Turner County
School Based
Health Clinic

Welcome to the Turner County School Based Health Clinic Tele-Health. Family Connection of Turner County and the Turner County Board of Education continue moving forward with its goal of serving the children and families of Turner County. With The Turner County School Based Health Clinic, our desire is to be available for your health care needs.

In addition to completely filling out the health questionnaire intake form, please also make sure to sign and date each form where indicated. You may use this checklist as a reference to make sure you have completed and signed each item in this packet.

☐ Privacy Practice/Consent Form
☐ Authorization to bill insurance
☐ Lab permission form
☐Data Collection Authorization
☐ Completely fill out intake packet
☐Attach a copy of your insurance card (front and back)
☐ If you have Medicaid, PeachState, or WellCare, call GBHC at 1-800-246-2757 and ask them to assign you to Dr. Richard Wheeler of Nashville.

Please contact Ms. Gwen Mathis, Clinic Coordinator, to ask questions or to request assistance in completing these forms. Her office is at Turner County Elementary School; phone number: 229-567-3613;
email: gmathis@turner.k12.ga.us

Thanks,
The Turner County School Based Health Clinic Team

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Authorization to Bill Insurance

Patient's Name: _____

Patient's Birth Date: ___-___-_____ Patient's Social Security # _____-_____-_____

Primary Insurance Company: _____
Name of person insured if patient is a dependent: _____
Insured's birth date ___-___-_____ Insured's Social Security # _____-_____-_____
Group # _____
Policy or Member # _____

Secondary Insurance Company: _____
Group # _____
Policy or Member # _____

Responsible Party:
Name: _____ Date of Birth: _____
Social Security # : _____-_____-_____ Employer: _____

Authorization
The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

1. Grant permission to all physicians who may work with this patient, therapist, laboratories, and any other professionals to perform and administer care and treatment of the patient, or designated other qualified health care provider for such services.
2. Grant permission to release to the third party payor (or payers), Medicare, Medicaid, their representatives and/or other physician(s) involved in the patient's care, any information in connection with any care rendered to patient.
3. Grant permission to bill third party payor or (payers) with benefits paid directly to the appropriate provider when assignment is accepted.

Letter of Responsibility:
I understand that I am responsible for any unpaid bills not covered by Medicaid, Medicare, and any other private insurance companies. The physicians will not accept any retroactive Medicaid cards on paid accounts. Thus, I will not be entitled to any refunds of Medicaid payments.

_____ _____
(Signature of Parent, guardian, caretaker) **(Date)**

_____
(Print Parent's Name)

We appreciate you for placing your confidence in us by choosing our staff for your medical needs. Our physicians and staff are dedicated to serving you.

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Tift Regional Medical Center
Consent Form for Laboratory Testing

I give consent for the Turner County School Nurse to perform venipuncture (blood work) and lab tests on me as requested by a licensed physician.

I understand that my insurance carrier will be billed and any subsequent deductible/balances will be my responsibility.

I understand that the ordering physician will be the only physician to have access to these results unless requested otherwise.

_____ _____

(Signature of parent, guardian, caretaker) **(Date)**

_____

(Print Parent's Name)

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PRIVACY PRACTICE/CONSENT FORM

(Consent to treatment, transportation, and authorization to release information and assignment of benefits)

The Turner County Board of Education has joined in partnership with Tift Regional Medical Center and Behavioral Health Providers to develop this comprehensive school-based collaborative healthcare center. The staff is comprised of pediatricians, mid-level providers (nurse practitioner, physician assistant), nurses, social workers, and interns from the local colleges and universities. Our services include onsite and telemedicine diagnosis and treatment of acute illnesses and minor injuries, management of chronic illnesses, management/maintenance of monthly medications, routine health physicals, counseling, health education/promotion, lab testing (including drawing blood), and referrals to medical subspecialists and community agencies. The primary focus of the center is to provide quality, accessible health care to the children and staff of Turner County Elementary School, Turner County Middle/High School, Turner County Special Service School / Pre-K in order to have a positive impact on the children's health, school attendance, and academic performance.

In order for you to receive services at the health center, this consent form must be completed and proper documentation of insurance obtained.

I hereby voluntarily give my consent for _____ to receive health services at the Turner County School Based Health Clinic. I further authorize any physician or physician-designated health professional working for the clinic to provide such medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of my health care.

I authorize release of information from my medical record of the family doctor or primary care provider designated by me whenever necessary for my care including referrals and/or emergency services.

I authorize release of written and verbal information pertinent to my health care from the Turner County Elementary School, Turner County Middle/High School, Turner County Special Service School/ Pre-K staff to the Turner County School Based Health Clinic whenever necessary for my care.

I authorize Turner County Elementary School, Turner County Middle/High School, Turner County Special Service / Pre-K, to release information regarding treatment to third party payers such as Medicaid or other insurers for the purposes of billing or for any other reason in accordance with acceptable medical practice pursuant to the law. I further give consent for this information to be used in connection with the National Evaluation of the Healthy Schools, Healthy Communities initiative and other Turner County BOE partners. Medicaid and other insurers will be billed for services rendered.

Charges for services rendered to students not insured and as HMO insured patients choosing to use our services out of network will be based on a sliding fee scale. No students will be denied services because of inability to pay.

I understand the Turner County School Based Health Clinic is permitted to disclose protected health information about me for the purposes of payment, continued care or treatment, and healthcare operations.

If my protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS), drug or alcohol abuse and/or mental illness, I hereby give consent to the disclosure of this information by these clinics only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I also understand that I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

I understand that my signing this consent allows the physicians and professionals at Turner County School Based Health Clinic to provide comprehensive health services. I also understand that I have the right to withdraw this consent at any time upon written notice to the clinic director.

I have read and understand the above information and give permission for treatment at The Turner County School Based Health Clinic. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the clinic at (229) 567-3613

_____
Name of Parent

_____ _____
Signature of Parent Date

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DATA COLLECTION AUTHORIZATION

REASON FOR DATA COLLECTION: Evaluation and Research of impact of school based health clinics on student outcomes

The Turner County School Based Health Clinic is part of a research body who is attempting to determine the impact that school-based health clinics have on the success of students. The Turner County School Based Health Clinic is largely funded by grants. All grants require certain information to be shared so that the administrators of the grant can see a snapshot the population of people that are being served. Because The Turner County School Based Health Clinic is a health clinic, your health information may be used or disclosed as required by law, and it may be shared with a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability and/or conducting public health surveillance, investigations or interventions. The privacy of your medical record is important to us. We want to tell you about a law that protects your medical record. The law is called the Health Insurance Portability and Accountability Act or HIPAA for short. Under HIPAA, your personal health information that identifies you receives greater protection.

Those who are working on The Turner County School Based Health Clinic project and who will release information are: Director of Family Connection of Turner County; Director of Turner County School Based Health Clinic; Norris Consulting Group; and Turner County Board of Education.

The Researchers and Regulators may use or disclose the following health information about you: Health and school records;

Other Items You Should Know: Those listed above who are working on The Turner County School Based Health Clinic Project are required by HIPAA to protect your health information. However, some of the other Information Recipients who receive your health information do not work for Turner County School Based Health Clinic, and they may not be required by HIPAA to protect your health information. These Information Recipients may share your information with others without your permission if the law permits them to do so.

You do not have to sign this authorization form, but if you do not, you may not participate The Turner County School Based Health Clinic.

Revoking your Authorization: You do not have to sign this Authorization. In addition, if you sign this Authorization, later, you may change your mind at any time and revoke (take back) this Authorization. If you want to revoke this Authorization you must write to: Executive Director, Family Connection of Turner County, 330 Gilmore Street, Ashburn, Georgia 31714.

If you revoke your Authorization, the Researchers will not collect any more health information that identifies you, but they may use or disclose information that you already gave them in order to notify any of the other Researchers that you have revoked your authorization; to maintain the integrity or reliability of the Research Study; and to comply with any law that they are required to obey.

Expiration Date: There is no defined expiration date. This is an on-going evaluation of clinic outcomes.

As a study participant, if you have any questions regarding the study, or if you have questions, concerns or complaints about the research you may call the Executive Director, at 229-567-3413.

Your participation in this research study allows us to bring more funds into our school based health clinic to serve you and your children. Thank you for participating!

Parent's Name: _____ Date: _____

Parent's Signature _____

_____ Date: _____

Signature of Turner County School Based Health Clinic Clinic Staff

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INTAKE FORM

Please complete all information on this permission form. You must **COMPLETE USING INK** then sign and date it in order to receive services from the Turner County School Based Health Clinic. It is your responsibility to notify us immediately of any changes in address, phone numbers or insurance.

Today's Date____________ Patient's Name___________________________ ___________________________ ________________

Last First Middle

Birth Date: _____________ Age: _____ Primary Language (circle one): English Spanish Other

Social Security Number: _________________________ Birth Country (circle one): USA Other Sex (circle one): Male Female

Race (circle one): Black White Hispanic Asian Multiracial Other: ___________________________________

Address:____ City________________________ State_____ Zip______________

Home Phone: _______________________ Cell Phone: _____________________ Work Phone: ______________________

How long at present address? ____Years ____Months How long at previous address? ______Years ______Months

Is present housing (circle one): Permanent Temporary Shelter None Unstable Foster Care Other

Who lives at home? Please list everyone who lives in home.

NAME	**RELATIONSHIP**	**AGE**

Patient's Employer: ______________________________ Address: ____________________________________

Position: ____ How long in current position? _____________________________

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Please list the name and contact information of a person (or persons) we can contact in case of emergency.

Emergency Name & Number____ Relationship to Patient_______________________

____ _______________________

____ _______________________

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Physician Information

Who is your primary care physician (the person you would see for a sore throat or a minor injury)? _____

Date of last visit: _____ Address for your primary care physician: _____

_____

Phone number: _____

For emergency visits, which clinic or Emergency care facility do you use? _____

Date of last visit: _____ Address for your clinic/emergency facility _____

_____

Phone number: _____

If you see a specialist for any reason, list that doctor and reason for seeing him/her: _____

Date of last visit: _____

Address for the special care physician: _____

_____

Phone number: _____

If you see someone for mental health/behavioral problems, list that person and reason for seeing him/her: _____

Date of Last Visit _____

Address for mental health professional: _____

_____

Phone number: _____

If you see a dentist, list that dentist: _____

Date of Last Visit _____

Address for your dentist: _____

_____

Phone number: _____

Please write the name & **phone #** of a nearby pharmacy in case you need prescription medicines.

Pharmacy/Phone# _____

Have you seen a doctor in the last year? _____Yes ____No

If yes, how many times? Circle: 1 time 2 times 3 times 4 or more times

Where? _____

Why? _____

Have you used a Hospital Emergency Room in the last year? ____Yes ____No

If yes, how many times? Circle: 1 time 2 times 3 times 4 or more times

Where? _____

Why? _____

Have you been in the hospital over night in the last year? ____Yes ____No

Where? _____

Why? _____ How Long _____

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HEALTH QUESTIONAIRE

Does you have any known allergies (foods, medications, etc)? ___Yes ___No
List all known allergies: _____

_____

Does you have any Physical Disabilities? ___Yes ___No
If yes, please explain: _____

_____

Are you currently being treated for any health problems? ___Yes ___No Specify who is providing the treatment: _____
If yes, explain: _____

_____

Do you take daily medications? ___Yes ___No
Please list all medications, the dosage, and when given:

Name of Medication	Dosage	When Given	Name of Medication	Dosage	When Given
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

FAMILY HISTORY

(Mother-M, Father-F, Brother-B, Sister-S, Grandmother-GM, Grandfather-GF, Aunt-A, Uncle-U)
Please specify who has or had any disease listed below by using abbreviations above.

	WHO		WHO
Asthma	_____	Heart Trouble	_____
Allergies	_____	High Blood Pressure	_____
Birth Defects	_____	Kidney/Bladder Problems	_____
Blood Disorders/Anemia	_____	Lung Diseases	_____
Cancer	_____	Tuberculosis	_____
Tumors	_____	Seizures	_____
Cystic Fibrosis	_____	Mental Retardation/Illness	_____
Diabetes (before 40)	_____	Muscle Disease/Weakness	_____
Early Childhood Death	_____	Death Under Age 50	_____
Ear/Eye Disorders	_____		

There is no family history of the above diseases _____

Do you or anyone in the home:

	YES/NO	WHO? RELATIONSHIP TO PATIENT
SMOKE		
DRINK ALCOHOL		
USE DRUGS		
CHEW TOBACCO		

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PATIENT'S MEDICAL HISTORY

Please specify if you have or had any disease listed below.

Allergies	__Yes__No	Frequent Colds	__Yes__No
Allergic to drugs	__Yes__No	Lung Problems	__Yes__No
Anemia	__Yes__No	Meningitis	__Yes__No
Kidney/Urinary Tract Problems	__Yes__No	Menstruation Started Age____	__Yes__No
Problems Walking	__Yes__No	Menstrual Problems	__Yes__No
Other Respiratory Problems	__Yes__No	Premature Birth Weight_____	__Yes__No
Asthma	__Yes__No	Obese/Overweight	__Yes__No
Stomach Ulcers	__Yes__No	Underweight	__Yes__No
Skin Rashes	__Yes__No	Pregnant	__Yes__No
Abdominal Pain	__Yes__No	Serious Acne	__Yes__No
Constipation/Diarrhea	__Yes__No	Sickle Cell Disease	__Yes__No
Serious Digestive Problems	__Yes__No	Sickle Cell Trait	__Yes__No
Chicken Pox Age____	__Yes__No	Other Blood Disorders	__Yes__No
Ear Problem	__Yes__No	Seizures/Epilepsy	__Yes__No
Ear Infections	__Yes__No	Speech Problem	__Yes__No
Hearing Aid	__Yes__No	Tuberculosis	__Yes__No
Eye Problem	__Yes__No	Cancer	__Yes__No
Wears Glasses	__Yes__No	AIDS/HIV	__Yes__No
Musculo-Skeletal Problems	__Yes__No	Other_____	__Yes__No
Rheutmatic Fever	__Yes__No		
Physical/Sexual Abuse	__Yes__No		
Hemophilia	__Yes__No		
Fainting Spells/Knocked Out	__Yes__No		
Frequent Sore Throat	__Yes__No		
Headaches	__Yes__No		
Heart Murmur	__Yes__No		
Heart Problems	__Yes__No		
High Blood Pressure	__Yes__No		
Thyroid Problems	__Yes__No		
Diabetes	__Yes__No		
Hepatitis	__Yes__No		
Injuries (major)	__Yes__No		
Brokens Bones	__Yes__No		

***Explain any illnesses marked yes:

_____
_____
_____
_____
_____
_____
_____
_____
_____

BEHAVIOR HISTORY

Nightmares	__Yes__No
Bedwetting	__Yes__No
Eating Problems	__Yes__No
Thumb Sucking	__Yes__No
Discipline Problems	__Yes__No
Overactive/Hyperactive	__Yes__No
Shy	__Yes__No
Sleeping Problems	__Yes__No
Slow Development	__Yes__No
Learning Disability	__Yes__No
Smoker	__Yes__No
Alcohol	__Yes__No
Inhalants	__Yes__No
Other Drugs _____	__Yes__No
Depression	__Yes__No
Other Behavior Problems	__Yes__No
Other Mental Problems	__Yes__No

***Please explain any area marked "yes":

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list any present concerns you may have about your mental health:

_____
_____
_____
_____
_____

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Other_____ __Yes__No _____

DENTAL HISTORY

Do you have dental problems? __Yes __No
How often do you brush your teeth? __Occasionally __Once a Day __Twice Daily __Other
Have you had a toothache recently? _Yes _No
Have you had any injury to the teeth or jaws? __Yes __No
When was your last dental visit? _____

If you have any other medical concerns, please list and describe in the space available below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Demographic Information

Your responses to this demographic information will assist us in better serving you.

Family Income: (*Please check one*)
___under $5000 ___$5000-$9999 ___$10,000-$14,999 ___$15,000-$19,999
___$20,000-$24,999 ___$25,000-$29,999 ___$30,000-$39,999 ___$40,000-$49,999
___$50,000-$74,999 ___$75,000-$100,000 ___$100,000 and over ___Unknown

Source of Family's Income: (*Check all that apply*)
___Full-time Employment ___Part-time Employment ___TANF ___Child Support
___SSI (Social Security Income) ___SS (Social Security Benefits) ___Private Disability Income
___VA-Veteran's Administration ___Other ___Unemployed, no source of income

Highest Level of Education: (*Check highest level)*
___Less than 9th grade ___Some high school ___GED ___High School Diploma
___Some technical training/some college ___Associate's Degree ___Bachelor's Degree
___Some Graduate School ___Graduate Degree

DFCS Involvement: (*Check all that apply*)
___No DFCS involvement ___Open child protection case ___Child Protection Service Investigation
___Child Protection Services, Substantiated abuse/neglect ___Recent Foster Care Placement
___ Child Protection Services, Unsubstantiated abuse/neglect
___Leaving Foster Care/Recently Returned Home ___Unknown

Court Involvement: (*Check all that apply*)
___No Court Involvement ___Charges Pending ___Probation ___Unknown

Special Needs: (*Check all that apply*)
___No disability ___Child has a disability ___Patient has a disability

Marital Status:
____Single, Never Married ___Living Together, Not Married ___Married, first time ___Remarried
____Separated ___Divorced ___Widowed

Employment Status:
___Full Time ___Part Time ___Odd jobs/Irregular part-time

(Check all that apply) ___Employed Student

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Please remember to attach a copy of your insurance card.

Thanks!

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