Print

Print Completed Form and Reset

Reset

SOUTH CAROLINA Telehealth ALLIANCE

BILLINSUR

School-Based Health Clinic Patient Demographic Form

Form Origination Date: 11/13
Version: 3

Version Date: 4/18

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

Grade: _____ Teacher Name: _____

Patient Name _____ _____ _____
Last First Middle

Patient Birth Date: _____ Age: _____ Primary Language: ☐ English ☐ Spanish ☐ Other _____

Sex: ☐ Male ☐ Female Social Security Number: _____

Race: ☐ Black ☐ White ☐ Hispanic ☐ Asian ☐ Multiracial ☐ Other: _____

Primary Care Provider _____

Parent or Guardian Name _____

Relationship to Patient _____

Parent or Guardian Birth Date _____

Parent or Guardian Social Security Number _____

Address: _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

List the name and contact information of a person (or persons) we can contact if parents/guardian cannot be reached.

Emergency Name & Number _____

Relationship to Patient _____

Emergency Name & Number _____

Relationship to Patient _____

PROVIDE PATIENT INSURANCE INFORMATION.
Include a copy of the front & back of your Medicaid/Insurance card.

☐ 1. Medicaid Number _____
Medicaid Plan: _____

☐ 2. Private medical health insurance:
Name _____
Policy # _____

Who (name) insures child? Relationship to insured child _____
Employers Name: _____

☐ 3. No Insurance.

Print | Print Completed Form and Reset | Reset

SOUTH CAROLINA Telehealth ALLIANCE

SCHOOLCONST

School-Based Clinic Consent for Treatment

Patient Name_____
MRN _____
PATIENT IDENTIFICATION LABEL

Form Origination Date: 11/13
Version: 6 Version Date: 4/18

Student Name:_____

I give my consent for my child, named above, to receive medical care from the School-Based Health Program. Care will be provided in a private manner and information will not be released without my consent. I allow physicians or designated health professionals to provide necessary and/or advisable treatment for my child and to bill for this service. I understand that supervised residents and students may assist in my child's care. I understand that my child may receive medical care from providers who are authorized by my child's school district.

I authorize the holder of medical or other information about me to release to any other third party responsible for payment such as information needed for decisions of Medicare, Medicaid or third party claims.

I acknowledge that I will be responsible for any payments not covered by my health plan, to include deductibles. I understand this consent form is valid, until I revoke it.

I received a copy of a "Notice of Privacy Practices" from providers who are authorized by my child's school district and/or a copy of the MUSC "Notice of Privacy Practices".

_____ _____
Signature of Legal Guardian/Representative Date
(or Student if 18 years or older or otherwise permitted by law)

_____
Printed Name of Legal Guardian/Representative
(or Student if 18 years or older or otherwise permitted by law)

PRINT PRINT COMPLETED FORM & RESET RESET

SOUTH CAROLINA Telehealth ALLIANCE

SCHOOLCONST

Patient Name_____

SCHOOL-BASED AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Form Origination Date: 11/13
Version: 5 Version Date: 8/18

MRN _____
PATIENT IDENTIFICATION LABEL

Patient Name:_____

All healthcare information is private. By signing this form, you are giving the school clinic, the school nurse, and the student's main health care provider consent to speak with and share medical information about the student's health with providers who are contracted to provide care in the school-based health program as needed. This information will be treated in a confidential way.

The purpose of the disclosure is: participation in school-based health services

Examples of protected health information that may be shared include but are not limited to

- medical history (including any medical diagnosis and treatment),
- physical examinations,
- consults,
- lab reports,
- and a list of current medications.

I understand this information may include references to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV /AIDS and / or alcohol abuse.

I understand that this information may be exchanged by mail, fax, email, phone, or a secure web-based software.

I understand that I have a right to cancel this permission at any time. I understand that if I cancel this permission I must do so in writing and present my written cancellation to the School-Based Health Program office. I understand that the cancellation will not apply to information that has already been released in response to this permission, as stated in the Notice of Privacy Practice. I understand this consent form is valid until I revoke it.

I understand that permitting the release of protected health information is voluntary. I can refuse to sign this form. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information. Upon request, I understand I will be given a copy of this authorization. Parental consent for release of health information is not required for students who are 18 years or older.

_____ _____
Signature of Legal Guardian/Representative Date
(or Student if 18 years or older or otherwise permitted by law)

_____
Printed Name of Legal Guardian/Representative
(or Student if 18 years or older or otherwise permitted by law)

_____
Relationship to Patient

To contact the South Carolina Telehealth Alliance School-Based Health Program office, in writing, the address is 169 Ashley Avenue MSC 332 Charleston, SC 29425; the phone number is (843) 876-0240.

CONSENT FOR RELEASE OF EDUCATION RECORDS AND INFORMATION

The _____ (the District) shall obtain written consent before disclosing any personally identifiable information from an education record. I understand that the District will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA), state statutes and regulations, and state and District policies and procedures to ensure confidentiality regarding the release of student information. No information will be released or secured without prior approval from the parent, except as provided by law.

The District has my permission to release and exchange medical, psychological, and other personally-identifiable confidential information, as necessary, to representatives of the School-Based Health program. I understand that the purpose of this consent is to refer my child for health-related services and treatment.

Consent to Release Confidential Information

By providing my signature below, I understand that granting consent for the release of personally-identifiable information from my child's education records is voluntary and may be revoked at any time. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked). I understand this consent form is valid until I revoke it.

By providing my signature below, I understand the recipient of these records must obtain my written consent before it can further share my child's information from the District with any other party, such as for the purpose of billing Medicaid. If I provide written consent for the service provider to share my child's information with another party, the re-disclosure of my child's information by the recipient may no longer be protected by the requirements of the FERPA.

_____ _____

Student's Name Student's Date of Birth

_____ _____

Signature of Parent/Guardian/Surrogate Parent Date

To contact the South Carolina Telehealth Alliance School-Based Health Program office, in writing, the address is 169 Ashley Avenue MSC 332 Charleston, SC 29425; the phone number is (843) 876-0240.

SOUTH CAROLINA
Telehealth
ALLIANCE

FAQs – Frequently Asked Questions about the School-Based Telehealth Program

What is the School-Based Telehealth program?
Your child may have the opportunity to participate in a school-based telehealth visit. The program is used to bring healthcare to children in the school setting. A nurse practitioner or a doctor examines your child with the assistance of the school nurse. Computers and monitors are used so that patients and providers can see each other, talk clearly, and share information. At times special equipment, like electronic stethoscopes and a camera to look inside a child's ears are used.

Who will be participating in the telehealth visit?
Individuals, such as the school nurse, will be present to operate the video equipment. They will take reasonable steps to maintain confidentiality of the information obtained.

How will information collected from the telehealth visit be used?
Medical information from your child's medical chart will be used for reports and to evaluate the school-based telehealth program, but your child will not be identified with this information. The video session is not recorded but some elements such as pictures may be taken. These materials will be maintained as a confidential medical record.

Is there any other information I should know?
You and your child have the right to ask the healthcare provider to discontinue the conference at any time. In addition, some parts of the exam may be conducted by the school nurse, or medical assistant, under the guidance of the healthcare provider who is evaluating the child.