SHANNON

School Telemedicine Program

Connecting Your Child to Convenient Care

Patient Registration Packet

2022 - 2023 School Year

Shannon's School Based Telemedicine Program

Shannon Clinic ("Shannon") is excited to be working with your child's school district to offer parents and students a new option for pediatric care. Through high-definition telemedicine video and communications equipment, the school nurse can connect with a Shannon physician or an advanced practice professional ("Provider) for quick assessment and treatment to care for your child while at school.

How does the program work?

With the parent's consent, a student may be evaluated by a Shannon Provider through a telemedicine conference. The school nurse will first quickly evaluate the student in person. If the nurse determines the child could benefit from further evaluation, they will contact the parent to inform them about the telemedicine visit and invite them to participate if available. The Provider will complete an assessment of the student to include input from the school nurse and participating parent or legal guardian during the visit.

The school nurse will assist the Provider during the evaluation through the use of special equipment, as needed. The provider can hear the student's heart and lungs with a digital stethoscope. The Provider can closely examine the student's ears, throat, rash, or abrasions with a high-definition camera.

Upon completion of the evaluation, the Provider will give instructions for follow-up care and submit an order to your pharmacy of choice for prescription medications, if needed. A record of your child's visit will be kept in their medical record at Shannon Clinic for future reference. The parent or legal guardian will have access to all treatment information through My Chart, Shannon's online health record portal.

What are examples of conditions that could be treated?

Examples of conditions that could be treated by telemedicine are:

- Earaches
- Fever
- Coughs and colds
- Rashes and minor skin infections
- Abrasions and scrapes
- Strep throat and Influenza
- Headaches
- Pinkeye
- Asthma
- Allergies
- Head Lice

There are medical needs that will require an in-person evaluation by a medical provider. You may be asked to schedule an appointment with your child's primary care physician directly if evaluation by telemedicine isn't sufficient for diagnosis.

How do I enroll my child for the program?

You can register by completing a paper packet (available at your school nurse's office) and return to your child's school. They will submit all required documentation to Shannon to enroll your child in the program.

What is the cost?

There is no cost to enroll in this program. If your child has a visit, we will bill your insurance and any required co-pay amounts after the visit. It will bill as an urgent care visit. Those without insurance will receive a self-pay discount and be billed after the visit.

How do I register to see my child's visit summary in the healthcare portal?

Once registration into the program is completed for your child, you may access Shannon's MyChart by taking the following steps:

If you are a current patient of Shannon, please login to your MyChart account, click Profile button for dropdown menu and choose, Personalize. Please follow instructions on filling out the online Request access to a minor's record.

If you are not currently a patient of Shannon, please call the MyChart Help Desk at 325-481-8810 or email mychart@shannonhealth.org.

How will I know if my child has a scheduled telemedicine appointment?

When a student presents to the school nurse's office, the nurse will assess the student's condition and contact the parent or legal guardian to discuss if it is appropriate to schedule an appointment. An appointment cannot be scheduled without the consent of the parent or legal guardian.

How can I participate in my child's telemedicine appointment?

You may participate in your child's telemedicine appointment in two different ways. The provider may ask you about your child's medical history or current medications so please have this information ready and available.

1) You may attend the telemedicine appointment in person at your child's school.

2) You may listen to your child's telemedicine appointment by phone.

Who should I contact if I have questions?

- Registration or Follow-up questions about my child's school based clinic visit – If you have questions regarding registration for the Shannon School Based Telehealth Program or questions regarding recommendations made for your child's care, medication questions, or to report a change in your child's condition, please contact the Shannon Pediatric Clinic at 325-481-2287.
- Routine Healthcare Needs – Please contact your child's primary care physician for any routine healthcare checkups/vaccinations.
- School Based Healthcare Needs – Please discuss any healthcare needs your child may have while at school directly with the school nurse at your child's campus.

Please return the following documentation to your school nurse:

1. Registration Form - Demographic and insurance information for your child.
2. Telemedicine Consent and Acknowledgements - Authorizes a Shannon Clinic provider to evaluate and treat your child by telemedicine.
3. Patient Information and Medical History Form - Medical history and general health information for your child that the Shannon Clinic provider will reference during your child's visit.
4. Notice of Privacy Practices - Detailed handout regarding Shannon Clinic's privacy practices for parent/guardian to keep. *Do not need to return.*

1. Registration Form

School Year: _____

Patient Information:

Full Name: _____ Date: _____

Last *First* *M.I.*

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Date of Birth: _____ *Age:* _____ *Sex:* ☐ *M* ☐ *F*

Primary Language Spoken: _____ *Race:* _____ *Social Security #:* _____

Student Grade: _____ *School ISD:* _____ *School Campus:* _____

Preferred Pharmacy: _____ *Pharmacy Phone No:* _____

Insurance Information: *I hereby give my permission for Shannon Clinic to bill my insurance as follows:*

Insurance Company: _____ *Policy Holder Name:* _____

Member ID: _____ *Group No.:* _____

Billing address. listed on card : _____ *PhoneNo. listed on card:* _____

Member employer: _____

Parent/Guardian Information:

Full Name: _____

Last *First* *M.I.*

☐ *Same as Student's Address Above*

Address: _____

Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Relationship to Patient: _____ *DOB:* _____ *Social Security #:* _____

Home No. _____ *Cell:* _____ *Work No.::* _____

Email: _____

Does the student have a Shannon MyChart account? □ Yes □ No

2. TELEMEDICINE CONSENT AND ACKNOWLEDGEMENTS

1. **Authorization and Consent to Care:** I consent to, and grant permission to, a Shannon Clinic Physician or Advanced Practice Professional ("Provider"), and to any designated substitute, to the employees of Shannon Clinic and to any student trainees affiliated with Shannon Clinic to render to my child, routine nursing and health care, including examinations, tests, medication, medical treatment, pictures, videos, and other services, determined advisable for the patient during the telemedicine visit. This includes permission to carry out the orders of the provider.
    - I understand the practice of medicine is not an exact science and that the diagnosis and treatment may involve risks. I understand that no one can guarantee the results of any healthcare treatment
    - Other healthcare providers could include other treating or consulting doctors, their associates, technical assistants, nurses, advanced practice professionals, and other hospital staff.
    - This consent applies during the evaluation, diagnosis and treatment of the patient being cared for by Shannon Clinic and its affiliated companies (also known as "Shannon"). Shannon companies include: Shannon Medical Center, Shannon Clinic, and Shannon Business Services.
    - I also consent to allow students (such as medical fellows, medical residents, medical students, student nurses and other authorized individuals that are enrolled in professional training programs) and physicians undergoing training to watch or join in the care provided as the treating doctors or dentists find appropriate, and as allowed by Shannon policy.

2. **Doctors and Independent Contractors**: Each patient within Shannon is under the care of a doctor. Doctors are not always employees of Shannon. Some doctors may be independent contractors. All doctors assume responsibility for the medical care they provide

3. **Accidental Exposure to Healthcare Worker:** I understand that Texas law states that if any healthcare worker is exposed to a patient's blood or other bodily fluid, then Shannon may perform test(s) for HIV (the "Human Immunodeficiency Virus") on that patient's blood or bodily fluid. I give consent to test for other diseases too, including hepatitis, syphilis, and others. I understand that these tests are necessary to protect healthcare workers who are caring for Shannon patients.

4. **Patient Rights and Responsibilities:** If I or my child is being admitted to Shannon Medical Center, I will be given written information on the rights and responsibilities of the patient. This information tells me how to file a complaint or grievance if I have a problem with the care the patient receives during the hospital stay.

5. **Authorization to Release Information:** I authorize Shannon to release information as to my health status, conditions, symptoms, or treatments from my child's record as necessary to exchange protected health information with SAISD as necessary for care. I understand that this information will identify my child and may relate to my child's history, diagnosis, treatment or prognosis; it may also include psychiatric information.

6. **Notice of Privacy Practices, Patient's Rights and Responsibilities:** I have received a copy of the Shannon Notice of Privacy Practices.

7. **Telemedicine Consent**
    - I voluntarily request a Provider of Shannon Clinic to participate in my child's medical care through telemedicine and related remote communication software, devices and technologies. I understand that telemedicine includes interactive audio, video or other electronic media.
    - I understand that the Telemedicine Providers will sometimes be at a remote location while providing healthcare services for me, but their expertise and availability via technology has the potential to enhance the quality of healthcare services I may receive, if used appropriately and when medically necessary.
    - I acknowledge that it is my responsibility to provide information about my child's medical history, condition and care that is complete and accurate to the best of my ability. It is also my responsibility to comply with instructions I receive from my health care providers and to report deviations from such instructions to my health care providers in a timely manner. I consent and authorize Telemedicine Providers to audio record, video record, and/or still photograph the visit as necessary for providing quality healthcare services via technology. I understand that all recordings, videos or images will become part of my medical record.
    - I understand that the use of technology for diagnosing or treating my health condition(s) presents certain risks, including but not limited to the following that may occur in rare instances:
        - Transmitted information may be distorted or insufficient to allow for appropriate medical decisions;
        - There may be unanticipated delays in diagnoses or treatments due to equipment or technology failure or deficiencies;

- Problems with Telemedicine Providers being able to access my complete medical records may result in adverse drug interactions, allergic reactions or other medical decision errors; and
- The use of technology to store and transmit my medical records introduces additional opportunities for someone to breach the security and privacy protocols intended by my Telemedicine Providers to otherwise protect my confidential information.

- I understand that the during a telemedicine encounter the Telemedicine Providers may determine that telemedicine is not appropriate in a specific circumstance. If such occurs, the Telemedicine Provider will terminate the telemedicine encounter and advise me on where and how I may receive ongoing healthcare services in light of the circumstances. I understand that, in the event of any technological or equipment failure during a telemedicine encounter, I should call the following number: 1-866-971-TYTO (8986) for directions on rescheduling the telemedicine encounter or directions on how and where I may receive ongoing healthcare services appropriate for my condition.
- At the end of each telemedicine encounter, I understand that my Telemedicine Provider will give me the contact information for the healthcare practitioner(s) who will be available to provide me with follow-up care in the event that I have any adverse or unexpected reactions to the telemedicine treatment recommendations. I understand that I have the right to withdraw this consent to the use of telemedicine at any time, without affecting my right to future care or treatment.

The information given to Shannon Medical Center for this registration is correct to the best of my knowledge. I agree that a photocopy or facsimile of this authorization shall be as effective and valid as the original. I agree to provide a valid photo Id and proof of legal guardianship as required by law.

THE PERSON SIGNING THIS CONSENT FORM CERTIFIES THAT: 1) HE/SHE IS EITHER THE PATIENT, PARENT OF THE PATIENT, OR LEGALLY AUTHORIZED REPRESENTATIVE OF THE PATIENT; 2) HAS READ (OR HAS BEEN READ) THIS FORM AND UNDERSTANDS WHAT IT SAYS; AND 3) AGREES TO THE TERMS OF THIS CONSENT FORM.

Patient's Name Printed: _____ Date of Birth: _____

Patient/Parent/Legal Guardian Signature:: _____ Date/Time _____

Witness: _____ Date/Time _____

3. Patient Information and Medical History

Patient Name: _____ DOB: _____

Primary Care Physician:_____ Phone: _____

Clinic/Facility: _____

ALLERGIES

As far as you know, is your child allergic to any medications? YES_____ NO _____

If YES, which medications, and what kind of reactions has he or she had? _____

_____

Any milk or food allergies? _____

HEALTH HISTORY (please check all that apply):

- □ ADD/ADHD
- □ Anemia
- □ Asthma
- □ Cancer
- □ Diabetes mellitus
- □ Headache
- □ Hearing loss
- □ HIV/AIDS
- □ Meningitis
- □ Obesity
- □ Otitis media
- □ Seizures
- □ Sickle cell anemia
- □ Strep throat (recurrent)
- □ UTI
- □ Other _____
- □ _____

SURGICAL HISTORY (please check all that apply):

- □ Abdominal surgery
- □ Appendectomy
- □ Ear tubes
- □ Eye surgery
- □ Fracture surgery
- □ Lymph node biopsy
- □ Meckel's diverticulum
- □ Tonsillectomy
- □ Umbilical hernia
- □ VP shunt
- □ Other _____

Please tell us about any health conditions marked on the prior list or any other concern's you may have about your child's health:

_____

_____

CURRENT MEDICATIONS: Name Dosage How Often Taking

_____

_____

Parent Signature:_____

Date:_____

4. NOTICE OF PRIVACY PRACTICES

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.

Shannon Medical Center, Shannon Clinic, and Shannon Business Services (collectively, "Shannon") are required by law to protect the privacy of your individual health information ("Protected Health Information" or "PHI") and to provide you with notice of our legal duties and privacy practices with respect to PHI. Shannon Medical Center may dispose of your medical records on or after the 10th anniversary on which you were last treated in the hospital.

Uses and Disclosures of Protected Health Information.

Shannon may use and disclose your PHI without your authorization for treatment, payment, and health care operations purposes either within Shannon, with health care providers, health plans, and those that process health care claims, benefits and related information. Your PHI may be exchanged electronically.

Treatment. Shannon may use and disclose your PHI for the purpose of providing, coordinating, or managing the delivery of healthcare services to you by one or more healthcare providers who are involved in taking care of you. For example, your primary care physician may consult with us regarding your condition or treatment. Shannon do not limit the use or disclosure of your PHI for purposes of your care or treatment. Otherwise, we limit use and disclosure of PHI to that which is reasonably necessary for a permitted purpose.

Payment. Shannon may use and disclose your PHI to obtain payment or reimbursement for providing healthcare services, such as when we request payment from your insurer, health plan, or a government benefit program.

Healthcare Operations. Shannon may use and disclose your PHI internally in a number of ways, including for quality assessment and improvement, for planning and development, management, and administration. Your information could be used, for example, to assist in the evaluation of the quality of services that you were provided. Healthcare operations also includes conducting training programs in which students, trainees or practitioners in areas of health care learn under supervision to practice or improve their skills.

In addition, 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, and we may contact you to raise funds for Shannon.

Opportunity to Object. Unless you object, Shannon may also disclose:

- Your name, location at Shannon Medical Center, and your condition, to persons who ask for you by name, and (along with your religious affiliation) to members of the clergy.
- PHI that is directly relevant their involvement with your care or payment related to your care to a member of your family or other relative, a close personal friend, or to any other person identified by you.
- PHI to notify, identify, or locate a member of your family, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your healthcare.
- PHI for the purpose of fundraising communications from Shannon.

Shannon will also use our judgment and experience regarding your best interest in allowing people to pick up filled prescriptions, medical supplies, test results or other similar actions involving disclosure of PHI. If you object to one of the disclosures listed above, please contact one the Privacy Officer listed below.

Authorized by Law. Shannon is also permitted to share your PHI, without your authorization, as required by law and in the following instances authorized by law.

- To public health authorities for the purposes of preventing or controlling disease or other public health purposes;
- To appropriate government authorities to report about victims of suspected abuse, neglect, or domestic violence;
- To the Food and Drug Administration to report quality, safety, or effectiveness of the FDA-regulated products or activities;
- In certain limited circumstances to an employer such as if we are asked to evaluate or treat a work-related illness or injury;
- To qualified health authorities for purposes of conducting health oversight activities;
- In response to subpoenas, discovery requests, or other lawful legal processes in the course of a judicial or administrative proceeding;

- To law enforcement authorities as required or permitted by law, such as to report a death, to report a crime on our premises, or if it appears necessary to alert law enforcement to respond to an emergency;
- In certain instances, for research purposes;
- To persons involved with respect to matters pertaining to a decedent, or relating to cadaveric organ, eye or tissue donation;
- If we believe, in good faith, that it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; or
- For certain specialized government functions, including to Armed Forces Authorities with reference to military personnel or for national security purposes.

Authorization. Other uses and disclosures will be made only with your written authorization, including use and disclosure of PHI for marketing purposes as well as disclosures that constitute a sale of PHI. Written authorization will generally always be required for the release of psychotherapy notes. You may revoke your authorization by notifying us by contacting our Privacy Officer as described below.

Your Privacy Rights

You may ask us to restrict uses and disclosures of your PHI to carry out treatment, payment, or healthcare operations or to restrict uses and disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care. Shannon is not required to agree to these restrictions, except restrictions on disclosures to a health plan for payment or health care operations purposes where the disclosure pertains solely to a health care item or service for which you paid out-of-pocket. If you wish to make such a request you must advise our Privacy Officer in writing.

You may request to receive communications of PHI by alternative means or at alternative locations. Shannon will accommodate the request, if reasonable.

You have the following rights with respect to your PHI: (i) to inspect and copy this information, including an electronic health record; (ii) to request to amend this information; (iii) to receive an accounting of the disclosures of this information by us, including disclosures made using an electronic health record; and (iv) to receive a paper copy of this notice upon request.

You have the right to be notified if there has been a breach of confidentiality with respect to your unsecured PHI.

If you wish to exercise any of the above rights, you must notify our Privacy Officer, identified below, in writing.

Shannon is required to abide by the terms of the Privacy Notice that is currently in effect. Shannon reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI we maintain, including PHI that is created or received prior to issuing the revised notice. Shannon will promptly revise and distribute a new Privacy Notice wherever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in this Notice. If we revise this Notice, the revision date will be the effective date of the Notice, and we will post the revised notice on our website: www.shannonhealth.com

If you believe your privacy rights have been violated you have the right to file a complaint with us by contacting the Privacy Officer identified below and/or to the Department of Health and Human Services by contacting its website (http://www.hhs.gov/ocr/privacyhowtofile.com) or calling them toll-free at 1-800-368-1019. Shannon will not retaliate against you in any way for the filing of a complaint.

For further information concerning our privacy policy, your privacy rights, or the complaint procedure, please contact our Privacy Officer:

Misty Sonnenberg

120 East Harris Avenue

San Angelo, TX 76903

325-747-5280

PrivacyOfficer@shannonhealth.org