Welcome to the Richardson Medical Center School Based Clinic

Dear Parent/Guardian:

Thank you for choosing to enroll your child in the Richardson Medical Center School Based Health Center (SBHC). We want to welcome your family and give you some information about the SBHC and the services provided. Please keep this letter and refer to it when necessary. If you have any questions, please contact the SBHC at (318) 728-4252.

The SBHC must have parental consent prior to enrolling a student as a patient. By signing the Enrollment/Consent and Privacy Notice contained in this packet, your child will be enrolled. Please note that a consent form may be revoked anytime by a parent/legal guardian.

The SBHC has nurse practitioners, a nurse and a counselor who care for the students and work hand in hand with the physicians in Rayville and the surrounding areas. All of these providers are licensed/certified professionals.

Parents do not pay out of pocket for any of the services that occur within the SBHC, however, insurance will be billed.

The services listed in the packet are recommendations/requirements from the American Academy of Pediatrics (AAP) and the Louisiana Department of Health. They recommend these services because they help to prevent illness and keep children healthy.

For more information please contact the SBHC, 318-728-4252.
Thank you and we hope to make this school year transition as easy as possible.

Evelyn Branch, FNP/Director

RICHARDSON MEDICAL CENTER SCHOOL-BASED HEALTH CENTER
2020-2021 LOUISIANA ENROLLMENT/CONSENT FORM

Student's Name: Last	First	Middle Initial		ID# (Office use only.)
Student's Address (include city):				Zip Code:
Student's Date of Birth:	Age:	Sex: ❑ M ❑ F	Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino	
Race: ❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑White ❑Native Hawaiian or Other Pacific Islander ❑More than one race				
Student's Social Security Number:	School:		Student's Grade:	
Preferred Language:	Parent/Guardian/Student Email:		Student's Cell Phone: ( )	
Name of Mother (include maiden name) or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Name of Father or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Emergency Contact:		Relationship:		Phone: ( )
Emergency Contact:		Relationship:		Phone: ( )
Name of Student's Primary Care Physician: Please check if student does not have a Primary Care Provider ❑				Phone: ( )
Name of Student's Dentist: Please check if student does not have a Dentist ❑				Phone: ( )
Preferred Pharmacy: (Name and location)	Names of siblings enrolled in School-Based Health Center:			

Please check the type of health insurance your child has:

Please send a copy of insurance card (front and back) to SBHC.

❑ Medicaid/Healthy Louisiana #: _____ (check one below)
❑ Aetna Better Health ❑ Healthy Blue ❑ AmeriHealth Caritas LA
❑ LA Healthcare Connections ❑ United HealthCare Community Plan
❑ Medicaid (dental)#: _____ ❑ No insurance
❑ Private/Other Insurance Co. Name:_____
Insurance Co. Address:_____
Phone #:_____ Policy #:_____ Group#:_____
Effective Date:_____
Name of policy holder:_____ Relationship to student:_____
Policy holder date of birth:_____ Policy holder Social Security #:_____
Does your insurance pay for prescriptions? __ No __Yes
Does your insurance pay for immunizations? __ No __Yes

If your child does not have health insurance, would you like information on no cost health insurance?
❑ Yes ❑ No

Has your child had a physical or well child visit in the last 12 months? ____yes ____no

Office use only.

Student's Name: _____ 2nd Identifier _____

Student Medical History (*Please fill out completely and indicate which of the following medical conditions your child has been treated for or you have concerns your child might have)*

Does your child have any known allergies to FOOD, MEDICATIONS, INSECTS, etc? ____ Yes ____ No
If yes, please list below:

List of current medications student is on with dosage (how much) and how often:

The School-Based Health Center can administer the following over the counter/prescription medications under standing orders from the School-Based Health Center Physician. Please circle any medications you <u>DO NOT WANT</u> your child to receive:

Tylenol/Acetaminophen	Mylanta	Benadryl	Orajel (toothache)
Motrin/Ibuprofen	Albuterol	Robitussin	Robitussin DM
Sore Throat Lozenge	Aquaphor	Calamine	Hydrogen Peroxide
Hydrocortisone Cream	Lotrimin Cream	Aleve/Naproxen	Saline Eye Wash
Bactroban	Silver Sulfadiazine Cream	Claritin	Ear Wax Drops
Azithromycin	Ceftriaxone	Lidocaine	Sudafed PE

***Generic forms may be substituted**

Y	N	Medical Condition	Y	N	Medical Condition
		Abnormal Bleeding			Ear Infections
		ADHD/ADD			Hearing Loss
		Allergies (Seasonal)			Speech Problems
		Asthma			Mental Health Concerns/Depression
		Birth Defect			Physical Disability
		Brain/Head Injury			Respiratory (Lung Problems)
		Broken Bones			Rheumatic (Scarlet) Fever
		Cardiovascular (Heart) Problems			Seizures
		High Blood Pressure			Sickle Cell Disease
		Dental Disease			Vision Problems/Eye Disorders
		Diabetes			Staph Infection (Abscess or Boil)
		Eating Problems/Poor appetite			COVID-19

Has your child ever had surgery? *(If yes, please specify below)* ❑ Yes ❑ No

Y	N	Surgery	Y	N	Surgery
		PE Tubes (Tubes in Ears)			Adenoidectomy
		Appendectomy			Bone or Joint Surgery
		Tonsillectomy			Other:

Office use only.

Student's Name: _____ 2nd Identifier _____

Has your child ever been admitted into a hospital? *(If yes, please specify below)* ❑ Yes ❑ No		
Hospital	**Date**	**Reason**

Student Surgical & Hospitalization History

Family Medical History *(Which of the following medical conditions apply to you or an immediate family member)*

Y	N	Condition & Details	Relationship to Student (Mother, Sister, etc.)	Y	N	Condition & Details	Relationship to Student (Mother, Sister, etc.)
		Asthma				Diabetes	
		Cancer				Seizures	
		High Blood Pressure				Sudden death before age 50	
		Heart Disease/Heart Attack				Sickle Cell	
		Emotional/Mental Health Concerns				Tuberculosis	
		Nervous/Mental Disorder: Anxiety, Depression, Bipolar D/O, other				Other:	
		COVID-19				Other:	

Declaration of Practices and Procedures (Licensed Professional Counselor)

Qualifications

Abby Hays earned a Master of Arts from the University of LA at Monroe, La. in 2015. She is a Licensed Professional Counselor #6500, and Licensed Marriage and Family Therapist #1292.

The Counseling Relationship

I see counseling as a process in which you, the client, and I, the Counselor, having come to understand and trust one another, work as a team to explore and define present problem situations, develop future goals for an improved life and work in a systematic fashion toward realizing those goals. Through this collaborative effort, we will work to explore and define present problems with client situations, develop future goals, personally and emotionally, and achieve success and personal fulfillment.

Tele-Mental Health Services

Tele-mental health services may not be appropriate for everyone. After a discussion between us, it will be determined if you meet the criteria for Tele-Mental Health Services. A tele-mental health session involves the transfer of information; therefore, it needs to be done in such a way as to maintain the privacy and security of that information. Collecting the information privately means conducting the session in such a way that no one who isn't supposed to be involved in the service can see or hear the consultation. It is incumbent on the person receiving the services to maintain and insure their own confidentially, as well. Sending the information securely means that only those who have a right to access it by being directly involved in the care of the person receiving the services are able to have access.

I, the mental health professional:

- will take steps to ensure that quality of communication during a telehealth encounter is maximized. Any significant technical deficiencies should be noted in the documentation of the consultation.
- will be familiar with the technology in use.

Office use only.

Student's Name: _____ 2nd Identifier _____

- am aware of and acknowledges the limitations of video/audio in the provision of telehealth health care services.
- have received education/orientation in telehealth communication skills prior to the initial telehealth encounter.
- will strive to determine, to the best of my ability, the appropriateness for, and level of comfort with, telehealth for each individual prior to or at the initial encounter, while recognizing that this will not be possible in all situations.
- to the extent possible, will ensure that the client receives sufficient education/orientation to the telehealth process and communication issues prior to their initial telehealth encounter.

Services Offered and Clients Served

I approach counseling/therapy from a cognitive-behavioral perspective in that patterns of thought and actions are explored in order to better understand the clients' problems and to develop solutions. Play, person-centered therapy, and brief solution-focused therapy are also utilized. I work with the clients in a variety of formats, including individually, as a family, and as groups.

Code of Conduct

As a Counselor/Therapist, I am required by law to adhere to the Code of Conduct for practice that has been adopted by my licensing board.

Privileged Communication

Material revealed in counseling will remain strictly confidential except for material shared under the following circumstances in accordance with state law: 1) The client signs a written release of information indicating informed consent of such release, 2) The client expresses intent to harm him/herself or someone else, 3) There is reasonable suspicion of abuse/neglect against a child, or 4) A court order is received directing the disclosure of information.

It is my policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprise clients of all mandated disclosures conceivable.

Client Responsibilities

You, the client, are a full partner in counseling/therapy. Your honesty and effort are essential to success. If as we work together you have suggestions or concerns about your counseling, I expect you to share these with me so that we can make the necessary adjustments. If it develops that you would be better served by another mental health provider, I will help you with the referral process. If you are currently receiving services from another mental health professional, I expect you to inform me of this and grant me permission to share information with this professional so that we may coordinate services to you. The client is responsible for having adequate internet.

Office use only.

Student's Name: _____ 2nd Identifier _____

TELEHEALTH DISCLOSURE

1. Telemedicine is the delivery of healthcare services using technology. Your telemedicine providers are listed below. Their areas of specialty are Family Medicine. They may be contacted at 177 Hwy 3048, Rayville, La. The phone number is 318-728-4181. Your telemedicine nurse practitioner's/counselor's role in your care is family medicine. The Nurse Practitioners and Counselors are:

   Evelyn Branch, APRN, NPC
   Abby Hays, LPC, LMFT

2. The SBHC providers have a role in your care and work directly with your Primary Health Care Physician.

3. To obtain follow-up care, or for emergencies, please call 9-1-1, contact your Primary Care Physician, or go to your nearest Emergency room.

4. You may wish to get a copy of your telemedicine medical records, or to send the records to another physician. This is how you can obtain your records: you may contact Amanda Free 318-728-4252 for instructions on how to obtain your medical records.

5. You may choose to stop any telemedicine visit or to withdraw your consent to telemedicine services and care at any time.

6. Equipment or technology failure may interfere with your evaluation, treatment, or medical care. If that happens, this is what you should do: contact your Primary Care Physician, or go to your nearest Emergency room.

7. While we use technology and equipment that we believe to be reliable, nothing is failsafe. A failure could cause the following: 1) Your care could be delayed. 2) Poor image resolution may interfere with appropriate medical decision making. 3) Telemedicine network and software security protocols which protect the confidentiality of your medical information could fail, causing your personal information to be inappropriately revealed.

Availability of Counselor:
Therapist is available during school hours only. If an emergency situation arises that requires immediate attention, you agree to call the National Suicide Prevention Lifeline at 1-800-273-8255, dial 911, or go to the nearest hospital emergency room.

Limits of Confidentiality:
You acknowledge that communication with your counselor through HIPPA compliant website are secure but not all personal emails are protected or encrypted.
Although your counselor has taken substantial steps to ensure the confidentiality and privacy of therapy provided online, Richardson Medical Center School-Based Health Centers cannot guarantee the privacy while a student is in the presence of others at their home.

YOU AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT DOCUMENTATION ON YOUR OWN COMPUTER AND IN YOUR OWN PHYSICAL LOCATION.
If your counselor believes you are a danger to, or may become a danger to, yourself or anyone else, She is MANDATED by law to inform others or insist that you be evaluated, in person, by another health care professional.

Office use only.

Student's Name: _____ 2nd Identifier _____

Technical Requirements:
To participate in online or distance counseling, you will be required to have access to a computer or smart device with internet access. A high-speed internet connection will be necessary for video sessions. Video and email sessions will take place through the HIPPA compliant website. It is understood that when communicating via the Internet or other electronic means, disruptions in service or other technical difficulties will likely occur from time to time. Should a disruption occur during a session, you agree to immediately phone your therapist by phone

Confidentiality: The School-Based Health Centers (SBHCs) adhere to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the exchange of relevant health information between Richardson Medical Center School-Based Health Center and the student's personal medical provider upon referral for medical care. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Richardson Medical Center School-Based Health Center have the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center or their website. My signature on this consent constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices.

We understand that the SBHC may participate in one or more health information exchanges (HIEs), whereby the center may share my health information with other health care providers for treatment, payment or health care operations purposes. We hereby consent to the disclosure of the SBHC's records into the HIEs.

We understand that the Office of Public Health ("OPH"), Adolescent School Health Program provides oversight to the SBHC and, as part of such program; the SBHC is required to provide information to OPH. Therefore, we consent to the disclosure of SBHC information to OPH, or its agent, in connection with the operation, funding and ongoing monitoring of school-based health centers. We recognize that the information needed by OPH may be compiled through a HIE and consent to the disclosure of information to a HIE for such purpose.

All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the exchange of relevant health information between Richardson Medical Center SBHC, and the student's personal physician upon referral for medical care. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Richardson Medical Center School-Based Health Center has the right to change this notice at any time. I may obtain a current copy by contacting the Health Center Coordinator. My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices. I understand that my health information is stored in a unified electronic medical record system (CPSI) owned and operated by the Richardson Medical Center. My signature on the health center enrollment/consent form gives consent for this sharing of information. The Notice of Privacy Practices describes how my health information may be used or disclosed.

Office use only.

Student's Name: _____ 2nd Identifier _____

I consent to the exchange of relevant health information (including information about physical exams, health histories, and other information) between the health center staff and the school nurse program, child welfare and attendance, and special services department as needed in order to facilitate evaluation of this student's health needs, special education multi-disciplinary evaluations, disciplinary referrals, attendance records, and immunization records. We understand that due to the confidential nature of services provided at the health center, only information regarding crisis or threat of grave or serious harm to self or others will be shared with the school principal. We also understand that the school health center may enter information into my child's LINKS (Louisiana Immunization Network for Kids Statewide) record, which is the state's immunization registry.

The school health center hereby agree that all medical information of the student is hereby declared confidential and may not be disseminated to any other person, firm, or organization other than (1) a health care provider (for diagnosis, treatment, or counseling purposes); (2) the authorized insurance or benefit payer or health care service plan which is liable for payment; or (3) the spouse, parent/guardian of the minor student. Although nothing herein contained may prohibit the treatment by a licensed physician of someone in a true emergency situation within the meaning of the Louisiana Emergency Treatment Act, visits and/or treatments must be disclosed to the parents as soon as reasonably possible after the visit and/or treatment, through a reasonable effort by written notice via the child to the parents/guardian and/or a phone call to the parents/guardian. The medical information obtained may not be used for any other purpose than the health examination, diagnosis and treatment by a licensed health care provider. The provisions of this paragraph do not apply in cases involving child abuse by a parent/guardian. Any medical information used for purposes of surveys or evaluating school health center performance will keep the identity of students anonymous, including references to social security numbers or other identification methods. Nothing herein contained shall constitute a medical consent to give supplies to a minor involving contraception, abortion, premarital sex, nor may an examination or treatment be made for the purpose of determining in whether counseling for such services or supplies is or is not appropriate. Nothing in this paragraph shall invalidate consent given on the Attachment.

At any time, the parent or guardian or minor themselves may refuse to provide information, including, but not limited to, long term medical history of the child and family members if the child chooses to do so or the parent restricts or prohibits the disclosure of such information. The limitation is not intended to prohibit the parent or child from giving medical history pertaining to the specific reason or purpose the child seeks medical treatment.

Louisiana Law R.S. 40:31.3 states that Health Centers in schools are prohibited from:

1. Counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion.
2. Distributing any contraceptive or abortifacient drug device, or similar product.

To report violations of the prohibitions against abortion counseling, advocacy, or referral; or distribution of contraceptives, abortifacient drugs, devices, or other similar products, contact the Adolescent School Health Program at the Office of Public Health at 504-568-3504.

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOOL HEALTH CENTER TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:

□ Primary and preventive health care □ Teleheath □ comprehensive history and physical examinations □ immunizations □ health screenings □ laboratory/diagnostic testing □acute care for minor illness and injury including medications, if indicated □ management of chronic diseases □ behavioral health services □ health education and prevention programs □ case management □ referral and follow-up for emergencies □ referral to specialty care □ dental services (where available)

Office use only.

Student's Name: _____ 2nd Identifier _____

Acknowledgements/Understandings and Consent for Services

I understand that:

- I have a right to request a restriction of how his/her protected health information is used and/or disclosed, but the request must be in writing,
- Richardson Medical Center School-Based Health Center is not required to grant my request, Richardson Medical Center School-Based Health Center does grant the request, it will be binding.
- We understand that the school health center is operated by Richardson Medical Center and its employees and contractors.
- I have received a copy of the Richardson Medical Center SBHC Notice of Privacy Practices which provided detailed information about how they may use or disclose my child's protected health information. I will consent to my child's protected health information being shared with a HIE.

I, as parent/guardian, understand that I will not be charged for any of the services provided at the school-based health center. I also understand that Richardson Medical Center School-Based Health Center or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to Richardson Medical Center School-Based Health Center**.**

By signing this consent, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the school-based health center. We both give permission for this student to receive the services provided by the program.
This consent is effective while the student is enrolled in Richland Parish School System unless the School-Based Health Center is notified, that I no longer wish for my child to receive services. I understand that I may be asked to complete a one page form every year to update important information.

_____ _____

Printed Name of Parent/Legal Guardian/Student **Relationship**

_____ _____

Signature of Parent/Legal Guardian **Date**

_____ _____

Signature of Student (optional) **Date**

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.