Dear Parents and Guardians,

Rockcastle Pediatrics & Adolescents (RockPeds) is excited to offer the first school-based clinic in our county at Rockcastle County High School, beginning this 2019-20 school year.

Through the combined efforts of RockPeds and Rockcastle County Schools, children can receive high quality health care services on-site, without missing school. This collaboration promotes positive outcomes for every child's health and education.

The providers at RockPeds, with the assistance of the RCHS school nurse, will be able to examine students through videoconferencing technology. Students at school in the presence of the school nurse will be able to see and hear the RockPeds pediatrician or nurse practitioner who will be located off-site, and the pediatrician or nurse practitioner will also be able to hear, see, and examine the student as if they were in the same room.

Important things to know:

- Healthcare providers Dr. Callie Shaffer, Dr. Sarah Oliver, Courtney Browning, APRN, and Megan Taylor Pittman, APRN from Rockcastle Pediatrics will be providing these services.
- Parents/Guardians must complete and return the attached forms: a consent to treat the child, a student health questionnaire, authorization to bill health insurance and health insurance policy information.
- Services include diagnosis and treatment of common illnesses, infections, and injuries, simple diagnostic laboratory testing, health education, and referrals.
- Caregivers will be contacted by the medical staff regarding diagnosis and treatment.
- Contact RockPeds at 606-256-4148 to with any questions about your child's school clinic visit, health concerns, or billing questions.

We look forward to providing this convenient and helpful service to students at Rockcastle County High School this year. **Please review and complete the attached forms and return them to school with your child as soon as possible.**

Callie Shaffer, MD FAAP

Sarah Oliver, MD FAAP

Courtney Browning APRN

Megan Taylor Pittman, APRN

ROCKCASTLE REGIONAL HOSPITAL ⁜ RESPIRATORY CARE CENTER
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Tel (606) 256-4148 • Fax (606) 256-7785
www.rockpeds.com

MINOR PATIENT REGISTRATION

By completing this form, I consent in advance to my child having access to any or all available school health services provided by Rockcastle Pediatrics and Adolescents (RockPeds) via telemedicine as long as my child remains enrolled in Rockcastle County Schools. Services include: diagnosis and treatment of common illnesses, infections and injuries, simple diagnostic laboratory testing, health education, and referrals as needed.

Students must have parental permission to receive school health services provided by RockPeds:

Student's Name: (First, Middle, Last): _____

DOB: _____ SSN: _____ Age: _____ Gender: M F School: _____

Mailing Address: _____ City: _____ Zip: _____

Primary Phone: _____ Parent Email: _____

Mother/Guardian: _____ Phone: _____

Father/Guardian: _____ Phone: _____

Who does the child live with most of the time? _____

In Case of Emergency, please tell us a local friend or relative (not living at the same address) whom we could contact:

Name: _____ Relationship: _____ Phone: _____

Person responsible for the bill: _____

Is this patient covered by insurance? YES or NO

Please fill in all of the following:

Primary Insurance:

Name of Insurance Company: _____ CoPay Amount: _____

Ins. ID Number: _____ Group Number: _____

Name of Subscriber: _____ DOB: _____ SSN: _____

Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: _____

Secondary Insurance:

Name of Insurance Company: _____ CoPay Amount: _____

Ins. ID Number: _____ Group Number: _____

Name of Subscriber: _____ DOB: _____ SSN: _____

Patient's relationship to Subscriber: SELF SPOUSE CHILD OTHER: _____

Student is an established patient of RockPeds: YES NO

Primary Care Doctor/Clinic: _____

Pharmacy: _____ Town: _____

□ I am not interested in my child receiving school clinic services provided by RockPeds at this time, by checking this box I opt out of these services for my child.

****Please provide a copy (front and back) of student's medical insurance card and return with this completed form****

No services can be provided without the following pages completed and signed. **(OVER)**

MINOR PATIENT REGISTRATION – pg 2

Child's Name: _____ DOB: _____

HIPPA/FERPA: All students have health issues that must be handled in a confidential manner. RockPeds staff will share confidential information only in the following situations:

- When it is educationally relevant for a student's academic progress
- When it is necessary to address a student's potential health care needs
- To ensure safety of the student, other students, and school personnel
- Other situations specified by law

For example, RockPeds staff may discuss the student's medication and other health care needs with the appropriate staff members who will administer the student's medicine and provide care to the student while the student is at school.

Additional detailed information about our Privacy Policies that govern Rockcastle Pediatrics and Adolescents are provided with this consent, please review.

TELEMEDICINE: Student encounters with RockPeds pediatrician or nurse practitioner will be performed using videoconferencing technology. Student will be at school in the presence of the school nurse and will be able to see and hear the RockPeds provider. Likewise the RockPeds provider will be able to hear, see, and examine the student as if they were in the same room. The information transmitted will be used for diagnosis, treatment and/or education. Safety measures are implemented to ensure the videoconference is secure, and no part of the encounter will be video or audio recorded.

I, the undersigned,

- Understand that the services provided include: diagnosis and treatment of common illnesses, infections and injuries, simple diagnostic laboratory testing, health education, and referrals as needed.
- Give permission and consent for my child to have treatment through and by Rockcastle Pediatrics and Adolescents. I understand the nature of this treatment, the way it is provided, and the details and limitations of this form and style of treatment.
- Give permission for RockPeds staff to receive information from the school about my child's health history.
- Acknowledge that I have been offered a copy of the Notice of Privacy Practices.
- Agree to release all records related to this treatment to my child's Primary Care Provider (if not a RockPeds provider).
- Agree that I will be responsible for all costs associated with said treatment and that I will provide any insurance information as requested. All costs and fees not covered by insurance will be my responsibility, including co-pays.
- As parent/guardian of the above student, I:
    - Authorize the release of any information necessary to process insurance claims for payment of benefits to RockPeds.
    - Authorize payment of benefits to RockPeds for services rendered.
    - Have provided details of all insurance policies that cover my child.

The information above and on the preceding page is true and complete to the best of my knowledge.

Parent/Guardian Name PRINTED: _____

Parent/Guardian Name SIGNED: _____ Date: _____

****Please provide a copy (front and back) of student's medical insurance card and return with this completed form****

Schools Student Health Questionnaire

Students must have parental permission to receive school health services provided by RockPeds:

_____

Student's Last Name First Middle

_____

Student's DOB Gender School

Does your child have any of the following conditions or health concerns?

- ☐ Allergies, other than medications (such as peanuts or beestings) – *Please List* _____
- ☐ Asthma - *date of last asthma attack* _____
- ☐ Seizures – *date of last seizure* _____
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Sickle Cell Anemia
- ☐ Heart Problems – *please list* _____
- ☐ Bleeding Disorders
- ☐ Orthopedic (bone or joint) Problems
- ☐ Anxiety/Depression
- ☐ Operations and/or Hospitalizations – *dates (details below)* _____
- ☐ Diseases in Siblings
- ☐ Other – *please explain* _____

*If you checked ANY boxes of the above conditions, please explain:

_____
_____
_____
_____
_____

Is your child on any medications?

- ☐ No
- ☐ Yes – please list _____

Is your child allergic to any medications?

- ☐ No
- ☐ Yes – please list _____

In signing this form, I am stating the following:

- The information provided is up-to-date and accurate.
- I will update RockPeds staff with any changes as soon as possible.

If you would like to speak with our medical provider about your child's health, please contact RockPeds at (606) 256-4148.

_____

Parent Signature Date

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- All reasonable requests will be considered.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Example: Our Organization may call you by name when presenting for services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date

April 14, 2003

Updated:
April 22, 2019

Privacy Officer

Debra Martin
Phone: 606-256-7727
E-mail: d.martin@rhrcc.org

This Notice of Privacy Practices applies to the following organizations:

Rockcastle Regional Hospital & Respiratory Care Center
Rockcastle Family Care
Rockcastle Family Dental Center
Rockcastle Family Wellness
Rockcastle Pediatrics & Adolescents
Rockcastle Regional QuickCare Clinic
Brodhead Family Care