

Greetings,

We are happy to announce that Palo Pinto General Hospital and your school are partnering to provide school-based telemedicine services for our students. Having access to a medical provider at any time during the school day is a win-win for us all. This news, as exciting as it is, may raise many questions for you as parents and guardians. Rest assured, we will do our best to answer each of those questions and alleviate any concerns you may have.

First and foremost, you as the parent/guardian will join the telemedicine visit via your iPhone/Android cell phone, or in person if preferred. If for some reason you cannot be present, permission will still be mandatory for *each* visit. The school nurse will remain with your child and help facilitate the visit via specialized telemedicine equipment.

Once the provider has completed your child's assessment, they will make the determination as to whether or not the child may remain at school or if they truly need to be sent home. Our goal is to keep our children in front of the teacher in the classroom setting as that is where the best opportunity to learn takes place. A letter with information on how to access the visit record, and who to contact should there be any questions or concerns will be sent home with your child. Also, a copy of the visit record will be sent to your child's primary care physician.

You will be asked to sign consents for your child to participate in telemedicine consults, applicable consents for the PPGH clinic network, and also to complete a health questionnaire for your child that the provider can reference when completing their assessment. Insurance will be filed, and co-payments/co-insurance or balances may be billed after the visit. Payments can be made electronically, by phone, or by mail, and instructions will be included with the bill.

We look forward to the upcoming school year and the opportunity to provide telemedicine services to our students. Our students' health and wellbeing are key to their success in school. Together we can achieve that success.

If you have any further questions, feel free to contact the *Palo Pinto Cares for Kids* Telehealth Coordinator, Stephanie Blue, at 940-328-7588.

Respectfully,
Your care team at Palo Pinto General Hospital & Your School
Please keep this copy



School-Based Telehealth Visits

Adapted from AHRQ - Agency for Healthcare Research and Quality

What is telehealth?

- Telehealth is a way to visit with healthcare providers, such as your doctor or nurse practitioner.
- Your child, along with the nurse, can talk to the provider from school, and you can join from work or your home. You don't go to a clinic or hospital.

How do I use telehealth?

- You talk to the provider by phone, computer, or tablet.
- You will use video so you and your provider can see each other.

How does telehealth help?

- Your child does not have to leave school to go to a clinic or hospital to see a provider.
- You won't miss work to take your child to see a provider.

Are there any negative affects when using telehealth?

- You and your provider won't be in the same room, so it may feel different than an
 office visit.
- Although uncommon, your provider may make a mistake because they cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will the telehealth visit be private?

- We will not record visits with your provider.
- If you choose to join the visit, please be aware that if people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

How much does a telehealth visit cost?

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

What does it mean if I sign the following document?

- If you sign the following document, you agree that:
- We provided the information in this document.
- We answered all your questions, or gave you contact information for any remaining questions. (*PPGH Telehealth Coordinator*, *940-328-7588*)
- You want your child to have access to telehealth visits.
- If you sign the following document, we will give you this copy of the information included.
- A record of your child's visit will be sent to the PCP provided.



Permission for School-Based Telehealth Visits

Adapted from AHRQ - Agency for Healthcare Research and Quality

What is telehealth?

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How do I use telehealth?

- You talk to the provider by phone, computer, or tablet.
- You will use video so you and your provider can see each other.

How does telehealth help?

- Your child does not have to leave school to go to a clinic or hospital to see a provider.
- You won't risk getting sick from other people.
- You won't miss work to take your child to see a provider.

Are there any negative affects when using telehealth?

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What does it mean if I sign this document?

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- We provided the information in this document.
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- You want your child to have access to telehealth visits.
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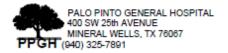
Your Child's name (please print)	
Your name (please print)	
Your signature	 Date



Patient Information

Name:	DOB: Sex:
Address:	Phone:
City, State, Zip:	Pharmacy Name:
Allergies:	Pharmacy Phone:
Medications currently taking:	
Medical/Surgical History:	
<u>Parent/Guardian Information</u> (Students only)	Emergency Contact
Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Daytime Phone:	Daytime Phone:
Email:	Present by phone/in person for visit? Y / N
School Information	Physician Information
Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:Fax:
Insurance Information	
Company:	Subscriber:
Policy Number:	DOB:
Group Number:	Social Security Number:

Please provide copies of <u>insurance card</u> and <u>ID</u> (Parent/Guardian ID if patient is a minor)



HIPAA Rev. 09/2017 1 of 1

Receipt of Notice of Privacy Practices - HIPAA

THIS NOTICE DESCRIBES AN OVERVIEW OF HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. A FULL COPY OF OUR PRIVACY PRACTICES IS AVAILABLE UPON REQUEST.

How we may use and disclose your health information. We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, fax, electronic mail, or other methods. We may disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any further uses and disclosures.

Your rights. In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information. Upon your request you may be excluded from public lists.

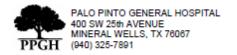
Our legal duty. We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. You can request a copy of our notice at any time. For more information about our privacy policies, contact the person listed below.

Privacy complaints. If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about your access to your health information. you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:
Risk Management/Quality Management at (940) 328-6232 or (940) 328-6277

Acknowledgment of receipt of Notice of Privacy Practices:

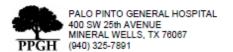
Signature Date/Time



Treatment Consent Rev. 11/2017 1 of 1

Health Maintenance Organization & MEDICAID

Health Maintenance Organizal requirements that a member must sat limited to any or all of the following confacilities and providers and/or 3) Tread definition specified in the member's given the prescribe program. Failure to do so may result in assumed by the patient/ insured party RENDERED. This notice is provided a Hospital emergency services are available pre-certification requirements associal	isfy in order to have benet nsiderations: 1) Notification tment of a condition consi- roup benefit agreement ar vices were indicated outsid d coverage requirements in a reduction or denial of l ANY APPLICABLE CO- as a reminder for patients lable to all patients who re	fit coverage for eme on of a Primary Car dered to be of an e nd /or 4) required se de of physician offic in order to ensure f benefit coverage in PAYMENTS ARE D to assist them in co	ergency care. These many of the Physician and/or 2) Use the Physician and/or 2) Use the Physician and available hours. It is the responsible the Physician and Physi	ay include but are not lse of participating ng to the HMO ble at the Primary Care nsibility of the der their HMO esponsibility must be AT SERVICES ARE spective HMO payer.
Medicaid Acknowledgement: the name of Palo Pinto General Hosp not be covered under the Texas Mediunderstand that if the Texas department agent determines that the services or performed with a prior authorization on to covered. I understand that Palo Phenefit of either traditional Texas Medibase-line studies, crutches, etc.) 2) Alliability will be determined by reviewing reduction in payment due to the medicharges applied to the spend-down. 4 General Hospital Clinic Network is not of Medicaid regulations.	ital Clinic Network, the ser cal assistance program as ent of Human Services he items I request and receiv r with a network provider, into General Hospital Distr licaid or one of the Manag I services incurred on non g the itemized statement a cally needy spend-down.	vices or items that being reasonable alth insurance ager re are not medically I am responsible for ied Care Medicaid's ecovered days due and identifying by de The recipient's liabi ovided to Managed	I have requested to be or medically necessary or the Medicaid Mana necessary, not a bene or payment of these senthe following: 1) Any sets (e.g. personal care ite to eligibility or spell of itates, the non-covered slity will be equal to the according to the core Medicaid recipier	provided to me may for my care. I also aged Care insurance efft, or they are not vices or items that are ervice that is not a ms, take-home drugs, illness limitation. Total services. 3) The amount of total hts that Palo Pinto
Relationship to Patient				
Signature of Patient or Repre	sentative		Date	
			-	



Insurance Authorization Rev. 11/2017 1 of 1

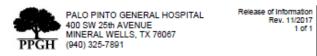
INSURANCE AUTHORIZATION

Insurance Authorization and Assignment: I hereby authorize PPGH Clinic Network to furnish information to insurance carriers concerning my illness and treatment and hereby assign to the PPGH Clinic Network all payments for medical service rendered to myself or my minor child. I understand that I am responsible for providing insurance information or I will be considered private pay. I understand I am responsible for any amount not covered by insurance. I hereby authorize the Social Services Department to contact and provide appropriate information to outside community resources as deemed necessary.

Guarantor statement: I assume financial responsibility for the payment of all charges for services rendered to the above patient.

Telephone Consumer Protection Act: You agree, in order for us to service your account or to collect monies you may owe, Palo Pinto General Hospital, and/ or agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text message or emails, using email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing services as applicable. I/we have read this disclosure and agree that Palo Pinto General Hospital, its employee and/or agents may contact me/us as described above.

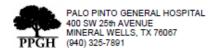
(Not all insurances accepted.)		
Signature of Patient or Representative	Relationship to Patient	Date



AUTHORIZATION FOR RELEASE OF INFORMATION

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THIRD PARTY PAYOR/SPECIFIED OTHERS

Patient Name:	
Patient Address:	
Phone:	
The undersigned hereby authorizes and requests PALO PINTO GENERAL HO any or all insurances, with access to my hospital records for the purpose of reverguest that information be released and copies provided as requested.	
The foregoing is subject to such limitations as indicated below:	
() Confined to records regarding admission and treatment for the following or injury () Covering records for the period of time from	ng conditions to discharge.
*() All records may be released.	
($\ \square$) All records may be released except treatment or diagnostics a	ssociated with:
(☐) Psychiatric care (☐) Human Immune Deficiency Virus (AIDS) (☐) Other: (please specify)	
This authorization is subject to revocation at any time except to the extent that	action has been taken in reliance thereon.
I waive all provisions of State and Federal law relating to the confidentiality and privilege nature of such information and release Palo Pinto General Hospital from the liability that may arise from the release of the above information.	
Signature	Date/Time
Witness Signature	Date/Time



Relationship to Patient

Signature of Patient or Representative

Treatment Consent Rev. 11/2017 1 of 1

Treatment Consent Form

CONSENT FOR MEDICAL TREATMENT: I hereby give my permissi child(ren) by physicians and/or mid-level providers at the PPGH Fam	
CONSENTIMIENTO PARA TRATAMIENTO MEDICAL: Doy mi permenores de edad por medicos en la Family Health Clinic, un servicio	
PLEASE READ AND INITIAL THE FOLLOWING: Por favor lee e inicial el siquiente:	
If you wish to change your treating physician to one of the providers a need you to initial below and request a Release of Medical Records I treating physician.	
Yes	No
Si usted deseara cambiar su medico tratante para uno de los provee necesitaremos inicial debajo y solicitaran una Liberacion de Forma d a su previo tratante medico.	
Yes	No
Acknowledgment of receipt of Patient Rights Pamphlet.	
Recibo de reconiciemento de Patient Rights Pamphlet.	

Date



HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF **HEALTH INFORMATION**

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print	Name of Patien	t:	
Date	of Birth:	SSN: _	
I.	Division 33, I school-based to the primary provided to the I authorize Pathe above patheres abov	exas Administrative Code, Title 1. Rule §354.1432; for a child receive setting, a notification including a care physician or provider, along the parent/legal guardian. The setting and the setting are parent/legal guardian. The setting are physician or provider, along the parent/legal guardian. The setting are physician in the setting are parent or provider and provider are physician: The setting are physician in the setting are parent or provider are physician:	Part 15, Chapter 354, Subchapter A, ing telemedicine medical services in a summary of the service must be provided with a copy of the summary being or disclose my child's health information. nation to the following recipient:
			Zip_
	Phone	Fax	
	Physician Em	ail	
	Parent/Legal	Guardian Email	
		of this authorization is to provide f the telemedicine providers at sch	for communication between my child's ool.
	This authorize	ation is in effect for the 2022-2023	school year.

Pursuant to Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter A, Division 33, Rule §354.1432; a child receiving telemedicine medical services in a schoolbased setting, a notification must be provided to the primary care physician or provider.

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

☐ - Patient is a minor: years of age
Signature of Authorized Representative:
Date:
Print Name of Authorized Representative:
•
Authority of representative to sign on behalf of the patient: \square - Parent \square - Legal Guardian
□ - Court Order □ - Other: