Triad Health Systems, Inc.
Welcome to the School-Based Health Clinic.
Dr. Mark Miller, Medical Director

The School-Based Health Clinic makes medical care available to all students when needed.

- Does not replace regular Doctor/No Changing of Doctor necessary

How the School-Based Health Clinic works:

- **You must complete ALL** pages and return them to the school. No services can be provider unless the attached forms have been completed and returned to the school. **PAGES ARE FRONT AND BACK**
- If the school staff sees your child is sick, **they will try to contact you first**.
- If your child needs a school or sports physical, the clinic will help you get a timely appointment at the **School-Based Health Clinic, if it is not possible with your regular doctor. All forms must be completed before appointment.**
- Your child will be examined and treated. If necessary, a prescription will be called into your pharmacy.
- After your child's visit with the clinic, **you will be contacted by telephone or in writing.**
- You will be encouraged to have any needed follow-up care with your child's physician and a summary of your child's visit at the clinic will be sent to that office upon request. However, if you do not have a regular doctor, we welcome that relationship here and can become your child's doctor. **If your child is already a patient Triad Health Systems, Inc., you still have to sign this consent to be a part of the School-Based Health Clinic.**

The HEALTH CARE SERVICES we may provide include:

- Sick Visits (Ex.: sore throat, rash, asthma attack, fever), tests and treatment/medications as needed.
- Minor injury evaluation, including first aid.
- Physical examination (including school, sports and work physicals)
- Health education and wellness promotion.
- Referral to outside agencies for further care that cannot be provided at the School-Based Clinic.

Services that are not provided at the School-Based Clinic:

- **No routine medications**
- **No vaccines/immunizations unless during a special immunization clinic. (Requires additional forms)**
- **Issues regarding contraception, pregnancy, STD, sexual or physical abuse will be referred out to appropriate facilities/authorities/organizations and are not in the scope of School Based Clinic care.**

Regarding PAYMENT FOR SERVICES:

- **Insurance**- THS accepts most commercial insurances, Medicaid and Medicare. **Insurance information must be provided with paperwork.**
- **No insurance—**THS offers a Sliding Fee Scale based on Household size and Household income. Please call 859-567-1591 for more information and how to apply. No child will be denied care due to inability to pay for services.
- **We can help you if you need assistance applying for Medicaid**, you can call 859-567-1591. You can also contact Cabinet for Health and Family Services at 502-732-4271.

Regarding the SHARING OF HEALTH INFORMATION:
The School-Based Health Clinic may request medical records/information from any health care provider or facility where your child has been seen. Results of the visit can be sent by the School-Based Health Clinic to your child's regular doctor/clinic upon request. The School-Based Health Clinic and school/school's nurse will share medical information with each other as deemed medically necessary including Immunization Records. The child's medical and any other information will only be used in the treatment, payment and health care operations of the School-Based Health Clinic. All of your child's information will be kept strictly confidential according to all state and federal laws.

*Please note that the **School-Based Health Clinic** is completely **optional. School nursing and emergency services will still be provided as always whether you consent to the School-Based Health Clinic or not.**

The consent will remain in effect until the end of the current school year or your child is no longer enrolled in Carroll County School District. The consent must be renewed every school year. You **may revoke** this consent for treatment at any time by requesting, in writing, Triad Health Systems, Inc. to have your child removed from School-Based Health Clinic. Please notify us at the number below and in writing for any changes in guardianship.
The School-Based Health Clinic is an excellent way to keep your child healthy and in school. **Please let us know if there is anything keeping you from enrolling your child.** If you have any questions or need help with the application, **please call Triad Health Systems, Inc. 502-732-1082 or contact your school nurse. Please keep this Program Description for your records. Thank you, Triad Health Systems, Inc. PO Box 845, 441 Hwy 42 West, Warsaw, KY 41095.**

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Triad School Based Clinic
REGISTRATION FORM

REVISED on: 07/20/18

Location
____

PATIENT INFORMATION -> *PLEASE COMPLETE ALL INFORMATION*

Last Name:	First Name:	Middle:	Previous Last Name:	Nickname:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security #: - -	Date of Birth: / /	Sex: ❑ M ❑ F

Physical Address:	City:	State:	ZIP Code:
Mailing Address \ PO Box:	City:	State:	ZIP Code:
Language: ❑ English ❑ Spanish ❑ Other:	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated		

Home Phone: ( )	Daytime Phone: ( )	Alternate Phone: ( )
Email Address:		

INSURANCE -> Must be provided for billing

Insurance:____

Policy #____________________Group #_________________________

Policy Holder's Name____________________ Social Security #_____ - _____ - _____

Triad Health Systems offers a Sliding Fee Scale for All Patients. Application Attached. Call 859-567-1591 for Details.

Ethnicity: ❑ Hispanic ❑ Not Hispanic	Veteran: ❑ Yes ❑ No	Number in Household:	Annual Household Income:

Race:
❑ White ❑ Black/African American ❑ American Indian/Alaskan Native ❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ More Than One Race

Are you homeless? ❑ Yes ❑ No	If so, what best describes your current situation? ❑ Staying with Friends/Family ❑ Shelter ❑ Street ❑ Transitional	Do you need an Interpreter? ❑ Yes ❑ No
Are you a Migrant Farm Worker? ❑ Yes ❑ No	If so, what describes your current situation? ❑ Migrant ❑ Seasonal	

RESPONSIBLE PARTY -> *WHO IS THE PERSON RESPONSIBLE FOR PAYING TODAY'S BILL?*

❑ Self ❑ Spouse ❑ Parent ❑ Other

Name:		
Physical Address:		
Mailing Address \ PO Box:		
Home Phone: ( )	Social Security #: - -	Date of Birth: / /

Sliding Fee Scale Application

Date:_______________

Patient Name: ____ DOB: _________________

Please Print

Total Household Members ___________

Triad Health Systems, Inc. provides health care services for residents and employees of Gallatin, Carroll and Owen Counties. In order to insure that all residents and employees can continue to receive healthcare that they can access and afford we must bill patients based on their ability to pay.

(Read & initial each line)
I understand that deliberate misrepresentation by/of any household member may result in:

______ All household members being exclude from the sliding fee scale program

______ All sliding fee scale discounts received due to misrepresentation will be voided and payable by me.

______ Prosecution under applicable Federal, State, and Local laws.

List **all** household members, regardless of age, and income for each. **Attach a copy of each type of income.** Examples of income are *(but not limited to):* Wages Self-Employment SSI Child and/or Spousal Support RSDI Workers' Comp Unemployment Veterans Pension Farm Income Food Stamps

	Name	Date of Birth	Amt. $$	(W) Weekly (BM) Bi-monthly (BW) Bi-weekly (M) Monthly (Y) Yearly	Source of Income
1					
2					
3					
4					
5					
6					
7					
8					

Has this been the average income for the past 12 months? Yes No If no, please explain the differences.

____

I certify the information given is true and correct. I also certify that I have reported all household income and agree to report any changes in household income. I understand that providing false information on this statement is subject to prosecution under Federal, State and/or Local law's, and can disqualify myself and all of my household members from the Sliding Fee Scale program.
I give Triad Health Systems, Inc. permission to obtain financial information for purposes of verification of household income.

Signature____ Phone # __________________________
Address ____City _________________ ST _____ Zip ________

TRIAD HEALTH SYSTEMS, INC.
SCHOOL-BASED CLINIC

Part A

I give my permission for the THSI to:

1. Call and leave a message on my voicemail regarding appointments, medical information, and to resolve insurance/billing issues. ___YES _______NO

2. Call my home to discuss and leave information with the following persons regarding appointments, medical information, and to resolve insurance/billing issues. I also give permission for those designated below to pick up appointment notifications, prescriptions, and to call and make an appointment for me. To obtain test results and medical information held for me to pick up. ____YES _______NO

3. Family or Friends to whom we may speak to and release medical information about your child:_______
____

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

4. I request to have a copy of privacy practices mailed to my address. ________YES _______NO

5. **Administration of Medication to your child**. The following list of medications will be on hand at the School Based Clinic to be administered by THSI after your child's complaint has been evaluated. Please review the following list of medications and **place a check by** the medications/treatments that **are allowed** for your child.

__Acetaminophen (Tylenol)
__Aloe Vera Gel
__Anti-Diarrhea Tablets (Imodium)
__Anti-Nausea Liquid
__Blistex
__Calamine Lotion
__Cough Drops
__Diphenhydramine(Benadryl)

__Nebulizer Treatments
__Bee Sting Swabs
__Hydrocortisone 1% Cream
__Ibuprofen (Advil)
__Sore Throat Spray
__Sterile Eye Drops
__Triple Antibiotic Ointment

__Tussin (Generic Robitussin)
__Tussin DM
__Orajel
__Antacids (Liquid/Chewable)
__Glucose Gel/Tablets
__Zofran (as needed)

6. **Medical History (Please list any Major Illnesses, Injuries, and Hospitalizations that your child has had in the past):**

____

____

10. Please list any medication your child is taking on a regular basis:

Medication ______________________ Strength _______________ How Often_____________________

Medication ______________________ Strength _______________ How Often_____________________

Medication ______________________ Strength _______________ How Often_____________________

Medication ______________________ Strength _______________ How Often_____________________

11. What is your preferred pharmacy:___________________________ Pharmacy's Phone________________

12. Does your child have any allergies to foods, medications, or environmental pollens? __Yes__No

If yes, please list **ALL** allergies:____

13. Does your child have history of or current use any of the following substances?

Tobacco? Yes No Alcohol? Yes No Drugs? Yes No

14. Does anyone in the household have history of or current use any of the following substances?

Tobacco? Yes __No Alcohol? Yes No Drugs? Yes No

15. Child's Family Physician?____
Doctor's Name Address Phone Number

16. Child's Dentist:____
Name of Dentist Phone Number

Part B

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Triad Health Systems, Inc. may use and disclose protected health information, (PHI) about me/my child to carry out treatment, payment and healthcare operations. Please refer to Triad Health Systems, Inc. Notice of Privacy Practice for a more complete description of such uses and disclosures.
I have the right to review the Notice of Privacy Practice prior to signing this consent. Triad Health Systems, Inc. reserves the right to revise it Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Triad Health Systems Inc. PO Box 845, Warsaw, KY 41095
With my consent, Triad Health Systems, Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my/my child's clinical care, including laboratory results among others.
With my consent, Triad Health Systems, Inc. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.
I have the right to request that Triad Health Systems Inc. restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
By signing this form, I am consenting to Triad Health System's uses and disclosure of my Protected Health Information to carry out treatment, payment and operation.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Triad Health Systems, Inc. may decline to provide treatment to me/my child.

Part C

TRIAD HEALTH SYSTEMS INC.
SCHOOL-BASED CLINIC
Financial Policy/Authorization for Medical Care and Billing

Thank you for selecting this Provider for your medical care. In order to prevent any misunderstanding concerning the responsibility for payment for outpatient medical services provided to our patients, the following information is supplied:

MEDICAID/MCO:

If you have Medicaid coverage, we must have your Medicaid card at the time of your visit. If you have Medicaid coverage pending, please advise the staff, and please send a copy of card when received.

MEDICARE:

Our providers are participating Medicare providers. Office visits to a doctor are covered under Part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay your annual deductible for the calendar year. If you have supplemental insurance, we require a copy of your insurance card and insurance mailing address. If Medicare rejects any procedure, you are responsible. Your signature below indicates you have been informed and you are in agreement.

COMMERCIAL INSURANCE:

If you have insurance coverage, we require a copy of your insurance mailing address, an assignment which allows your insurance company to send payment to Provider. You will be billed for any deductible and/or co-pay. If your statement of account is returned because of insufficient address, you will be required to pay at time of service.

SLIDING SCALE:

A Sliding Scale is offered which allows a reduction in charges for eligible patients, with co-payment billed. Any charges not covered under Sliding Scale will be billed. Application is attached.

Non-covered medical services are the responsibility of the patient, or in the case of a minor, the responsibility of the minor's parents or legally appointed guardian.

I authorize payment directly to the provider benefits including any major medical benefits otherwise payable to me, but not to exceed the regular charges for this period of illness. I understand that I am financially responsible for charges not covered by this assignment.

I authorize the release of any medical information necessary, to process my claims. I do hereby consent to such medical, dental, and/or surgical examination and treatment as is necessary and authorize the provider to release to Third Party Sources information necessary to obtain payment for services rendered.

I also consent to authorize the provider to release any referring doctor information necessary for evaluation and treatment.

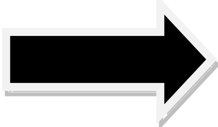
I certify that the information I have given the provider is true and correct to the best of my knowledge. I understand that supplying false information denies my family and me of services from the provider. I further understand that a copy of this information is supplied to an agency of the Federal Government. I have read all the information above and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

Expiration Date of Authorization and Right to Terminate or Revoke Authorization: Expiration Date of Authorization ends 06/30/2018 unless revoked or terminated in writing by the patient (if 18 yrs. old or older), parent OR Legal guardian. You may revoke or terminate this authorization by submitting a written revocation.

I have read, understand and consent to Parts A, B, and C of this form. By signing this form, **I give my consent for my child, ____to receive services at the School Based Clinic.**

Child's Name

THSI cannot/will not provide services to your child without this signed consent (except for emergency first aid). The consent can be withdrawn at any time by the parent or guardian by informing the clinic in writing.



Parent/Legal Guardian SIGNATURE: ___________________________________DATE: _____________