HUDSON HEADWATERS
HADLEY-LUZERNE STUDENT HEALTH

STUART M. TOWNSEND
ELEMENTARY SCHOOL

PO BOX 200
27 HYLAND DRIVE
LAKE LUZERNE, NY 12846-0200

518-824-2580
FAX: 518-824-2579

WWW.HHHN.ORG

Dear Parent/Guardian,

Hudson Headwaters Health Network has been providing care to children and teens in the North Country for over three decades. We are thrilled to now be partnering with the Hadley-Luzerne School District to bring high-quality primary care to students at the new school-based health center, Hadley-Luzerne Student Health. We'd like to share some information, so you and your child know what to expect.

Opening and Hours of Operation:
The health center is open every day that school is in session from 8:00 a.m. to 12:00 p.m. You will be able to reach a member of our pediatric health care team by phone until 5:00 p.m.

Services:
Primary care services provided to students may include annual physicals, sports physicals, illness or injury referred by the school nurse, vaccinations, chronic disease management, women's health or other care not routinely provided by the district's nurse.

Consent and Participation:
All students in the Hadley-Luzerne School District (including **both** Hadley-Luzerne Junior/Senior High School and the Stuart M. Townsend Elementary School) are eligible to enroll in the school-based health program.

To receive services, parents must complete the enclosed enrollment forms. Additionally, these forms are available at the school or online at www.hhhn.org. Enrollment in the program can be completed at any time.

All parents are encouraged to enroll their child in the program, even if they already have a primary care provider. Enrolling your child gives you the option of using the school-based health center if needed. The school-based health center team will work with your family doctor to provide back-up care when necessary and to help monitor chronic conditions.

Eligibility, Insurance, Payment:
There are no income or insurance requirements to participate in this program. Services are provided with **no out of pocket costs** to families. If your child has insurance, we will bill your insurance company if applicable. Should your child need additional services **outside** of Hadley-Luzerne Student Health, we offer financial and billing assistance through budget agreements, a Sliding Fee discount for medical, dental and other services, and RX Assist for financial assistance with ongoing prescription needs. For more information about our financial assistance programs please call 518-824-8640 or visit our website.

Appointments:
Students may access services from the health center through direction from the school nurse if they are enrolled in the program. Parents will also be able to schedule appointments for their children at this location.

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If your child becomes ill at school, the school nurse will determine if it is necessary for your child to receive care. We will always attempt to contact you by phone if your child is seen for an acute illness or injury and will send home a written explanation of the care given and the necessary follow-up. Medications and prescriptions will not be sent home with your child. Prescriptions will be sent to the pharmacy of your choice.

If your child is ill, **please do not** send him/her to school. If you would like your child to be seen at Hadley-Luzerne Student Health, please call and make an appointment for your child to be seen. Parents are always welcome to come to their child's appointment. If you are unable to attend the appointment, we can see your child during the school day and call you before and after their appointment.

If needed, transportation from the Hadley-Luzerne Junior/Senior High School to Hadley-Luzerne Student Health will be provided by the school.

After Hours/Urgent Care:
When school is not in session and your child is ill, please contact your child's primary care provider. If you do not have a primary care provider for your child, please contact our Pediatric and Adolescent Health office at 518-798-6400.

Hudson Headwaters also offers **urgent care** for health concerns that arise suddenly but are not life-threatening at two of our facilities, the Health Center on Broad Street in Glens Falls and the Warrensburg Health Center seven days a week with evening hours. Please visit our website for more information.

Patient Portal:
As a parent or legal guardian, you can manage your child or teen's personal health information on our secure online health portal. Our portal allows you to access medical information you need like medications, immunizations, and appointment summaries from the convenience of your computer or mobile device. To register, select "yes" on the enrollment form and share your email address. You may also register for the patient portal by calling the health center.

Meet the Hadley-Luzerne Student Health Team:
Our team of experienced pediatric providers and medical assistant, Lauren Eckard, will work closely with the school nurse, Annie Horn to make sure your child receives the high-quality healthcare they need. Our team is available should you have any questions or concerns. We look forward to caring for the students of the Hadley-Luzerne School District.

Irene Flatau, M.D.
Pediatrician

Krysta Brown, PNP
Pediatric Nurse Practitioner

Lia Braico, FNP
Family Nurse Practitioner

www.hhhn.org

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Hadley-Luzerne Student Health Enrollment and Consent Form

Please complete the front and back of this form and return to the health center.

Student and Guardian Information:

Student's Name: _____ **Date of Birth**: _____ /_____ /_____ **Grade:** _____

Social Security #: _____ **Gender Identity:** ☐Female ☐Male ☐Other, please specify: _____

Preferred Language: _____ **Ethnicity:** ☐Hispanic/Latino ☐Not Hispanic or Latino ☐Refuse to Report

Race: ☐Native-Hawaiian ☐Black/African American ☐White American ☐Indian/Alaska Native ☐Asian
☐Unreported/Refuse to Report ☐Other _____

Student Address: _____

Parent/Guardian First and Last Name: _____ **Relationship to Student:** _____

Phone #: _____ **Cell #:** _____ **Work #:** _____

E-Mail Address: _____ **Would you like to register for our patient portal? YES NO**

Who is your child's primary care provider? ☐Hudson Headwaters Health Network

Practice Name: _____ Provider Name: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Emergency Contact:

Name: _____ Relationship to Student: _____

Home Phone #: _____ Cell Phone #: _____

Insurance Information:

Does your child have health insurance: **YES NO**

If your child does not have health insurance, would you like to be contacted by an enrollment specialist from Adirondack Health Institute who can assist you with obtaining free or low-cost health insurance? YES NO

Insurance Company: _____ Phone #: _____

Address to submit claim to: _____

Policy/ID #: _____ Group #: _____

Name of Policy holder: _____ Date of Birth: _____

Social Security #: _____ Employer: _____

(*over*)

HUDSON HEADWATERS
HADLEY-LUZERNE STUDENT HEALTH

Consent for Health Services

I give my consent for my child to receive applicable medical services provided by the staff of Hudson Headwaters Health Network Hadley-Luzerne Student Health, including;

- Comprehensive physical exams, including those for school sports
- Lab test when necessary to detect illness or infection (ie: strep throat)
- Immunizations
- First aid and assessment of acute illness, injuries and emergency care
- Prescriptions and medication administration when necessary
- Referrals to an outside agency for services not provided at Hadley-Luzerne Student Health
- Health Education Counseling

I give consent for, _____to receive the above healthcare services provided by the professional staff of Hudson Headwaters Health Network Hadley-Luzerne Student Health.

I further give consent to the staff of Hadley-Luzerne Student Health to examine my child's full medical and school records including any information that may assist them in helping my child. In addition, if necessary, you may contact our family physician or any other healthcare provider to share information regarding my child's treatment.

I also authorize the release of any medical information necessary to process any insurance claim to my designated insurance carrier and made payable directly to Hudson Headwaters Health Network Hadley-Luzerne Student Health.

I understand that when necessary every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. New York State law does not require parental consent for treatment or advise about drug abuse, alcoholism, sexually transmitted disease, reproductive health or outpatient mental health services.

All care provided will be in collaboration with your child's Primary Care Provider.

The staff of Hadley-Luzerne Student Health considers parental involvement very important. Accordingly, the staff will encourage every student to involve his/her parents or guardian in counseling and medical care decisions. We encourage parents to visit or call the center at any time.

Date: _____ Signature: _____

Print Name: _____

Relationship to student: _____

Please complete the front and back of this form and return to the health center.

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Health History Form

Please complete the front and back of this form and return to the health center.

Child's Name: _____ **Today's Date:** _____

Date of Birth: _____**Gender Identity:** ☐Female ☐Male ☐Other, please specify: _____

Person completing this form: _____**Relationship to child:** _____

When was your child's last physical? _____

Please list any health concerns you may have about your child: _____

Please list any hospitalizations, accidents, broken bones, and surgeries:

_____

Has your child had his/her hearing tested? **YES** **NO** date: _____ Hearing Aid **YES** **NO**
Has your child had his/her eyes tested? **YES** **NO** date: _____ Eyeglasses/Contacts **YES** **NO**
When was your child's last visit to the dentist? _____

Medications: Does your child take any medication regularly? **YES** **NO**
Please write the name, dose and frequency of each medication:
Name of medication ***Amount and how often taken***

_____

_____

Allergies: Does your child have any allergies? ☐ No Allergies

If **YES, PLEASE LIST ALL** allergies to medications, foods, insects or other substances:

_____

Does anyone in the household smoke? **YES** **NO**

Family/Household Information

Mother's Name_____Employer_____Phone_____

Father's Name_____Employer_____Phone_____

Please list all the people who live in the house with the child.

_____

Please list important people in your child's life outside the home (ex. daycare provider).

_____

(*over*)

Family History:

Check any of the following that relatives (including, aunts, uncles, cousins, grandparents) have and indicate their relationship to your child:

- ☐ ADD or Hyperactivity _____
- ☐ High Cholesterol _____
- ☐ Anxiety _____
- ☐ Learning Problems _____
- ☐ Asthma _____
- ☐ Cancer _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Eczema _____
- ☐ Anemia _____
- ☐ Hay Fever _____
- ☐ Cystic Fibrosis _____
- ☐ Heart Attack before 50_____
- ☐ Birth Defects _____
- ☐ High Blood Pressure _____
- ☐ Mental Retardation _____
- ☐ Obesity _____
- ☐ Drug Abuse _____
- ☐ Seizure Disorder _____
- ☐ Alcoholism _____
- ☐ Stress _____
- ☐ Suicide _____
- ☐ Stroke before 50 _____
- ☐ Tuberculosis _____
- ☐ Kidney Disease _____
- ☐ Death before 50 (list cause) _____

Past Illnesses:

Has your child ever had any of the following?

- ☐ Chickenpox
- ☐ Meningitis
- ☐ Ear Infections
- ☐ Hepatitis
- ☐ Mononucleosis
- ☐ Cancer/Tumor
- ☐ Tonsillitis
- ☐ Urinary tract infections
- ☐ Lead Poisoning
- ☐ Rheumatic Fever
- ☐ Skin problems
- ☐ Victim of child abuse
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Bronchitis
- ☐ Other_____

Chronic Illnesses:

Does your child have any of the following illnesses that require regular medical attention or medication

- ☐ Asthma
- ☐ Intestinal Disease
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Convulsions (epilepsy/seizures)
- ☐ Blood Disorders
- ☐ High Blood Pressure
- ☐ Cystic Fibrosis
- ☐ Blood Disorders
- ☐ High Blood Pressure
- ☐ Cystic Fibrosis
- ☐ Heart Disease
- ☐ Other_____

Emotional and/or Behavior Concerns:

Please check any concerns you may have about your child's behavior:

- ☐ Bed-wetting
- ☐ Problems Sleeping
- ☐ Jealousy
- ☐ Hyperactivity
- ☐ Frequently Worried
- ☐ Trouble learning
- ☐ Fighting
- ☐ Bad Temper
- ☐ Soiling in underwear
- ☐ Aggressive behavior
- ☐ Mood swings
- ☐ Frequently sad
- ☐ Refuses to obey
- ☐ Trouble making friends
- ☐ Bullying
- ☐ Other_____

Please complete the front and back of this form and return to the health center.

HUDSON HEADWATERS HEALTH NETWORK
RELEASE OF INFORMATION

I understand that my health information may be used or disclosed for the purposes of treatment, payment, and operations in accordance with state and federal regulations for privacy and security. I understand that this may include disclosures of information to my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to Hudson Headwaters Health Network for medical services rendered to myself and/or my dependents. I am responsible for understanding the limitations of my insurance coverage and to present any co- pay (co- insurance, deductible) or other personal obligations at the time service is rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I give Hudson Headwaters Health Network permission to disclose to a relative or friend my location and general condition, or other information directly relevant to that person's involvement in my care, to those I have named below: (please note: Certain medical conditions may require a separate release.)

_____	_____
(First and last name)	*(Relationship with patient)*
_____	_____
(First and last name)	*(Relationship with patient)*
_____	_____
(First and last name)	*(Relationship with patient)*
_____	_____
(First and last name)	*(Relationship with patient)*
_____	_____
(First and last name)	*(Relationship with patient)*

X_____ X_____

Patient's Signature or Parent/Guardian's Signature Date

☐ Patient or Parent/Guardian refused to sign.

Please complete the front and back of this form and return to the health center.

HUDSON HEADWATERS HEALTH NETWORK
ASSIGNMENT OF BENEFITS

Because Hudson Headwaters Health Network receives funding from the Federal Government, we are required to collect information about income ranges. **Please determine family size and check the appropriate income category box.**

Family Size	CATEGORY 1: ☐	CATEGORY 2: ☐	CATEGORY 3: ☐	CATEGORY 4: ☐
1	$0 - $12,490	$12,491 - $18,735	$18,736 - $24,980	$24,981 +
2	$0 - $16,910	$16,911 - $25,365	$25,366 - $33,820	$33,821 +
3	$0 - $21,330	$21,331 - $31,995	$31,996 - $42,660	$42,661 +
4	$0 - $25,750	$25,751 - $38,625	$38,626 - $51,500	$51,501 +
5	$0 - $30,170	$30,171 - $45,255	$45,256 - $60,340	$60,341 +
6	$0 - $34,590	$34,591 - $51,885	$51,886 - $69,180	$69,181 +
7	$0 - $39,010	$39,011 - $58,515	$58,516 - $78,020	$78,021 +
8	$0 - $43,430	$43,431 - $65,145	$65,146 - $86,860	$86,861 +

☐ Patient or Parent/Guardian refused to indicate income category.

X_____ X_____

Patient's Signature or Parent/Guardian's Signature — Date

☐ Patient or Parent/Guardian refused to sign.

Please complete the front and back of this form and return to the health center.

HUDSON HEADWATERS HEALTH NETWORK
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand and have been provided with a copy of Hudson Headwaters Health Network Privacy Practices that provides a more complete description of how the Network may use and disclose my protected health information in accordance with state and federal regulations for privacy and security. I further understand that Hudson Headwaters Health Network reserves the right to change its privacy practices. In the event of a change, a copy will be posted in a prominent location in the practice site, or upon my request, a copy will be sent to the address I have provided.

I,_____, date of birth_____, understand,
Patient First and Last Name Date of birth

that as part of my health care, Hudson Headwaters Health Network originates and maintains paper and/or electronic records describing health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means to facilitate coordination of care among the health professionals, including referrals, who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for healthcare options of the Network such as assessing quality of care and reviewing competence of healthcare professionals.

I understand that Hudson Headwaters Health Network may send test results and correspondences associated with my care to the address I have provided. We may also leave messages at the telephone numbers I have provided either to confirm appointments or to request I call on medical, dental or billing items.

If you require a restriction on the above please see a staff member at the desk.

X_____ X _____
Patient's Signature or Parent/Guardian's Signature Date
☐ Patient or Parent/Guardian refused to sign.

(over)

HUDSON HEADWATERS HEALTH NETWORK
9 Carey Road, Queensbury, NY 12804 · www.hhhn.org

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how your medical information may be used and disclosed and how you can get access to this information. For more information please contact our Risk Management and Compliance department at 518-761-0300 ext. 31350 or compliance@hhhn.org

Your Rights

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

➢ *For more information on these **rights** and **how to exercise them**, please see your nearest health center*

Your Choices

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

➢ *For more information on these **choices** and **how to exercise them**, please see your nearest health center*

Our Uses and Disclosures

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 more information on these **uses and disclosures**, please see your nearest health center*