Irwin County School-Based Health Center

Welcome to the Irwin County School-Based Health Center. The Irwin County Board of Education and Tift Regional Medical Center continues moving forward with its goal of serving the children and families of Irwin County to ensure students are healthy and ready to learn. With the Irwin County School-Based Health Center, our desire is to be available for our students' health care needs.

What is The Irwin County School-Based Health Center?

- The Irwin County School-Based Health Center is a comprehensive Pediatric Primary Care site inside Irwin County Schools.
- Only Irwin County students, faculty and staff can be served at this time.

What services will the Irwin County School-Based Health Center offer?

- Care for acute illnesses (i.e. sore throat, earache, colds, rashes, eye infections)
- Minor injuries (i.e. Scrapes and muscle strains)
- Management and ongoing care of existing medical conditions (i.e. asthma, sickle cell, blood pressure)
- Monthly medication management/medication maintenance
- Mental health, substance abuse, and family-centered case management

What if I need blood work or other labs?

The Irwin County School-Based Health Center has partnered with Tift Regional Medical Center to perform any laboratory testing. If laboratory test are required, the Irwin County School nurse will perform the venipuncture procedures, collect other specimens, urines, etc. and then send these specimens to the Irwin Center. TRMC Lab will not be performing any lab testing on the school campus. Irwin Center will send the specimens to Tift Regional Medical Center Lab for PAS lab registrar to register as a reference lab, filling any insurance that the child has and TRMC will process and send results to the physicians that ordered the lab tests.

How do I enroll with The Irwin County School Based Health Clinic?

- Contact The Irwin County School-Based Health Center Coordinator, Regina Cook, at (229) 468-9421.
- Fill out the health questionnaire and consent forms.
- Give a copy of your insurance card to the Irwin County School-Based Health Center.

What type of insurance does The Irwin County School-Based Health Center accept?

The Irwin County School-Based Health Center is not a billing agent. Each doctor is responsible for their own billing. The TeleHealth doctors have their own billing requirements.

When is The Irwin County School-Based Health Center open?

- Monday-Friday, during school hours
- For after hours service, you will need to be seen at a local emergency room or urgent care facility.

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Which doctors are participating in The Irwin County School-Based Health Center?
We have access to hundreds of physicians via the TeleHealth network. If you need a specialist (dermatology, psychiatry, allergist, etc.) we may be able to access that person via TeleHealth. If you know the name of the physician you are looking for, the Center staff can determine if that physician is in the Georgia Partnership For TeleHealth Network. Currently, we are scheduling the acute care appointments (earaches, sore throats, sinus issues, and etc.) with Dr. Conner in Ocilla, Ga. He practices pediatrics and internal medicine.

What is TeleHealth?

TeleHealth is a model of health care that has been around for many years. Once used primarily by the military, TeleHealth can now be seen in many environments…hospitals, acute care clinics, doctor's offices…and now, school based health clinics! Using the TeleHealth equipment, the doctor can see images of a person's throat/mouth, ears, eyes, skin rashes, etc. TeleHealth is amazing technology and gives rural areas (such as ours) access to medical care that we may otherwise have to travel hours to receive.

In addition to completely filling out the health questionnaire/intake form, please also make sure to sign and date each form where indicated. You may use this checklist as a reference to make sure you have completed and signed each item in this packet.

- ☐ Privacy Practice/Consent Form
- ☐ Authorization to bill insurance
- ☐ Lab permission form
- ☐ Data Collection Authorization
- ☐ Completely fill out intake packet
- ☐ Attach a copy of your insurance card (front and back)

Irwin County School-Based Health Center

Authorization to Bill Insurance

Patient's Name:____

Patient's Birth Date: ________________Patient's Social Security #________________

Primary Insurance Company: ________________________________

Name of person insured if patient is a dependent: ______________________

Insured's birth date: ____________ Insured's Social Security # ________________

Group # ________________ Policy or Member #: ____________________

Responsible Party:
Name: ________________________ Date of Birth ________________

Social Security #: ________________ Employer: ____________________

Authorization

The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

1. Grant permission to all physicians (Dr. Conner and any other physicians who may work with this patient), therapist, laboratories, and any other professionals to perform and administer care and treatment of the patient, or designated other qualified health care provider for such services.
2. Grant permission to release to the third party payor (or payers), Medicare, Medicaid, their representatives and/or other physician(s) involved in the patient's care, any information in connection with any care rendered to the patient.
3. Grant permission to bill third party payor or (payers) with benefits paid directly to the appropriate provider when assignment is accepted.

Letter of Responsibility:

I understand that I am responsible for any unpaid bills not covered by Medicaid, Medicare, and any other private insurance companies. The physicians will not accept any retroactive Medicaid cards on paid accounts. Thus, I will not be entitled to any refunds of Medicaid payments.

____
(Signature of Patient and/or guardian) (Date)

____
(Print Patient's Name)

We appreciate you for placing your confidence in us by choosing our staff for your medical needs. Our physicians and staff are dedicated to serving you.

Irwin County School-Based Health Center

Tift Regional Medical Center
Consent Form for Laboratory Testing

I give consent for the Irwin County school nurse to perform venipuncture (blood work) on me and/or my child as requested by a licensed physician.

I understand that my insurance carrier will be billed and any subsequent deductible/balances will be my responsibility.

I understand that the ordering physician will be the only physician to have access to the results unless requested otherwise.

____ ____________________________
(Signature of Patient or Guardian) (Date)

____
(Print Patient's Name)

Irwin County School-Based Health Center

Privacy Practice/Consent Form

(Consent to treatment, transportation, and authorization to release information and assignment of benefits)

The Irwin County Board of Education has joined in partnership with Tift Regional Medical Center to develop this comprehensive school-based collaborative healthcare center. The staff is comprised of pediatricians, mid-level providers (nurse practitioner, physician assistant), nurses, social workers, and interns from the local colleges and universities. Our services include onsite and telemedicine diagnosis and treatment of acute illnesses and minor injuries, management of chronic illness, management/maintenance of monthly medications, routine health physicals, counseling, health education/promotion, lab testing (including drawing blood), and referrals to medical subspecialist and community agencies. The primary focus of the center is to provide quality, accessible health care to the children and staff of Irwin County Schools, in order to have a positive impact on the children's health, school attendance, and academic performances.

In order for you to receive services at the health center, this consent form must be completed and proper documentation of insurance obtained.

I hereby voluntarily give my consent for ____ to receive health services at the Irwin County School-Based Health Center. I further authorize any physician or physician-designated health professional working for the clinic to provide such medial test, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of my health care.

I authorize release of information from my medical record of the family doctor or primary care provider designated by me whenever necessary for my care including referral and/or emergency services.

I authorize release of written and verbal information pertinent to my health care from the Irwin County School staff to the Irwin County School-Based Health Center whenever necessary for my care.

I authorize Irwin County Schools to release information regarding treatment to third party payers such as Medicaid or other insurers for the purposes of billing or for any other reason in accordance with acceptable medical practice pursuant to the law. I further give consent for this information to be used in connection with the National Evaluation of the Healthy Schools, Healthy Communities initiative and other Irwin County BOE partners. Medicaid and other insurers will be billed for services rendered.

Charges for services rendered to students not insured and as HMO insured patients choosing to use our services out of network will be based on a sliding fee scale. No students will be denied services because of inability to pay.

THIS IS NOT A FREE CLINIC.

I understand the Irwin County School-Based Health Center is permitted to disclose protected health information about me for the purpose of payment, continued care or treatment, and healthcare operations.

If my protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS), drug or alcohol abuse and/or mental illness, I hereby give consent to the disclosure of this information by these clinics only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I also understand that I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

I understand that my signing this consent allows the physicians and professionals at Irwin County School-Based Health Center to provide comprehensive health services. I also understand that I have the right to withdraw this consent at any time upon written notice to the clinic director.

I have read and understand the above information and give permission for treatment at The Irwin County School-Based Health Center. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the clinic at (229) 468-9421.

_______________________________________ (Name of Patient)

_______________________________________ (Signature of Parent or Guardian)

_______________________________________ (Date)

Irwin County School-Based Health Center

DATA COLLECTION AUTHORIZATION

REASON FOR DATA COLLECTION: Evaluation and Research of impact of school based health clinics on student outcomes.

The Irwin County School-Based Health Center is part of a research body that is attempting to determine the impact that school-based health clinics have on the success of students. The Irwin County School-Based Health Center will be partially funded by grants. All grants require certain information to be shared so that the administrators of the grant can see a snapshot the population of people that are being served. Because The Irwin County School-Based Health Center is a health clinic, your health information may be used or disclosed as required by law, and it may be shared with a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability and/or conducting public health surveillance, investigations or interventions. The privacy of your medical record is important to us. We want to tell you about a law that protects your medical record. The law is called the Health Insurance Portability and Accountability Act or HIPAA for short. Under HIPAA, your personal health information that identifies you receives greater protection.

Those who are working on The Irwin County School-Based Health Center project and who will release information are: Director of Irwin County Connection-Communities In Schools of Irwin County, Director of Irwin County School-Based Health Center, Tift Regional Medical Center and Irwin County Board of Education.

The Researchers and Regulators may use or disclose the following health information about you: Health and school records;

Other Items You Should Know: Those listed above who are working on the Irwin County School Based Health Clinic Project are required by HIPAA to protect your health information. However some of the other information recipients who receive your health information do now work for Irwin County School Based Health Clinic, and they may not be required by HIPAA to protect your health information. These Information Recipients may share you information with others without you permission if the law permits them to do so.

You do not have to sign this authorization form, but if you do not you may not participate in The Irwin County School-Based Health Center.

Revoking your Authorization: You do not have to sign this Authorization. In addition, if you sign this Authorization, you may change your mind at any time and revoke (take back) this Authorization. If you want to revoke this Authorization you must put your request in writing.

If you revoke your Authorization, the Researchers will not collect any more health information that identifies you, but they may use or disclose information that you already gave them in order to notify any of the other Researchers that you have revoked your authorization: to maintain the integrity or reliability of the Research Study; and to comply with any law that they are required to obey.

Expiration Date: There is no defined expiration date. This is an on-going evaluation of clinic outcomes.

As a study participant, if you have any questions regarding the study or if you have questions, concerns or complaints about the research you may call Regina Cook at (229)468-9421 or email rcook@irwin.k12.ga.us.

Your participation in this research study allows us to bring more funds into our school based health center to serve you and your children. Thank you for participating!

____
(Name of Patient)

____ ____________________________
(Signature of Parent or Guardian) (Date)

____ ____________________________
Signature of Irwin County School-Based Health Center Staff (Date)

Irwin County School-Based Health Center

INTAKE FORM

Please complete all information on this permission form. You must **COMPLETE USING INK** then sign and date it in order to receive services from the Irwin County School-Based Health Center. It is your responsibility to notify us immediately of any changes in address, phone numbers, or insurance.

Today's Date:__________________

Patient's Name: ____ Age:__________
Last First Middle

Birth Date:____________________ Sex: ☐ Male ☐ Female Race:________________________

Primary Language:____________________________ Birth Country:______________________________

Social Security Number:_______________________

Address:____
Street City State ZIP

Home Phone:_________________________ Cell:________________________ Work:______________________

How long at present address? ______Yrs. _____ Mos. How long at previous address? ______________________

Is present housing: ☐ Permanent ☐ Temporary ☐ Shelter ☐ Unstable ☐ Foster Care ☐ Other

Who lives at home? Please list everyone who lives in the home.

Name	**Relationship**	**Age**

Patient's Employer:___________________________________ Address:__________________________________

Position:____ How long in current position?__________________

Please list the name and contact information of a person (or persons) we can contact in case of emergency.

Emergency Name & Number	Relationship to Patient

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Physician Information

Primary Care:

Who is your child's primary care physician (the person you would see for a sore throat or a minor injury)?

______________________________Date of last visit:______________

Address:______________________________Phone:______________

Emergency Care:

For emergency visits, which clinic or Emergency care facility do you use?

______________________________Date of last visit:______________

Address:______________________________Phone:______________

Mental Health/Behavioral Health Care:

If you see someone for mental health/behavioral problems, list that person and reason for seeing him/her:

______________________________Date of last visit:______________

Address:______________________________Phone:______________

Dental Care:

Who is your child's dentist?______________________________Date of last visit:______________

Address:______________________________Phone:______________

Pharmacy:

What pharmacy do you use?______________________________Phone:______________

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HEALTH QUESTIONAIRE

Have you seen a doctor in the last year? ☐ YES ☐ NO If yes, how many times? ________________________

Where? ____ Why?____

Have you used a Hospital Emergency Room in the last year? ☐ YES ☐ NO If yes, how many times?__________

Where? ____ Why?____

Have you been in the hospital over night in the last year? ☐ YES ☐ NO

Where? ____ Why?____

Do you have any known allergies (foods, medications, etc.) ☐ YES ☐ NO If yes, list all:____________________

____

Do you have any Physical Disabilities? ☐ YES ☐ NO If yes, please explain:______________________________

____

Are you currently being treated for any health problems? ☐ YES ☐ NO If yes, explain:______________________

____

Do you take daily medications? ☐ YES ☐ NO

Name of Medication	Dosage	When Given

FAMILY HISTORY:

Please specify who has or had any disease listed below by using the following abbreviations: Mother-M, Father-F, Brother-B, Sister-S, Grandmother-GM, Grandfather-GF, Aunt-A, Uncle-U

Asthma	________	Heart Trouble	________
Allergies	________	High Blood Pressure	________
Birth Defects	________	Kidney/Bladder Problem	________
Blood Disorder/Anemia	________	Lung Disease	________
Cancer	________	Tuberculosis	________
Tumors	________	Seizures	________
Cystic Fibrosis	________	Mental Retardation/Illness	________
Diabetes before age 40	________	Muscle Disease/Weakness	________
Early Childhood Death	________	Death under age 50	________
Eye/Ear Disorder	________		________

There is no family history of the above disease(s):____

Do you or anyone in the home:		Who/Relationship to patient
Smoke	☐ YES ☐ NO	______________________
Drink Alcohol	☐ YES ☐ NO	______________________
Use Drugs	☐ YES ☐ NO	______________________
Chew Tobacco	☐ YES ☐ NO	______________________

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PATIENT'S MEDICAL HISTORY

Please specify if you have or had any disease listed below.

	Yes	No
Allergies		
Allergic to drugs		
Anemia		
Kidney/Urinary Tract Problems		
Problems Walking		
Other Respiratory Problems		
Asthma		
Stomach Ulcers		
Skin Rashes		
Abdominal Pain		
Constipation/Diarrhea		
Serious Digestive Problems		
Chicken Pox Age		
Ear Problem		
Wear Glasses		
Muscular-Skeletal Problems		
Rheumatic Fever		
Physical/Sexual Abuse		
Hemophilia		
Fainting Spells/Knocked Out		
Frequent Sore Throat		
Headaches		
Heart Murmur		
Heart Problems		

	Yes	No
Frequent Colds		
Lung Problem		
Meningitis		
Menstruation Started Age:_____		
Menstrual Problems		
Premature Birth weight		
Obese/Overweight		
Underweight		
Pregnant		
Serious Acne		
Sickle Cell Disease		
Sickle Cell Trait		
Other Blood Disorders		
Seizures/Epilepsy		
Speech Problems		
Tuberculosis		
Cancer		
AIDS/HIV		
Broken Bones		
Major Injuries		
Hepatitis		
Diabetes		
Thyroid Problems		
High Blood Pressure		

Other:____

Please explain any areas marked "Yes":____

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____

____

____

Irwin County School-Based Health Center

BEHAVIOR HISTORY

	Yes	No		Yes	No
Nightmares			Sleeping Problems		
Bedwetting			Slow Development		
Eating Problems			Learning Disability		
Thumb Sucking			Smoker		
Discipline Problems			Alcohol		
Overactive/Hyperactive			Inhalants		
Shy			Other Drugs		
Depression			Other Behavior Problems		
Other Mental Problems			Other:______________________		

Please explain any areas marked “Yes”:

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Please list any present concerns you may have about your mental health:

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Irwin County School-Based Health Center

DENTAL HISTORY:

Do you have a dental problem? ☐ YES ☐ NO

How often do you brush your teeth? ☐ Occasionally ☐ Once Daily ☐ Twice Daily ☐ Other

Have you had a toothache recently? ☐ YES ☐ NO

Have you had any injury to the teeth or jaws? ☐ YES ☐ NO

When was your last dental visit? ____________________________

IF YOU HAVE ANY OTHER MEDICAL CONCERNS, PLEASE LIST AND DESCRIBE IN THE SPACE AVAILABLE BELOW.

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PLEASE REMEMBER TO ATTACH A COPY OF YOUR INSURANCE CARD.

THANK YOU!