Laurel Health School Based Mobile Health Center

Consent for Treatment, Payment and Health Care Operations (TPO)

Students Name: **Date of birth:** **Medical Record Number:**

Students Current School: **Students Current Grade:**

Consent for Routine Care and Treatment

I, _____ (**print name)** on behalf of_____ (patient name and relationship) authorize Laurel Health School Based Health Center (SBHC) and its medical, nursing and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgement of Laurel Health medical personnel, is deemed necessary or advisable in my child's care. This may include all routine diagnostic point of care tests, testing and treatment of sexually transmitted diseases, pregnancy testing, vision and hearing screenings and the administration of medications. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by Laurel Health personnel.

I understand I may be contacted by Laurel Health or representative by cellular phone, which may include the use of pre-recorded/artificial voice messages, and/or an automated dialing device ("auto dialer") or by text message or e-mail in connection with any communication made to me or related to my accounts. **_____ Patient Initials (required)**

Consent for Telehealth Services

I, _____ (**print name**) on behalf of _____ (patient name and relationship) consent to participate in a telemedicine consultation, also known as "telehealth," services. Telehealth is the delivery of health care services using two-way audio/video communications and/or the electronic exchange of information.

Some possible risks associated with the use of Telehealth services include, but may not be limited to:

- Instances in which the electronic information may not be sufficient for appropriate medical decision making by the provider.
- Equipment issues, which could cause delays in your medical evaluation and treatment.
- Security measures could fail, possibly exposing your privacy and your personal medical information.
- In some cases, telehealth services may not be as complete as in-person services, and if your provider believes an in-person visit is necessary, he or she may recommend that you schedule an in person visit.

It is important that you understand and agree to the following statements:

1. I understand that engaging in a telemedicine visit with my provider is optional. I have the right to discontinue this service at any time. I further understand that in place of telehealth services, I may request a face-to-face visit with my provider.

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2. I have been informed and understand the alternatives to the Telehealth services that are available to me and give my consent to proceed with telehealth services.
3. I understand that my provider will be at a different location from me. I understand that a telemedicine visit will not be the same as a direct face to face visits since I will not be in the same room as the consulting provider.
4. I understand that there will be no recording of either the video or audio portions of the telehealth visit.
5. I understand that others may also be present during the visit other than my provider in order to operate the video equipment and/or facilitate the telehealth consultation. I further understand that I will be informed of their presence on the visit, and thus will have the right to request the following: (1) Omit specific details of my medical history/physical patient examination that are personally sensitive to me; (2) ask other personnel to leave the telemedicine examination room; (3) end the visit at any time; and/or (4) request the presence of the school nurse during a telehealth visit with my minor child if a parent or guardian is unable to be present for the examination.
6. I understand that I have the right to request a copy of this informed consent and upon request it will be provided to me.
7. I understand there is a possible risk of an incomplete or ineffective visit due to technological issues, and that if any of the technological issues occur, the visit may end. The technological issues include but are not limited to: (1) failure, interruption, or disconnection of the audio/video connection: (2) a picture that is not clear enough to meet the needs of the visit: (3) a minor risk of access to the visit through the interactive connection by electronic tampering.
8. I understand that my provider or I can stop the telemedicine visit if the connection quality is not adequate for the situation.

ACKOWLEDGEMENT & CONSENT: I have read and understand this consent. I have been given an opportunity to ask questions and all my questions have been answered to my satisfaction. The risks, benefits, and alternatives of the telehealth visit have been explained to me and I hereby consent to participate in Telehealth services as described in this document during treatment.

_____Patient Initials (required)

Beneficiary Agreement.

I have been notified that my insurance company may deny payment for some service. If my insurance company denies payment, I agree to personally be responsible for payment.

_____ Patient Initial(required)

Payment & Collection Policy.

It is the parents or guardian's responsibility to provide the Laurel Health SBHC with accurate information regarding current address, health insurance, and applicable financial resources to

determine whether the patient is eligible for coverage through existing private insurance, available public assistance programs or the Laurel Health Center Sliding fee program.

Payment is expected upon receipt of the first statement or in accordance with a mutually agreed upon payment agreement. If payment cannot be made in full upon receipt of the first statement, a payment agreement is necessary. It is the patient's responsibility to request an agreement.

The following methods of payment are acceptable:

1. Cash
2. Check
3. Money Order
4. Visa/MasterCard/Discover Credit and Debit Cards

Accounts with no payments following two statements will be turned over to a collection agency following review of the account. Collection agencies may determine that an account is eligible for legal action if it is determined that income/assets are available to the guarantor to meet their financial obligations on the account.
If turned over to a collection agency, future appointments may be limited to emergency visits only until payment arrangements are made.
If you have questions or concerns regarding your account, please call the Laurel Health Center Billing Office at 1-833-LAURELHC (528-7354)

_____ Patient Initials(required)

Receipt of Notice of Privacy Practice/ Release of Information.

I have been provided the Laurel Health Notice of Privacy Practices, either now or previously
_____ Patient Initials (required)

I give Laurel Health and its designees permission to use my information as described in the Laurel Health Notice of Privacy Practices. **_____ Patient Initials (required)**

Health Record & Exchanges: Laurel participates in the EpicCare Community Health Record by UPMC MedChart, which can share information through Health Information Exchanges to assist with care coordination between specialists and primary care; you may opt out of these exchanges. Full details and a list of participating providers/exchanges may be found at upmc.com/patients-visitors/privacy-info/notice-of-privacy-practice#coverage.

After Hours Coverage.

For after-hours emergencies, including evenings and weekends, a physician is available on call 24 hours a day. Just dial 1-844-284-6589.

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Meeting Your Concerns.

Communication between the patient and our Laurel Health SBHC team is an important element of good health care. If you have concerns about any aspect of your health care, we ask that you first discuss the problem directly with your nurse or provider. If you are not satisfied, please contact the Laurel Health Center Administration Office at 1-833-LAURELHC (528-7354). If you remain dissatisfied, you may also call the Pennsylvania Department of Health Hotline for Complaints at 1-800-254-5164, or write to the Pennsylvania Department of Health, Division of Acute and Ambulatory Care, 625 Forester Street, Room 532, Health and Welfare Building, Harrisburg PA. 17120.

Confidential Demographic Information (Optional).

Laurel Health Centers receives federal grant funding to support our services. Annually we are asked to provide reporting on demographic, clinical, operational, and financial data. Your assistance in gathering this information will help us apply for future grant funding. All information provided is completely confidential and we thank you for your cooperation.

Acknowledgement of , Patient Rights/ Responsibilities Policy/ Patient Non-Discrimination Policy.

I have received notice of the Patients' Rights and Responsibilities Policy. I understand my rights and responsibilities. I have also received notice of the Patient Non-Discrimination Policy. I agree to participate actively in my care in accordance with these rights and responsibilities.

_____ Patient Initials (required)

I have read this Consent for Treatment, Payment and Health Care Operations form for school-based care or have had it read to me, and it has been explained to my satisfaction. I understand that this Consent for Treatment, Payment and Health Care Operations form is valid for one (1) year from the date that I sign it and applies to Laurel Health School Based Health Care only. For outpatient behavioral health services and Laurel Health Center services, a separate consent is required for an encounter.

___ Yes, I consent for my child to receive medical care at the School Based Mobile Health Center.

___ No, I do not wish for my child to receive medical care at the School Based Mobile Health Center.

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Laurel Health School Based Mobile Health Center

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Patient Signature Representative	Date	Time	Signature of LHSBHC

Signature/Identity on behalf of patient/ Representative Relationship Name	Date	Time	Signature of LHSBHC

Legal Guardian Name:	Address	Phone Number

Legal Guardian Name:	Address	Phone Number

Insurance Company:	Policy ID # & Group #:
Subscriber Name/Date of Birth:	Patient Relationship to Subscriber: __ Self __Spouse __Child __ Other

We are a Federally Qualified Health Center (FQHC) and so are covered by the Federal Tort Claims Act (FTCA), meaning all malpractice claims are subject to federal procedural law. This health center receives funding from the United States Department of Health and Human Services (HHS) and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals. For more information, see bphc.hrsa.gov/ftca

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