Virtual Care for MSD Decatur Township

Students who see the school nurse with an illness may escalate their care by seeing a Community Health Network Provider through *Virtual Care*. *Virtual Care* is essentially an online Doctor visit completed from the convenience of the nurses office. Strep throat, pink eye, rash or ear infection are all common illnesses that can be diagnosed by the team of health care professionals through *Virtual Care*. Once diagnosed, if a prescription is necessary, it can be sent to the pharmacy of the parents' choice. By taking the provider to the student, we will eliminate the inconvenience for parents of taking their child out of school to head to the Doctor's office. This interaction with the health care provider only occurs if the student's parent or guardian have completed the consent form.

Community Health's Foundation will assist financially to make this cost neutral for all families during this pilot year as we hope families can take advantage of this opportunity if and when necessary. If you choose to participate, we ask that you complete and sign the parental consent form below to make your child eligible for these services.

Community Health Network Patient Consent Agreement

THIS PATIENT CONSENT AGREEMENT

THIS PATIENT CONSENT AGREEMENT applies to all services provided by Community Health Network, Inc., Community Hospital North, Community Hospital East, Community Hospital South, Community Heart and Vascular Hospital (a facility of Community Hospital East), Community Howard Regional Health, Community Hospital Anderson, Community Physician Network, Community Home Health, Community Surgery Center North, Community Surgery Center East, Community Surgery Center South, Community Surgery Center Hamilton, Community Surgery Center Northwest, Community Surgery Center Howard, Community Surgery Center Plus, Community Endoscopy Center Indianapolis, Community Digestive Center Anderson and Figleaf Boutique (each of these health care providers whether individually licensed or operating under the license of another hereinafter referred to collectively as "Community"). This Patient Consent Agreement covers all services provided by Community including, but not limited to, in-person, virtual, telephone and e-visit services.

Medical Treatment

I request or authorize Community to provide and perform under the direction of my physician(s) and/or advanced practice provider(s) (each a "provider") and/or his/her designee such care, procedures, services and supplies as are considered advisable for my health and wellbeing. I am aware the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me by my provider(s) or Community as to the result of any treatments, examinations, procedures or other services provided by Community. I authorize Community to dispose of any tissue, severed or amputated member, body part, or medical device removed in connection with services provided by Community. I understand it is the responsibility of the provider to explain to me the nature of any diagnostic, therapeutic, medical and/or surgical procedures necessary to treat me and to explain risks and consequences associated with the services.

Virtual Services

I understand Community may provide certain services virtually by remote telehealth technology ("virtual visit"). A virtual visit uses two-way audio and video communications in order for a provider to see my image on the screen and hear my voice to provide health care services, diagnosis, consultation, treatment, or education. These communications may use the Internet, local phone lines or wireless connections. The provider will determine whether my condition and/or concern is appropriate for a virtual visit, and I understand there is no guarantee of diagnosis, treatment, or prescription. Further, I understand I may have to travel to see a provider in-person for certain diagnosis and treatment matters or if there are any issues or failures with the equipment or connection.

Patient Rights and Advance Directives

If I am receiving hospital inpatient services or ambulatory surgical center services, I acknowledge I have been given written materials on my patient rights and responsibilities, which include my right to an advance directive. For all other Community services, I understand that information about advance directives is available upon request.

Consent to Release Medical Records

I understand Community will make every effort to treat my medical record information as confdential; however, I realize information must be shared with other providers involved in my care or in the payment of my care. Further, I understand other healthcare providers involved in my care will have access to my medical information as permitted by state and federal law. I consent to the release of my medical information for treatment, payment and health care operational purposes as allowed by state and federal law, including the release of communicable disease information.

Legal Relationships

I understand my services may be provided by: (1) providers who are not employees of Community but who have a contract with Community to provide services, such as emergency physicians, anesthesiologists, radiologists, pathologists and other independent physicians; and (2) providers who have no employment or other contractual relationship with Community (collectively, "Independent Providers"); and these Independent Providers may or may not participate in my insurance plan. I understand Community is responsible for carrying out the instructions of such Independent Providers, but I acknowledge (a) Independent Providers are not employees or agents of Community; and (b) **Community is not responsible for the medical decisions, acts or omissions of Independent Providers.**

Communications

I authorize Community and its agents to contact me at any telephone number I provide to Community including wireless (cellular) telephone numbers by calling or text messages, which could result in charges to me. Methods of contact may include using pre-recorded/artifcial voice messages and/or use of an automatic dialing device, as applicable. I understand I will be able to opt out of text messages. Community and its agents may also contact me by email at any email address I provide.

Assignment of Insurance Benefits
If my insurance is accepted by Community, I assign payment to: (1) Community; and (2) Independent Providers involved in my care. I understand I will receive separate bills for services performed by Independent Providers who may or may not participate in my insurance plan. I understand Community verifies my benefits and/or bills my insurance plan as a courtesy to me. I authorize Community to release to Medicare and its agents any information needed to determine my benefits for services received. I authorize the release of my medical records and any other information necessary to obtain payment from Medicare, Medicaid and other payers. I request that payment of authorized benefits from Medicare, Medicaid and other insurance plans be made on my behalf to Community for services provided by Community. Further, I understand verification of my benefits is not a guarantee the insurance plan will pay those benefits and I am responsible for ensuring that any prior authorization required for my services is obtained in advance of treatment. In addition, I hereby appoint Community and its employees and agents as my representative(s) to file grievances and appeals for me with my insurance plan as allowed by Indiana State law.

Responsibility for Payment
I understand that I may request and receive an estimate of anticipated charges. I understand and acknowledge: (1) an estimate is not a guarantee; (2) the estimate is not binding upon Community; and (3) actual charges will be determined based on the services I receive and may be more or less than the estimate. I understand I am financially responsible for all amounts not paid by insurance or other payers for services provided to me by Community and any Independent Providers and I agree to pay all charges when due or in accordance with any financial arrangement made at the time of discharge. Further, if I have overpaid on any account with Community, I agree that the overpayment may be applied to any outstanding charges on other Community accounts. I understand Community provides □nancial assistance and payment options to those who qualify. I understand if I opt out of using my insurance, I will not be eligible for financial assistance under Community's Financial Assistance Policy. I understand I can request additional information on payment options or financial assistance if I believe I may not be able to pay or may not be able to pay timely. In the event I do not pay such charges when due or I fail to comply with any payment arrangement, I agree to pay costs of collection, including attorney fees and interest and authorize Community or its agent to access my credit report.

Release of Responsibility for Valuables
I understand Community is not liable for personal possessions including, but not limited to, money, valuables, dentures, eyeglasses, hearing aids or other property, that are lost or damaged. I know Community has the right to search anything on its premises, including wallets and purses, for the safety and welfare of its patients and visitors. If Community decides an item could be a threat to health or safety, Community may: (1) dispose of it; (2) put it in a safe; or (3) give it to law enforcement. I know I can avoid having my possessions searched by sending them home.

Pictures and Recordings
I consent to closed circuit monitoring, videotaping, digital or audio recordings, photography and/or images of my care for Community's internal purposes including, but not limited to, identi□cation, clinical care, education, performance improvement and/or safety related purposes. I understand I will be asked to sign a separate consent if a recording or image may be used for external purposes.

Receipt of Notice of Privacy Practices
I acknowledge that I have received or have been offered the Community Health Network Notice of Privacy Practices and understand I may also access a copy at www.eCommunity.com.

By signing below, I acknowledge that I have read and agree to pages 1, 2 and 3 of this Patient Consent Agreement and my questions have been answered. Changes will not be accepted to this Patient Consent Agreement. Everything in this Agreement continues and does not expire or terminate. I understand that I can request a copy of this Agreement.

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

Patient/Legal Representative: _____ Date: _____

Relationship: _____ **Parent/Legal Representatice Phone #:** _____

Telehealth Visit Permission
The school nurse has my permission to initiate a telehealth visit with a Community Health Network (CHNw) provider for my student if the school nurse deems it to be of benefit to address an acute illness such as a sore throat. There is no cost to me for conducting this visit. The nurse will contact me prior to the visit but if they are unable to reach me, they will try to reach others authorized to consent for health care for my child. If/when we reach you or an authorized adult, your student will be registered into the CHNw system and you will be able to participate remotely in the telehealth visit. Records of the exam will become part of the Community Health Network provider's record, and available through their office.

Over-the-Counter (OTC) Medications Available for use in the School Nurse Clinic with Telehealth Visit
The school nurse will participate in the visit, and if recommended by the CHNw provider, may administer the following over-the-counter (OTC) medications from the supply available in the school nurse office, during the school day. Please check which medications you approve of the provider ordering to give to your student. If nothing is checked below we will not administer any of the OTC below, unless you consent during the telehealth visit. Check all that apply.

- ☐ Acetaminophen
- ☐ Ibuprofen
- ☐ Saline Solution
- ☐ Eye Wash
- ☐ Contact Lens Solution
- ☐ Tums chewable tablets
- ☐ Calamine Lotion
- ☐ Vaseline
- ☐ Wound Irrigation
- ☐ Throat Lozenge - Luden's or equivalent

Add'l Parent/Guardian Name: _____ Add'l Parent Guardian Phone #: _____

If your student has a telehealth visit and a prescription is ordered by the Community Health Network Provider, list the pharmacy where the prescription should be sent.

Pharmacy Name: _____ Pharmacy #: _____
Pharmacy Location: _____