SOUTHERN INDIANA Community Health Care

PAOLI • MARENGO • WEST BADEN • ENGLISH • SALEM • BEDFORD • MITCHELL

CONSENT FOR SCHOOL-BASED TELEHEALTH CLINIC

PATIENT NAME **DATE OF BIRTH**

DAYTIME PHONE NUMBER (PREFERRED) **PHARMACY**

GRADE

Please indicate which School Corporation you or your child is attending an SICHC Telehealth Clinic.

_____ **Springs Valley Community Schools**, 498 South Larry Bird Blvd, French Lick, IN 47432

_____ **Paoli Community Schools**, 501 South Elm Street, Paoli, IN 47454

_____ **Orleans Community Schools,** 200 West Wilson Street, Orleans, IN 47452

Before anyone is seen at the School-Based Telehealth Clinic ("Telehealth Clinic"), this consent form must signed and on file and proper documentation of insurance obtained. I, the undersigned,

- Give permission and consent for the patient to be seen by a licensed health care provider through and by the Telehealth Clinic. I consent to the encounter and understand that the healthcare provider will do their best to provide reasonable medical advice and treatment based on the patient's telehealth visit.
- Have received a description of services and understand the nature of the treatment provided at the Telehealth Clinic, the way it is provided, and that there are limitations of this form and style of treatment.
- Understand that this consent form is valid for one school year at the school the patient is enrolled in at the time of registration and I may revoke the consent at any time by providing notice to the school nurse.
- Understand that this consent constitutes the establishment of a provider-patient relationship between the patient and any provider employed by Southern Indiana Community Health Care, Inc. who examines the patient through the Telehealth Clinic for encounters at the school the student is enrolled in at time of registration, and that I may revoke this consent at any time by providing notice to the school nurse.
- Give permission for Southern Indiana Community Health Care to receive information from the school about the patient's health history including medical history, allergies, and medications.
- Acknowledge that the school nurse and nurse assistants are employees of the school listed above and will be participating and assisting in the treatment of the student.
- Give permission for the SICHC Telehealth provider, the school nurse, nurse assistants, and the patient's primary health care provider to speak with and share medical information about the patient's health issue on an as needed basis, with the understanding that this information will be treated in a confidential way.
- Understand that Southern Indiana Community Health Care, Inc. will document each encounter with the patient in a medical record maintained by SICHC and not at the school listed above.
- Acknowledge that I have been offered a copy of the Southern Indiana Community Health Care, Inc. HIPAA compliance Patient Consent Form, which addresses the ways in which Southern Indiana Community Health Care, Inc. maintains, uses, and discloses the patient's protected health information.
- Understand that I will receive a visit summary from the school nurse or nurse assistants for the patient's encounter, either in writing or over the phone, which will include diagnosis, treatment options, any need to seek additional care, instructions for follow-up care, and any prescriptions issued.

Verbal consent for each visit: In addition to written consent, for any patient under the age of 18, a parent/guardian will be contacted before each visit to receive verbal consent. If the verbal consent cannot be provided due to inability to answer phone, phone number disconnected, etc. please indicate if the patient can or cannot be seen by a provider at the Telehealth Clinic. Please initial the appropriate line below regarding verbal consent.

_____ I give permission for the patient to be seen at the Telehealth Clinic if parent/guardian cannot be reached and verbal consent is not received. "See my child even if you cannot reach me."

_____ I give permission for the patient to be seen at the Telehealth Clinic only if verbal consent from parent/guardian is received for each appointment. I understand that if parent/guardian cannot be reached, the patient will not be seen at the Telehealth Clinic. "I want to speak with the school nurse before my child is seen."

Sharing records with Primary Care Provider (PCP): Telehealth Clinic providers will provide a copy of the visit's medical record, including lab results, medications prescribed, assessment and plan of treatment for any patient that has an established primary care provider outside SICHC. Sharing of medical information with the PCP requires the consent of the patient or patient's parent/guardian.

Please initial the appropriate line below and provide name, address, and phone number for the primary care provider.

_____ I consent to sharing medical information to patient's PCP when seen at the Telehealth Clinic.

_____ I DO NOT consent to sharing medical information to patient's PCP when seen at the Telehealth Clinic.

Primary Care Provider Name _____

Primary Care Provider Address _____

Primary Care Provider Phone Number _____

Labs: Southern Indiana Community Health Care, Inc. may order in-house laboratory tests (strep, flu, etc.) to determine the appropriate diagnosis and treatment plan. Please initial if the provider can order in-house labs for the patient.

_____ I consent to ordering in-house labs.

_____ I DO NOT consent to order in-house labs.

Insurance: As the patient or parent/guardian of the patient, I: (please initial)

_____ Authorize the release of any information necessary to process insurance claims for payment of benefits to Southern Indiana Community Health Care, Inc.

_____ Authorize payment of benefits to Southern Indiana Community Health Care, Inc. for services rendered.

_____ Have provided details of all insurance policies that cover the patient.

I have had the opportunity to read this form and the information provided. All my questions have been answered to my satisfaction. The information on the proceeding pages is true and complete to the best of my knowledge.

Patient's Name _____

Date of Birth_____ Patient's Grade_____

Parent/guardian name PRINTED_____

Patient or Parent/Guardian SIGNATURE_____ Date_____