August 26, 2020

Dear Parent or Guardian:

The Roane General Hospital Rural Health Clinic is pleased to offer services for your child for the 2019-2020 school year at the following locations: Walton Elementary and Middle School, Geary Elementary and Middle School, Spencer Elementary School, Spencer Middle School, and Roane County High School. If you would like for your child to receive services at the center please fill out the attached forms.

Given the precarious times we are facing related to the COVID-19 pandemic and the re-entry of students and faculty to our schools, Roane General Hospital (RGH) has partnered with the Roane County Board of Education (RCBOE) to assist with on-site COVID related services. The safety of students and faculty as well as the community are of utmost importance during this time. The focus of the clinics relates to infection control, screening, isolation, testing, treatment, and quarantine as well as return to school services for children and faculty having COVID related symptoms. Please note that testing is not mandatory as part of the evaluation of students and faculty and is based upon consent. The following symptom screening will occur for students and faculty at all school entry points: temperature equal to or above 100.0F, shortness of breath, chills, muscle pain, sore throat, fatigue, congestion, loss of taste or smell, diarrhea, vomiting, nausea, and rash. If the symptoms are present, the student or faculty member will be asked to isolate and await evaluation by RGH clinic staff if desired. Assessment and treatment are not required for students and faculty placed in isolation based upon symptom screening if alternate medical care or release to home is desired. Traditional walk-in services received from our school-based health centers will be suspended to support the school re-entry plan. The clinics are open to all students enrolled in Roane County schools and all school board employees.

Roane General Hospital will bill private insurance, Medicaid and the Children's Health Insurance Program (CHIP) for eligible students. Students without insurance will be billed as self-pay or may apply for financial assistance through RGH. Please provide us with the needed insurance information (see enclosed form). No student will be denied care due to inability to pay.

We would like to hear from you directly if you have any further questions. After evaluating your child, we will call about their visit. We plan to help your child have a healthy, safe, and successful school year!

Roane General School Based Health Center Staff

Leann Thomas APRN-FNP-BC Medical Provider

Kelley Smith APRN-FNP-BC Medical Provider

The Roane General School Based Health Centers are a project of Roane General Hospital.

HEALTH HISTORY FORM

If you want to receive health services at the Medical Clinic, please read carefully, complete the questions and sign. **Please fill out front and back of form**

Name of Child__________________________________ (name that appears on birth certificate

Student's Birth Date: ____/___/___ Grade: __________

The following information will help the Clinic staff evaluate your child's health. Please answer to the best of your knowledge. Please fill out front and back of form.

Is your child allergic to any medications? Yes ___ No ___ If yes please list medication name and reaction.

Medication	Reaction
_____________________	_____________________________
_____________________	_____________________________
_____________________	_____________________________
_____________________	_____________________________

1. List any medications your child is taking now

Medication	Dosage and how often taken	Reason for taking
___________________	_________________________	________________
___________________	_________________________	________________
___________________	_________________________	________________
___________________	_________________________	________________

2. Name of Preferred Pharmacy __________________________
3. Has your child ever had any serious sports related injuries or been hospitalized overnight
   Yes ___ No ___ if yes explain. Please list date or age
   ____
4. Has there been any change in your child's health during the past year? Yes ___ No ___ If yes describe illness or injury____

Please check if your child currently has any of the following health problems:

___ADHD	___High Blood Pressure	___Other _________________
___Anemia or blood disorders	___Mental illness or depression	__________________________
___Asthma	___Mononucleosis	__________________________
___Bladder or kidney disease	___Pneumonia	__________________________
___Bronchitis	___Obesity	Surgeries: Please list with dates
___Cancer	___Rheumatic fever	__________________________
___Chicken Pox	___Scoliosis	__________________________
___Diabetes	___Seizures	__________________________
___Ear Problems	___Severe Acne	__________________________
___Hepatitis	___Sports Injuries or Fractures	__________________________
___Headaches/Migraines	___Thyroid Disease	
___Heart Murmur	___Tuberculosis	
___High Cholesterol	___Ulcer or digestive problems	

5. Please check if your child's blood relatives (Parents, grandparents, aunts, uncles, brothers or sister), living or deceased, had any of the following problems. Please state the relative's relationship to your child.

Condition	Yes	Relationship	Condition	Yes	Relationship
Alcoholism/Drug use	___	___________	High Cholesterol	___	___________
Allergies/Asthma	___	___________	High Blood Pressure	___	___________
Arthritis	___	___________	Kidney Disease	___	___________
Birth Defects	___	___________	Lung Disease	___	___________
Blood Disorders	___	___________	Tuberculosis	___	___________
Sickle Cell Anemia	___	___________	Mental Health/Depression	___	___________
Cancer (Type) ________	___	___________	Mental Retardation	___	___________
Diabetes	___	___________	Obesity	___	___________
Endocrine/gland disease	___	___________	Seizures/Epilepsy	___	___________
Heart Attack	___	___________	Stroke before age 55	___	___________
Thyroid Disease	___	___________	Other: ___________________________		

6. Does your child have a family doctor or pediatrician? Yes ___ No___ if yes please list the name ______________________.When did your child have his or her last complete physical exam? _____________

7. Does your child have any special needs (Physical handicap, learning disabilities, special dietary needs, etc.)? ___Yes ___No

The above information is accurate and complete to the best of my knowledge. I have disclosed all known allergies chronic illnesses prior medications or drugs that have resulted in adverse reactions, and current medications with respect to my child.

___________________________________ ________________

Parent/Guardian Signature Date

____

Relationship to Child

Health Center Parent Consent Form

Informed Consent for Health Services at Roane General School Based Health Center

(Please Complete front and back page)

Because young children and adolescents go through rapid physical and emotional changes, have significant risk to their health and have problems getting to health services, we provide the following services.

A) Well child exams and sports physicals
B) Health care for illness/Injury
C) Screening for vision, weight and blood pressure
D) Medically necessary laboratory tests
E) Immunizations (only given with special consent from parent)
F) Health Education
G) Prescriptions when necessary
H) Over the counter medications when necessary
I) Insurance Billing

If you want your child to receive health services at the Health Center, please read this form carefully, complete the questions and sign.

Name of Child:______________________________ ____________ __________

Please list name as it appears on birth certificate | Date of Birth | Grade

______________________________ ______________________________

Parent/guardian name (please print) | Relationship to child

____

Mailing Address | City | State | Zip Code

________________ ________________ ________________

Home Phone Number | Cell Phone Number | Work Phone Number

May we call you at work? Yes No

Childs Social Security Number ___ ___ ___/___ ___/___ ___ ___ ___
(needed to create account for children)

Sex (circle): Male Female

Birth mothers maiden name:______________

Race (circle): White Black Other:________

Preferred Pharmacy:__________________________

If we are unable to reach you who should we call? ______________________________

Name of Alternate Contact

______________________________ ______________________________

Relationship to child | Phone Number

By signing below I authorize my child to be seen at the Health Center. I agree to all services listed at top of page except what I have listed below: (no immunizations, shots or any type of blood work will be done without receiving parent/guardian special consent.) ______________________________

____

I authorize a nurse practitioner or designated health professional to provide necessary and /or advisable treatment for my child. I authorize release of information pertinent to my son/daughters health between the school nurse and health center staff when necessary for his/her care. I authorize the Health Center to release information regarding treatment to third party payers, such as Medicaid, CHIP and private insurance as necessary. 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. I understand that this consent form will be good for the current school year or until I provide the Health Center staff with written directions otherwise. I am the legal guardian of the above named child.

______________________________ ______________________________ __________

Parent/Guardian Signature | Relationship to child | Date

Go to back page

Insurance Information

We are a health care facility and we depend on our ability to collect payment from your insurance carrier in order to maintain the Health Center's current hours. **Please complete only the section that applies to your child.** If your child does not have insurance, please check the NO box below.

Child's Information

Grade___________

Child's Legal Name:_____________________________ Phone Number:___________________

Birth Date:_________________ SSN:__________________________

Address:____

Parent's Information

Mother: ____________________ Date of Birth: _____________ Social Security # ___________
Father: ____________________ Date of Birth: _____________ Social Security # ___________
Guardian: ___________________ Date of Birth: _____________ Social Security # ___________

If child is covered by an insurance plan? Yes ___ No___ If yes please fill in the appropriate section below

Medicaid Information

Medicaid ID # __ __ __ __ __ __ __ __ __ __ __ (11 digit number listed before child's name on card)

Doctor or office listed on card if any:________________________ Phone #_________________

Is Medical Card through: UNICARE Yes__ No__, UNISYS Yes__ No__, CARELINK Yes__ No__

Children's Health Insurance Program (CHIP)

Name Listed on Card:__________________________________

ID # on Card: __ __ __ __ __ __ __ __ __ Group #: 7771

From (month/year):_________________ To (month/year):___________________

Private Insurance Information

Insured parent/legal guardian: _____________________________________

Birth date of insured person___________________ SSN (We cannot bill without SSN):__________________

Address (if different from child)____

Employer Name: ______________ Address of Employer: ____________________ Phone#:_________

Insurance Company Name and Phone Number: ____

Group Number:______________________ ID Number:______________________________

From (month/year):________________________ to (month/year): _______________________

NOTICE OF PRIVACY PRACTICES

ROANE GENERAL HOSPITAL
200 HOSPITAL DRIVE
SPENCER, WV 25276
Privacy Officer: 304-927-6352

EFFECTIVE: April14, 2003
REVISED: January 15, 2014

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, or another healthcare provider, a record of your visit is made. Typically, this record contains symptoms, examination and test results, diagnoses, treatment, and the plan for future care or treatment. This has the following functions:

- It serves as the basis for planning your care and treatment.
- It serves as the means of communication among the various health professionals who contribute to your care.
- It describes the care you received.
- It serves as the means by which you or a third-party payer representing you can verify that billed services were actually provided.
- It is used as a tool in the education of healthcare professionals.
- It is a source of data for medical research.
- It is a source of information for the public health officials charged with improving the health of the nation.
- It is a source of data for facility planning and marketing.
- It serves as a tool for assessing and continually improving the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; better understand who, what, when, where and why others may access your health information; and make more informed decisions about authorizing the disclosure of your healthcare information to other parties.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the property of the healthcare practitioner or facility that compiled it, the information in the record relates to you. You have certain rights in connection with your health information. You have the right to:

- Request a restriction on certain uses and disclosures of your information. You may do so by putting your request in writing and sending it to the privacy officer (address is at the end of this notice). You may request to restrict certain disclosures of information to an insurance company if you agree to pay for services in full and out of pocket.
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and copy your health record as provided for in 45 CFR 164.524, by calling the Medical Record Department at 304-927-6352 to set up an appointment. A minimal fee may be charged for costs of copies.
- Amend your health record as provided in 45 CFR 164.528. You may put your request for amendment in writing. We will consider your requested amendment, but are not required to agree to the amendment.
- Obtain an accounting of disclosures for your health information as provided in 45 CFR 164.528. Call the Medical Records Department at 304-927-6227 for information on obtaining a copy of your accounting of disclosures.
- Request communications of your health information by alternative means or at alternate locations.
- Opt out of receiving fundraising communications.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken, (For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, see the "For More Information or to Report a Problem" section.) You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance

We will be releasing Back to School excuses to the child's school.

on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other law may allow the insurer to continue to use your information to contest the claim or your coverage, even after you have revoked the authorization.

OUR RESPONSIBILITIES

This organization has certain responsibilities in connection with your health record. We are required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction on uses and disclosures of health information.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Notify you of a breach of unsecured patient health information in the event that you are affected. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. Should our information practices change, we will provide you with a new Notice of Privacy Practices on your next visit to Roane General Hospital or upon your request. We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact the privacy officer at Roane General Hospital, Medical Records Department, 200 Hospital Drive, Spencer, WV 25276, 304-927-6352. If you believe your right to privacy has been violated, you can file a complaint with the privacy officer or with the Secretary of Health and Human Services, Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independent Avenue, S.W. Room 509F, HHH Bldg., Washington, DC 20201. We will not retaliate against you for filing a complaint.

EXAMPLES OF DISCLOSURE FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

1. We will use information about you for the purpose of diagnosis and treatment.
   For example, a hospital nurse may read your medical chart to care for you properly. We will also disclose your information to others who need it in order to provide you with medical treatment or services. For example, we may send your doctor the results of laboratory tests we perform.
   We will also provide your physician or other hospitals and healthcare providers with copies of various reports to assist him or her in treating you once you have been discharged from this hospital.
2. We will use your health information to request payment for the services you receive.
   For example, a bill may be sent to your insurance company or others responsible for payment for your care. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures performed and services provided at the hospital and supplies used in providing your care.
3. We will use your health information for regular healthcare operations in our facility.
   For example, members of the medical staff, nurses, therapists and other staff and employees of the hospital may use information from your health record to assess the care and clinical outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare services we provide.
4. We will share your health information with our business associates only when necessary to conduct operations or provide services.
   For example, outside business associates sometimes provide physician services in the emergency department and for radiology and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to perform and then bill you or your insurance company or other person responsible to pay for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

5. We will share limited information about you in our directory of patients unless you notify us that you object.
   For example your name, location and religion in the facility may be used for directory purposes. This information may be provided to the clergy or other people who ask for you by name.
6. We will share limited information about you (your location and general condition) for the purpose of notifying your family members, personal representatives, or other people involved in your care.
7. We will share limited information about you for the purpose of communication with your family or close personalfriends.
   For example, using their best judgment, healthcare professionals may disclose to a family member, relative, close personal friend, or any other person you designate for your care, health information relevant to that person's involvement in your care or payment.
8. We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
9. Consistent with applicable law, we may disclose health information to coroners, medical examiners or funeral directors so that they can carry out their duties.
10. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplantation.
11. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
12. We may share demographic information and dates of service to our foundation for fund-raising.
13. We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
14. We may disclose health information to the extent authorized by, and to the extent necessary to comply with, laws relating to Workers' Compensation or other similar programs established by law. [We may also make disclosures to employers- see section164.512 (b)(1)(v)].
15. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
16. If you are an inmate of a correctional institution, we may disclose to the institution or its agents thereof health information necessary for your health and the health and safety of other individuals.
17. We may disclose health information for; (a) law enforcement purposes by court order, (b) to avert a serious threat to a person or the public, (c) in response to a valid subpoena, (d) as required by law, (e) for specialized government functions related to military or veterans affairs or in connection with national security or intelligence activities.
18. We may disclose information about you to government authorities or social service organizations if we reasonably believe you are a victim of abuse, neglect or domestic violence [section 164.512 cc].
19. We may disclose information about you for health oversight activities authorized by law, including audits, investigations, and inspections involving the hospital or a government benefit program [section 164.512 (d)].
20. All other uses and disclosures not described in this Notice of Privacy Practices will be made only with your authorization.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.