



EFFINGHAM HEALTH TELEMED

TRANSFORMING HEALTHCARE FOR CHILDREN

SAFE • FAST • CONVENIENT

Effingham Health System offers this innovative medical program, where parents may opt-in to use telemedicine to diagnose and treat their sick children while in school.

Effingham Health TELEMED will make healthcare for children more convenient and accessible, avoid delays in treatment, and enhance learning by decreasing absenteeism.

Our **award-winning TELEMED program** provides fast, safe, convenient access to healthcare within your child's school. Parents may enroll at the beginning of the school year, or opt-in at any point during the year.



2020-2021 SCHOOL YEAR

The Effingham Health System telemedicine program, in partnership with Effingham County Schools, is available in **all public elementary schools, Effingham County Middle School, and South Effingham Middle School**. Effingham Health System is also proud to partner with Global Partnership for Telehealth.



TREATMENT

With the parent's permission, a physician or advanced practitioner from Effingham Health System will perform an assessment and diagnose your child. Our exceptionally trained team will advise on medical treatment and call in any prescriptions for parents to pick up at their pharmacy.

Enrollment occurs at the beginning of each school year, or you may contact your school nurse for more information.



TECHNOLOGY

Today's telemedicine has evolved to include **cutting-edge medical treatment and innovative technology**. A Bluetooth stethoscope, HD digital exam cameras, and monitors provide a high-definition picture of the patient for the physician, who communicates via live cameras and a computer. A secure connection assures patient privacy.



School-Based Telemed Frequently Asked Questions

What is School-Based Telemed?

School-Based Telemed is an innovative and established model to complement and expand existing school health services to meet the needs of children through the use of technology, i.e. interactive audio, video, or other telecommunications or electronic technology that connects the child and faculty/staff in the school to a health care provider in another location.

What is the goal of the School-Based Telemed Program?

The program's goal is to keep children healthy, in school and ready and available to learn.

Who is eligible to access services in the School-Based Telemed program?

Students and staff at all elementary schools, South Effingham Middle School, and Effingham County Middle School, are eligible to enroll in the School-Based Telemed program.

What services will be provided by the School-Based Telemed program?

The program will provide acute care services such as checking for ear infections and sore throats. If needed the provider examining the child will write a prescription that can be sent electronically to the family's pharmacy.

How do children enroll in the School-Based Telemed program?

Parents will need to complete an enrollment packet that will be sent home with your child on the first day of school. They will also be available on the schools website and in the school nurse's office.

How do faculty/staff enroll in the School-Based Telemed program?

Faculty/staff will need to complete an enrollment packet that will be distributed during pre-planning. They will also be available on the schools website and in the school nurse's office.

Is there a cost for the School-Based Telemed Program services?

Medicaid/PeachCare and Private Insurance will be billed. No child will be refused treatment due to inability to pay. Financial Assistance is available.

When will health services be available in the School-Based Telemed program?

Medical Services will be provided during the school day with the exception of school closures for the School-Based Telemed program, at all elementary schools, South Effingham Middle School and Effingham Co. Middle School.

Does a parent have to be present for the Telemed appointment?

Parents are always welcome to attend, but it is not required for acute appointments.

What if the provider orders labs for my child?

If labs are ordered by the provider, you may take your child to the lab at Effingham Hospital, Effingham Family Medicine or any lab you prefer. Strep, and Flu tests may be performed at the school clinic.

Will my child still be seen by the school nurse if I do not participate in the School-Based Telemed program?

Yes. Students will be seen as previously in the school clinic. However, they will not be seen by a provider unless proper forms are completed for the School-Based Telemed program.

Who will be providing the School-Based Telemed Program?

Effingham Health System (EHS) in partnership with Effingham County Board of Education (ECBOE). EHS health care professionals in conjunction with the ECBOE school nurse will provide medical services for School-Based Telemed program.

How will the School-Based Telemed program be monitored?

Monitoring of the Telemed system will be done in accordance with Georgia State guidelines/regulations and standards of practice for Telemedicine. Protocols will provide guidance on the implementation of the project and to assure compliance with State medical regulations regarding but not limited to HIPAA, FERPA, and medical practice. Confidentiality of medical records will be maintained according to electronic health records standards and regulations.

Who owns the School-Based Telemed program medical records?

Medical records will be maintained by Effingham Health System.



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Patient Information

School _____

Mr. /Mrs. /Ms.

Last _____ First _____ MI _____

Address _____ City _____ State _____ Zip Code _____

Mailing address _____ City _____ State _____ Zip Code _____

Phone Home _____ Cell _____

Work _____ Ext _____

Date of Birth _____ Male or Female _____ Single/Married/Widowed/Divorced _____

Social Security No. _____ Employed Y/N _____ Employer _____ Full/Part/Retired _____

Student? Y/N _____ Full Time/Part Time _____ E-mail _____

(Over 18yrs of age only)

Emergency Contact

Last _____ First _____

Relationship _____

Address _____ City _____ State _____ Zip Code _____ Date of Birth _____

Phone Home _____ Cell _____

Work _____ Ext _____

Guarantor * (Financially responsible person who is signing the attached forms)

Last _____ First _____ MI _____ M/F _____

Relation _____

Phone No. _____ Date of Birth _____ Social Security No. _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Full /Part _____ Phone _____

Address _____ City _____ State _____ Zip Code _____



Insurance Information

Medicare No. _____ Part A/A&B /B Medicaid No. _____

Wellcare No. _____ Amerigroup No. _____ PeachState No. _____

Primary _____ ID No. _____ Group No. _____

Policy holder _____ Date of Birth _____ Social Security No. _____

Address _____ City _____ State _____

Phone _____

Secondary _____ ID No. _____ Group No. _____

Policy holder _____ Date of Birth _____ Social Security No. _____

Address _____ City _____ State _____

Phone _____

Self Pay Yes or No if yes, please select one of the following

____ Pay balance in full at the time of service **or** ____ Make a payment arrangement prior to being seen

Additional Info

Race Black/African American Hispanic White
Other _____

Ethnicity Hispanic or Non-Hispanic

Pharmacy Used _____ Location _____ Phone _____

Have you ever received care in any of our offices in the past? If so, which one?

How long ago? _____ under what name did you receive care? _____

Accident Information

Is this illness due to an accident? Yes or No

If yes, work or auto accident _____ date of accident _____

Place of accident _____

If work accident,
Employer _____

Contact person _____ Phone _____



Effingham Health System is a Tobacco Free facility. The use of any tobacco products, e cigarettes or vaping equipment is prohibited on all properties, including parking areas, owned or occupied by Effingham Health System.

Release of Information

_____: Initial I hereby authorize payment of the hospital benefits otherwise payable to me and applicable only to unpaid charges, for this visit directly to this office. I give my permission of this office to release medical information for insurance purposes.

Patient Responsibility

_____: Initial I understand that Effingham Physician Practices will file my insurance as a courtesy, but it is my responsibility to understand my insurance coverage. I understand that I will be responsible for any charges my insurance will not cover.

Consent to be photographed

_____: Initial I understand that photographs or other images may be recorded to document my care, and I consent to this. Effingham Health System will retain the ownership rights to these images. Images will be stored in a secure manner in my medical record. Images that identify me may be used at Effingham Health System only for purposes of treatment, payment or healthcare operations and will not be released and/or used outside the organization for any purpose unless authorized by me or my legal representative.

Prescription (Rx) History Consent

_____: Initial I authorize Effingham Physician Practices to access my prescription history in order to perform accurate medication reconciliation.

Patient's Rights And Responsibilities

I acknowledge that I have been offered a copy of the **PATIENT'S RIGHTS AND RESPONSIBILITIES**, which details my rights as a patient at Effingham Health System (EHS).

Effingham Health System is committed to providing and supporting healthcare excellence to the citizens we serve. Our commitment to patients is reflected in our willingness to provide patient care and services and not be influenced by age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression. Any person who needs emergency treatment at our facility will be treated in accordance with the Emergency Medical Treatment and Labor Act (EMTALA) and be discharged and referred without discrimination."

Let it be known that in any instance Effingham Health System is mentioned, **all** departments and locations of the Health System are included.

Date/Time

Signature

Patient's Printed Name

Relationship: _____ Witness: _____

(Must be signed by Patient or Relative when photograph(s) are obtained)



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Patient Name: _____ Date of Birth: _____

Medical History – Have you ever had any of the following conditions of diagnoses? Check all that apply.

- Allergies Yes No
- Anemia Yes No
- Anxiety Yes No
- Arthritis Yes No
- Asthma Yes No
- Cancer Yes No
- Depression Yes No
- Diabetes Type 1 Type 2 Gestational
- GERD Yes No
- Heart Disease Yes No
- Hypercholesterolemia Yes No
- Hypertension Yes No
- Seizures Yes No
- Stroke Yes No
- Other: _____

Surgical History - Have you ever had any of the following surgeries? Check all that apply.

- Appendectomy Yes No
- Cholecystectomy Yes No
- Eye surgery Yes No
- Fracture repair Yes No
- Heart Bypass Surgery Yes No
- Heart stent Yes No
- Heart Valve Repair Yes No
- Hernia Repair Yes No
- Tonsillectomy Yes No
- Other: _____

Medications

Medication Name (include all prescriptions, over the counter, and vitamins)	Dose	Frequency	For what?

Patient Name: _____

Date of Birth: _____

Family History

Has your mother had any of the following?

- Diabetes Hypertension Heart Disease Stroke
 Mental Illness Cancer Unknown

Has your father had any of the following?

- Diabetes Hypertension Heart Disease Stroke
 Mental Illness Cancer Unknown

Has your siblings had any of the following?

- Diabetes Hypertension Heart Disease Stroke
 Mental Illness Cancer Unknown

Has your maternal grandfather had any of the following?

- Diabetes Hypertension Heart Disease Stroke
 Mental Illness Cancer Unknown

Has your maternal grandmother had any of the following?

- Diabetes Hypertension Heart Disease Stroke
 Mental Illness Cancer Unknown

Has your paternal grandfather had any of the following?

- Diabetes Hypertension Heart Disease Stroke
 Mental Illness Cancer Unknown

Has your paternal grandmother had any of the following?

- Diabetes Hypertension Heart Disease Stroke
 Mental Illness Cancer Unknown

Other family history: _____

Depression Screening – For patients 12 years old and older.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things?

- Not at all Several days More than half the days Nearly every day

Feeling down, depressed, or hopeless?

- Not at all Several days More than half the days Nearly every day

Trouble falling or staying asleep, or sleeping too much?

- Not at all Several days More than half the days Nearly every day

Feeling tired or having little energy?

- Not at all Several days More than half the days Nearly every day

Poor appetite or overeating?

- Not at all Several days More than half the days Nearly every day

Feeling bad about yourself or that you are a failure or have let yourself or your family down?

- Not at all Several days More than half the days Nearly every day

Trouble concentrating on things, such as reading the newspaper or watching television?

- Not at all Several days More than half the days Nearly every day

Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?

- Not at all Several days More than half the days Nearly every day

Thoughts that you would be better off dead or of hurting yourself in some way?

- Not at all Several days More than half the days Nearly every day

Patient Name: _____

Date of Birth: _____

Tobacco Use – For patients 18 years old and older.

Are you a smoker?

- current smoker former smoker never smoker light tobacco smoker
 heavy tobacco smoker

If current smoker, how often do you smoke cigarettes?

- every day some days but not every day

If current smoker, how many cigarettes a day do you smoke?

- 5 or less 6-10 11-20 21-30 31 or more

If current smoker, how soon after you wake up do you smoke your first cigarette?

- within 5 min 6-30 min 31-60 min after 60 min

If current smoker, are you interested in quitting?

- Ready to quit Thinking about quitting Not ready to quit 21-30
 31 or more

Alcohol Screening – For patients 18 years old and older.

Did you have a drink containing alcohol in the past year?

- Yes No

How often did you have a drink containing alcohol in the past year?

- never (0 points) monthly or less (1 point) 2 to 4 times a month (2 points)
 2 to 3 times a week (3 points) 4 or more times a week (4 points)
 6 or more times a week (4 points)

How many drinks did you have on a typical day when you were drinking in the past year?

- 1 or 2 drinks (0 points) 1 to 2 drinks (0 points) 3 or 4 drinks (1 point)
 5 or 6 drinks (2 points) 7 to 9 drinks (3 points) 10 or more drinks (4 points)

How often did you have 6 or more drinks on an occasion in the past year?

- never (0 points) monthly (2 points) less than monthly (1 point)
 weekly (3 points) daily or almost daily (4 points)

Interpretation Positive Negative

(The alcohol screening is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive. In women, a score of 3 or more is considered positive.)



PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of protected health information. Protected Health Information (PHI) is the use or disclosure about your medical treatment, payment or healthcare operations

PLEASE PRINT BELOW THE PERSON(S) TO WHOM WE MAY DISCUSS YOUR PHI AND RELEASE INFORMATION TO:

1. _____
2. _____
3. _____
4. _____

I wish to be contacted in the following manner (check all that apply)

_____ Home Telephone _____

_____ Cell Phone Number _____

_____ Email _____

_____ Mail _____

You may leave a message with, discuss my treatment, appointments, release information, or other scheduling that may occur or give information as necessary with the above family, friend or personal representatives. I understand that Effingham Health System will refuse to discuss my information with anyone **not** listed above, except in an emergency. I also understand that this consent does not apply to medical providers for continuity of care.

Patient's Signature and Date

Patient's Printed Name

Date of Birth