Email completed registration form to telemed@shchc.org.

Dear Parent:

As you know, Southeast Community Health Systems has been providing counseling and medical services to St. Helena students for over 20 years! This letter is a simple reminder of the benefits to completing the attached consent form.

Medical services:

- Primary and preventive health care
- Comprehensive history and physical examinations
- Immunizations
- Health screenings
- Laboratory/diagnostic testing
- Acute care for minor illness and injury including medications, if indicated
- Management of chronic diseases
- Health education and prevention programs
- Tele-Medicine

Behavioral health services:

- Individual, group, and family therapy
- IEP meetings, and support/advocacy for the student where needed
- Anger management
- Conduct problems
- ADHD
- Anxiety/Depression
- Grief
- General issues surrounding transitioning to a new grade, school, or family situation
- Tele-Behavioral Health
- Psychiatric Assessment
- Medication Management

These services are provided to your student by highly trained and licensed medical and behavioral health staff. With your consent, our providers will be able to share basic information with St. Helena Parish School Board and your child's teacher as needed to ensure your child is receiving the academic resources needed for their success. We are your child's biggest advocate at their school. Please take the time to complete the packet. If you have any questions, concerns, or would like to discuss your child's specific needs, please contact us at 225.306.2001. Thank you!

Sincerely,

Benjamin Larisey, LCSW, MHA
Coordinator of Behavioral Health and School-Based Services
Southeast Community Health Systems

Patient Name: ______________________________________ Birth date: ________________ Date:_____________

The following information is a copy of the general consent, patient rights, patient responsibilities, advanced directive acknowledgement, and the acknowledgement of receipt of privacy practice. Your signature is required and is requested at the end of the following consent packet. **Please keep the next two pages for your records.**

GENERAL CONSENT FOR TREATMENT

1. I hereby authorize and consent to all necessary medical procedures needed for diagnosis and treatment for me and/or my dependents by Southeast Community Health Systems (SCHS).
2. I understand that no guarantee or assurance has been made as to the results that may be obtained.
3. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees of a cure have been made to me as a result of examinations or treatments by SCHS.
4. I give permission to release to my insurance company medical information necessary in the filing of lawful claims by SCHS' staff for services rendered by SCHS to me or my dependents.
5. I hereby authorize payment directly to SCHS of benefits relative to pending claims and/or Major Medical benefits otherwise payable to me, not to exceed SCHS' regular charges for this service.
6. I certify that the information that I have provided in applying for payments under Title XVII of the SSA Act is correct. I authorize any holder of medical or other information intermediaries, carriers, or any other insurer, any information needed for this or any related Medicare/Medicaid Claims. I request benefits be paid on my behalf.
7. I agree that a photocopy of this form is as valid as the original.
8. I agree and understand that the medical records are the property of SCHS; however, I can request a copy for a nominal fee at any time.
9. I understand that general information regarding my child's diagnosis and treatment can be shared with IEP committee members, his/her teacher, and other staff connected with the St. Helena School Board as needed to assist in coordinating appropriate care of your child.
10. I understand that I can provide written objection of what information is shared with the school staff.
11. I certify that the information provided is true to the best of my knowledge.

PATIENT RIGHTS

1. Effective communication, to know what is going on. If you do not know, ask questions until you are sure you understand.
2. Be interviewed and counseled about personal matters in a private office.
3. Know why certain information is wanted, needed, or asked for.
4. Consent in advance to any visits made to your home
5. Expect that your medical records will not be given to anyone without your permission
6. Expect that your case will only be discussed with those involved in your care.
7. Know what the doctor has found as a result of examining you, and any anticipated outcomes.
8. Know about any medication or treatment that the doctor believes you should have
9. Accept or refuse any medication or treatment
10. Be treated with respect and dignity as an individual person, having your cultural, spiritual, psychosocial values and beliefs respected
11. Make known immediately to to any member of administration (Front Desk, Supervisor, Management, etc.) any problems encountered during a visit to the Health Center. If a member of the organization cannot address your concerns, you are encouraged to contact the Southeast Community Health Centers

Corporate Compliance Officer at **(855) 368-6272** or email Compliance@shchc.org to report your concern.

12. Be free from abuse, neglect and exploitation
13. Expect pain management considerations
14. Patients are encouraged to choose a doctor of record as their primary care provider to optimize continuity of care.
15. I have read and understand my rights and responsibilities as a patient of Southeast Community Health Systems and understand that if the quality of my care is compromised and if SCHS management staff cannot address it in a timely fashion, I have the option to report the healthcare compromise to the Joint Commission on Accreditation of HealthCare Organizations at (800) 994-6610, or complaint@iointcommission.org

PATIENT RESPONSIBILITY

1. I acknowledge that I am fully responsible for any and all expenses incurred at Southeast Community Health Systems for myself and/or dependents/family members.
2. I understand that all payments are due at the time of service.
3. I understand that all payments must be made towards any outstanding balance in addition to the payment for the current date of service rendered.

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

I understand that Southeast Community Health Systems does not honor Advanced Directives. In the event of a medical emergency during the clinic visit, first aid measures will be provided, 911 called and hospital transfer initiated.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I wish to place the following restrictions on disclosure of my health information (Please list below or write N/A if no restrictions)

INSURANCE ASSIGNMENT: I assign directly to Southeast Community Health Systems (SCHS) all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize SCHS to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions and for a copy for this statement and my signature to be kept on file and used in place of this original.

Patient Name: ______________________________________**Birth date:** ________________**Date:**_____________

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Southeast Community Health Systems

St. Helena College and Career Academy Enrollment/Consent Annual Update

Welcome back to SHCCA for the 2019-2020 school year! Please complete and return this form to update your child's medical records and renew your permission for them to continue receiving services at Southeast Community Health Systems. **Please complete in Blue or Black ink.**

Name of Student: ____ DOB: ______Age: _____Grade:_____

Student Gender (Select One): Male▪ Female ▪ Other (Explain): ______________________________________

Sexual Orientation (Select One): Straight ▪ Lesbian ▪ Gay ▪ Refuse to Report ▪ Other (Explain):____________

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White

☐Native Hawaiian or Other Pacific Islander ☐More Than One Race

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic of Latino

Migrant Status (If Applicable): ____

Preferred Language: __________________________________

Address: ____ City/State/Zip: _________________________________

Student Email: ______________________________________ Student Phone: ________________________________

Parent/Guardian Name: ____

Phone #: (c) __________________ (w) __________________ Email: ______________________________________

Parent/Guardian Name: ____

Phone #: (c) __________________ (w) __________________ Email: ______________________________________

Emergency Contact Name: ____ Phone #:_________________________

Medical Clinic/Doctor/Primary Care Provider: ____

Pharmacy: ____

Has there been any changes to your child's **insurance coverage**, since last year? YES NO

If yes, please list: ____

Is your child taking any daily **medications**? YES NO

If yes, name of medication and dose: ____

Does your child have any known **allergies**? YES NO

Please list: ____

Has your child been treated by a physician in an **emergency room** or his/her office for a serious illness or injury during the summer break? YES NO

List changes in family medical history in the past year.____

Patient Name: ____ Birth date: ________________ Date: _____________

FAMILY INCOME INFORMATION

We request income on all patients for governmental reporting purposes. If eligible for the Sliding Fee Scale, please complete separate Sliding Fee Application.

Income Period: __ Weekly __ Bi-Weekly __ Monthly __ Quarterly __ Annually __ Other:

Gross Household Income: $_____________ Number of Individuals Income Supports: $___________

We (student and parent/guardian) have read and understand the services to be provided at the school-based health center. This student may continue to receive the services provided by Southeast Community Health Systems. The original Enrollment/Consent form is unaffected and shall continue in effect in accordance with its terms.

______________________________________ ______________________________________
Printed Name of Parent/Legal Guardian Relationship

______________________________________ ______________________________________
Signature of Parent/Legal Guardian Date

______________________________________ ______________________________________
Signature of Student Date

This consent may be withdrawn or modified at any time with written request 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.

I acknowledge that I have been provided information regarding:

- ☒ **General Consent for Treatment**
- ☒ **Patient Rights**
- ☒ **Patient Responsibilities**
- ☒ **Advanced Directive Acknowledgement**
- ☒ **Acknowledgement of Receipt of Notice of Privacy Practice**
- ☒ **Insurance Assignment**

Signature of Patient (or Guardian): ______________________________________ Date: __________________

Relationship to patient if not signed by patient: ____

Patient Name: ____Birth date: ________________Date:_____________

Consent for Tele-Health Services

Telemedicine allows patients access to medical care using audio-video interface such as videoconferencing. For the purposes of this consent form, all treatment is referring to medical and behavioral health care. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

A licensed health care professional who can adequately and accurately assist with access to medical records, orders, and emergency patient care will be in the examination room with the patient at all times that the patient is receiving telemedicine services.

Expected Benefits:

- Continuity of care with same healthcare provider.
- Improved access to medical care.
- Obtaining expertise of a distant specialist.

Possible Risks:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the consultant.
- Delays in evaluation and treatment could occur due to equipment failure.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. To prevent this from occurring, the software that is being used is compliant with HIPAA standards and employs a firewall, router, and VPN-based access controls to secure the private-service networks and backend servers.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to other entities.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telemedicine interaction, and may receive copies of this information upon request
4. I understand that alternative methods of medical care may be available to me and that I may request to choose an alternative method of care (pending availability of other healthcare providers).
5. I understand that it is my duty to the extent that I am able to inform my healthcare provider of any change in my mental and/or physical health.
6. I understand that I may expect the anticipated benefits from medical care, but that no results can be guaranteed or assured.

Patient Consent to the Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, have discussed it with my healthcare provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine to provide medical and behavioral health care.

Patient's Name: ____ Date of Birth: ________

Guardian Signature: ________________________ Date: _________ Email: _________________________