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|  |  | | | | | |  | | For Office Use Only 2012 | | | | | |
|  |  | | | | | |  | | Location: Grainger Co. Telehealth | | | | | |
|  |  | | | | | |  | | Account #: | | | | | |
|  | **School Telehealth Registration** | | | | | |  | | Date: | | | | | |
| *(Please Print)* | | | | | | | | | | | | | | |
| **Patient Information** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Patient’s Name Last First MI | | | Social Security # | | | | | Gender | | | Age | Birth Date | | |
|  | | |  | | | | | 🞏 M 🞏 F | | |  |  | | |
| Name of School | | Homeroom Teacher ‘s Name Grade | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | |  |
| Race/Ethnicity  🞏 Caucasian 🞏 African American 🞏 Native Alaskan 🞏 Hispanic/Latino 🞏 American Indian 🞏 Asian/Pacific Islander 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |  |
|  |
| Physical Address City/State/Zip Code County | | | | | | | | | | | Home Phone # | | | |
|  | | | | | | | | | | | ( ) | | | |
| Mailing Address City/State/Zip Code | | | | | | | | | | | Work Phone # | | | |
|  | | | | | | | | | | | ( ) | | | |
| 🞏 **If your child is insured, please provide a copy of his/her insurance card so we can bill timely and accurately** | | | | | | | | | | | | | | |
| 🞏 If uninsured, a sliding fee discount is available to you and explained on the back of this form. | | | | | | | | | | |  | | | |
| Mother ‘s Full Name | | | Social Security # | | | | | Birth Date | | | Home Phone # | | | |
|  | | |  | | | | |  | | | ( ) | | | |
| Home Address City/State/Zip Code | | | | | Employer | | | | | | Work or Alternate Phone # | | | |
|  | | | | |  | | | | | | ( ) | | | |
| Father ‘s Full Name | | | Social Security # | | | | | Birth Date | | Home Phone # | | | | |
|  | | |  | | | | |  | | ( ) | | | | |
| Home Address City/State/Zip Code | | | | | | Employer | | | | | Work or Alternate Phone # | | | |
|  | | | | | |  | | | | | ( ) | | | |
| Legal Guardian (if applicable) | | | | Relationship to Patient | | | | | | | Home Phone # | | | |
|  | | | |  | | | | | | | ( ) | | | |
| Home Address City/State/Zip Code | | | | | | | | | | | Work or Alternate Phone # | | | |
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| **Consent to Treat Authorization** | | | | | | | | | | | | | | |
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| I hereby voluntarily give my consent to receive health care services offered by Cherokee Health Systems through the school based telehealth services. Services may include treatment for cuts/abrasions, rash, sore throat, pink eye, head lice, earache, cough, cold, and/or flu-like symptoms.  I understand that if my child requires medical treatment that is beyond the scope of this Telehealth Service, the staff will initiate a referral to another health care provider. I am assured that I, as parent/guardian, will be contacted before any billable service is provided, and no services will be performed, including transportation or transfer to another medical provider or facility, without verbal permission unless emergency lifesaving treatment is necessary.  I understand that the Cherokee Health Systems Telehealth will adhere to the confidentiality and care standards as mandated in the Health Insurance Portability and Accountability Act (HIPAA). A summary of these rules is located in the School Clinic.  🞏 I would like a copy of the HIPPA mailed to my home.  By signing below, I authorize Cherokee Health Systems to treat my child. I understand that I may revoke this consent to release confidential information at any time. Unless I revoke this authorization, this authorization shall remain in effect for the current school year (1) year. I hereby certify that I have read and understand this consent authorization and accept the terms herein.  🞏 Yes, I want my child seen in the Cherokee Health School Telehealth Program .  🞏 Yes, I do want my child seen in the Cherokee Health School Telehealth Program , BUT I MUST BE PRESENT.  🞏 No, I DO NOT WANT MY CHILD TO PARTICIPATE in the Cherokee Health School Telehealth Program.  **Please complete the back of this form before turning in to school nurse** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Signature **X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Student | | | | | | | | | | | | | | |
| Witness **X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |  | |
| Emergency Contact Name/Relationship Contact Address City/State/Zip Code Phone Number  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) | | | | | | | | | | | | |  | |
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| **Insurance Information**  **In order for insurance to be billed, we need the following completed** | | | | | | | |
| ***(Please give your insurance card to the nurse.)*** | | | | | | | |
| Person Responsible for Payment Mailing Address City/State/Zip Code | | | | | | | |
|  | | | | | | | |
| Employer Employer Address City/State/Zip Code | | | | | | Employer Phone # | |
|  | | | | | | ( ) | |
| Primary Insurance Company Claims Mailing Address City/State/Zip Code | | | | | | | |
|  | | | | | | | |
| Phone # | Effective Date | Group # | ID # | Who is coverage through? Their Date of Birth:\_\_\_\_\_\_\_\_\_ | | | |
| ( ) |  |  |  | 🞏 Self 🞏 Mother 🞏 Father 🞏 Spouse 🞏 Other | | | |
| Secondary Insurance Company Claims Mailing Address City/State/Zip Code | | | | | | | |
|  | | | | | | | |
| Phone # | Effective Date | Group # | ID # | Who is coverage through? Their Date of Birth: \_\_\_\_\_\_\_\_\_ | | | |
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| **Insurance Authorization** | | | | | | | |
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| There are fees for all services provided by Cherokee Health Systems (CHS.) It is expected that patients pay for the services provided through the SMART program. Health insurance policies may cover a portion of the fees and CHS staff will assist you in making claims. It is expected that you will inform us of changes in your financial status or health insurance coverage. Please read the *Authorization for Insurance Billing/Release of Information* section below, fill in the name of your insurance company(s), and sign. | | | | | | | |
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| **Authorization for Insurance Billing/Release of Information** | | | | | | | |
|  | | | | | | | |
| By signing below, I authorize Cherokee Health Systems to assist me in obtaining third party benefits, to file benefit claims on my behalf, and to release any information necessary for the processing of my claim(s) to: *Name of Insurance Company, or Other Third Party Benefit Agent(s)* | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |
| I understand that such information may include diagnosis, dates of service, types of treatment, results of evaluations/assessments, actual progress notes, and other information about services received. This release shall remain in effect until all claims filed on my behalf have been processed.  I authorize and request direct payment of my health insurance benefits to Cherokee Health Systems. This authorization shall apply to all covered health services that I receive at SMART. If requested, I have been provided with a copy of the fee scale. | | | | | | | |
| Patient’s signature (or legal guardian’s, if applicable) **X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |
| Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |
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| **ONLY COMPLETE THIS SECTION IF YOU ARE UNINSURED and WOULD LIKE TO APPLY FOR A DISCOUNT** | | | | | | | |
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| If you do not have health insurance benefits, you may apply for a discount by providing written proof of your total household income. Income may include, but is not limited to salary or wages, SSI, Social Security, retirement, disability payments, veterans benefits, Black Lung benefits, alimony, child support, interest income… Our fundors require that you provide written proof of your total household income **BEFORE** a discount can be arranged. You may use paycheck stubs for at least three consecutive pay periods, benefits check stubs, W-2 forms, a copy of your most recent Federal Income tax return, or a copy of applications for any agency benefits if it includes household income and number of household members. Once you supply the required documentation, the application will be reviewed to determine your eligibility for the discount. If you have questions, please call our CHS Telehealth Office at 865.225.2110.   |  |  |  |  | | --- | --- | --- | --- | | **Name** | **Age** | **Relationship** | **Monthly Income** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | | | | | | | | |
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| I certify that the information and documentation I have provided is accurate. I know that my application information will need to be updated periodically as changes occur.  Patient’s signature (or legal guardian’s, if applicable) **X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |