CONCORDIA SCHOOL-BASED MOBILE HEALTH CENTER

NEW PATIENT PAPERWORK

PATIENT INFORMATION

Today's date:_____

Mr. Mrs. Ms. Dr. *(circle one)* Name: First_____ MI_____ Last_____

Mailing Address:_____ City_____ State_____ ZIP_____

Physical Address: _____ City_____ State_____ ZIP_____

SS#:_____ Birthdate:_____ ☐ Male ☐ Female

School:_____ Grade: _____

Student Email:_____ Student Cell Phone #: _____

Primary Care Physician *(Shown on Insurance Card):*_____ Phone:_____

Dentist:_____ Phone:_____

Names of siblings enrolled in Concordia School-Based Mobile Health Center:_____

Primary Care Physician *(Shown on Insurance Card):*_____

Preferred Language::_____

Race: *(check one)* ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ More than one Race

Ethnicity: *(check one)* ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Sexual Orientation: *(check one)* ☐ Straight/Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Refuse to Answer Other *(explain)* _____

Gender Identity: *(check one)* ☐ Male ☐ Female ☐ Transgendered ☐ Refuse to Answer Other *(explain)*_____

PARENT/ GUARDIAN INFORMATION

Mr. Mrs. Ms. Dr. *(circle one)* Name: First_____ MI_____ Last_____

Home #:_____ Work #:_____ Cell#: _____

Billing Address:_____

SS#:_____ Birthdate:_____ Male/Female_____

Relationship to Patient:_____

EMERGENCY CONTACT *(Neighbor or Relative not living with you)*

His/Her Name:_____ Relation:_____

Home #:_____ Work #:_____ Cell#:_____

CONCORDIA SCHOOL-BASED MOBILE HEALTH CENTER

NEW PATIENT PAPERWORK CONT.

INSURANCE INFORMATION *(Please check the type of health insurance:)*

☐ **Medicaid/Healthy Louisiana Plan** *(formerly Bayou Health)* #:_____

☐ Amerigroup Real Solutions LA ☐ AmeriHealth Caritas LA ☐ Aetna Better Health LA

☐ LA Healthcare Connections ☐ United Healthcare Community Plan LA

☐ **Medicaid (dental) #:**_____

☐ **Medicare #:**_____

☐ **No Insurance**

☐ **Private/Other Insurance Name**_____

Employer/ Address:_____ Phone #:_____

Policy #:_____ Group #:_____ E ective Date:_____

Name of policy holder:_____ Relation:_____

Policy holder date of birth:_____ Policy holder Social Security #:_____

Does your insurance pay for prescriptions? ☐ No ☐ Yes Dental Coverage? ☐ No ☐ Yes

☐ **Secondary Insurance Name**_____

Employer/ Address:_____ Phone #:_____

Policy #:_____ Group #:_____ E ective Date:_____

Name of policy holder:_____ Relation:_____

Policy holder date of birth:_____ Policy holder Social Security #:_____

Does your insurance pay for prescriptions? ☐ No ☐ Yes Dental Coverage? ☐ No ☐ Yes

PREFERRED PHARMACY

Name: _____ Street:_____Phone: _____

CONCORDIA SCHOOL-BASED MOBILE HEALTH CENTER

PATIENT HISTORY

STUDENT'S NAME _____ **2ND IDENTIFIER** _____

MEDICAL AND HOSPITALIZATION INFORMATION:

Is your child allergic to any food? Medicine? Insect? Latex? Other? ____No ____Yes

If yes, list:_____

List of current medications student is on with dosage (how much) and how o en:

_____

_____

Has your child been admitted into a hospital or had surgery: ____No ____Yes If Yes, Year: _____

Reason: _____ Hospital:_____

Date of last comprehensive physical/well check____/____/____

Performed by PCP_____ or Someone else_____

PLEASE MARK THE ITEM(S) THAT APPLY TO YOUR CHILD'S MEDICAL HISTORY:

☐ Asthma
☐ Allergy
☐ Tonsillitis
☐ Seizures
☐ Kidney Disease
☐ Skin Problems
☐ Chicken Pox
☐ Major Injuries
☐ Behavior Problems
☐ Depression
☐ Substance Abuse
☐ Anxiety
☐ ADHD
☐ Heart Disease/Murmur Reasons
☐ Ear or Sinus infections
☐ Hearing & Speech Problems
☐ Endocrine *(Diabetes, Thyroid, Pituitary)*
☐ Infectious Disease *(Hepatitis, HIV, TB, Meningitis)*
☐ Missing Organ *(Kidney, Eyes, Testicles)*
☐ Blood Disorder
☐ Birth Defects - Genetic Disorder
☐ Vision Problems
☐ Been Restricted from Sports/PE
☐ Other (specify) _____

Please describe any item marked: _____

_____

FAMILY HISTORY:

Please mark the item(s) that apply to your family's history: *(B=brothers, S= sisters, P= parents and G=grandparents)*

____Cancer
____Asthma
____Seizures
____Allergy
____Anemia
____Depression
____Substance Abuse
____Anxiety
____ADHD
____Diabetes
____Genetic Disorder
____Sickle Cell
____Heart Disease/Heart Problem
____High Blood Pressure
____Other (specify) _____
____Stroke
____Tuberculosis

Please describe any item marked (Who/When): _____

_____

CONCORDIA SCHOOL-BASED MOBILE HEALTH CENTER

PATIENT CONSENT

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS

By signing this consent, you are agreeing to allow the School-Based Health Center to provide the following services to your child:

- Primary And Preventive Health Care
- Comprehensive History And Physical Examinations
- Immunizations
- Health Screenings
- Laboratory/Diagnostic Testing
  (Including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law)
- Management Of Chronic Diseases
- Acute Care For Minor Illness And Injury Including Medications, If Indicated
- Behavioral Health Services
- Referral And Follow-Up For Emergencies
- Case Management
- Referral To Specialty Care
- Health Education And Prevention Programs
- Dental Services (Provided By Tensas Dental Clinic)

MEDICATION CONSENT:

Concordia Mobile Health Center will administer medications with the NP and/or Doctor's orders. Over-the- Counter medications may be administered such as Pain Relievers, Cold Medications, Ear Drops, Eye Drops, Stomach Medication (Pepto-Bismol, Mylanta, Midol), Wound Medications, Anti-Itch Medication, and other topical cream/gels for other complaints, such as Orajel, Carmex, or Vaseline. Prescription medication may be given if found necessary after examination as well. Antibiotic injections such as Rocephin may be given if deemed necessary by the NP or MD. Nebulizer medications may be administered for asthma type symptoms, if necessary, for treatment of students. Age appropriate Immunizations will be given to bring the student up to date according to the CDC guidelines, if the student is not up to date at the time of the exam.

I understand this student may receive all medications offered at the Mobile Health Center except those which I have written here:_____

IMMUNIZATION CONSENT:

Age appropriate immunizations, including the Flu and HPV vaccines, **will be given** to bring the student up to date according to the CDC guidelines, if the student it not up to date at the time of the exam.

I understand my student may receive all immunizations offered at the School-Based Health Center except those which I have written here or checked below: _____

I DO NOT WANT CHILD TO HAVE: *(please check below if you do not want your child to receive either the flu or HPV vaccine):*

☐ **FLU VACCINE** – Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact. Anyone can get the flu, but the risk of getting flu is highest among children. Each year thoughts of people in the United State die from flu, and many more are hospitalized, This vaccine will help prevent contraction of the flu virus.

☐ **HPV VACCINE-** This vaccine is recommended for males and females ages 11-26 years of age. HPV is the most common sexually transmitted virus in the United States. This vaccine can prevent most cases of cervical cancer in females, if it is given before exposure to the virus. In addition, if can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both male and females.

TELEMEDICINE:

I hereby authorize the use of telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. I understand the rationale for using telemedicine in place of in-person services, as well as the risks and benefits of the utilization of telemedicine, including privacy related risks, and acknowledge that all electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws. I acknowledge that I have had the opportunity to ask my questions regarding the use of telemedicine and the risks and benefits of alternative methods, including the risks and benefits of no treatment.

CONCORDIA SCHOOL-BASED MOBILE HEALTH CENTER

GENERAL CONSENT

CONFIDENTIALITY:

The School-Based Health Centers (SBHCs) adhere to all current laws regarding confidentiality of health services in general and specifi ally as they relate to services to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the exchange of relevant health information between Tensas School-Based Health Center and the student's personal medical provider upon referral for medical care. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Tensas Parish School-Based Health Center has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center or their website. My signature on this consent constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices.

LAHIE STATEMENT:

We understand that the SBHC may participate in one or more health information exchanges (HIEs), whereby the center may share my health information with other health care providers for treatment, payment or health care operations purposes. We hereby consent to the disclosure of the SBHC's records into the HIEs.

I, as parent/guardian, understand that I will not be charged for any of the services provided at the School-Based Health Center. I also understand that Tensas Community Health Center or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits di ected to Tensas Community Health Center,

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the School-Based Health Center. We both give permission for this student to receive the services provided by the program.

This consent is e ective while the student is enrolled in any school within Tensas Parish unless the School-Based Health Center is notified in writing, that I no longer wish for my child to receive services. That form may be obtained from my nearest health center. I also understand that I may be asked update important information every year.

We also understand Tensas School-Based Health Center is operated by Tensas Community Health Center and its empoyees and contractors.

Printed Name of Parent/Legal Guardian/Student	Relationship
Signature of Parent/Legal Guardian	Date
Signature of Student (optional)	Date

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

CONCORDIA SCHOOL-BASED MOBILE HEALTH CENTER

MEDICAL RELEASE FORM

As required by the Health Insurance Portability and Accountability Act (HIPPA) of 1996, TVCHC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the use and disclosure of protected health information described herein.

I, _____understand that the information contained in my

record is confidential. However, I give consent of _____

At _____to release all of my records or information

concerning such records to **Concordia Mobile Health Center.**

I understand that the document authorized to be released by me include, but are not limited to, family histories, reports of clinic findings and diagnosis, laboratory test, X-rays, reports of examination and/or evaluation, and any hospital admission or discharge records.

I understand that I may revoke this consent at any time except to the extent that action has been taken thereon. I further understand that this consent will expire upon_____(not to exceed six months) and cannot be renewed without my written consent.

Signature_____

Signature of Witness_____

PATIENT IDENTIFYING DATA

Name: First_____MI_____Last_____

Address:_____City_____State_____ZIP_____

SS#:_____Birthdate:_____

CONCORDIA SCHOOL-BASED MOBILE HEALTH CENTER

900 Carter Street Vidalia, LA 71373 Phone: (318) 414-3020

CONCORDIA
SCHOOL-BASED
MOBILE HEALTH CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please return this form to Dawn Johnson, Privacy Offi er at 402 Levee Street Saint Joseph, LA 71366 acknowledging your receipt and review of Tensas Community Health Center, Inc.'s Notice of Privacy Practices.

Name: _____

Signature: _____

Relationship if not Patient:_____ Date:_____

CONCORDIA SCHOOL-BASED MOBILE HEALTH CENTER

900 Carter Street Vidalia, LA 71373 Phone: (318) 414-3020

CONCORDIA SCHOOL-BASED MOBILE HEALTH CENTER

FAQS

What is a School-Based Health Center?
A school-based health center (SBHC) is a clinic located in the school or on school property that provides comprehensive primary medical, social, and behavioral health services, as well as health education, promotion, and prevention services to help minimize health-related absences from school and support the students for success in the classroom. The Concordia Mobile SBHC is operated by Tensas Community Health Clinic (TCHC) and adheres to state and federal laws, policies, and professional standards for provision of medical and mental health care.

What are the benefits of SBHCs?
SBHCs help reduce barriers that may prevent students from seeking health care services such as accessibility, transportation, cost, and confidentialit concerns. The Concordia Mobile SBHC visits area schools so students are able to receive the health care services they need and then return to learning in their classrooms. SBHCs also help eliminate the need for parents to take off time from work to take their child to a doctor. Students may be seen at the SBHC without their parent/guardian present, once consent is provided.

What are the hours of SBHC?
We are open whenever school is in session.

What is the cost?
There is no copay for any child seen at a SBHC. TCHC will bill all insurance providers.

Do parents need to give permission for students to visit the SBHC?
Yes. Parents/guardians must sign consent forms in order for their children to receive care.

Can students make appointments during class time?
Yes. SBHCs want to help students stay in school and learn, so every e ort is made to schedule appointments so that students are not absent from core classes.

Does a student need to be enrolled in the SBHC in order to use the services?
Yes. Only students who have enrolled in the SBHC can be seen by the Concordia Mobile SBHC provider, which includes a consent form signed by parent/guardian and a registration packet detailing patient information and health history. Enrollment documents may be found on the TCHC website: www.TensasHealth.com

If my child is sick at home, can they be brought to the Mobile SBHC to be seen?
We encourage students who are sick at home to be seen at Vidalia Community Health Center or by their primary care provider (PCP).

Does a student need to have health insurance to be seen at the SBHC?
No. Concordia Mobile SBHC proves care to students whether insured or uninsured. TCHC will bill private insurance and Medicaid for the services provided when appropriate.

What if the student already has a PCP?
If the student has a PCP, the Mobile SBHC staff will serve to supplement the student's health care. If necessary, and parent/guardian consent provided, the Mobile SBHC staff will communicate and collaborate with the PCP to ensure the student receives the best health care possible.

Can members of the community be seen at the Mobile SBHC?
No. Only students, faculty, and staff from any school within Concordia Parish, are allowed to receive services.

Will the SBHC provide prescription medication on site?
The Mobile SBHC may administer select medications on site, if deemed necessary by the provider, but all prescriptions will be sent to the pharmacy identifie on the student's enrollment form.

CONCORDIA SHOOL-BASED MOBILE HEALTH CENTER
900 Carter Street Vidalia, LA 71373 Phone: (318) 414-3020

CONCORDIA SCHOOL-BASED MOBILE HEALTH CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY, SIGN THIS FORM, AND RETURN TO THE RECEPTIONIST.

OUR COMMITMENT

Tensas Community Health Center, Inc. ("Clinic") remains committed to protecting the privacy of our patients' protected health information ("PHI") and is dedicated to complying with laws governing the privacy of PHI. This Notice explains our privacy practices, legal duties, and your rights concerning your PHI. PHI includes information about your health care and treatment combined with information like your name, age, birth date, address, or financial information. This Notice is e ective as of August, 24, 2020 and will remain in e ect until revised.

We protect your PHI by:

- Treating all PHI as confidential.
- Maintaining policies and practices that govern our staff in handling your PHI, as well as provide sanctions for violations.
- Restricting access to your PHI to only those that need it in providing services to you.
- Disclosing only the PHI that is minimally necessary for an outside service to perform a function on behalf of the Clinic and requiring that they agree to confidentiality of PHI disclosed.
- Maintaining administrative, physical, and technical safeguards to protect your PHI.

TYPES OF USES AND DISCLOSURES OF YOUR PHI

We will use and disclose health information about you for treatment, payment and health care operations. For example:

- **Treatment:** We may use and disclose your PHI to other healthcare providers currently treating you to assist in such treatment.

- **Payment:** We may use and disclose your PHI to obtain payment for services we provide to you.

- **Healthcare Operations:** We may use and disclose your PHI for our healthcare operations, including quality assessment and improvement activities, reviewing the competence or qualifi ations of healthcare professionals, evaluating practitioner and provider performance, conducting training and educational programs, accreditation, certifi ation, licensing, or credentialing activities.

OTHER PURPOSES FOR WHICH CLINIC IS AUTHORIZED TO USE OR DISCLOSE YOUR PHI

- **Your Authorization:** In addition to our use of your PHI for treatment, payment, or healthcare operations, you may give us written authorization to use or disclose your PHI for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not a ect any use or disclosures permitted by your authorization while it was in e ect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

- **Persons Involved in Care:** We may use or disclose PHI to notify, or assist in the notifi ation of a family member, your personal representative, or another person responsible for your care, of your location, general condition, or death. If you are present and capacitated, then we will provide you with an opportunity to object to such uses or disclosures. In the event of your in capacity or emergency circumstances, we will use our professional judgment to determine if disclosure is in your best interest and only disclose PHI that is directly relevant to the person's involvement in your care.

- **Required by Law:** We may use or disclose your health information when we are required to do so by law, including, but not limited to, court orders, warrants, subpoenas, discovery requests, or other lawful process.

- **Public Health Activities:** We may use or disclose your PHI to a public health authority for public health activities such as preventing the spread of a communicable disease.

- **Abuse or Neglect:** We may disclose your PHI to a government authority if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes.

- **To Avert a Serious Threat to Health or Safety:** We may disclose your PHI to the extent necessary to avert a serious threat to health or safety.

- **Workers' Compensation:** We may disclose your PHI to a workers' compensation insurer when related to treatment of an injured worker.

- Clinic will not use or disclose your psychotherapy notes or any PHI for marketing or sale. However, PHI may be used or disclosed in connection with the future sale of all or part of Clinic. In the event that PHI is used for fundraising purposes, you have the right to opt out of such communications.

PATIENT RIGHTS

You have the right to request all of the following:

- **Restriction Requests:** You have the right to request a restriction on the uses and disclosures of your PHI. Although we are not always required to grant a restriction, those granted will be upheld. Further, you have the right to request restriction, and such request will be granted, re garding certain disclosures of PHI to a health plan where the individual or someone on his or her behalf pays out of pocket for the health care item or service provided.

- **Confidential Communication:** You have the right to request that communication containing PHI be conducted in an alternate way or at an alternate location.

- **Your Right to Inspect PHI:** You have the right to request and inspect your PHI, subject to reasonable copying expenses. Inspection will not be allowed if we determine that the information could be harmful to you or another person or if it involves psychotherapy notes, records compiled in reasonable anticipation of litigation, or PHI whose release is prohibited by federal or state laws.

- **Amendment:** You have the right to request an amendment to your PHI in writing.

- **Accounting of Disclosures:** You have the right to request an accounting of disclosures of your PHI, outside of those disclosures permitted without authorization, for the past six (6) years. The accounting will include: the date, name of person or entity, description of the PHI disclosed, the purpose of the disclosure, and other related information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.

- **Electronic Notice:** If you received this notice by electronic means, you are entitled to request a paper copy.

DUTIES OF THE CLINIC

Clinic is required by law to maintain the privacy of PHI, to provide this Notice, and to notify a ected individuals following a breach of unsecured PHI. Moreover, Clinic is required to abide by the terms contained in this Notice. Clinic reserves the right to change this Notice and make the new Notice e ective for all PHI we maintain. In the event of a change, the revised Notice will be posted in the waiting room and website of the Clinic.

COMPLAINTS

You have the right to complain to the Clinic, and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. Complaints may be filed with the Privacy Offi er at 402 Levee Street Saint Joseph, LA 71366. Clinic will not engage in any retaliatory acts in response to the filing of a omplaint.