Your school, your nurse, our help

Prisma Health and Midlands school districts partner for telehealth programs.

Prisma Health now offers telehealth opportunities in several schools throughout the Midlands. Students with health needs may now be instantly connected to a Palmetto Health–USC Medical Group nurse practitioner or Prisma Health–Midlands Children Hospital physician for non-emergency needs and have prescriptions sent to the pharmacy of choice following the visit.

This service does not replace existing primary care. The parent or guardian will be contacted before any telehealth visit occurs with participating students.

All participating students require parent/guardian consent forms on file. An online link is available: *https://sbth.palmettohealth.org*

The clinical telehealth program is aimed toward:

- Helping students feel better, quicker
- Reducing missed time from school
- Reducing parents' missed work days
- Eliminating transportation barriers

For questions or additional information, please call 803-296-3764 or Monica.Caldwell@PrismaHealth.org.

PRISMA HEALTH℠

Palmetto Health USC MEDICAL GROUP

PRISMA HEALTH

School-Based Telehealth Enrollment Forms

Prisma Health and your child's school are excited to offer the School-Based Telehealth (SBTH) Program. The SBTH visits require the same documents that a parent or guardian would complete at a regular doctor's visit.

There are **five forms to complete** in order to enroll your child in the program.

Page	Form Name	Purpose
1	Consent for Treatment	Signing this form allows your child to receive medical care in the school when appropriate. ***You will be contacted before any treatment occurs.***
2	Telehealth Acknowledgement Form/ Consent for Release of Education Records and Information	Signing this form lets us know that you understand the medical visit will take place using real time video conferencing equipment rather than in person. However, the visit will feel the same as a regular doctor's visit. This form also allows the school and the healthcare team to work together in treating your child's needs
3	Authorization to Disclose Protected Health Information	Signing this form allows the school and the healthcare team to coordinate care for your child.
4	Patient Demographic Form	This form gives the medical team the necessary patient and insurance information.
5	Patient Financial Billing Policy	Signing this form ensures understanding of the billing process. The program does not require any upfront co-pays and visits are covered by most insurances.
6	Joint Notice of Privacy Practices	No signature required. Please keep for your records.

If you have any additional questions, please contact your ***school nurse*** *or the Prisma Health* ***Office of Community Health*** *at 803-296-3764.*

PALMETTO HEALTH-USC MEDICAL GROUP SCHOOL-BASED TELEHEALTH CONSENT FOR TREATMENT

Student/Patient's Name: _____ DOB: _____ MRN: _____

Student General Consent:
Expanded information on each of these topics available upon request.

1. I am the parent/guardian of _____ date of birth _____. I consent to Palmetto Health- USC Medical Group in coordination with the school nurse performing as applicable: examinations and treatments, as may be necessary in accordance with the judgment of the physician supervised nurse practitioners, physician assistants, residents, and telehealth providers **WITHOUT MY BEING PRESENT.** I understand that I will be contacted and will provide verbal consent prior to and during treatment. I understand that **treatment will be provided by authorized employees of Prisma Health, the University of South Carolina or the Palmetto Health /USC Medical Group.** I acknowledge that no guarantee can be made concerning the results of examinations or treatment plans.

2. I acknowledge that my child's photograph may be taken for identification purposes, that cameras and video cameras may be used for observation, medical documentation purposes, telemedicine and that the images are the property of Palmetto Health-USC Medical Group and Prisma Health unless I withdraw my consent in writing.

3. I give permission to share my child's electronic medical record among his/her health providers and obtain medication history through a Provider Health Information Exchange (HIE) which will follow state and federal laws regarding access by medical providers of any protected information. I may opt out of the HIE exchange and continue to receive care.

4. I consent to the use of the electronic prescription system which allows prescription history and related information to be electronically shared between his/her providers and my pharmacies.

5. I understand that certain circumstances require mandatory disclosure to organizations such as the state health department and department of health and environmental control and that this entity participates in the South Carolina Dept. of Health's statewide immunization registry which complies with federal health information privacy laws.

6. I agree to fill out current medical history on my child and provide contact information related to any current medical providers for my child. I give permission to send or fax childhood immunization records to schools or, upon request.

7. I authorize the release of medical information to any third party responsible for payment of benefits, information needed for decisions of Medicare, Medicaid or third party claims. I understand that I will be responsible for any costs not covered by insurance. In the event that I fail to make payment or comply with payment arrangements, collection measures may be initiated and my credit report can be obtained. _____

8. I give permission to leave messages on my answering machine/voicemail. Phone #_____
   I give permission for appointment reminders to be emailed and/or texted to me at _____
   I give permission to leave messages on my voicemail at my place of employment. Phone #_____
   I can be reached at the following number in case of emergency. Phone #_____
   Emergency contact is _____ at Phone#_____

I FULLY UNDERSTAND AND AGREE TO THE CONDITIONS CONTAINED IN THIS FORM. I HAVE RECEIVED A COPY OF PALMETTO HEALTH "NOTICE OF PRIVACY PRACTICE"

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Print Name Date

_____
Relationship to Student/Patient

SCHOOL-BASED TELEHEALTH ACKNOWLEDGEMENT FORM

I understand that as participants, my child _____ and I _____ may communicate by special video equipment with physicians and health care professionals at Prisma Health and other organizations participating in the Telehealth Program. I further understand that the video encounter is not recorded but some elements such as pictures may be taken. These materials will be maintained as a confidential medical record.

- I understand that medical information from my child's medical chart will be used for reports and to evaluate the school-based health center, but my child will not be identified with this information.
- I also understand other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.
- I understand that I have the right to ask the healthcare provider to discontinue the conference at any time.
- I understand that some parts of the exam may be conducted by individuals at my location at the direction of the consulting health care provider.

CONSENT FOR RELEASE OF EDUCATION RECORDS AND INFORMATION

The School District shall obtain written consent before disclosing any personally identifiable information from an education record. I understand that the District will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA), state statutes and regulations, and state and District policies and procedures to ensure confidentiality regarding the release of student information. No information will be released or secured without prior approval from the parent, except as provided by law.

The District has my permission to release and exchange medical, psychological, and other educational or personally-identifiable confidential information (i.e., absences, academics or nurse visits), as necessary, to representatives of the School-Based Telehealth program. I understand that the purpose of this consent is to refer my child for health-related services and treatment.

Consent to Release Confidential Information

By providing my signature below, I understand that granting consent for the release of personally-identifiable information from my child's education records is voluntary and may be revoked at any time. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

By providing my signature below, I understand the recipient of these records must obtain my written consent before it can further share my child's information from the District with any other party, such as for the purpose of billing Medicaid. If I provide written consent for the service provider to share my child's information with another party, the re-disclosure of my child's information by the recipient may no longer be protected by the requirements of the FERPA.

_____ _____

Student's Name Student's Date of Birth

_____ _____

Signature of Parent/Guardian/Surrogate Parent Date

SCHOOL-BASED AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Student/Patient's Name_____ DOB_____ MRN: _____

I hereby authorize Prisma Health and Palmetto Health-USC Medical Group (hereinafter "Medical Group") and the School Clinic to use or disclose my protected health information as described below. All healthcare information is private. **By signing this form, you are giving the school clinic, the school nurse, and your child's main health care provider consent to speak with and share medical information about your child's health issue on an as needed basis, with the understanding that this information will be treated in a confidential way. The purpose of the disclosure is: participation in school-based health services**. Examples of protected health information that may be shared include but is not limited to history and physical, consults, lab, reports, and medication list. I understand this information may include references to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV /AIDS and / or alcohol abuse.

I understand that the exchange of this information may be exchanged by mail, fax, email, phone, or secure web-based software.

I understand that I have a right to cancel this permission at any time. I understand that if I cancel this permission I must do so in writing and present my written cancellation to the School-Based Health Program office. I understand that the cancellation will not apply to information that has already been released in response to this permission, as stated in the Notice of Privacy Practice.

Unless otherwise canceled, this permission will expire at the end of the current school year. I understand that permitting the release of protected health information is voluntary. I can refuse to sign this form. I do not need to sign this form for my child to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information. I understand I will be given a copy of this authorization.

I understand that the information I authorize a person/facility to receive may be subject to re-disclosure by the recipient and may no longer be protected state and federal regulations.

Entity Providing Information (Address)

Palmetto Health-USC Medical Group
3555 Harden Street, Ext.
Columbia, SC 29213

Person or Entity Receiving Information (Address)

School Address Name_____

_____
Pediatrician or Health Care Provider Name and Address

I understand that if the purpose for use or disclosure of my protected health information is for marketing, the Medical Group may receive direct or indirect payment in connection with the marketing.

_____ _____
Parent/Guardian Signature or Legally Qualified Representative Patient/Guardian Print Name
Date

_____ _____
Relationship to Patient Date

Patient Information

Palmetto Health **USC**
MEDICAL GROUP

Patient Information

Patient Name (last, first, middle)_____

SSN_____ Birth Date_____ Gender ☐ Male ☐ Female Marital Status_____

Address_____

City/State/Zip_____

Phone: Home_____ Cell_____ Work_____

Email_____

Employer_____

Race and Ethnicity_____ Primary Language_____

Do you have a Health care Power of Attorney? ☐ Yes ☐ No Are you an organ donor? ☐ Yes ☐ No

Emergency Contact Information

Name_____

Relationship to Patient_____ Phone_____

Parent/Legal Guardian Information (as applicable)

Name_____ Name_____

Address_____ Address_____

City_____ State_____ Zip_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Home Phone_____ Work Phone_____

Cell Phone_____ Cell Phone_____

Guarantor's Information (Financially Responsible Party)

☐ Check if patient is guarantor

Name_____ SSN_____ Birth Date_____

Address_____ City/State/Zip_____

Phone_____ Relationship to Patient_____

Insured's Information

Primary Insurance Company_____ Secondary Insurance Company_____

Insurance ID_____ Insurance ID_____

Group ID_____ Group ID_____

Name_____ Name_____

SSN_____ Birth Date_____ SSN_____ Birth Date_____

Phone_____ Phone_____

Relationship to Patient_____ Relationship to Patient_____

Release of Information

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for any amount not covered by my insurance. I request that payment of authorized Medicare benefits be made to my physicians.

_____ _____ _____

Patient's Signature or Legally Qualified Representative | Patient/Guardian Print Name | Date/Time

_____ _____

Relation to Patient | Date/Time

Patient Financial Billing Policy

Palmetto Health **USC**
MEDICAL GROUP

Patient's Name | DOB

It is the policy of Palmetto Health – USC Medical Group to provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to all patients.

Patients are responsible for the payment of all services provided by Palmetto Health – USC Medical Group.

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay for the office visit before services are rendered
- In addition, any remaining balance on your account after receiving treatment will be collected at discharge.

Insurance Policy

- If you are a patient with insurance, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- If we have not received a payment from your insurance company within sixty (60) days after the claim has been filed, you will be responsible for the balance due.
- Deductibles, co-payments, and coinsurance will be collected before services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.
- If you do not want PHUSCMG to file to your insurance, please inform the registration staff at check-in. Services not filed to your insurance will be considered self-pay, and payment is due at time of service.

Past Due Balances

- All over-due patient balances will be sent to collections.
- All accounts sent to collections will be charged a 20% collection fee in addition to the account balance.

To help in this policy, we ask that you assist us by:

- Providing us with current and updated information on yourself and your insurance company.
- Presenting an updated photo identification card and insurance card when changes are made.
- Making the appropriate payment at the time of service, whether it is a deductible, co-pay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical team members. Please discuss any account information with the checkout associate or front desk members.

Patient's Signature or Legally Qualified Representative | Date/Time

Patient/Guardian Print Name | Relation to Patient

Palmetto Health-USC Medical Group Representative | Date/Time

Joint Notice of Privacy Practices

Effective Date 10-3-2016

Palmetto Health USC
MEDICAL GROUP

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.

At the Palmetto Health-USC Medical Group ("Medical Group"), protecting the privacy of our patients is important. We understand that medical information about you is personal. We create a medical record of information about you and the care that you receive at the Medical Group. We need this record to provide you with high quality care. We are required by law to make sure that medical information about you is protected. We are also required by law to provide you a copy of this Notice and to comply with the current Notice.

The Medical Group's medical staff, practitioners and non-practitioners who provide services in any Medical Group facility fall under the Joint Notice of Privacy Practices and may use and/or share your health information for treatment, to obtain payment for treatment, for administrative purposes, to evaluate the quality of care that you receive and for any and all other purposes described in this notice. Some medical providers in the Medical Group may be employed by the University of South Carolina School of Medicine and may be solely subject to the liabilities of the South Carolina Tort Claim Act. We reserve the right to change this Notice. The Notice will contain the effective date in the top right corner of the first page. A copy of our current Notice of Privacy Practices will be available for you upon request. You may also view the current Notice on the Medical Group's website at **https://phuscmg.org**.

How we may use and disclose your protected health information without your written authorization

For treatment: We use and disclose your protected health information to provide your medical care, both routine and emergent. Doctors, nurses, technicians, medical students and other health care staff may share your health information to plan, coordinate and manage your health care. For example, a doctor treating you for a broken arm would need to know about your diabetes since diabetes would probably slow your healing. We may also disclose medical information about you to family members or others involved in your treatment or in payment for your treatment.

For payment: We may use and disclose your protected health information to obtain payment for the treatment and services we provide for you. For example, we may give your health plan information about treatment you received from the Medical Group so that the health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to have the treatment approved or make arrangements for payment. We may disclose to agencies and courts for collection of unpaid bills.

For health care operations: We may use and disclose protected health information about you for our administrative activities and operations that are needed to run the Medical Group. For example, we may use medical information to review our treatment to evaluate the performance of our staff in caring for you. We may ask that you sign in for your appointments and we may call your name in the waiting room. We may also disclose your information to doctors, nurses, health care students and other personnel for learning purposes. We may disclose your protected health information to comply with State and Federal law.

For appointment reminders: We may use and disclose protected health information to contact you by mail or phone or leave a message for reminding you of an appointment. The phone number that you give us may be used for automatic messages, unless you notify us to use another number.

For treatment alternatives and services: We may use and disclose protected health information to let you know about treatment options or health-related services that may be of interest to you.

For "business associate" functions: We may share your protected health information with our business associates that perform various functions for the Medical Group, such as billing and transcription service. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written agreement that contains terms to protect the privacy of your information.

For abuse or neglect: If we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your protected health information to an agency authorized to receive such information.

For legal proceedings: We may disclose protected health information in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) or in certain conditions in response to a subpoena, discovery request or other lawful process.

For other required or permitted uses: We may use and disclose your protected health information as required by law and to comply with the requirements of workers' compensation, law enforcement, national security, military activities, organ donation, health

oversight agencies, coroners, funeral directors and public health authorities. We must provide, upon request, patients' protected health information to the Secretary of the Department of Health and Human Services. We may use and disclose your protected health information whenever necessary to respond to a serious threat to your health or safety or the health or safety of another person. For armed forces members and veterans, we may disclose your protected health information as required by military command authorities.

For inmates: We may use or disclose your protected health information whenever required.

For fundraising: We may use your information to contact you to raise funds for the benefit of the Medical Group by the Palmetto Health Foundation and USC Office of Development; however the patient has the right to opt-out of such communications.

For research: Under certain circumstances, we may use and disclose protected health information about you for research purposes. We may disclose your protected health information to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the protected health information does not leave the Medical Group. We may also disclose information to researchers when an Institutional Review Board has approved a research proposal and its protocols to ensure the privacy of your protected health information.

Uses and disclosures of your protected health information based on your written authorization

Some uses and disclosures of your protected health information may be made only with your prior written authorization. For example, disclosure for marketing purposes requires your authorization. You may revoke an authorization at any time, in writing, and we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We cannot take back disclosures that have been made before the authorization is revoked.

Your rights regarding your protected health information

Although your medical record is the physical property of the Medical Group, you have the right to look at and obtain a copy of your medical record, except for psychotherapy notes and in certain circumstances. To inspect and copy your medical record, you must submit your request in writing to our receptionist who will forward your request to our office administration. In very limited circumstances we may deny your request. If you are not allowed to look at your record or receive a copy, in most cases you have the right to submit a written request for this decision to be reviewed. When you receive a copy of your medical record, the Medical Group may charge a fee for the associated cost.

You have the right to request in writing a restriction on certain uses and disclosures of your protected health information. We may not agree to a requested restriction. You have the right to be able to request in writing that we communicate with you by alternative means or at alternative locations and we will try to accommodate your requests. You have a right to request in writing an accounting of certain disclosures of your protected health information. Disclosures for treatment, payment and health care operations, as well as those with your signed authorization, are not included in an accounting. You have the right to have us restrict certain protected health information from disclosure to health plans where you pay out of pocket, in full, for the care and request such a restriction. Most uses and disclosures of psychotherapy notes uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require authorization.

If you believe that the medical information we have about you is incorrect or incomplete, you have the right to request that your protected health information be amended. Your request must be in writing and must state the reason you are requesting the amendment. In certain cases, we may deny your request for the amendment. If we deny your request for the amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive notifications whenever a breach of your unsecured PHI occurs. Other uses and disclosures not described in the Notice will be made only with authorization from the individual.

Complaint process

If you believe that your privacy rights have been violated by us, you may complain in writing, or by phone to the Department's Administrative Director, phone number 803-545-5690; or to the Medical Group's Privacy Officer, phone number 803-545-5692 ; or to the Secretary of the Department of Health and Human Services in Washington, DC. You will not be penalized in any way for filing a complaint. The Medical Group considers the privacy of your protected health information an important part of your health care.