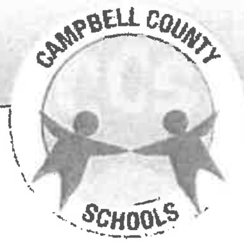

Superintendent David A. Rust, Ed.D.
101 Orchard Lane
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Phone: (859) 635-2173
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To: Campbell County School Families

From: Diana Taylor, District Health Coordinator

Date: August 5, 2021

Campbell County Schools, in collaboration with St. Elizabeth Health, is excited to announce virtual school-based telehealth visits for our students starting this school year.

- Telehealth visits can be set up for students who present non-emergent health issues and can be seen by a physician via the computer (aka telehealth visit) while the student is at school.
- The school health provider will determine if the student's health issue is appropriate for a physician telehealth visit and initiate the process.
- The parent will be contacted and have the option of participating in the telehealth visit with the physician. Parents will **ALWAYS** be contacted prior to a potential telehealth visit.
- All telehealth visits always remain CONFIDENTIAL in nature.
- Any prescriptions needed as a result of the telehealth visit can be called in to the family's pharmacy.
- Each telehealth visit would be treated and billed exactly as a medical office visit.
- Insurance will be billed by St. Elizabeth. Any co-pay requirement, or non-insurance coverage, will be billed to the parent.

If a child's primary care physician is not affiliated with a St. Elizabeth, they can still participate in the telehealth visit program with St. Elizabeth by completing a registration form. www.stedocs.com/schoolhealth. Only registered students are eligible to participate in the virtual telehealth visits.

Children learn best when they are healthy. We hope families find this to be a convenient option to keep their child healthy and learning.

Parents should contact their child's school if they need additional information about the telehealth program.

"I was scrambling to find someone to pick up my daughter and take her to the doctor until I remembered we had signed up for this. My daughter was able to return to class and I was able to pick up meds on my lunch break and bring them to her." - Participating Telehealth Parent

The Campbell County School district does not discriminate on the basis of race, color, national origin, age, religion, sex, genetic information, or disability in employment, educational programs, or activities.

PATIENT REGISTRATION / Consent to Treat

Please print the information below and have your insurance card and legal photo ID available for the receptionist to scan.

School Based Telehealth Consent Form

Introduction

The ______________________ partners with Summit Medical Group, Inc. dba St. Elizabeth Physicians ("SEP") to offer School-Based Telehealth Services. These telehealth services do not take the place of your regular doctor and participating in this program does not mean you are changing your doctor. You are encouraged to have any needed follow-up care with that physician and a summary of your telehealth visit with SEP will be sent to your doctor.

Enrollment Information For Staff

Name: ______________________________

Date of Birth: ______________________________

School: ______________________________

Primary Care Provider: ______________________________

Consent to Treat

By signing this Consent for Health Services, I agree to the terms and conditions regarding Authorization to Release Information and Assignment of Insurance Benefits as explained on Page Two of this Consent. I also acknowledge that I have received information about how to receive Notice of Privacy Practices as explained in this Consent. I also have received and understand available services as described in the frequently asked questions which accompanied this Consent.

I voluntarily give my consent to receive telehealth services through SEP. I authorize any physician or advanced practice provider working with SEP to provide such care. I understand that this consent will remain valid throughout the 2021 – 2022 academic year unless revoked by me. **I may revoke this consent for treatment at any time by requesting in writing that the District remove me from services**. I understand that I should contact the Virtual Health Department or my Primary Care Provider if I have questions regarding any necessary follow up care or instructions. It is my responsibility to notify SEP's Virtual Health Department of all updates or changes to my health conditions or insurance coverage.

Notice of Privacy Practices

I have been notified that I can ask for a copy of the Notice of Privacy Practices for SEP at any District school building. I acknowledge that I have received a copy of St. Elizabeth Physicians **Notice of Privacy Practices**. The effective date of the notice is: 09/23/13.

Consent to Device Use

I understand that the use of peripheral devices such as but not limited to a digital otoscope and digital stethoscope may be recommended to use to aid in assessment and/or diagnosis by the SEP Provider. I understand that use of these devices is not without risk and that I have the option

to decline use of the device(s), request aid in use of the devices(s) from the school nurse/trained health office staff, and or use the device(s) myself. SEP is not responsible for injury as a result of device use.

Insurance Information

Insurance or other health care coverage programs are billed for the cost of care provided by SEP. I authorize SEP to submit claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other program that I identify for which a benefit may be available to pay for services provided to my child.

If you do not have health insurance, you will be responsible for the bill in accordance with standard SEP billing practices.

____

Name

____

Signature

____

Date

PATIENT REGISTRATION / Consent to Treat
Please print the information below and have your insurance card and legal photo ID available for the receptionist to scan.

PATIENT INFORMATION

Social Security #____-______-________ Last Name ____________________ First Name __________________ Middle____

Address ____ City __________________ St_____Zip __________

Home Phone (___) ___-________ Work Phone (___)____-_________ Ext.________ Email: __________________________

Date of Birth____________ Marital Status___________ Race________ Sex_Alternate Phone (___) ____-_______

Emergency Contact ____ Phone (___) ____-_______
(Name) (Relationship)

Patient Employer______________________ Emp. Address ____________________________ Emp. Phone (___) ____-

Pharmacy most used by patient ____ Pharm. Phone (___) ____-__________

Referring Provider (Specialist office only) ____

PERSON WHO SHOULD RECEIVE THE BILL - RESPONSIBLE PARTY (Guarantor)

Relationship to Patient: Self Parent Spouse Other ________________________________

Social Security #____-____-_______Name

Address ____ City ___________________ St______Zip __________

Home Phone (___)_____-________Work Phone (___)____-_________ Ext.________ Email: __________________________

Date of Birth____________ Marital Status___________ Race________ Sex _____Alternate Phone (___) ____-

Employer____________________________ Emp. Address ____________________________ Emp. Phone (___) ____-______

PRIMARY INSURANCE COMPANY NAME____ **No Insurance** (Circle if applicable)

Subscriber Relationship to Patient: Self Parent Spouse Other ____________________________

Subscriber Name: ______________________________________ Date of birth______________ SS# ____-____-

Employer ____ PCP _____________________________ Copay _______________

SECONDARY INSURANCE COMPANY NAME____

Subscriber Relationship to Patient: Self Parent Spouse Other _______________________________

Subscriber Name: ______________________________________ Date of birth______________ SS# ____-____-

Employer ____ Copay _______________

I understand that I am responsible for payment for all services rendered. I authorize St. Elizabeth Physicians to act as my agent in helping me obtain payment from my insurance companies. I authorize payment be made directly to St. Elizabeth Physicians. I authorize release of information to all my insurance companies which may be necessary to collect any payments. I further authorize release of medical information to any and all providers involved in my care. I permit a copy of this authorization to be used in the place of the original. I authorize the use of "signature on file" to be used on all of my insurance submissions. I understand that I am responsible for notifying the office of any precertification or referral needed for my insurance. According to recognized coding rules, you may receive separate charges for procedures, physicals and/or other problems during a single visit.

I further authorize the access of my clinical and medication information for treatment by my Primary or Specialty Care Provider and to any and all providers directly involved in my care.

Signature X ____ Date______________________