RITCHIE REGIONAL HEALTH CENTER

RRHC Telehealth Kiosk Consent Forms

STUDENT'S INFORMATION

Student's Full Name: ______________________ Date of Birth: ____________ Sex: ______

Student's Preferred Name (if different than legal name): ______________ Social Security #: ____________

Mailing Address: ____

Preferred Phone #: ______________ School: ______________ Grade: ______

PARENTS/LEGAL GUARDIAN (Please list all working numbers)

Father's Name	Date of Birth	Home Phone	Cell Phone	Other Phone
Mother's Name	Date of Birth	Home Phone	Cell Phone	Other Phone
Guardian's Name	Date of Birth	Home Phone	Cell Phone	Other Phone

Student lives with: ☐ Father ☐ Mother ☐ Both ☐ Guardian ☐ Other: ______________

Parent/Guardian Email: ______________________ Communication Preference: ☐ Call ☐ Text ☐ Email

Would you like to enroll in RRHC's Patient Portal: ☐ Yes ☐ No ☐ I'm already enrolled but would add student to my account

EMERGENCY CONTACT(S) / SHARING OF PROTECTED INFORMATION (PHI)

Please list anyone other than yourself, that has permission to bring the student to be seen AND indicate if we have permission to share the student's medical results with (you do NOT need to list medical providers or other medical institutions).

Name	Relationship to Student	Home Phone	Cell Phone	Other Phone

Do we have permission to share student's medical results with this individual: ☐ Yes ☐ No

Name	Relationship to Student	Home Phone	Cell Phone	Other Phone

Do we have permission to share student's medical results with this individual: ☐ Yes ☐ No

HEALTH INSURANCE INFORMATION

☐ Primary Insurance: ____

Name of Insurance Company	Policy/ID Number	Insurance Company Zip Code
Insured's Name	Insured's DOB	Insured's SS#

☐ Secondary Insurance: ____

Name of Insurance Company	Policy/ID Number	Insurance Company Zip Code
Insured's Name	Insured's DOB	Insured's SS#

☐ **No Insurance:** RRHC is a nonprofit organization that receives federal funds, which enables us to offer the Sliding Fee Scale Program. The Program provides discounted rates for services based on family size and income level. If the student is uninsured or underinsured, please contact us to request a Sliding Fee Scale application.

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GUARANTOR INFORMATION (who is responsible for the bill e.g., copay)

*Please fill out regardless of insurance status. Do NOT list insurance company's information here.

Guarantor's Name	Date of Birth	Primary Phone	Alternative Phone

Mailing Address

Relationship to Student

STUDENT'S HEALTH INFORMATION

Primary Care Provider: ______________________ Dentist: ______________________

Pharmacy: ______________________ Pharmacy Address: ______________________

Has your child ever had allergic reactions to any of the following:

Bee Sting - Yes / No If yes, does your child have a prescription for an EpiPen - Yes / No

Food Allergies - Yes / No If yes, please list: ______________________

Medication - Yes / No If yes, please list AND describe the reaction: ______________________

Please list any current medications, the dosage (mg), and instructions. Be sure to include vitamins or supplements:

CURRENT/PAST MEDICAL HISTORY (Please check all that apply, indicating if they are current or past)

	Current	Past
ADD/ADHD		
Asthma		
Birth Defects		
Bladder Problems		
Constipation		
Diabetes		
Diarrhea		
Drug/Alcohol		
Ear Infections		
Epilepsy/Seizures		
Hearing Problems		
Heart Problems		
Kidney Disease		

	Current	Past
Mental Illness/Depression		
Mononucleosis		
Pneumonia		
Rheumatic Fever		
Scoliosis		
Sinus Problems		
Speech Problems		
Stomach Problems		
Thyroid Disease		
Urinary Disease		
Other:		

Does the student have a disability - Yes / No

If yes, please describe the disability: ______________________

RACE, ETHNICITY, HOUSING STATUS, AND LANGUAGE

Race

- [ ] White/Caucasian
- [ ] American Indian/Alaska Native
- [ ] Hispanic/Latino
- [ ] Black or African American
- [ ] Native Hawaiian/Other Pacific Islander
- [ ] Asian
- [ ] Multiracial: ____________________
- [ ] Do not wish to answer

Ethnicity

- [ ] Not Hispanic or Latino
- [ ] Hispanic or Latino

Housing Status

- [ ] Not Homeless
- [ ] Homeless Shelter
- [ ] Public Housing

Language

- [ ] English
- [ ] Spanish
- [ ] Other: __________

ANNUAL INCOME AND NUMBER OF HOUSEHOLD MEMBERS

Ritchie Regional Health Center is a nonprofit organization that receives federal funds, which enables the health centers to provide services to our patients at discounted rates based on family size and income level through the Sliding Fee Program. Please help us ensure that funding is continued by completing the information below. We appreciate your cooperation.

Annual Income:

- [ ] $0 - $15,000
- [ ] $15,001 - $25,000
- [ ] $25,001 - $35,000
- [ ] $35,001 - $45,000
- [ ] $45,001 - $55,000
- [ ] $55,001 - $65,000
- [ ] $65,001 - $75,000
- [ ] $75,001 - $85,000
- [ ] $85,001 - $95,000
- [ ] $95,001 - $100,000
- [ ] $100,001+

Number of Household Members: __________

TELEHEALTH INFORMED CONSENT

Telehealth services involve the use of secure interactive videoconferencing equipment (Let's Talk Interactive) that enable health care providers to deliver health care services to patients when located at different sites.

1.) I understand that the same standard of care applies to a telehealth visit as applies to an in-person visit.

2.) I understand that my child will not be physically in the same room as my provider. I will be notified of and my consent obtained for anyone other than the provider present in the room.

3.) I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.

- If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that the provider may discontinue the visit and make other arrangements to complete the visit.

4.) I understand that I have the right to refuse to my child's participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my child's medical record. I also understand that my refusal will not affect my child's right to future care or treatment.

5.) I understand that the laws that protect privacy and the confidentiality of health care information apply to telehealth services.

6.) I understand that my child's health care information may be shared with other individuals for scheduling and billing purposes.

- I understand that my insurance carrier will have access to my child's medical records for quality review/audit.

- I understand that the guarantor will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my child's telehealth visit.

- I understand that health plan payment policies for telehealth visits may be different from policies for in-person visits.

7.) I understand that this document will become part of my child's medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternative to telehealth visits shared with me in a language I understand; and (3) am located in the state of West Virginia and will be in West Virginia during my telehealth visit(s)

Parent/Guardian Initials: ____________ **Date:** ____________

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TEXTING CONSENT

1.) RRHC offers patients, parents or guardians the opportunity to communicate by text messaging. Text messaging is not to be used to convey medical information or to discuss medical conditions. Text message communication has a number of possible risks that patients, parents or guardians should consider before using text messaging. If the patient, parent or guardian is worried about any information being seen by other people, or if the question or problem is urgent, other form(s) of communication such as telephone or portal communication should be used. Some of the possible risks of using text messaging include, but are not limited to, the following:

> *- Text messages can be sent on to other people, stored on a computer, or printed out on paper for storage. b. Text message senders can easily misaddress their message. c. Text message information is easier to change than handwritten or signed documents. d. Text message information may be kept on computers/electronic devices even after the sender or the recipient believes they deleted his or her copy. e. Employers and on-line services have a right to archive (store) and look at text messages transmitted through their systems. Some, but not all, employers store text messages indefinitely. f. Text messages can occasionally be intercepted, changed, forwarded, or used without authorization or detection. g. Text messages can be used as evidence in court.*

2.) The health care providers will use reasonable means to protect the security and confidentiality of text message information sent and received. However, because of the risks outlined above, the health care providers cannot guarantee the security and confidentiality (privacy) of text messaging communication, and will not be liable for improper use and/or disclosure of confidential information (including Protected Health Information that is the subject of the federal Health Insurance Portability and Accountability Act of 1996). Thus, the patient, parent or guardian must consent to the use of text for patient information.

I acknowledge that I have read and fully understand the information the health care provider/Practice has provided me regarding the Risks of using text messaging. I understand the Risks associated with the communication of text messages between the health care provider/Practice and me, and consent to the Conditions outlined. In addition, I agree to the above instructions, as well as any other instructions that the health care provider/Practice may impose regarding text message communications.

Parent/Guardian Initials:________________ **Date:** ________________

PARENT/LEGAL GUARDIAN CONSENT

In case of an emergency, every effort will be made by the health center staff to notify the parent/guardian. The health center will attempt to call parents/guardians when a child presents themselves to the health center. If we are unable to contact anyone, a note will be sent home with your child. I authorize that my child's photo can be taken for identity/security purposes for their electronic medical records. I authorize release of written and verbal information pertinent to my child's health care between the school nurse and the health center staff only when necessary for his/her care. I authorize a physician, physician's assistant, family nurse practitioner, behavioral health professional, or other health professional to provide necessary and/or advisable treatment for my child. Notice of Privacy Practice is posted at the health center. I authorize the health center to release information regarding treatment to third party payer such as Medicaid or insurance for the purposes of billing and for any reason in accordance with acceptable medical practice pursuant to the law. I assign my insurance benefits to be paid directly to the health center. I am financially responsible for non-covered services but understand that services will not be denied due to inability to pay.

Parent/Guardian Signature:____________________________ **Date:** ________________