HUDSON HEADWATERS
HADLEY-LUZERNE STUDENT HEALTH

STUART M. TOWNSEND
ELEMENTARY SCHOOL
27 HYLAND DRIVE
LAKE LUZERNE, NY 12846
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:
Our anticipated opening for Hadley-Luzerne Student Health is September 30, 2019. The health center will be 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.

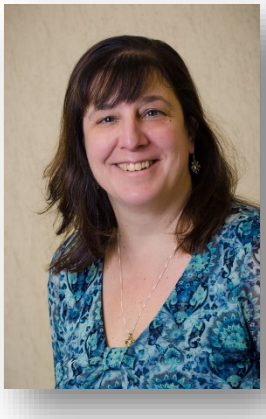
If needed, transportation from the Hadley-Luzerne Junior/Senior High School to Hadley-Luzerne Student Health will be provided by the school.

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.

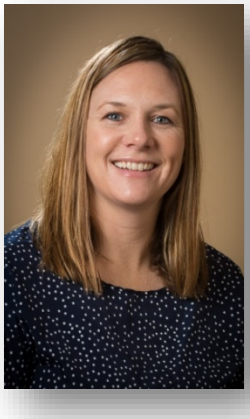
Hudson Headwaters also offers **urgent care** for health concerns that arise suddenly but are not life-threatening at two of our facilities, the Health Center on Broad Street in Glens Falls and the Warrensburg Health Center seven days a week with evening hours. Please visit our website for more information.

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.

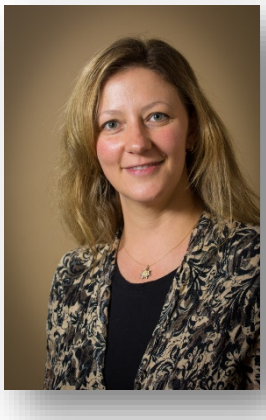
Meet the Hadley-Luzerne Student Health Team:
Our team of experienced pediatric providers and medical assistant, Lauren Eckard, will work closely with the school nurse, Annie Horn to make sure your child receives the high-quality healthcare they need. Our team is available should you have any questions 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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Hadley-Luzerne Student 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 the last time your child was seen by his/her primary care doctor? _____

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*)

HUDSON HEADWATERS
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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
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 Signature of Patient Representative Date
☐ Patient refused to sign.

(*over*)

HUDSON HEADWATERS HEALTH NETWORK
RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS

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 HHHN 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 HHHN 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.)

_____

(please **print** first name, last name and relationship)

Because Hudson Headwaters 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 refused to sign.

X_____ X_____

Patient's Signature or Signature of Patient Representative — Date

☐ Patient refused to sign

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

Hixny Electronic Data Access Consent Form
Hudson Headwaters Health Network

In this Consent Form, you can choose whether to allow Hudson Headwaters Health Network to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Hudson Headwaters Health Network to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Hudson Headwaters Health Network's staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Hudson Headwaters Health Network may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision.
You have two choices:

- ☐ **I GIVE CONSENT for Hudson Headwaters Health Network to access ALL of** my medical records through Hixny in connection with providing me any health care services, including emergency care.

- ☐ **I DENY CONSENT for Hudson Headwaters Health Network to access** my medical records through Hixny for any purpose, *even in a medical emergency*. Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through Hixny.

_____ _____ _____
Print Name of Patient Date of Birth Date

_____ _____
Signature of Patient or Patient's Legal Representative Print Name of Legal Representative (if applicable)

_____
Relationship of Legal Representative to Patient (if applicable)

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

Details about patient information in Hixny and the consent process:

How Your Information Will Be Used

Your electronic health information will be used by Hudson Headwaters Health Network only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information About You Are Included

If you give consent, Hudson Headwaters Health Network may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems*
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

***If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.**

Where Health Information About You Comes From

Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information About You, If You Give Consent

Only these people may access information about you: doctors and other health care providers who serve on Hudson Headwaters Health Network's medical staff who are involved in your medical care; health care providers who are covering or on call for Hudson Headwaters Health Network's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

Penalties for Improper Access to or Use of Your Information

There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Hudson Headwaters Health Network at: 607-729-9166 or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

Re-disclosure of Information

Any electronic health information about you may be re-disclosed by Hudson Headwaters Health Network to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period

This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Hudson Headwaters Health Network. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

Copy of Form

You are entitled to get a copy of this Consent Form after you sign it**.**