____ Patient's Social Security # _____-_____-_____

Primary Insurance Company: _____

Name of person insured if patient is a dependent: _____

Insured's birth date ___-___-_____ Insured's Social Security # _____-_____-_____

Group # _____

Policy or Member # _____

Secondary Insurance Company: _____

Group # _____

Policy or Member # _____

Responsible Party:

Name: _____ Date of Birth: _____

Social Security # : _____-_____-_____ Employer: _____

Authorization

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

1. Grant permission to all physicians (Dr. Keith Childers, Asthma Allergy Clinics of Georgia Physicians and PA's and Dr. Brian Griner and any other physicians who may work with this patient), therapist, 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 payor (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 payor 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 physicians will not accept any retroactive Medicaid cards on paid accounts. Thus, I will not be entitled to any refunds of 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 physicians and staff are dedicated to serving you.

School-Based Collaborative HealthCare Center

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 Coffee 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 (circle one): English Spanish Other

Social Security Number: _____ Sex (circle one): Male Female

Race (circle one): Black White Hispanic Asian Multiracial Other: _____

Address:_____ City_____ State_____ Zip_____

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

Is present housing (circle one): Permanent Temporary Shelter None Unstable Foster Care Other

School:_____ Teacher: _____ Grade____ Remedial/Special Education ___Yes ___No

Name of Parent(s)/Legal Guardian: _____

Lives with (circle one): 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 student? Please list everyone who lives in home.

NAME	RELATIONSHIP	AGE

Please list the name and contact information of a person (or persons) 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: _____
Phone: _____
Last Date Seen: _____

Does your child see a medical specialist? YES NO
Reason for seeing specialist: _____
_____

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

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

Name of Provider: _____
Address: _____
Phone: _____
Last Date Seen: _____

Does your child have a dentist: YES NO

Name of Dentist: _____
Address: _____
Phone: _____
Last Date Seen: _____

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

Was your child in the hospital over night 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 Coffee TeleHealth needs to be aware of? YES NO
If "yes", please explain:
_____
_____
_____
_____

HEALTH QUESTIONAIRE

Does your child have any known allergies (foods, 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, 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 Coffee 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 has or had 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:

	YES/NO	WHO? RELATIONSHIP TO STUDENT
SMOKE		
DRINK ALCOHOL		
USE DRUGS		
CHEW TOBACCO		

CHILD'S MEDICAL HISTORY

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

Allergies	__Yes__No
Allergic to drugs	__Yes__No
Anemia	__Yes__No
Kidney/Urinary Tract Problems	__Yes__No
Problems Walking	__Yes__No
Other Respiratory Problems	__Yes__No
Asthma	__Yes__No
-Shortness of breath during exercise	__Yes__No
Stomach Ulcers	__Yes__No
Skin Rashes	__Yes__No
Abdominal Pain	__Yes__No
Constipation/Diarrhea	__Yes__No
Serious Digestive Problems	__Yes__No
Chicken Pox Age____	__Yes__No
Ear Problem	__Yes__No
Ear Infections	__Yes__No
Hearing Aid	__Yes__No
Eye Problem	__Yes__No
Wears Glasses	__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
Brokens Bones	__Yes__No

Frequent Colds	__Yes__No
Lung Problems	__Yes__No
Meningitis	__Yes__No
Menstruation Started Age____	__Yes__No
Menstrual Problems	__Yes__No
Premature Birth Weight_____	__Yes__No
Obese/Overweight	__Yes__No
Underweight	__Yes__No
Pregnant	__Yes__No
Serious Acne	__Yes__No
Sickle Cell Disease	__Yes__No
Sickle Cell Trait	__Yes__No
Other Blood Disorders	__Yes__No
Seizures/Epilepsy	__Yes__No
Speech Problem	__Yes__No
Tuberculosis	__Yes__No
Cancer	__Yes__No
AIDS/HIV	__Yes__No
Other_____	__Yes__No

***Explain any illnesses 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 Drugs _____	__Yes__No
Depression	__Yes__No
Other Behavior Problems	__Yes__No
Other Mental Problems	__Yes__No
Other_____	__Yes__No

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____

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.

Coffee TeleHealth

School-Based Collaborative HealthCare Center

Please remember to attach a copy of your insurance card.

Thanks!

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 or 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 consultations for the procedure(s) described above.

Signature: _____

If signed by someone other than the patient, indicate relationship: _____

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

_____

If signed by someone other than the patient, indicate relationship: _____

DATE: _____ TIME: _____

WITNESS: _____

DATE: _____ TIME: _____