2021-2022 School Telehealth Patient Information Form

PATIENT INFORMATION

*Child's Name (Last, First, Middle) _____ ◯ Male ◯ Female

*Date of Birth (MM/DD/YYYY) _____ Social Security Number 9-digit SSN _____

*Address (Street , City, State, Zip) _____

*Pharmacy _____ *Cross Streets _____

*Pediatrician/PCP _____ *PCP Phone # _____

*School District _____ *School Name _____

Race/Ethnicity ◯ Asian ◯ Black/African American ◯ Latino/ Hispanic ◯ Native American ◯ White/ Caucasian ◯ Other

*Medication Allergies (N/A if does not apply)

*Medical History (N/A if does not apply)

PARENT/GUARDIAN INFORMATION

*Child lives with: ◯ Mother & Father ◯ Mother ◯ Father ◯ Guardian/Other

*Parent/Guardian Name (Last, First, Middle) _____

*Primary Phone _____ Alternate Phone _____

*Date of Birth _____ *Email _____ No email contact ☐

*EMERGENCY CONTACT _____ *Phone _____

*Relationship _____ ACRMC Family Medicine may disclose Medical and Billing information to this contact ☐ Yes ☐ No

INSURANCE INFORMATION

*Type of Insurance ☐ Commercial ☐ CHIP ☐ Medicaid ☐ None

*Person responsible for paying the bill ☐ Mother ☐ ☐ Guardian/Other _____

*Full Name _____ *Phone _____ *DOB _____

*Address same as child ◯ Yes ◯ No _____

*Insurance Policy Holder ☐ Child ☐ Mother ☐ Father ☐ Other

*Insurance Policy Name _____ *DOB _____

*Employer _____ *Insurance Name _____

*Insurance ID# _____ *Group#_____ *Phone _____

Consent for Telemedicine Services / Virtual Visit Care and Treatment

General Consent: I consent for Patient, which may be defined as me, my child or a child for whom I have legal responsibility, to receive care and treatment at an Adams County Regional Medical Center hospital, facility, entity or program (collectively referred to as "ACRMC") through Telemedicine Services (which may also be referred to as a Virtual Visit). Telemedicine Services may be provided by physicians, nurses, and other health care providers employed or contracted by or affiliated with ACRMC (''Telemedicine Providers'') and may include the evaluation, diagnosis, consultation on, and treatment of Patient's medical or health condition using advanced telecommunications technology. For School Health Telemedicine Services, I agree that by signing this form, I consent for Patient to receive Telemedicine Services in my absence. I understand that photos or video of Patient may be taken in connection with Telemedicine Services and for operational, quality improvement, research, and education purposes. I understand that ACRMC is a teaching institution and agree that residents, fellows, students and other approved individuals may observe and participate in the Telemedicine Services under appropriate supervision. I understand that alongside the Telemedicine Provider and the school nurse, my child may be seen by students performing tasks such as taking temperature and blood pressure, as part of a learning environment as overseen by the school nurse/teacher.

I understand that Telemedicine Services include interactive audio, video or other electronic media and that there are both risks and benefits to being treated via telemedicine. I understand that Telemedicine Providers (i) may be in a location other than where Patient is located, (ii) will examine Patient face-to-face via a remote presence but will not perform a ''hands-on'' physical examination while using the Telemedicine Services, and (iii) must rely on information provided by Patient and any on-site health care provider(s). I further understand that Telemedicine Services may be limited or unavailable as a result of technological or equipment failures, incomplete or inaccurate data to perform the Telemedicine Services, or distortions of images or other information from electronic transmissions. I acknowledge that the Telemedicine Providers cannot be held liable for advice, recommendations and / or decisions based on factors not within their control, such as incomplete or inaccurate data provided by Patient / others or distortions of diagnostic images or specimens that may result from electronic transmission.

If the Telemedicine Providers determine that Telemedicine Services do not adequately address Patient's medical needs, the Telemedicine Providers will refer Patient for on-site medical evaluation at another provider location. If after the Telemedicine Services, Patient experiences an urgent or emergent matter, such as a negative reaction to any treatment, or if the telemedicine session is interrupted due to a technological or equipment failure, alternative treatment may be needed and I will obtain follow up care and treatment for Patient as needed. I understand that Telemedicine Services may not be appropriate for all conditions, such as a medical emergency, and that ACRMC will only treat the Patient if Telemedicine Services are appropriate.

I understand that precautions are taken to protect the confidentiality of Patient's medical information by preventing unauthorized disclosure; however, I understand and acknowledge that the security of electronic transmission of data, video images, and audio information cannot be guaranteed and confidentiality may be compromised by illegal or improper tampering.

No Guarantee: I acknowledge that no guarantees or warranties have been made with respect to treatment or services to be provided at ACRMC. I understand that all supplies, medical devices and other goods provided to Patient are provided by ACRMC **AS IS** and ACRMC disclaims any expressed or implied warranties.

Text Messaging: I agree that if I or the Patient provides a cell phone number for text messaging, ACRMC can provide notifications to my or the Patient's cell phone. I acknowledge that standard text messaging rates and fees will apply, text messaging utilizes a public telephone network and full security is not guaranteed, and that to prevent another person who has access to my phone from seeing these messages, I will need to protect my phone with a password or PIN. I understand that text messaging may not be used by me to notify ACRMC of Patient's health care needs.

Duration of Consent: I understand and agree this Consent for Telemedicine Services Care and Treatment is valid 1) for School Health Telemedicine, for the current school year, and 2) for all other Telemedicine Services / Virtual Visits, for the present and future visits for one (1) year from the date of signature below unless I revoke the consent prior to that time.

I have read and understand the information in this Consent for Telemedicine Services / Virtual Visit Care and Treatment form.

Signature of Patient / Parent or Legally Authorized Representative*	Date/Time
Printed Name of Patient / Parent or Legally Authorized Representative	Relationship to Patient

General Consent for Telemedicine Services / Virtual Visit and Acknowledgements

Protected Health Information - Notice of Privacy Practices: ACRMC's Notice of Privacy Practices addresses how ACRMC may use and disclose Patient's Protected Health Information (PHI) for treatment, payment, and healthcare operations and for other purposes allowed or required by law. I acknowledge that I have received the ACRMC Notice of Privacy Practices and that any questions or concerns may be directed to the ACRMC Privacy Officer.

Use and Disclosure of information: I understand that Patient's medical records are confidential and cannot be disclosed without my written authorization except as authorized by law. Authorized disclosures are addressed in the Notice of Privacy Practices. I understand that Patient's medical information includes past, present and future information and may include genetic testing / counseling, communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment / psychiatric care and alcohol / substance abuse diagnosis or treatment (collectively, ''Medical Information''). I authorize release of that Medical Information as part of Patient's medical record. I understand that ACRMC must keep Patient's medical records for a time period required by law and then may dispose of such medical records as permitted or required by law.

Electronic Sharing of Medical Information: I authorize ACRMC to use Patient's Medical Information for the purposes of treatment, payment, healthcare operations (collectively referred to as "Purposes"), or as otherwise allow by law. I acknowledge that ACRMC will release and send, electronically or otherwise, Patient's Medical Information to third parties for the Purposes set forth above, or as otherwise allowed by law. I understand that Medical Information may no longer be protected by federal and state privacy laws once it is disclosed, and therefore, may be subject to re-disclosure by the recipient. Medical Information may become part of Patient's medical records kept by non-ACRMC healthcare providers and may be further disclosed.

Health Information Exchange: ACRMC participates in Health Information Exchange programs (''HIE(s)'') to store and exchange Patient's Medical Information. Patient's Medical Information from non-ACRMC healthcare providers may also be stored and shared in HIE(s), and ACRMC and these other providers can use HIE(s) to see Patient's Medical Information for the Purposes set forth above, to coordinate Patient's care, and as allowed by law. I understand that Patient may opt out of HIE(s) Medical Information sharing by indicating that decision below. Patient may opt back in to HIE(s) Medical Information sharing at any time. I understand that even if Patient opts out of HIE(s) Medical Information sharing, Patient's Medical Information will still be stored in HIE(s). I understand that Patient does not have to participate in HIE(s) Medical Information sharing to receive care.

☐ I do not want Patient's Medical Information shared in HIE(s). I understand, however, that if Medical Information sharing with HIE(s) is required by law, ACRMC must act in compliance with the law. I further understand that certain Medical Information may be shared with HIE(s) in a manner that does not identify Patient.

Financial Responsibility and Assignments - Financial Responsibility: I agree to pay for the full billed charges associated with goods and services provided to Patient regardless of any applicable insurance or benefit payments and understand that all amounts are due upon request and are payable to ACRMC and any provider who provides services to Patient at a ACRMC hospital, facility, entity or program (together with the Telemedicine Providers, collectively referred to as the ''Provider(s)''). Except as prohibited by law, I agree to pay for any charges not covered and covered charges not paid in full by any applicable insurance and / or benefit plan including charges payable as co-insurance, deductibles, and non-covered benefits due to policy and / or plan limitations, exclusions, and / or failure to comply with insurance and / or plan requirements. An estimate of the anticipated charges is available upon request. I understand that estimates may vary significantly from the final charges because of a variety of factors such as the course of treatment, intensity of care, Provider practices, and the need to provide additional goods and services. I also agree and understand that if Patient's account becomes delinquent and is referred to an attorney or agency for collection or suit, I will be responsible for paying all charges, reasonable attorney fees, costs, and collection expenses. I consent to credit bureau inquiries and to receiving auto-dialed, computer generated and pre-recorded message calls to my cellular telephone and to any telephone number provided during Patient's registration process from ACRMC, Providers, and their affiliates and agents including, without limitation, any account management companies, independent contractors, or collection agents.

Medicare / Medicaid Patients Only: I understand that the goods and services that I request to be provided to Patient may not be covered under Medicare / Medicaid as being reasonable and medically necessary for Patient's care. I understand that Medicare / Medicaid or their insuring agent determine the medical necessity of the goods and services requested for Patient. If Medicare / Medicaid determine that certain goods and services are not medically necessary for Patient's care and I request such goods and services be provided despite Medicare / Medicaid's denial, I understand I am solely responsible for payment for those goods and services. If Patient is a Medicare / Medicaid managed care Patient, these provisions may not apply. I certify that the information given by or on behalf of Patient in applying for payment under Medicare / Medicaid is correct. I authorize the release of medical or other information about Patient to the Social Security Administration, intermediaries, or carriers as needed for Medicare / Medicaid claims.

Assignment of Benefits: I irrevocably assign and convey directly to ACRMC, and any Provider, all benefits and all interest and rights, including any causes of action, ERISA (Employee Retirement Income Security Act) breach claim or other legal / administrative claim and the right to enforce payment, under any insurance policies, benefit plans, indemnity plans, prepaid health plans, third-party liability policies, or from another payor providing benefits on Patient's behalf for goods and services provided to Patient by ACRMC and Providers. I also authorize direct payment to ACRMC and Providers for the goods and services ACRMC and Providers provide to Patient. I authorize Patient's plan administrator, insurer, and / or attorney to release to ACRMC and Providers all plan documents, summary benefit description, insurance policy, and settlement information upon written request from ACRMC or Providers needed to claim medical benefits.

Under this assignment, I convey to ACRMC and Providers all of my rights to claim or place a lien on benefits related to goods and services provided by ACRMC and Providers to Patient, including rights to any settlement, insurance or applicable legal or administrative remedies, including damages arising from ERISA breach claims, and the right to appeal or pursue any denied or delayed claims. ACRMC and Providers have the right to: (1) obtain all information regarding the claim; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; and / or (5) participate in any administrative and judicial actions and pursue claims, a cause of action, or right against any liable party, insurance company, benefit plan, or plan administrator. ACRMC and Providers may bring suit against any such benefit plan, plan administrator or insurance company in my name and / or Patient's name with derivative standing. This assignment is not and shall not be construed as an obligation of ACRMC and/or Providers to pursue such interest and rights.

I have read and understand the information in the Acknowledgments for Protected Health Information and Financial Responsibility and have received ACRMC's Notice of Privacy Practices.

Signature of Patient / Parent or Legally Authorized Representative* _____ Date/Time _____

Printed Name of Patient / Parent or Legally Authorized Representative _____ Relationship to Patient _____