Student Telehealth Enrollment Packet

Please Complete All Pages

Please be sure to fill out all information in the packet, signing and dating all required areas.
This enrollment packet is only required to be filled out once. Each school year, you will receive a short information update form to complete and return. If you wish to withdraw your child from THE COFFEE TELEHEALTH CLINIC, please provide written notice of such request. Thank you for your interest in this program.

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STUDENT INFORMATION PACKET

Date:_____Grade:_____Homeroom:_____School year:_____

Patient Information

Name: _____

Date of Birth_____ Age_____ Sex: M / F

Street Address_____

City:_____State:_____Zip Code:_____County: _____

Social Security Number:_____Primary Language:_____

Race:

African American/Black Asian Caucasian/White Hispanic/Latino Other_____ Student Resides With:

Both Parents Mother Father Step-Parent Grandparent(s) Other:_____

Mother's/Guardian's Information

Name:_____

Date of Birth:_____Race:_____Social Security Number:_____

Street Address:_____

City:_____State:_____Zip Code:_____County:_____

Employer:_____Work Number/Ext:_____

Home Phone:_____Cell Phone:___Other:_____

Email Address: _____

Father's /Guardian's Information

Name:_____

Date of Birth:_____Race:_____Social Security Number:_____

Street Address: _____

City:_____State:_____Zip Code:_____County: _____

Employer:_____Work Number/Ext: _____

Home Phone:_____Cell Phone:_____Other:_____

Email Address: _____

Person to Notify in Case of Emergency (other than parent/guardian)

Name: _____

Relationship to Patient:_____

Street Address: _____

City:_____State:_____Zip Code: _____

Home Phone:_____Cell Phone:_____Other:_____

TELEHEALTH CONSENT

I hereby voluntarily give my consent for my child listed below to receive telehealth services through **THE COFFEE TELEHEALTH CLINIC** for the purpose of healthcare service(s) and/or procedure(s). I authorize any physician or designated health/mental health professional working with **THE COFFEE TELEHEALTH CLINIC** to provide care. I understand that additional 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 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. 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 _____

Name of Dentist_____

Address_____ Phone Number _____

Name of any other Health Care Provider_____

Address_____ Phone Number _____

Name of Pharmacy_____

Address_____ Phone Number_____

List Medication Allergies

1)_____ **2)**_____

3)_____ **4)**_____

List All Medical Problems (Ex: Asthma, ADD/ADHD, Autism, Hypertension, etc.)

1)_____ **2)**_____ **3)**_____

4)_____ **5)**_____ **6)**_____

List all Previous Surgeries

1)_____ **2)**_____

3)_____ **4)**_____

Current Medication List (Include dosage and time)

1)_____ **2)**_____

3)_____ **4)**_____

5)_____ **6)**_____

Family History (Ex: Hypertension, Cancer, etc.)

Mother_____

Father_____

Please list any religious/personal beliefs that may affect your care: _____

_____

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
_____ Other

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

Parent/Guardian Signature_____**Date** _____

AUTHORIZATION TO BILL INSURANCE

Please note that THE COFFEE TELEHEALTH 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 Date of Birth_____Patient's Social Security Number_____

Primary Insurance Company

Insurance Company_____ Person Insured_____

Insured's Date of Birth_____ Insured's Social Security Number_____

Policy or Member Number_____ Group Number_____

Secondary Insurance Company (if applicable)

Insurance Company_____ Person Insured_____

Insured's Date of Birth_____ Insured's Social Security Number_____

Policy or Member Number_____ Group Number_____

Responsible Party

Name_____

Date of Birth_____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.

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 to keep.

I acknowledge receipt of the HIPAA Notice of Privacy Practices from **THE COFFEE TELEHEALTH CLINIC**.

Parent/Guardian Signature_____**Date**_____