# Heywood Healthcare

ATHOL HOSPITAL | HEYWOOD HOSPITAL | HEYWOOD MEDICAL GROUP | QUABBIN RETREAT
SCHOOL BASED SERVICES

# SCHOOL BASED SERVICES

**Kids shouldn't have to miss school**

**You shouldn't have to miss work**

Heywood Healthcare is pleased to partner with local school districts to offer school based services. Services our team provides include behavioral health, medical, and assistance with community resources. We work alongside your child's school to provide a wrap-around care team (*services may differ depending on what school your child goes to*).

To register your child, please complete the attached form in advance or forms may be completed at the time of service. A referral can be placed at any time through your child's school care team.

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| Form Name | Purpose |
|---|---|
| Registration Form & Consents | Signing this form allows your child to receive services from the Heywood School Based Services Team. |
| Release of Information (ROI) | Signing this form allows for care coordination between the Heywood School Based Services, your child's school care team and primary care provider. |
| Family Educational Rights and Privacy Act (FERPA) Consent Form | Signing this form allows the school to share medical, psychological, and other personal information about your child with the Heywood School Based Services team. |
| TeleMed OTC Medication Consent Form | Signing this form gives consent for the type of medical services and medications you want your child to receive. |

**For more information or any questions, please contact us:**

sbtelehealth@heywood.org

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**Privacy Notice of Disclosure of Protected Health Information**

Effective Date: January 2, 2018

The Heywood Medical Group, and all of its providers, staff and agents, is obligated to protect the health information of its patients. The Heywood Medical Group takes its' obligation to protect patient privacy very seriously and will only share your health information when necessary. This disclosure identifies the most common situations and circumstances in which the Heywood Medical Group may provide to others health information about you. This is an important document so please keep this for your future reference.

Your health information may be shared with health care facilities and other providers who are involved in the care you receive by providers in the Heywood Medical Group, or who are providers to whom your physician is referring you for continued care or services. This is necessary in order to assure we are providing appropriate care and services to meet your medical and health care needs, The Heywood Medical Group is a multispecialty medical practice and therefore the health information system is shared among all of its offices. Strict confidentiality practices are in place for each specialty office that assures protected health information is only accessed when it is appropriate to do so and in accordance with the uses described in this notice.

Your health information may be shared with your insurance company in order for the Heywood Medical Group to be paid for services it provides to you. Only minimally necessary information is shared to allow the Heywood Medical Group to receive payment for those services.

Your health information may be shared with selected health care and medical professionals who are involved in the operations of the Heywood Medical Group. These individuals are required to maintain strict patient confidentiality and the Heywood Medical Group has in place special policies and procedures to monitor compliance with confidentiality. These individuals include those who:

- Review the quality of care or services provided to our patients.
- Evaluate how we deliver care and services to see if there are ways to improve what we do.
- Evaluate the medical and health care needs of people in our community to make sure we are meeting their needs as much as possible.
- Help to teach and train nursing students, medical students, and other students who come to the Heywood Medical Group as part of their education and training to become health care or medical professionals.
- Evaluate the cost of providing health care or medical services to assure the Heywood Medical Group is using its financial funds wisely while still meeting the needs of our patients.
- Coordinate care provided to our patients in any setting and by different health care or medical professionals so that patients get what they need when they need it.

- Review the care and services we provide in order to credential or accredit different types of health care or medical programs.
- Are part of official government reviews to determine the Heywood Medical Group's compliance with rules, regulations, and laws.
- Are official agents of public health authorities involved in the study and evaluation of diseases or illnesses that pose a possible safety threat.

Sometimes specific authorizations are required from our patients to allow us to release a patient's health information to others. Specific authorization would be required any time any individual, agency, or organization NOT involved in your care or treatment, payment for treatment, or in health care operations (as defined above) requests your health information, AND they are NOT authorized by law or regulations to see your health information, your health information will not be released without your specific authorization to release that information.

You have the right to view your own medical record and add an amendment if you believe the information recorded is not correct. You have the right to request in writing that the Heywood Medical Group modify its Privacy Practice in relation to your health information. The Heywood Medical Group is not obligated to comply with your request. However, if we do agree to your request, we are obligated to comply with it. Any agreement that the Heywood Medical Group makes to modify its Privacy Practice will be provided only in writing.

The Heywood Medical Group may also share general information with patients who have received services from providers in the Heywood Medical Group. This information may be health education information, information about health services available to the community, information about opportunities for individuals to participate in fundraising efforts, and other general information. If you do not wish to receive this type of information, please let the medical receptionist know that you wish to opt out of receiving such communications as described in this paragraph.

If you have any questions about the Heywood Medical Group Privacy Practices, please feel free to contact our Privacy Officer at 978-630-6268 or Corporate Compliance Officer at 978-630-6538.

If you wish to receive a paper copy of this notice, please ask the medical receptionist.

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# School Based Services Patient Demographic Form

## Student Information

**Student's School District:**
- ❑ Athol-Royalston
- ❑ Gardner
- ❑ Narragansett Regional
- ❑ RC Mahar Regional
- ❑ Winchendon

**Student Name:** ______________________________ **Date of Birth:** ___________ **Grade:** _____

**Street Address:** ____________________________________________________________________

**City:** ________________________ **State:** ______________ **Zip Code:** _______________

**Sex:** ❑ Male ❑ Female ❑ Transgender ❑ Non-Binary ❑ Other

**Pronouns:** ________________________

**Race**: ❑ Black or African American ❑ White ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander

**Ethnicity:** ❑ Hispanic ❑ Non-Hispanic

**Primary Language:** _____________________________

**Interpreter Services Needed?** ❑ Language ❑ Hearing ❑ None

**Primary Care Provider:** _______________________________________________

***Please list an emergency contact name and contact information for in the event the parents/guardians cannot be reached.***

**Emergency Contact Name:** __________________________________________________

**Phone Number:** __________________________________________________________

**Relationship to Student:** ___________________________________________________

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## Parent/Guardian Information

**1. Parent/Guardian Name:** ______________________________

**Relationship to Patient:** ______________________________

❑ Joint Custody ❑ Legal Custody ❑ Sole Custody

**Address:** ______________________________

**City**: ______________ **State:** ________ **Zip:** ________

**Phone:** ______________ **Email:** ______________

**2. Parent/Guardian Name:** ______________________________

**Relationship to Patient:** ______________________________

❑ Joint Custody ❑ Legal Custody ❑ Sole Custody

**Address:** ______________________________

**City**: ______________ **State:** ________ **Zip:** ________

**Phone:** ______________ **Email:** ______________

## Insurance Information

**Insurance status:** ❑ Active Insurance ❑ No Insurance ❑ In Process ❑ Needs assistance

| Primary Insurance: | |
|---|---|
| Member ID / Policy Number: | |
| Group Number: | |
| Name of Primary Insured: | |
| Primary Insured's DOB: | |
| Relationship to child: | |

| Secondary Insurance *(if applicable):* | |
|---|---|
| Member ID/ Policy Number: | |

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## Consent for Treatment

I give my consent for my child, named above, to receive care from Heywood's School Based Services Program. Care will be provided in a private manner and information will not be released without my consent. I allow physicians or designated health professionals to provide necessary and/or advisable treatment for my child and to bill for this service. I understand that my child may receive medical care from providers who are authorized by my child's school district. I authorize the holder of medical or other information about me to release to any other third party responsible for payment such as information needed for decisions of Medicare, Medicaid, or third party claims.

***No Show Policy:*** As a courtesy, we ask if your student's schedule changes or he/she cannot keep their appointment, to please contact us at least 24 hours in advance. Your advanced notice will allow another student access to that appointment time. After three consecutive "no shows", our program reserves the right to discharge the student from treatment.

Initial: ______________ ❑ SELF ❑ OTHER______________________ (relationship)

## Insurance Consent

I authorize HEYWOOD HEALTHCARE to directly bill my insurance company and I further authorize any third-party payer through which I have benefits to make payment directly to HEYWOOD HEALTHCARE. I also authorize HEYWOOD HEALTHCARE or insurance companies to use and disclose any healthcare information for the purpose of obtaining payment for services and determining insurance benefits.

*Copay/deductible balance may be due for outpatient behavioral health services depending on the patient's insurance plan.*

Initial: ______________ ❑ SELF ❑ OTHER______________________ (relationship)

## Acknowledgment of Receipt of Privacy Notice - HIPAA

I have been presented a copy of the Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Initial: ______________ ❑ SELF ❑ OTHER______________________ (relationship)

## Consent to Text or Email Usage For Appointment Reminders and Other Healthcare Reminders

I consent to receive text messages from the practice at my phone number or email to receive appointment reminders, and/or general health reminders of information. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I also acknowledge this means of communication is not considered secure for the transmission of private information.

Initial: ______________ ❑ SELF ❑ OTHER______________________ (relationship)

________________________________________ ________________________________________

Parent/Guardian Signature Date Parent/Guardian Signature Date

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## Release of Information (ROI)

**Student Name:**__________________________________ **DOB:**________________

All healthcare information is private. By signing this form, you are giving your child's school care team, primary care physician, and the Heywood School Based Services team to provide care in the school-based health program as needed. This information will be treated in a confidential way. By completing the below information, you are authorizing information to be shared to and from:

**Student's School District:**

- ❑ Athol-Royalston
- ❑ Narragansett Regional
- ❑ Winchendon
- ❑ Gardner
- ❑ RC Mahar Regional

**Primary Care Physician:** ____________________________________ **Phone:** ____________________

**Office Address:** _______________________________________________________

**You must initial next to each category of information below in order to authorize Heywood to disclose that type of information:**

_____ Treatment summary/history
_____ Diagnosis
_____ Psychological test results
_____ Psychiatric evaluation/medication history
_____ Substance use disorder
_____ HIV/AIDS testing
_____ Other (specify)____________________________________________________

**The purpose of the disclosure is:** *Evaluation/assessment and/or coordinating treatment efforts*

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. Information that you authorize to be disclosed may be subject to re-disclosure and no longer protected by law to the extent applicable. I understand that my record may contain information that is considered sensitive under the law. PHI cannot be used or disclosed unless you specifically authorize such use or disclosure under 42-CFR Part 2 of the federal confidentiality regulations. This information shall not be transmitted without specific authorization as provided in these regulations. I understand that this information may be exchanged by mail, fax, email, phone, or a 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 Services Department. 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. I understand this consent form is valid until I revoke it.
*I understand that permitting the release of protected health information is voluntary. I can refuse to sign this form. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information. Upon request, I understand I will be given a copy of this authorization. Parental consent for release of health information is not required for students who are 18 years or older.*

____________________________________ ____________________________________
Parent/Guardian Signature Date Parent/Guardian Signature Date

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# Family Educational Rights and Privacy Act (FERPA) Release Form

**Student's Name:** ______________________________________________

**Student's School District:**

- ❑ Athol-Royalston
- ❑ Narragansett Regional
- ❑ Winchendon
- ❑ Gardner
- ❑ RC Mahar Regional

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. 1232g; 34 CFR Part 99) is a federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

In accordance with FERPA, your child's school district must withhold certain educational records unless the student and/or the parent/guardian (in the event the student is under the age of 18) provides consent to disclose the information. The purpose of this form is to provide consent for your child's school district and <u>Heywood Healthcare's School Based Services Program</u> required by FERPA.

I, undersigned, hereby authorize the release/discuss the specified educational records and information:

**Educational Records and Information (please check all that apply):**

- ❑ Review of all Educational Records
- ❑ Grades of the academic year
- ❑ Progress Reports
- ❑ Other: ______________________________________________________________

This release does not permit the disclosure of these records to any other persons or entities without my written consent or as permitted by law.

________________________________ ________________________________

Parent/Guardian Signature Date Parent/Guardian Signature Date

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## Parent Authorization for Telemedicine Over-the-Counter Medication Administration

Student Name: ______________________________ Date of Birth: __________ Grade: _____

Medical Conditions: ____________________________________________________

Allergies: ____________________________________________________

Medications currently being taken (both prescription and over the counter): ____________________

____________________________________________________________________________

Patients seen for a telemedicine appointment by the School Based Health Center require a signed consent form by a parent/guardian for any medications that will be administered by the school nurse. A signed medication order by the ordering provider through the School Based Health Center will be sent to the school nurse to have on file.

*Medication will only be administered after assessment by the School Nurse and with written parental permission and medication order, as is required under Massachusetts General Law; Chapter 112, Section 80B and the Medication Protocol accepted by your child's school district.*

**Please check the appropriate medication(s) listed below if you wish to have your child receive them during school hours or check to decline any medications to be administered. I hereby authorize the school nurse to administer:**

_____ Acetaminophen/Tylenol: per weight/age directions on bottle (< or = 650mg), every 4 hours as needed for pain, fever, or headache.

_____ Ibuprofen/Motrin/Advil: per weight/age directions (< or 400mg), every 6 to 8 hours as needed for pain, fever, or headache.

____ Cough Drops/Throat lozenges: 1 cough drop/lozenge per package directions for weight/age. For the relief of throat pain and/or coughing.

____ Allergy Eye Drops: one drop in affected eye PRN per package directions. For relief of itching, burning, or inflammation due to airborne allergens, pollen, or dust.

____ Tums or Generic Equivalent (Only for Students over 12 years): 1-2 tablets every 2 hours as needed symptoms of heartburn or upset stomach.

____ I do not wish for my child to be administered any medications

*I give permission for my child to be given the medication(s) I have checked off above by the school nurse, as ordered by the medical provider through the School Based Health Center.*

______________________________ ______________________________

Parent/Guardian Signature Date Parent/Guardian Signature Date

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