children's Hospital at Erlanger

Ronald McDonald House Charities® Chattanooga

School-Based Health Clinic Program — Patient Registration

Please ask your school nurse for details.

Patient Information: Please complete all of this section (blue or black ink only)

_____ _____ _____
Student's Last Name **First** **Middle**

_____ _____
Student's Street Address **City** **State** **Zip**

_____ _____ _____
Student's Social Security Number **Date of Birth** **Primary Care Doctor** **Phone**

Pharmacy Name/Location: _____ **Pharmacy Phone:** _____

Sex: (Please Circle One) M F **Race:** (Please Circle One) White Black Hispanic Asian Bi-Racial Other

Language of Choice: _____

School: _____ **Teacher:** _____ **Grade:** ____

Parent/Guardian Information:

Parent/Guardian's Name: _____ **Date of Birth:** _____

Relationship to Patient: _____

Parent/Guardian Employer: _____ **Phone:** _____

Home Phone: _____ **Mobile Phone:** _____ **Other Phone:** _____

May we leave a message? _____**Yes** _____**No**

Insurance Information: Please fill in all the information so that we do not have to copy your card.

My child has: ___ No Insurance
___ TennCare -ID# _____ (required for billing)
___ Private/Commercial Insurance (please provide all details below) Deductible $_____

Primary Insurance Company: _____

Name of Policy Holder: _____ **Relationship to Student:** _____

Member ID or Policy #:_____ **Group #:** _____ **Co-Pay: $**_____

Social Security # of Policy Holder: _____ **Policy Holder Date of Birth:** _____

Emergency Contact Information: Alternate contact if parent cannot be reached.

Name: _____ **Relationship:** _____ **Phone:** _____
May We Leave A Message? Yes No

Please list any people that you authorize to have access to your child's health information:

As a Parent/Guardian of the above student:

I authorize the release of any medical information necessary to process insurance claims for payment of medical benefits to the School-Based Health Clinic Program. I have provided details of all insurance policies that cover my child.

_____ _____ _____
Parent/Guardian Signature **Parent/Guardian PRINTED Name** **Date**

BW04183

Student Health History

Student's Name: _____ **Date of Birth:** _____

Pediatrician _____ **Pediatrician's Phone #:** _____ **Last Physical:**_____

Patient's Medical History

ADD/ADHD	Yes	No	Heart Disease	Yes	No
Asthma	Yes	No	Kidney/Renal Disease	Yes	No
Bladder/Urinary Problems	Yes	No	Nosebleeds	Yes	No
Blood Disorder	Yes	No	Pneumonia	Yes	No
Bowel Problems/Constipation	Yes	No	Premature Birth	Yes	No
Cancer/Leukemia	Yes	No	Spine Disorders	Yes	No
Depression/Anxiety	Yes	No	Seizures	Yes	No
Diabetes Mellitus	Yes	No	Sickle Cell	Yes	No
Earaches/Ear Infections	Yes	No	Stomach Aches	Yes	No
Eczema	Yes	No	Wears Glasses or Contacts	Yes	No
Frequent Infections	Yes	No	Wears Hearing Aid	Yes	No
Headaches	Yes	No	Weight Issues	Yes	No

Other: _____

Current Medications:

Does your child take any medications, vitamins, supplements, or natural remedies? Yes No

If yes, please list: _____

_____

Allergies:

Does your child have allergies? Yes (if yes, please list allergies below) No

Food Allergies: _____

Medication Allergies: _____

Animal or insect Allergies: _____

Do allergies Require Epi Pen? Yes No

Asthma Information:

Does your child have an inhaler? Yes No If yes, type of preventive inhaler: _____

Will your child bring inhaler to school? Yes No If yes, type of emergency inhaler: _____

Does child use a nebulizer at home? Yes No

Surgeries/Hospitalizations:

Has your child stayed overnight in the hospital? Yes No Number of visits to the Emergency last year _____

Has your child had a serious injury? Yes No If yes, list: _____

Has your child had surgery? Yes No If yes, list: _____

Family History (maternal and paternal grandparents, parents, siblings)

Have any Blood Relatives of your child had the following problems? (Please check all that apply.)

☐ Anemia	☐ AIDS	☐ High Blood Pressure	☐ Sickle Cell
☐ Diabetes	☐ High Cholesterol	☐ Asthma	☐ Drug Abuse
☐ Headaches/Migraine	☐ Muscle or Joint Problems	☐ Stroke	☐ Tuberculosis
☐ Sudden Infant Death	☐ Arthritis	☐ Alcoholism	☐ Seizures
☐ Early Deafness	☐ Cancer	☐ Heart Disease	☐ Cystic Fibrosis

Social History

Exposed to cigarette smoke at home? Yes No

Primary guardian(s): _____

Relationship: _____

Signature

_____ _____ _____

Guardian's Signature **Guardian's Printed Name** **Date**

School-Based Health Clinic Program
Consent to Treat

Name of Child: _____ **Date:** _____
(Please Print Child's Full Name)

I, the undersigned, consent for my above-named child to receive health care services at the Ronald McDonald Care Mobile® or School-Based Health Clinic (the **"Services"**), which is staffed by State-licensed professionals of Children's Hospital at Erlanger ("Erlanger") and licensed and credentialed physician members of Erlanger's medical staff. Services include, but are not limited to medical care and treatment, including diagnosis of acute and chronic illness and disease and prescribing medications in person or via video conferencing technology (telemedicine), and albuterol treatments (with prior consent). I understand that there are certain hazards and risks connected with all forms of treatment and consent is given in light of this knowledge. I understand that Children's Hospital at Erlanger is a teaching hospital and that my child may be included in its teaching, research, and training programs. I also understand that I may be contacted for participation and/or follow-up regarding such programs.

I understand that some parts of a telemedicine exam may involve physical tests conducted by the individuals at my child's location at the direction of the telemedicine consulting health care provider. I understand that video conferencing will not be the same as a direct patient care visit due to the fact that I or my child will not be in the same room as the health care provider. I understand the potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue my child's telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.

I understand that I will be notified prior to my child's encounter with the medical provider including potential telemedicine visits. I give my permission for my child to receive care at the Ronald McDonald Care Mobile® or School-Based Health Clinic whether or not I can accompany my child at each visit. I agree to make myself available for communication regarding my child's health needs. I authorize staff to summon emergency services (9-1-1) for my child if necessary. Expenses related to ambulance or other emergency referral will be my responsibility.

I authorize the Ronald McDonald Care Mobile® or School-Based Health Clinic staff to disclose all or any portion of my child's medical record to persons or entities pertinent to his/her health care, including but not limited to his/her primary care physician, other health providers on the care team, care coordinators, pediatric subspecialty medical providers, the school nurse, and the Ronald McDonald Care Mobile® staff. I further understand that all information in my child's medical record is confidential and will not be released to any unauthorized person or agency without written consent, except when permitted by law.

I give consent to release any information regarding treatment to third party payers (insurance) for the purpose of billing. I understand it is my duty to inform the Ronald McDonald Care Mobile® or School-Based Health Clinic staff of any change in the child's guardianship. I assign to Erlanger Health System, my physician, and other healthcare professionals involved in my child's care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available to pay Erlanger Health System for medical services provided. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. Medical services provided by the Ronald McDonald Care Mobile School-Based Health Clinic Program or at the school are billable services and may be billed directly to my insurance company.

I agree Erlanger Health System can obtain my credit report at any time, and Erlanger may only provide my report to a third party for the purpose of collection evaluation and efforts.

If my account is not paid in full within 30 days of the initial bill being sent to the last address I provided Erlanger, and Erlanger has not agreed in writing to a payment plan, my account may be turned over for collection at Erlanger's option. If my account is turned over to an attorney for collection, I agree to pay 33.33% of the balance for attorneys' fees, regardless of whether a lawsuit is filed to collect the balance. If a lawsuit is filed, I agree to pay all costs to file the lawsuit including but not limited to filing fees, court costs, process service fees, alias summons costs and all costs of post judgement proceedings (ex: post judgement interest, garnishment costs, execution fees). If my account is turned over to a collection agency, I agree to pay the costs of collection in addition to the balance of the debt.

I agree that you may call me on any phone numbers I give Erlanger, including land lines, cell phones, Skype numbers, or any other numbers. The numbers I provide may be used to communicate with me regarding my child's treatment, services rendered, regarding any unpaid balance on my account, or for any other purpose.

If my child is covered by commercial insurance, I certify by signing below that I have received and read the Notice Regarding Potential Out-of-Network Charges on page 2 of this Consent.

I also certify, by signing this form, that I am legally authorized to provide this consent. This consent will remain in force for a period of one year, or until I revoke said consent in writing.

I acknowledge that I have been offered a copy of Erlanger's Joint Notice of Privacy Practices (NPP) that details how my child's protected health information (PHI) is collected for the provision of treatment, collection of payment, and performance of hospital operations. _____ Initials.

I have declined to receive a copy of Erlanger's Joint NPP _____ Initials

I received Erlanger Health System's Plain Language Summary of Erlanger's Financial Assistance Policy, and I have been verbally advised about Erlanger's Financial Assistance Policy _____ Initials

_____	_____	_____
Parent/Guardian Signature	**Parent/Guardian PRINTED Name**	**Date**

Notice Regarding Potential Out-of-Network Charges

I understand that my child may receive Services from Erlanger-based physicians who may be out-of-network and do not have a current contract with my insurer. I understand that the physicians and other providers that may treat my child at the Ronald McDonald Care Mobile® or School-Based Health Clinic may not be employed by Erlanger and may not participate in my child's insurance network. I agree for my child to receive medical services by an out-of-network provider.

Anesthesiologists, radiologists, emergency room physicians, and pathologists are not employed by Erlanger. Services provided by those specialists, among others, will be billed separately.

Before my child receives services, I should check with my child's insurance carrier to find out if my child's providers are in-network. Otherwise, I may be at risk of higher out-of-network charges.

Erlanger has a contract with the following physician groups to provide the following services:

Anesthesia Services: Ace Anesthesiology Phone: (423) 778-7608 https://aceanesthesia.com/	**Emergency Services:** Tennessee River Physicians, PLLC Phone: 1 (888) 568-5443 https://www.quickpayportal.com	**Radiology Services:** Tennessee Interventional and Imaging Associates (TIIA) Phone: (423) 778-7234 http://www.tiiarad.com/
Pathology Services: Path Group Phone: (423) 305-0227 http://www.pathgroup.com/resources/patient-resources/patient-service-centers/	**Lab Services:** LabCorp Phone: (423) 634-1162 https://www.labcorp.com/contact-us	

If Erlanger is out-of-network with my child's insurance carrier, I authorize my child to receive medical services by Erlanger and I acknowledge that I may receive a bill for the amount unpaid by my child's insurance company, which may be greater than the amount I would pay for services at an in-network facility.

If my child is admitted to Erlanger, or has a scheduled medical procedure, I acknowledge that I will be billed for additional charges, including any out-of-network charges, if my child is provided medical services by a healthcare provider that is not in-network. In particular, I should ask Erlanger if my child will be provided any medical services by anesthesiologists, radiologists, emergency room physicians, or pathologists who are not in my child's insurance network.

If my child is admitted to Erlanger, I understand he or she may be transferred to another facility during the course of his or her care and treatment. If my child is transferred to an out-of-network facility, I acknowledge that I may receive a bill for the amount unpaid by my child's insurance company, which may be greater than the amount I would pay for services at an in-network facility. I understand that Erlanger will provide information about a transfer to a facility that is in my child's insurance network, if the in-network facility has similar treatment available to me and will not risk my health.

By signing this form, I acknowledge I may receive a bill for up to 100 percent (100%) of billed charges for any amount unpaid by my child's insurer for out-of-network healthcare services.

I will receive a separate estimate/ statement of Erlanger charges for items and services in accordance with my health benefits coverage. This estimate/ statement will be provided once healthcare providers determine what treatment and services my child requires.