TeleHealth

School-Based Collaborative HealthCare Center

ADULT FORM

The Coffee County Board of Education along with the Coffee TeleHealth – School-Based Collaborative are proud to announce the opening of **Coffee TeleHealth** - School-Based Collaborative HealthCare Centers.

What is Coffee TeleHealth?

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

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, blood pressure)
- Monthly medication management/medication maintenance
- Mental health, substance abuse, and family centered case management

How do I enroll with Coffee TeleHealth?

- Contact the nurse at your school or 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 type of insurance does Coffee TeleHealth accept?

Coffee TeleHealth is not a billing agent. Each doctor is responsible for their own billing. Dr. Keith Childers, Dr. Brian Griner and Allergy Asthma Clinics of Georgia accept most insurance companies. The Telehealth doctors have their own billing requirements and we can find out what they accept on a case-by-case need.

When is Coffee TeleHealth open?

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

Which doctor's are participating in Coffee TeleHealth?

Locally, Dr. Keith Childers, Asthma Allergy Clinics of Georgia, and Dr. Brian Griner from Valdosta, have partnered with Coffee TeleHealth. All telehealth doctors are doing telehealth appointments. Dr. Griner is using his PAs and is solely doing telehealth. In addition to these doctors, we also have access to 100s more via the telehealth network. If you need a specialist (dermatology, psychiatry, allergist, etc) we may be able to access that person via telehealth. If you know the name of the doctor you are looking for contact the Coffee TeleHealth Coordinator and she can see if that person is in the Georgia Telehealth Network.

What is Telehealth?

Telehealth is a model of health care that has been around for many years. Once used primarily by the military, telehealth can now be seen in many environments...hospitals, acute care clinics, doctor's offices...and now, school-based health clinics! Using the telehealth equipment, the doctor can see images of a person's throat/mouth, ears, eyes, skin rashes, etc. Telehealth is amazing technology and gives rural areas (such as ours!) access to medical care that we may otherwise have to travel hours to receive.

What if the doctor prescribes medication?

We have established a partnership with Fulco Discount Pharmacy and McRaes Pharmacy. They have agreed to deliver all telehealth medications to the school each afternoon. The pharmacy will bill your insurance and if you owe anything else, will bill you directly.

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In addition to completely filling out the health questionnaire/intake form, please also make sure to sign and date each form where indicated. You may use this checklist as a reference to make sure you have completed and signed each item in this packet.

☐ Privacy Practice/Consent Form
☐ Authorization to bill insurance
☐ Lab permission form
☐ Data Collection Authorization
☐ Completely fill out intake packet
☐ Attach a copy of your insurance card (front and back)

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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 Patient) **(Date)**

____
(Print Patient'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

PRIVACY PRACTICE/CONSENT FORM

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

The Coffee 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 and staff of Coffee County Schools, in order to have a positive impact on the children's health, school attendance, and academic performance.

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

I hereby voluntarily give my consent for ______________________________ to receive health services at
(insert patient's name)
Coffee County Schools, Coffee TeleHealth – School-Based Collaborative HealthCare Center. I further authorize any physician or physician-designated health professional 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 health care.

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 health care from the Coffee County Schools TeleHealth Clinics whenever necessary for my care.

I authorize Coffee County Schools 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 Coffee County Schools and Coffee TeleHealth - School-Based Collaborative HealthCare Center is permitted to disclose protected health information about me for the purposes of payment, continued care or treatment, and healthcare operations.

If my 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 physicians and professionals at Coffee County Schools and Coffee TeleHealth School-Based Collaborative Health Care Centers and 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 treatment at the Coffee TeleHealth Clinic. 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 Patient

______________________________ ______________________________
Signature of Patient 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 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 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 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 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, Director, 1311 South Peterson Ave., 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!

Patient's Name: ______________________ Date: ____________

Patient's Signature ____________________

______________________________ Date: ____________

Signature of Coffee TeleHealth Clinic Staff

School-Based Collaborative HealthCare Center

INTAKE FORM

Please complete all information on this permission form. You must **COMPLETE USING INK** then sign and date it in order to receive services from Coffee TeleHealth. It is your responsibility to notify us immediately of any changes in address, phone numbers or insurance.

Today's Date____________ Patient's Name____________________________ ____________________________ ________________

Last First Middle

Birth Date: _____________ Age: _____ Primary Language (circle one): English Spanish Other

Social Security Number: ___________________________ Birth Country (circle one): USA Other Sex (circle one): Male Female

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

Address:____ City__________________________ State_____ Zip_____________

Home Phone: ________________________ Cell Phone: ______________________ Work Phone: ___________________________

How long at present address? ____Years ____Months How long at previous address? ______Years ______Months

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

Who lives at home? Please list everyone who lives in home.

NAME	RELATIONSHIP	AGE

Patient's Employer: _____________________________ Address: _____________________________________

Position: _____________________________________ How long in current position? ______________________________

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Please list the name and contact information of a person (or persons) we can contact in case of emergency.

Emergency Name & Number____ Relationship to Patient________________________

____ ________________________

____ ________________________

Physician Information

Who is your primary care physician (the person you would see for a sore throat or a minor injury)? ______________________

Date of last visit: ______________ Address for your primary care physician: ______________________

____

Phone number: ______________________

For emergency visits, which clinic or Emergency care facility do you use? ______________________

Date of last visit: ______________ Address for your clinic/emergency facility ______________________

____

Phone number: ______________________

If you see a specialist for any reason, list that doctor and reason for seeing him/her: ______________________

Date of last visit: ______________

Address for the special care physician: ______________________

____

Phone number: ______________________

If you see someone for mental health/behavioral problems, list that person and reason for seeing him/her: ______________________

Date of Last Visit ______________

Address for mental health professional: ______________________

____

Phone number: ______________________

If you see a dentist, list that dentist: ______________________

Date of Last Visit ______________

Address for your dentist: ______________________

____

Phone number: ______________________

Please write the name & **phone #** of a nearby pharmacy in case you need prescription medicines.

Pharmacy/Phone# ______________________

Have you 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? ______________________

Have you 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? ______________________

Have you been in the hospital overnight in the last year? ____Yes ____No

Where? ______________________

Why? ______________________ How Long ______________________

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HEALTH QUESTIONAIRE

Do you have any known allergies (foods, medications, etc)? ___Yes ___No
List all known allergies: ____

____

Do you have any Physical Disabilities? ___Yes ___No
If yes, please explain: ____

____

Are you currently being treated for any health problems? ___Yes ___No Specify who is providing the treatment: ____________
If yes, explain: ____

____

Do you take 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

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 ____

Do you or anyone in the home:

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

PATIENT'S MEDICAL HISTORY

Please specify if you have 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
Rheutmatic 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	__Yes__No
-Weight______	
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:

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____

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____

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____

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 may have about your mental health:

____

____

____

____

____

____

DENTAL HISTORY

Do you have dental problems? __Yes __No

How often do you brush your teeth? __Occasionally __Once a Day __ Twice Daily __Other

Have you had a toothache recently? _Yes _No

Have you had any injury to the teeth or jaws? __Yes __No

When was your last dental visit? ____________________

If you have any other medical concerns, please list and describe in the space available below.

____

____

____

____

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____

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____

____

____

Coffee TeleHealth

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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: ______________