August 4, 2022

Dear Parents and Guardians,

We are excited to invite you to enroll your child in the School-Based Health Program. Your child has the opportunity to be examined, diagnosed, and treated by a local provider from Bamberg Family Practice while at school via telehealth. Advantages of the program include reduced missed class time for students and reduced missed work for parents or guardians.

Please note that your child may receive medical care from a provider at Bamberg Family Practice. Utilizing this service will not make your child a patient of Bamberg Family Practice. We will make sure to update your child's current primary care physician of any visit.

To enroll, please return the completed school-based health consent forms to the school nurse. Insurance carriers are billed for, and copays and deductibles apply. SC Medicaid covers the visits. Other insurance companies may vary. Please consult your insurance carrier if you have questions about coverage.

For questions, please contact Breanna Parham, MA School-Based Telehealth Coordinator at (803) 245-2672.

Sincerely,

Danette McAlhaney, MD
Bamberg Family Practice

SCHOOL-BASED HEALTH ENROLLMENT FORMS

We are so excited to offer the School-Based Health Program in your child's school. There are **four places you need to sign & date** to enroll you child in the program:

Form Name	Purpose
Consent for Treatment	Signing this form allows your child to **received medical care in the school**.
Authorization to Disclose Protected Health Information	**This form allows the health care team to work with the school.** Signing this form allows the healthcare providers, the school nurse, and your child's main healthcare provider to share medical information about your child's health.
HIPPA Notice of Privacy	**This form allows the health care team to work with the school.** Signing this form allows the healthcare team to share medical information about your child's health in relation to treatment, payment, or health care operations and other purposes that are permitted or required by law.
Consent for Release of Education Records and Information	**This form allows the school to work with the healthcare team.** Signing this form allows the school to share medical, psychological and other personal information about your child with the health care provider.

If you have any additional questions, please contact your school nurse or Breanna Parham, MA School-Based Telehealth Coordinator at (803) 245-2672.

If you do not wish to participate in the program, please check the box below and return this page to your school nurse.

☐ I **do not** wish to participate in the School-Based Health Program.

CONSENT FOR TREATMENT

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 affiliated with Bamberg Family Practice.

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 Bamberg Family Practice "Notice of Privacy Practices"

_____ _____

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

Date

_____

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

HIPAA NOTICE OF PRIVACY PRACTICES

F. MARION DWIGHT, MD, PA • BAMBERG FAMILY PRACTICE
2113 MAIN HWY. • PO BOX 120
BAMBERG, SC 29003 803-245-5168

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected health information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related service. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, naming of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations- You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request, if physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our 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
(of Student if 18 years or older or otherwise permitted by law)

_____

Relationship to Patient/Student

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Student 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 F. Marion Dwight, MD PA 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. 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 protected 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. 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
(or Student if 18 years or older or otherwise permitted by law)

Date

_____

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

_____

Relationship to Patient/Student

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 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 billing Medicaid. If I provide written consent for the service provider to share my child's information by the recipient may no longer by protected by the requirements of the FERPA.

Student's Name	**Student's Date of Birth**
Signature of Legal Guardian/Representative	**Date**

SCHOOL-BASED HEALTH CLINIC PATIENT DEMOGRAPHIC FORM

Grade: _____ **Teacher**: _____

Student: _____ DOB: _____

Age: _____ **Social Security Number (SSN)**: _____

Primary Language: □ English □ Spanish □ Other: _____

Sex: □ Male □ Female

Race: □ Black □ White □ Hispanic □ Asian □ Other: _____

Primary Care Provider: _____

Parent/ Guardian Name: _____

Relationship to Student: _____

Parent/ Guardian DOB: _____

Parent/ Guardian SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____

Cell: _____

Work: _____

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

Emergency Contact: _____

Number: _____

Emergency Contact: _____

Number: _____

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 Number: _____
   Who (name) insures child? Relationship to insured child?
   _____
   Employers Name: _____
3. □ No Insurance.