Palo Pinto
Cares For Kids

Greetings,

We are happy to announce that Palo Pinto General Hospital and Graford ISD are partnering to provide school-based telemedicine services for our students. Having access to a medical provider at any time during the school day is a win-win for us all. This news, as exciting as it is, may raise many questions for you as parents and guardians. Rest assured, we will do our best to answer each of those questions and alleviate any concerns you may have.

First and foremost, you as the parent/guardian will have the opportunity to join the telemedicine visit via your iPhone/Android cell phone. You are not required to do so but we want you to have that option should you choose to be present when the provider assesses your child. The school nurse will remain with your child and help facilitate the visit via specialized telemedicine equipment.

Once the provider has completed your child's assessment, they will make the determination as to whether or not the child may remain at school or if they truly need to be sent home. Our goal is to keep our children in front of the teacher in the classroom setting as that is where the best opportunity to learn takes place. A letter with information on how to access the visit record, and who to contact should there be any questions or concerns will be sent home with your child. Also, a copy of the visit record will be sent to their primary care physician.

You will be asked to sign a consent for your child to participate in telemedicine consults. You will also be asked to complete a health questionnaire for your child that the provider can reference when completing their assessment.

We look forward to the upcoming school year and the opportunity to provide telemedicine services to our students. Our students' health and wellbeing are key to their success in school. Together we can achieve that success.

Respectfully,
Your care team at Palo Pinto General Hospital
& Graford ISD

Please keep this copy

Palo Pinto Cares For Kids

School-Based Telehealth Visits

Adapted from AHRQ – Agency for Healthcare Research and Quality

What is telehealth?

- Telehealth is a way to visit with healthcare providers, such as your doctor or nurse practitioner.
- Your child, along with the nurse, can talk to the provider from school, and you can join from work or your home. You don't go to a clinic or hospital.

How do I use telehealth?

- You talk to the provider by phone, computer, or tablet.
- You will use video so you and your provider can see each other.

How does telehealth help?

- Your child does not have to leave school to go to a clinic or hospital to see a provider.
- You won't miss work to take your child to see a provider.

Are there any negative affects when using telehealth?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Although uncommon, your provider may make a mistake because they cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will the telehealth visit be private?

- We will not record visits with your provider.
- If you choose to join the visit, please be aware that if people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

How much does a telehealth visit cost?

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

What does it mean if I sign the following document?

- If you sign the following document, you agree that:
- We provided the information in this document.
- We answered all your questions, or gave you contact information for any remaining questions. (Telehealth Coordinator, 940-328-7588)
- You want your child to have access to telehealth visits.
- If you sign the following document, we will give you this copy of the information included.
- A record of your child's visit will be sent to the PCP provided.

Palo Pinto
Cares For Kids

Permission for School-Based Telehealth Visits

Adapted from AHRQ – Agency for Healthcare Research and Quality

What is telehealth?

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How do I use telehealth?

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- You will use video so you and your provider can see each other.

How does telehealth help?

- Your child does not have to leave school to go to a clinic or hospital to see a provider.
- You won't risk getting sick from other people.
- You won't miss work to take your child to see a provider.

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_____

Your Child's name (please print)

_____

Your name (please print)

_____ _____

Your signature Date

Palo Pinto
Cares For Kids

Patient Information

Name: _____ DOB: _____

Address: _____ Sex: _____

City, State, Zip: _____ Medical History: _____

Allergies: _____ _____

Medications currently taking: _____

Pharmacy name, phone number: _____

Parent/Guardian Information

Name: _____

Address: _____

City, State, Zip: _____

Daytime Phone: _____

Email: _____

Emergency Contact

Name: _____

Address: _____

City, State, Zip: _____

Daytime Phone: _____

Present by phone/in person for visit? Y / N

School Information

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Physician Information

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Insurance Information

Company: _____ Subscriber: _____

Policy Number: _____ DOB: _____

Group Number: _____ Social Security Number: _____

Please provide copies of insurance card and parent driver's license

PALO PINTO GENERAL HOSPITAL
400 SW 25th AVENUE
MINERAL WELLS, TX 76067
PPGH (940) 325-7891

Receipt of Notice of Privacy Practices - HIPAA

THIS NOTICE DESCRIBES AN OVERVIEW OF HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. A FULL COPY OF OUR PRIVACY PRACTICES IS AVAILABLE UPON REQUEST.

How we may use and disclose your health information. We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail , fax, electronic mail, or other methods. We may disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any further uses and disclosures.

Your rights. In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing. you have the right to request that we correct the existing information or add the missing information. Upon your request you may be excluded from public lists.

Our legal duty. We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. You can request a copy of our notice at any time. For more information about our privacy policies, contact the person listed below.

Privacy complaints. If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about your access to your health information. you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:
Risk Management/Quality Management at (940) 328-6232 or (940) 328-6277

Acknowledgment of receipt of Notice of Privacy Practices:

Signature **Date/Time**

PALO PINTO GENERAL HOSPITAL
400 SW 25th AVENUE
MINERAL WELLS, TX 76067
(940) 325-7891

Health Maintenance Organization & MEDICAID

_____Health Maintenance Organization Notification: Most Health Maintenance Organizations (HMOs) have certain requirements that a member must satisfy in order to have benefit coverage for emergency care. These may include but are not limited to any or all of the following considerations: 1) Notification of a Primary Care Physician and/or 2) Use of participating facilities and providers and/or 3) Treatment of a condition considered to be of an emergent nature according to the HMO definition specified in the member's group benefit agreement and /or 4) required services were not available at the Primary Care Physician's office and/or required services were indicated outside of physician office hours. It is the responsibility of the patient/insured to follow the prescribed coverage requirements in order to ensure full benefit coverage under their HMO program. Failure to do so may result in a reduction or denial of benefit coverage in which case financial responsibility must be assumed by the patient/ insured party. ANY APPLICABLE CO-PAYMENTS ARE DUE AT THE TIME THAT SERVICES ARE RENDERED. This notice is provided as a reminder for patients to assist them in coordination with their respective HMO payer. Hospital emergency services are available to all patients who request such care. The hospital cannot be responsible for pre-certification requirements associated with these services.

_____Medicaid Acknowledgement: I understand that, in the opinion of Palo Pinto General Hospital District operating under the name of Palo Pinto General Hospital Clinic Network, the services or items that I have requested to be provided to me may not be covered under the Texas Medical assistance program as being reasonable or medically necessary for my care. I also understand that if the Texas department of Human Services health insurance agent or the Medicaid Managed Care insurance agent determines that the services or items I request and receive are not medically necessary, not a benefit, or they are not performed with a prior authorization or with a network provider, I am responsible for payment of these services or items that are not covered. I understand that Palo Pinto General Hospital District may bill me for the following: 1) Any service that is not a benefit of either traditional Texas Medicaid or one of the Managed Care Medicaid's (e.g. personal care items, take-home drugs, base-line studies, crutches, etc.) 2) All services incurred on non-covered days due to eligibility or spell of illness limitation. Total liability will be determined by reviewing the itemized statement and identifying by dates, the non-covered services. 3) The reduction in payment due to the medically needy spend-down. The recipient's liability will be equal to the amount of total charges applied to the spend-down. 4) The services that are provided to Managed Care Medicaid recipients that Palo Pinto General Hospital Clinic Network is not contracted with. This does not waive any rights that I may be entitles to or under the law of Medicaid regulations.

_____
Relationship to Patient

_____
Signature of Patient or Representative Date

PALO PINTO GENERAL HOSPITAL
400 SW 25th AVENUE
MINERAL WELLS, TX 76067
(940) 325-7891

INSURANCE AUTHORIZATION

Insurance Authorization and Assignment: I hereby authorize PPGH Clinic Network to furnish information to insurance carriers concerning my illness and treatment and hereby assign to the PPGH Clinic Network all payments for medical service rendered to myself or my minor child. I understand that I am responsible for providing insurance information or I will be considered private pay. I understand I am responsible for any amount not covered by insurance.
I hereby authorize the Social Services Department to contact and provide appropriate information to outside community resources as deemed necessary.

Guarantor statement: I assume financial responsibility for the payment of all charges for services rendered to the above patient.

Telephone Consumer Protection Act: You agree, in order for us to service your account or to collect monies you may owe, Palo Pinto General Hospital, and/ or agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text message or emails, using email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing services as applicable. I/we have read this disclosure and agree that Palo Pinto General Hospital, its employee and/or agents may contact me/us as described above.

(Not all insurances accepted.)

Signature of Patient or Representative	Relationship to Patient	Date

PALO PINTO GENERAL HOSPITAL
400 SW 25th AVENUE
MINERAL WELLS, TX 76067
(940) 325-7891

AUTHORIZATION FOR RELEASE OF INFORMATION

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
TO THIRD PARTY PAYOR/SPECIFIED OTHERS

Patient Name:

Patient Address:

Phone:

The undersigned hereby authorizes and requests PALO PINTO GENERAL HOSPITAL to release and provide information to any or all insurances, with access to my hospital records for the purpose of review and examination and further authorize and request that information be released and copies provided as requested.

The foregoing is subject to such limitations as indicated below:

(☐) Confined to records regarding admission and treatment for the following conditions or injury_____.
(☐) Covering records for the period of time from_____ to discharge.

*(☐) All records may be released.

(☐) All records may be released except treatment or diagnostics associated with:

(☐) Psychiatric care
(☐) Human Immune Deficiency Virus (AIDS)
(☐) Other: (please specify)

This authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereon.

I waive all provisions of State and Federal law relating to the confidentiality and privilege nature of such information and release Palo Pinto General Hospital from the liability that may arise from the release of the above information.

Signature **Date/Time**

Witness Signature **Date/Time**

PALO PINTO GENERAL HOSPITAL
400 SW 25th AVENUE
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(940) 325-7891

Treatment Consent Form

CONSENT FOR MEDICAL TREATMENT: I hereby give my permission to receive medical treatment for myself or my minor child(ren) by physicians and/or mid-level providers at the PPGH Family Health Clinic, a service of Palo Pinto General Hospital.

CONSENTIMIENTO PARA TRATAMIENTO MEDICAL: Doy mi permiso para recivir tratamiento par mi y mis criaturas de menores de edad por medicos en la Family Health Clinic, un servicio de Palo Pinto General Hospital.

PLEASE READ AND INITIAL THE FOLLOWING:
Por favor lee e inicial el siquiente:

If you wish to change your treating physician to one of the providers at the PPGH Family Health Clinic, we will need you to initial below and request a Release of Medical Records Form from the front desk to send to your previous treating physician.

_____ Yes _____ No

Si usted deseara cambiar su medico tratante para uno de los proveedores en the PPGH Family Health Clinic, le necesitaremos inicial debajo y solicitaran una Liberacion de Forma de Registros Medica de frente escritorio a enviar a su previo tratante medico.

_____ Yes _____ No

Acknowledgment of receipt of Patient Rights Pamphlet.

Recibo de reconiciemento de Patient Rights Pamphlet.

_____
Relationship to Patient

_____
Signature of Patient or Representative Date

Palo Pinto
Cares For Kids

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

Pursuant to Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter A, Division 33, Rule §354.1432; for a child receiving telemedicine medical services in a school-based setting, a notification including a summary of the service must be provided to the primary care physician or provider, along with a copy of the summary being provided to the parent/legal guardian.

I authorize Palo Pinto General Hospital to use or disclose my child's health information. The above party may disclose this health information to the following recipient:

Primary Care Physician: _____

Address:_____

City _____ State _____Zip_____

Phone _____ Fax _____

Physician Email _____

Parent/Legal Guardian Email _____

The purpose of this authorization is to provide for communication between my child's physician and the telemedicine providers at school.

This authorization is in effect for the 2020-2021 school year.

Pursuant to Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter A, Division 33, Rule §354.1432; a child receiving telemedicine medical services in a school-based setting, a notification must be provided to the primary care physician or provider.

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

☐ - Patient is a minor: _____ years of age

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient: ☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____