School Telehealth Patient Information Form

Patient Information

*Child's Last Name | *Child's First Name | Child's Middle Name

*Gender ☐ Male ☐ Female | *Child's Date of Birth | Social Security Number

*Street Address

*City | *State | *Zip code

*Preferred Pharmacy Name | *Street/Address

*Pediatrician/PCP | *PCP Phone #

*School District | *School Name

Race/Ethnicity (Select appropriate group):

Asian ☐ Black/African American ☐ Latino/Hispanic ☐ Native American ☐
☐ White/Caucasian ☐ Other

* Allergies (Type N/A if this does not apply)

*Medical History/Surgical History

PARENT/GUARDIAN INFORMATION

*Child Lives With:

Mother & Father ☐ Mother ☐ Father ☐ Guardian/Other ☐

*Parent/Guardian's Last Name | *Parent/Guardian's First Name | Middle Initial

*Parent/Guardian Date of Birth | *Primary Phone Number | Alternate Phone Number

*Email Address ☐ Opt out of email contact (Check box to opt out)

EMERGENCY CONTACT

In case of an emergency, who should we contact

*Emergency Contact Full Name

*Emergency Contact Phone Number | *Relationship to Patient:

INSURANCE INFORMATION

*Select the type of Insurance for the patient: Commercial Insurance ☐ CHIP ☐ Medicaid ☐ None ☐

Insurance Name | Insurance ID Number | Group Number

*Name of Responsible Party | *Primary Phone Number

*Responsible Party Address

*City | *State | *Zip Code

*Relationship to Child

Father ☐ Mother ☐ Other ☐

*Responsible Party Date of Birth

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

Signature of Patient/Parent or Legally Authorized Representative

Today's Date & Time

Date | Time

*457272

ValleyHealth
Page Memorial Hospital

Telehealth: What to Expect

Rappahannock County School District is working in partnership with specialists at Valley Health to offer you telehealth services.

What is Telehealth?

Telehealth is the exchange of medical information from one site to another via electronic communications. The telehealth service offered to you will allow you to have a medical appointment with a specialist via secure and interactive video equipment. You will be able to speak in real-time with the specialist during your telehealth appointment.

Is Telehealth Safe?

Yes, all telehealth sessions are secure, encrypted and follow the same privacy (i.e. HIPAA) guidelines as traditional, in-person medical appointments. Your telehealth appointments will always be kept confidential. In addition, telehealth appointments are NEVER audio or video recorded without the patient's consent.

Can I Choose Not to Participate?

Of course, with this program you have been offered the option of seeing a specialist via secure and interactive video equipment within your primary care office. It is your choice to follow this referral.

Things to Remember about Your Telehealth Appointment:

1. On the day of your appointment the patient will check-in with the school nurse. The school nurse will call the parent/guardian to alert them of the appointment
2. At the time of your appointment, a nurse or medical assistant will escort you into the telehealth patient room.
3. If you have any questions before or after the session, you may ask the office staff at Valley Health.
4. The *Telehealth New Patient Packet* must be completed prior to scheduling your first telehealth appointment. You must complete these forms to schedule your first appointment:
    - *Telehealth Consent* form
    - Any other forms/consents the spoke/patient or hub/specialist site or legal team require, including the *Notice of Privacy Practices*, *Patient Rights and Responsibilities* form and the *HIE Consent* to View form.
5. If you are prescribed medication(s) by the specialist you will be able to pick it up directly at your pharmacy of choice as the specialist will either phone in or electronically prescribe your medication(s)

If you have any questions or concerns after reading this form, please contact Rappahannock County Elementary School: 540-227-0200

Telehealth Consent Form

1. I authorize Rappahannock County School District and Valley Health to allow me/the patient and/or my child to participate in a telehealth (video-conferencing) service with Valley Health
2. The type of service to be provided by via telehealth is pediatrics and family medicine
3. I understand that this service is not the same as a direct patient/healthcare provider visit, because I/the patient will not be in the same room as the healthcare provider performing the service. I understand that parts of my/the patient's care and treatment which require physical tests or examinations may be conducted by providers and their staff at my/the patient's location under the direction of the telehealth healthcare provider.
4. My/the patient's physician/therapist has fully explained to me the nature and purpose of the video-conferencing technology and has also informed me/the patient of expected risks, benefits and complications (from known and unknown causes), possible discomforts and risks that may arise during the telehealth session, as well as possible alternatives to the proposed sessions, including visits with a physician in-person. The possible risks of not using telehealth sessions have also been discussed. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.
5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my/the patient's healthcare provider or I can discontinue the telehealth service if we believe that the video-conferencing connections are not adequate for the situation.
6. I understand that the telehealth session will not be audio or video recorded at any time.
7. I agree to permit my/the patient's healthcare information to be shared with other individuals for scheduling and billing. I agree to permit individuals other than my/the patient's healthcare provider and the remote healthcare provider to be present during my/the patient's telehealth service to operate the video equipment, if necessary. I further understand that I will be informed of their presence during the telehealth services. I acknowledge that if safety concerns mandate additional persons to be present, then my or guardian permission may not be needed.
8. I acknowledge that I have the right to request the following:
    a. Omission of specific details of my/the patient's medical history/physical examination that are personally sensitive, or
    b. Asking non-medical personnel to leave the telehealth room at any time if not mandated for safety concerns, or
    c. Termination of the service at any time.
9. When the telehealth service is being used during an emergency, I understand that it is the responsibility of the telehealth provider to advise my/the patient's local healthcare provider regarding necessary care and treatment.
10. It is the responsibility of the telehealth provider to conclude the service upon termination of the video-conference connection.

11. I/the patient understand(s) that my/the patient's insurance will be billed by both the local healthcare provider **and** the telehealth healthcare provider for telehealth services. I/the patient understand(s) that if my insurance does not cover telehealth services I/the patient will be billed directly by both the local healthcare provider **and** the telehealth care provider for the provision of telehealth services.
12. My/the patient's consent to participate in this telehealth service shall remain in effect for the duration of the specific service identified above, or until I revoke my consent in writing.
13. I/the patient agree that there have been no guarantees or assurances made about the results of this service.
14. I/the patient acknowledge the telehealth's program no-show policy which states that I/the patient will be discharged from the telehealth program if I/the patient no-show for two, consecutive telehealth appointments, without prior contact to the scheduling staff at spoke site.
15. I confirm that I have read and fully understand both the above and the *Telehealth: What to Expect* form provided. All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

Patient/Relative/Guardian Signature*	**Print Name**
Relationship to Patient (if required)	**Date**
Witness	**Date**
Interpreter (if required)	**Date**

*The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risk of and alternatives to (including no treatment) the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Provider's Signature	**Date**

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD

067272

ValleyHealth
Urgent Care

AGREEMENT & CONSENT TO CONDITIONS OF TREATMENT

MEDICAL AND CLINICAL CONSENT: I consent to all associated treatment and services including but not limited to diagnostic or x-ray treatments, as ordered or performed by the attending healthcare provider considered medically necessary in his/her judgment. I consent to the use of telehealth as may be necessary for my treatment. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made or implied regarding my care and treatment.

PATIENTS RIGHT TO DECIDE: I understand that I have the right to make decisions about my care. I have the right to refuse or accept treatment. I have the right to have a "Living Will", Advance Directive or to designate someone to make decisions for me by using a "Durable Power of Attorney for Health Care". I will advise receptionist/healthcare provider if I have such document and will provide copy to Urgent Care Center.

FINANCIAL AGREEMENT: I authorize payment of all medical benefits otherwise payable to me directly to Urgent Care Center. I understand that I am responsible for all health insurance deductibles and coinsurance. I understand that I remain financially responsible to Urgent Care Center for any and all charges not met by the proceeds of this assignment, and for all charges if payment is not received within a reasonable time after charges are filed or if payment is deemed retroactively. I accept responsibility for payment in full or agreed upon payment arrangements, for services provided within thirty (30) days of receiving a statement. In the event I do not meet my financial responsibility with Urgent Care Center, I agree to pay collection agencies fees up to 20%.

RELEASE OF INFORMATION: I authorize Urgent Care Center and any physician or other medical service providers who renders service to me to release to my physician and other health care providers treating me, insurance company, reimbursing agency, Valley Health system affiliated entities, attorneys and others as allowed by law, whatever information, including a copy of, or access to, my medical record for determination of benefits payable or for additional medical care. Further, I authorize the Social Security Administration to release any information regarding my benefits of Medicare eligibility to any health care provider or other independent medical care provider.

CONTACT: In addition with this authorization, Urgent Care Center may call my home or other designated location and/or number and leave a non–specific message on my voicemail, contact me in person or by mail. If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed and prerecorded messages) and /or text messaged (including SMS messaging) at that wireless number from the hospital and its successors, and the affiliates, agents and independent contractors, including servicers and collection agents and attorneys, regarding services rendered at Urgent Care Center or my related financial obligations. For specific information, I am aware that I will need to complete the Consent to Release Protected Health Information form, prior to information being released, as specified in the VH HIPAA Notice of Information Practices.

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

A law was enacted in Virginia in 1989 and amended in 1993 which authorizes healthcare providers to test their patients for HIV, Hepatitis B and C antibodies when the healthcare provider is exposed to the body fluids of a patient in a manner which may transmit these antibodies. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing and to the release of the test results to the healthcare provider who may have been exposed. You will be informed prior to your blood being tested for HIV, Hepatitis B or C antibodies. The testing will be explained, and you will be given the opportunity to ask any questions.

ACCESS TO PATIENT CARE AND PROTECTED HEALTH INFORMATION: I hereby give permission to the person(s) listed to inquire about information regarding my medical care. In order to obtain information by telephone, the party calling the practice must share my date of birth.

1. _____ _____
   Name Relationship
2. _____ _____
   Name Relationship

ValleyHealth
Urgent Care

I, the undersigned, have read and understand this Consent for Treatment and agree to be bound by all its terms. I have been given a copy of Valley Health System's Notice of Privacy Practices, version effective September 9, 2013.

Print Patient Name Date

Medical Record Number

Patient/Authorized Person Signature Date

Witness Signature Date

Print Authorized Person Name/
Reason Authorized Person signed for Patient

OPEN TO ALL RCPS STUDENTS (AGES 5 AND UP) & STAFF

RCPS FIT KIDS CLINIC

RCPS

Conditions treated include asthma, allergies, cough, colds, flu, ear aches, sore throats, fever, headache, head lice, pink eye, skin irritations, and more.

Parents- Leaving work is not always easy if your child gets sick at school. Telehealth makes it easier.

With your consent, the clinic nurse, Ms. Prince, will be able to use video telehealth technology to connect your child with a provider at Valley Health. In most cases, your child can be diagnosed without leaving school or you having to leave work. Plus, prescriptions can be sent directly to your pharmacy.

To make an appointment, please call 540-793-1371.

Ms. Prince will begin scheduling appointments at 8am for students and staff. If she is busy assisting another patient, please leave a message for her to return your call.

As a friendly reminder, our Fit Kids Clinic is open to ALL RCPS students (ages 5 and up) and staff. This is a fantastic resource to be quickly seen without leaving the campus. To make an appointment with Tara Prince, our amazing telehealth nurse, call 540-793-1371.