PATIENT INFORMATION AND INSURANCE PACKET

School Name : _____

Address: _____

_____

Date_____

Name _____ _____ _____

Last *First* *Middle*

Social Security Number: _____ Sex: Male / Female

Date of Birth: _____ Age: _____ Race (circle one): Black White Hispanic Asian Multiracial Other: _____

Street Address_____

City_____ State _____ Zip Code_____ County _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Language (circle one): English Spanish Other: _____ **EMAIL:** _____

Primary Insurance: _____ Policy # _____

Subscriber / Policy Holder Name: _____

Subscriber / Policy Holder Date of birth: _____

Subscriber / Policy Holder SS#: _____

Secondary Insurance: _____ Policy # _____

Subscriber / Policy Holder Name: _____

Subscriber / Policy Holder Date of birth: _____

Subscriber / Policy Holder SS#: _____

Mother's/Guardian's Information Name _____

Street Address_____

City_____ State _____ Zip Code_____ County _____

Employer_____ Work Number/Extension_____

Home Phone_____ Cell Phone_____ Other_____

Father's /Guardian's Information Name _____

Street Address_____

City_____ State _____ Zip Code_____ County _____

Employer _____ Work Number/Extension_____

Home Phone_____ Cell Phone_____ Other_____

Person to Notify in Case of Emergency

Contact (other than parent/guardian) Name _____ Relationship to patient _____

Street Address_____

City_____ State _____ Zip Code_____ County _____

Home Phone_____ Cell Phone_____ Other_____

NAME OF PHARMACY _____

ADDRESS _____

PHONE NUMBER _____

NEW PATIENT INTAKE & MEDICAL HISTORY FORM

School Name: _____

Name: _____ Today's Date: _____

DOB: _____

Sex: ○ **Male** ○ **Female**

Reason for being seen: _____

VITALS

Height	
Weight	
Temp	
BP	
Pulse Oximetry	

Allergies and Sensitivities

□ ***NO KNOWN ALLERGIES***

Allergy	Reaction

Current Medications

□ ***NO KNOWN CURRENT MEDICATIONS***

Medication Name	Dosage

Past Medical History

□ ***NO KNOWN SIGNIFCANT MEDICAL HISTORY***

Please check all that apply

□ Abdominal Pain	□ Anxiety	□ Cancer	□ Ear Infections	□ Sinusitis	***List any other:***
□ Acid Reflux/Heartburn	□ Arthritis	□ Constipation	□ Eczema	□ Strep Throat	
□ ADD	□ Asthma	□ COPD	□ Heart Disease	□ Substance Abuse	
□ ADHD	□ Autism	Depression	□ Heart Murmur	□ Thyroid Disorder	
□ Alcoholism	□ Behavioral Problems	□ Diabetes Type I	□ High Blood Pressure	□ Ulcer	
□ Allergies	□ Broken Bones	□ Diabetes Type II	□ Irritable Bowel Syndrome	□ Urinary Tract Infections	
□ Anemia	□ Bronchitis	□ Diarrhea	□ Seizures	□ Wheezing	

Surgical History

□ *NO KNOWN SIGNIFICANT SURGICAL HISTORY*			
Surgery	Year	Physician	Hospital

Family History

□ *NO KNOWN SIGNIFICANT FAMILY HISTORY*			
□ ADD/ADHD	□ Cancer	□ Eczema	□ Seizures
□ Alcoholism	□ Colon Polyps	□ Heart Disease	□ Sickle Cell Disease
□ Anemia	□ COPD	□ High Blood Pressure	□ Sleep Apnea
□ Anxiety	□ Cystic Fibrosis	□ High Cholesterol	□ Stroke
□ Arthritis	□ Depression	□ Kidney/Bladder Disease	□ Thyroid Disorder
□ Asthma	□ Diabetes Type I	□ Lung Disease	□ Tumors
□ Birth Defects	□ Diabetes Type II	□ Mental Illness	
□ Bleeding Disorder	Ear/Eye Disorders	□ Migraine	***List any other:***

Social History

ETOH Use	□ Never □ Rarely □ 1-2 week □ Daily
Smoking Status	□ Never □ Rarely □ 1-2 week □ Daily
Illicit Drug Use	□ Never □ Rarely □ 1-2 week □ Daily
Caffeine Intake	□ Never □ Rarely □ 1-2 week □ Daily
Additional:	

ADDITIONAL INFORMATION:

INFORMED CONSENT FOR TELEHEALTH/TELEMEDICINE SERVICES

PURPOSE: The purpose of this form is to obtain your consent, to take part in telehealth/telemedicine consultations/visits in connection with your school or other originating sites.

Patient Name: _____ **DOB:** _____
School Name: _____ **SS #:** _____

Telehealth/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up, and/or education, and may include any of the following: Patient Medical Records, Medical Images, Live two-way audio & video, Output data from medical devices, sound, & video files.

NATURE OF TELEMEDICINE CONSULT: During a telemedicine consultation:

a. Details of your medical history, examinations, x-rays, and test will be discussed with health professionals through the use of interactive video, audio, and telecommunication technology.
b. A physical examination of you may take place.
c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s).

MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to telemedicine consultations. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for a telemedicine interaction to researchers or other entities shall not occur without your consent.

CONFIDENTIALITY: Reasonable and proper efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultations, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during telemedicine consultations.

RIGHTS: You may withhold or withdraw consent to any telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

DISPUTES: You agree that any dispute arriving from a telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telemedicine. You have had the opportunity to ask questions about the information presented on this form and telemedicine consultations. All your questions have been answered,
and you understand the written information provided above.

EDUCATIONAL RECORDS: You consent to the disclosure of your education records by (i) your school to ESE TeleHealth, LLC and its medical providers in expectation of telemedicine consultations and (ii) by ESE TeleHealth, LLC and its medical providers to your school and parents after telemedicine consultations, in accordance with the Family Educational Rights and Privacy Act (FERPA). You have a right to inspect any written records released pursuant to this FERPA consent. This consent shall remain in effect and your educational records will continue to be provided for the purposes described above.

NOTE:
The term "parent" is defined by FERPA as including natural parents, a guardian, or an individual acting as a parent in the absence of a parent or a guardian.

○ **YES, I agree to participate in telemedicine consultation(s) for the procedure(s) described above.**

_____	_____	_____
Signature of Patient or Legal Representative	***Relation to Patient***	***Date***

○ **NO,** I **refuse** to participate in a telehealth/telemedicine consultation for the procedure(s) described above.

_____	_____	_____
Signature of Patient or Legal Representative	***Relation to Patient***	***Date***

FINANCIAL OBLIGATION

TODAY'S DATE _____

Patient Information

Name _____ _____ _____
Last *First* *Middle*

Social Security Number: _____ ***Date of Birth:*** _____

Street Address_____
City_____ State _____ Zip Code_____ County _____

GUARANTOR (PERSON RESPONSIBLE FOR PAYMENT)

Name _____ _____ _____
Last *First* *Middle*

Street Address_____
City_____ State _____ Zip Code_____ County _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Thank you for choosing ESE Telehealth providers. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Insurance: Your responsibility of payment depends upon your particular plan. You are responsible for co-payments, co-insurance, and deductibles at the time services are rendered. Your claim will process according to your plan. Verification of your insurance benefits are not a guarantee of payment.

Medicare Patients: Please make certain that you fully understand your benefits and your financial responsibility if your benefits are not covered. Medicare requires a deductible. Supplement coverage may not cover that deductible. If you do not have supplemental coverage, you will be expected to meet pay until it is met. Your co-insurance responsibility will be 20%, due at time services are rendered.

Medicare Supplements: We will only bill your supplement insurance once. If payment is not received in 45 days, any pending balance will be transferred to patient responsibility.

Medicaid Patients: Please be sure to provide the correct Medicaid information to process claims. If you are covered under a CMO such as WellCare or Peachstate, you will need to provide the member id listed on that card. CMO's will have a different member id than Medicaid. Claims denied for invalid subscriber id will be

Out of Network: If you have insurance coverage under a plan in which we do not have contract, you will be treated as self-pay (cash-pay) patient and may request documentation to assist you in filing your claim.

Uninsured Patients: If you do not have insurance and would like to be treated as a self-pay patient, you will be charged $65.00 for new patient visits and $45.00 for established patient visits. Additional charges may occur according to services rendered such as Strep or Flu testing. Payments are due at time services are rendered.

Co-pay and Co-insurance: Co-pay, Co-insurance, and/or any balance are expected prior to services rendered.

Deductibles: Some insurance plans require patients to pay a pre-determined dollar amount prior to services rendered.

Charges for Medical Records and/or Forms: You may print your medical records at any time from patient portal. Requests for records in house will have a charge of $2.00 per visit note.

Payment Responsibility: The patient or legal representative is responsible for all charges of services rendered. This includes any "non-covered" services. We are happy to help assist you in an attempt to "overturn" an adverse determination. However, we will not falsify and/or change a diagnosis, symptom, or medical documentation. If you are unsure whether a service is covered by your plan, it is your responsibility to call your insurance company to inquire what benefits are allowed.

Prescriptions: Refill and/or new prescriptions that are not requested during the appointment may require an additional visit. This will be determined by the provider at time of request. Approved prescriptions may take up to 24-48 hours. We encourage you to call your pharmacy during those hours as repeated requests may cause delay in processing.

At the conclusion of your visit with us, you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

Payments may be made on the patient portal located at www.esetelehealth.com

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PATIENT FINANCIAL RESPONSIBILITY

By signing below, I am attesting that I have read, understand, and agree to the provisions provided in this form.

- I am responsibility for payment of services rendered.
- It is my responsibility to provide updated insurance information prior to being seen and will be accountable for any charges incurred if correct insurance is not supplied.
- I am responsible for co-pay, co-insurance, deductibles, and/or any services not covered by my insurance.
    - $25 charge for returned checks
    - $ 2.00 charge per visit for medical records
    - Any costs associated with collections, legal fees, and/or interest should my account become delinquent.

_____ _____

Signature of Patient or Legal Representative *Date*

NOTICE OF PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

This Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or oral, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse and disclose your health information.

As required by HIPAA, we have prepared this statement of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care related services by one or more health care providers. An example of this would include a physical examination.

Payment means such activities, as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to our insurance carrier for payment.

Health care operations include business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction if we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of December 12, 2006, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reservice the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request a written copy of a review Notice of Policy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provision of this notice or the policies and procedure of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information about HIPAA or to file a complaint, by asking to speak to our Privacy Officer or for written inquires, note "Attention Privacy Officer."

The U.S. Department of Health & Human Services
Office of Civil Rights 200 Independence Avenue
SW Washington, DC 20201
PH (202) 619-0257 or toll free: 1-877-696-6775

Acknowledgement of Receipt of Notice of Privacy Practices

Respect for our patients' privacy is of utmost importance to us. As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices that describes the health information privacy practices. Our medical staff and affiliated health care providers value your privacy as much as your well-being.

Our Notice will be posted on our website and in any other locations where we provide services. You will also be able to obtain your own copy of the Notice by accessing the patient portal or our website at www.esenetworks.com , or asking for one at the time of your next visit.

By signing below, I acknowledge that I have been provided a copy of this Notice and have therefore been notified of how health information about me, may be used and disclosed, and how I may obtain access to and control this information.

Finally, by signing below, I consent to the use and/or disclosure of my health information as described in this Notice, including treatment, to seek and receive payment for services given me, and for the business operations of the practice and its staff.

_____ _____

Signature of Patient or Personal Representative *Date*

_____

PRINTED Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

If you have any questions about this Notice or would like further information, please contact the Privacy Officer at 877-543-7221.

For Office Use Only: If the patient does not sign this acknowledgement form, record here the good faithefforts made to obtain this acknowledgement and consent.

AUTHORIZATION TO DISCUSS HEALTH INFORMATION
Patient Privacy

Please list the family members and/or significant others, if any, whom we may inform and/or speak with about the following:

- Your medical condition
- Your diagnosis
- Your treatment plan(s)
- Your payment plan(s)

Name: _____ Relationship: _____ Phone: ( ) _____
Address: _____ Check if in case of emergency only: □

Name: _____ Relationship: _____ Phone: ( ) _____
Address: _____ Check if in case of emergency only: □

Please indicate whether you agree to receive phone calls about your appointments, follow up visits, test results, etc.
□ Yes □ No Print telephone number if different than your home or cell number: ( ) _____
Can appointment reminders be left on your voice mail or answering machine? □ Yes □ No
Can other confidential messages be left on your voice mail or answering machine? □ Yes □ No

_____ _____ _____
Patient/Legal Representative ***Relation if other than patient*** ***Date***