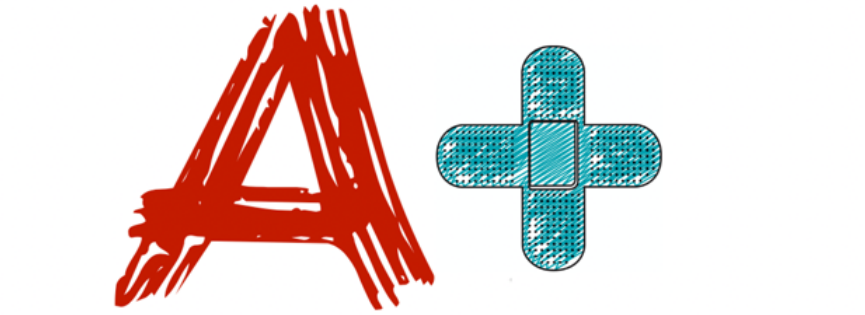

NOTICE:

This packet must be completed for your child to see the school nurse for ANY service; such as administration of Tylenol, Ibuprofen, Band-Aids, etc.

The telehealth consent on page 8 is optional. If you do not complete the telehealth consent on these pages, your child can still be seen by the school nurse, but not a provider.

If you have any questions, please contact A Plus Family HealthCare at 270-975-4050.

Edmonson County School Based Health

KidCare

A HEALTHCARE CLINIC LOCATED IN YOUR CHILD'S SCHOOL!

The Edmonson County Board of Education (ECBOE) and A Plus Family HealthCare (APFHC) have partnered to provide on-site healthcare services at our schools. APFHC School Based Clinics are comprehensive primary care health centers staffed by ARNP, LPNs, and MAs. Our goal is to create a healthier school environment by promoting general health, increasing attendance, and improving classroom behavior for the benefit of our students and staff. Your child can receive care during the school day, so they don't miss school. A Plus Family HealthCare's KidCare Clinics are primarily for acute care services and chronic care ailments will be managed and treated at one of APFHC's main clinics and/or by your primary care provider.

APFHC School Based Clinics provide on-site and telemedicine healthcare services at:

South Edmonson Elementary, Kyrock Elementary, Edmonson County 5/6 Center, Edmonson County Middle School, and Edmonson County High School.

The HEALTH CARE SERVICES we may provide include:

Sick Visits (sore throat, rash, fever, etc.), Tests, Treatments & Medications, Minor Injury Evaluation & First Aid, Health Education and Referrals to outside Providers for Care that cannot be provided at the School-Based Clinic, and more!

School & Sports Physical Examination, Immunizations, and Preventative Medicine services will only be provided on scheduled dates determined by ECBOE and APFHC.

Hours: APFHC School Based Clinic is open during the school day, please check each school for specific hours and days of operation. Students may be seen by appointment or just walk-in. Parents are encouraged to come to the student's clinic visit but will not be required if approved in advance.

Staffing: APFHC staff are highly qualified and experienced in providing health care to young people. The ARNP/LPN/MA works in collaboration with a physician and is qualified to diagnose, treat illness and prescribe medications. If your child has a primary care provider, your child can still come to the APFHC School Based Clinic. A school clinic visit does not replace your child's primary care provider, in fact, APFHC School Based Clinic will coordinate with your primary care provider to provide the best care possible for your child. If your child is currently a patient at APFHC, you must still fill out this paperwork for your child to be seen at school.

Billing & Costs: *Medicaid and Most Private Insurance Companies Cover our Services!*

We accept most forms of public and private health insurance. Copays and balances for services WILL NOT be collected from your child at the time of the visit, you will receive a billing statement. Copays and balances for services WILL be collected from all adults at the time of the visit. If you do not have insurance, APFHC staff can help determine if you qualify for assistance and help you enroll in the program that best fits your needs, Contact APFHC Patient Services at 270-975-4050 for details. APFHC School Based Clinic offers a Sliding Fee Scale based on household size and household income, please fill out the enclosed form if you are interested.

Confidentiality: APFHC School Based Clinics adhere to all laws regarding confidentiality of health services. Please review the Notice of Privacy Practices, which outlines how we may use and disclose your child's protected health information. An authorization for release of your child's information is included with this packet, please read it before signing.

Consent to Treat: To receive APFHC School Based Clinic services, students must have this consent packet completed and signed by their parent or guardian. If the student is 18 years or older, or emancipated, the student can sign their own consent packet. Each year the APFHC School Based Clinic services consent packet must be completed for your child to remain a patient. The consent will remain in effect until the end of the current school year, unless your child is no longer enrolled in Edmonson County School District or if you revoke the consent for treatment. You may revoke the consent to treat your child at any time by notifying APFHC, in writing, that the APFHC School Based Clinic no longer has consent to treat your child as a patient. Please notify us at the number below and in writing, if there are any changes in guardianship of your child.

Please note that the School-Based Health Clinic is completely optional.
If deemed necessary, emergency nursing services may be provided whether you consent to the School Based Clinic authorization or not.

Please Complete all Forms and Return to School with a Copy of the Child's Insurance Card.

We look forward to serving your child's healthcare needs!

A Plus Family HealthCare
210 South Main Steet · Suite 101 · Brownsville, KY 42210 ·
Office: 270-975-4050 · Fax: 866-809-8145
Website: www.aplushealth.org
Email address: aplusfamilyhealthcare@gmail.com

Consent for Treatment

Please complete all information, sign and date this consent for your child to receive services from APFHC School Based Clinic.

Students Name:_____ **Date of Birth**:_____ **School**:_____

I, _____, (Child's Parent/Legal Guardian) am the parent/guardian of _____, (Child's Name) and have the legal authority to consent for my child to receive medical treatment and services from APFHC School Based Clinic. I give APFHC School Based Clinic permission to provide healthcare services, perform necessary medical tests, evaluations, and provide management of my child's medical care, which may include, but is not limited to, any of the following services:

Assessment of acute or chronic illnesses; Physical exams; Assessment of growth and development*; Treatment of minor health problems; Preventive health examinations; Vision/Dental Examinations; Health Screenings; First aid; Immunizations-(including all required and recommended vaccinations unless otherwise specified by the parent/guardian in the separate immunization consent); Prescribing medication; Administration of over-the-counter medications-(if separate consent is signed and in student's record); Administration of prescription medications-(if separate consent is signed and prescribing healthcare provider order is in student's record); Laboratory and medical tests; Health education; Referrals to outside Providers for services that may not be available at the School Based clinic;*

Minor Child's Right to Consent: Kentucky law does not require the consent of a parent or a legal guardian for a minor child, under the age of 18, who have given their consent, to be examined, advised, treated and/or prescribed medication, for venereal diseases, pregnancy (including contraception), childbirth and alcohol or other drug abuse or addiction issues. The parent or legal guardian will not be notified of the minor's consent to be treated or the outcome of the treatment or other aspect of the care of the minor. Emancipated minors or any minor who has contracted a lawful marriage or borne a child may give consent to the furnishing of medical care to his or her child or himself or herself. A healthcare professional may inform the minor's parent or legal guardian of any treatment given or needed where, in the judgment of the healthcare professional, informing the parent or guardian would benefit the health of the minor patient. A Plus Family HealthCare will advise the minor patient to seek medical care in their best interest and will advise that they speak to a trusted parent or guardian concerning their medical treatment and/or need for contraception. It is important to understand that a minor can receive these services without parental consent at any medical facility in the state of Kentucky under KY. rev. stat. § 214.185.

APFHC School Based Clinic may not release information or communicate with the parent/ guardian if the minor child has the authority to act on their own to obtain certain health care services. Students will be encouraged to involve their parents or guardians in counseling and medical care decisions.

RIGHT TO REVOKE: I understand that I may revoke this consent for treatment, in writing, at any time. This consent will expire at the end of the school year. If APFHC School Based Services has acted prior to the consent

to treatment being revoked, that action is considered valid.

I, parent/guardian of the above-named student, have read the consent for treatment, and understand all information contained herein. I had all my questions answered to my satisfaction. I understand that by signing this form I am giving my consent to my minor's child treatment by APFHC School Based Clinic, as long as my child is a student in the Edmonson County School System or until I withdraw my consent in writing. I understand that the practice of medicine is not an exact science and no guarantee can be made as to the results of my child's treatment. I am voluntarily signing this form to give my consent for my child's treatment, and I understand that there may be specific health conditions and services, stated in this consent, that will remain confidential between my child and the APFHC School Based Clinic healthcare provider in accordance with Kentucky law.

Child's Full Name:_____ Child's Date of Birth:_____

Parent/Legal Guardian Full Name: _____
Parent/Legal Guardian Signature: _____
Witness Signature: _____ Date: _____

CONSENT FOR WELL-CHILD EXAMS

As part of overall health care for children, the school requires Kindergarten and 6th Grade Well Child Exams and it is recommended that all children have a Well Child Exam on a yearly basis. The Nurse Practitioner can complete the exam if you want to get your child's check-up through the school clinic. All you need to do is sign below giving permission if you would like us to complete your child's Well Child Exam or School Grade Entry Exam. If your child has already had a well-child exam or the required school check-up at their primary care physician's office, please forward a copy of it to the school as soon as possible. Well Child exams are billable and will be billed to your insurance/medical card. Although, for private insurance NO COPAY will be billed to you because well-child exams are covered 100% by insurance. It will be NO COST to you. All of the exam can be completed at the school clinic including any required immunizations (shots) if they are available at the time of the exam. If the required immunizations are not available at the time of exam, the school nurse will help you schedule an appointment with your child's physician or the health department.

☐ Yes, I would like for A Plus Family HealthCare to complete my child's exam at school.

☐ My child has already had their required school exam or the well-child exam.

☐ I give my permission for A Plus Family HealthCare to request a copy of the well-child exam from _____ (location of records/physician's office)

Signature: _____
Best Phone Number to reach you: _____

Authorization to Release

Student's Name_____ Date of Birth_____ School attending: _____

I, PARENT/GUARDIAN, GIVE CONSENT FOR APFHC SCHOOL BASED CLINIC TO;
Contact me by phone or text and/or leave a message on an answering machine regarding my child's appointments, medical information, and to resolve insurance/billing issues; ☐YES ☐NO

I, parent/guardian of that above-named student, give permission to the adult(s) named below to seek treatment for my minor child, schedule and attend medical appointments, pick up prescriptions, obtain test results, receive information on behalf of my child and otherwise stand in my place at APFHC School Based Clinic;

NAME	BIRTHDATE	ADDRESS	PHONE #	RELATIONSHIP TO MINOR

I agree to allow APFHC School Based Clinic to contact my child's primary care provider(s) and my child's other healthcare providers to assist in my child's care.

Pediatrician/Primary Care Provider: _____
Address_____ City_____ State_____ Zip Code_____
Office Number: _____ Fax Number: _____ Email address:_____

Other Provider: _____
Address_____ City_____ State_____ Zip Code_____
Office number:_____ Fax number:_____ Email address:_____

As mandated by Kentucky Law, official health care forms in compliance with the applicable Kentucky law, for physical examinations, vision screenings, dental screenings, hearing screenings and immunization will be given to the Edmonson County School District. Additional health information will be shared with the Edmonson County School District only on a need to know basis as determined by the APFHC School Based Clinic to secure the health and welfare of the child and the school. **APFHC School Based Clinic student medical records will be maintained as a confidential medical record**; it is not a school record. I also understand that confidentiality will be observed between school staff and the students using the APFHC School Based Clinic.

I give consent:

1. For APFHC School Based Clinic to disclose and release my minor child's billing and medical records to appropriate insurance agencies and medical practitioners for services provide by APFHC School Based Clinic.
2. For APFHC School Based Clinic to obtain records or information from any agency, private professional and healthcare provider or clinic regarding my child's care. APFHC School Based Clinic is released from all liability that may arise from the release of such information.
3. In order for APFHC School Based Clinic to provide services for my minor child, I authorize the ECBOE to release my child's school records.
4. APFHC School Based Clinic may release medical records to my child's school to assist in the treatment and/or continuity of care for my child.
5. I hereby authorize the APFHC School Based Clinic to release any of my child's records required by the insurer to obtain payment. My insurance company, Medicaid, Medicare, other third-party payors and/or other agencies responsible for payment for services provide by APFHC School Based Clinic on behalf of my minor child, will be billed for services rendered by APFHC School Based Clinic.
6. To allow APFHC School Based Clinic to follow the Health Insurance Portability and Accountability Act (HIPAA) rules, specifically, APFHC School Based Clinic will use and share my child's Personal Health Information (PHI) for: 1) treatment of my child's health condition and maintaining the continuity of my child's care, 2) payment for health services provided to my child.
7. I hereby authorize APFHC School Based Clinic to contact my insurance carrier in order to determine eligibility for medical services. I understand that my insurance will be billed for services rendered by APFHC School Based Clinic and medical. I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by APFHC School Based Clinic, I will within five days of receipt of this check make payment in the amount of said check to the APFHC School Based Clinic.
8. Financial Responsibility: I understand, regardless of my insurance benefits, that I alone am fully financially responsible for the fees for the services rendered.
9. I understand that should I not pay in a timely manner for treatment received from APFHC School Based Clinic, that I may be turned to collections and will be responsible for all attorney fees and collection balances.
10. If the parent/legal guardian or other authorized person as written above cannot be reached in an emergent situation, I give consent for the APFHC School Based Clinic to render medical care as deemed necessary.

    Please note: If you do not have insurance at the time you sign this consent, but obtain it later, APFHC School Based Clinic will bill your insurance company for services provided using your signature below as authorization to bill.

I understand that APFHC School Based Clinics may release patient information WITHOUT parent/guardian permission if: 1) the patient poses a threat to him/herself or others; 2) The patient is unable to protect him/herself from risk of harm; 3) There is evidence of child abuse, neglect, and/or

exploitation; 4) There is evidence of domestic violence; 5) Patient information is requested under court order and/or if a patient willingly enters their treatment history into a court proceeding.

Electronic Prescriptions (e-Prescribing): I, parent/guardian, voluntarily authorize the APFHC School Based Clinic to allow e-Prescribing for the patient's prescriptions, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice; review pharmacy benefit information and medication dispense history as long as this child is a patient in this office, or until I withdraw my consent

Written Acknowledgement of Receipt of Notice of Privacy Practices: I, parent/guardian, acknowledge receiving the APFHC School Based Clinic Notice of Privacy Practices ("Notice"). The Notice explains how School Based Clinic may use and disclose your child's protected health information for treatment, payment and health care operations purpose. "Protected health information" means your personal health information, or the personal health information of your minor child, found in your, or your child's, medical and billing records. If you have questions about the Notice, please contact A Plus Family HealthCare. Contact information is located in the Notice.

RIGHT TO REVOKE: I understand that I may revoke this Authorization, in writing, at any time. This Authorization will expire at the end of the school year.

SIGNATURE AUTHORIZATION: On behalf of my minor child; I have read this form and agree to the uses and disclosures of the information as described. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I further understand that APFHC School Based Clinic, its employees, officers and agents, are released from legal responsibility or liability for the use and disclosure to the extent indicated and authorized.

I, PARENT/GUARDIAN OF THE STUDENT, HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT'S REPRESENTATIVE VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

INSURANCE BENEFITS: I PARENT/GUARDIAN OF THE STUDENT, I GIVE PERMISSION TO THE APFHC SCHOOL BASED CLINIC TO RELEASE INFORMATION REGARDING TREATMENT AND/OR SERVICES TO MY OR MY CHILD'S INSURANCE PROVIDER(S) FOR THE PURPOSE OF BILLING. I HEREBY AUTHORIZE IRREVOCABLY ASSIGNMENT OF INSURANCE PAYMENT FOR MY CHILD'S BENEFITS DUE FOR THE SERVICES RENDERED BY THE APFHC SCHOOL BASED CLINIC MADE DIRECTLY TO THE APFHC SCHOOL BASED CLINIC.

SIGNATURE X

_____

Signature of Patient's Legal Representative

_____

Printed Name of Legal Representative

DATE: _____(month)_____(day)_____(year)

_____

Printed Name of Student

DOB: _____(month)_____(day)_____(year)

REGISTRATION FORM

SCHOOL	❑ South Edmonson Elementary ❑ Edmonson County Middle School ❑ Kyrock Elementary ❑ Edmonson County High School ❑ Edmonson County 5/6 Center

PATIENT INFORMATION

NAME	LAST	FIRST	MI	NICKNAME
DATE OF BIRTH	____/____/_____	**SSN**	_____-_____- _____	**GENDER** ❑ MALE ❑ FEMALE
MAILING ADDRESS	STREET/PO BOX			
	CITY	STATE	ZIP	
PHYSICAL ADDRESS ❑ ***SAME AS MAILING***	STREET			
	CITY	STATE	ZIP	
PHONE	HOME | CELL		| WORK	EXT
EMAIL ADDRESS		**MARITAL STATUS:**	❑ SINGLE ❑ MARRIED	
STUDENT STATUS	❑ FULL TIME ❑ PART TIME			
PREFERRED PHARMACY		**CITY/STATE**		
ALTERNATE PHARMACY		**CITY/STATE**		
RACE	❑ AMERICAN INDIAN ❑ AFRICAN AMERICAN ❑ ASIAN ❑ CAUCASIAN/WHITE ❑ HISPANIC ❑ NATIVE HAWAIIAN OR PACIFIC ISLANDER ❑ OTHER_____			
ETHNICITY	❑ NON-HISPANIC ❑ HISPANIC	**LANGUAGE**	❑ ENGLISH ❑ SPANISH ❑ OTHER _____	
Sexual Orientation	❑ STRAIGHT ❑ LESBIAN/GAY ❑ TRANSGENDER ❑ BISEXUAL ❑ UNKNOWN ❑ REFUSE TO ANSWER	**THIS IS A FEDERALLY REQUIRED QUESTION AND CONFIDENTIAL.**		
EMPLOYMENT STATUS	❑ FULL TIME ❑ PART TIME ❑ NOT CURRENTLY EMPLOYED	**NAME**		
ADDRESS		**PHONE**		

RESPONSIBLE PARTY INFORMATION

NAME	LAST	FIRST	MI	SSN
MAILING ADDRESS ❑ ***SAME AS ABOVE***	STREET/PO BOX			
	CITY	STATE	ZIP	
DATE OF BIRTH	____/____/_____	**RELATIONSHIP TO PATIENT**		
PHONE	HOME | CELL		| WORK	EXT

RESPONSIBLE PARTY EMPLOYER INFORMATION

EMPLOYMENT STATUS	❑ FULL TIME ❑ PART TIME ❑ RETIRED ❑ DISABLED ❑ ACTIVE MILITARY ❑ SELF EMPLOYED ❑ UNEMPLOYED		
NAME		**PHONE**	
ADDRESS			

EMERGENCY CONTACT INFORMATION

NAME	| PHONE	| RELATIONSHIP TO PATIENT
NAME	| PHONE	| RELATIONSHIP TO PATIENT

TELEMEDICINE
INFORMED CONSENT FORM

Students Name: _____ **Date of Birth**: _____ **School**: _____

Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient and the healthcare provider at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment that provide a two-way interactive video and audio. Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care.

Possible Risks:

There are potential risks associated with the use of telemedicine which include, but may not be limited to:

1. A provider may determine that the telemedicine is not yielding enough information to make an appropriate clinical decision and stop the telehealth visit;
2. Technology problems may delay medical evaluation and treatment for today's encounter;
3. In very rare instances, security protocols could fail, causing a breach of privacy or personal medical information.

By signing this form, I, parent/guardian or student, understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies my child will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my child's care at any time, without affecting my child's right to future care or treatment.
3. I also understand that if the provider believes my child would be better served by a traditional face -to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit.
4. I understand that my child may expect the anticipated benefits from the use of telemedicine in my child's care, but that no results can be guaranteed or assured. I hereby release APFHC School Based Clinic from liability due to unintentional breach of privacy of my child's medical information, and unintentional interruption or technical difficulties.

Consent to the Use of Telemedicine

I, _____, (Child's Parent/Legal Guardian) am the parent/guardian of _____, (Child's Name) and have the legal authority to consent for my child to receive Telemedicine treatment and services from APFHC School Based Clinic. I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care.

I give APFHC School Based Clinic permission to provide Telehealth services and perform necessary medical tests. 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 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 video conferencing connections are not adequate for the situation.

AN APFHC employee will attempt to contact child's parent/legal guardian in order to receive verbal consent before telemedicine visit. If we are unable to reach you within 10 minutes, we will proceed to examine your child as deemed necessary.

❑ **YES, TREAT MY CHILD IF UNABLE TO CONTACT ME.**

❑ **NO, *DO NOT* TREAT MY CHILD WITHOUT CONTACTING ME.**

Child's Full Name:_____ Child's Date of Birth:_____

Parent/Legal Guardian Full Name: _____

Parent/Legal Guardian Signature: _____

Financial Policy

In order to prevent any misunderstanding concerning the responsibility for payment for medical services provided to our patients, the following information is supplied:

1. Commercial Insurance: If you have insurance coverage through a commercial provider (Humana, Anthem, UMR, etc.), we require you provide us with your mailing address, an assignment allowing your insurance company to send payment, and a copy of your insurance card. You will be billed for any deductible and/or copay. If your statement of account is returned because of out of date information, you will be required to pay prior to treatment at any APFHC facility.
2. Medicaid: If you have Medicaid coverage, we must have your Medicaid card in order to properly bill for any services. If you have Medicaid coverage pending, please advise us and please send a copy of card when received.
3. Medicare: Our providers are participating Medicare providers. Office visits to a primary care provider are covered under Part A 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.
4. Sliding Scale: APFHC offers a sliding scale to patients who do not have health insurance. The sliding scale adjusts charges for medical services based upon the household size and total combined household income. To qualify for the sliding scale, it is required that you provide APFHC with proof of your income (i.e.: w2, pay stubs, statement from Medicaid office). Failure to do so within 60 days of applying for the sliding scale will render the patient ineligible for the sliding scale and the guarantor will be responsible for 100% of charges from any services provided by APFHC.
5. Collection Policy and Right to Refuse Treatment: APFHC School Based Clinic will follow APFHC's patient account collection policies.

Insurance Information

Insurance Type	❑ Commercial ❑ Medicaid ❑ None/Self Pay ❑ Other: _____		
Primary	Name	| Policy #	| Subscriber DOB
Secondary	Name	| Policy #	| Subscriber DOB

Financial Assessment for Patients Without Health Insurance

If you have insurance, you may skip the next section

If you do not have health insurance, you may qualify for the APFHC sliding scale. We ask that you please provide us with the following information which will determine eligibility. Please call 270-975-4050 with any questions.

A Plus Family HealthCare
Discount Eligibility Application
ALL INFORMATION IS CONFIDENTIAL

Why do we need to know your household income?

- Some of our funding may come from grant money. For most of these grants, income information from our patients is necessary to prove financial need in the communities we serve.
- These grants allow us to provide a much higher level and greater availability of care than we could otherwise afford
- In order to obtain these grants, and to keep them, we need to provide demographic information, including financial resources of patients, to prove that we are serving the people the grant money has been set aside for.

Definitions:

Household members:

All members of a household who are pooling financial resources in addition to room and board and/or are supporting one another financially are counted as one family.

Income:

Income is defined as cash receipts received from all sources before taxes, including:

- Wages and Salaries
- Receipts from self-employment less operating expenses
- Payments from public assistance, social security, strike benefits, military allotments, disability, child support, government or private pensions, regular insurance or annuity payments
- Income from dividends (including permanent fund & longevity dividends), interest, rents, royalties, estates or trusts

_____ I am **NOT interested** in disclosing my financial information; therefore I acknowledge my family and I are not eligible for the sliding fee discount program. (If you checked this box, please skip the following sections)

Eligibility Determination

Household members/ Household income:
List your name and the name(s) of ALL individuals who live with you.

Name:	**Relationship:**	**Age**	**Annual Income**

If you need more space, please continue on the back of this form.

TOTAL # IN HOUSEHOLD: _____ **TOTAL HOUSEHOLD INCOME:** _____

Household Address: _____

Do you or anyone living with you have Health Insurance, Medicare or Medicaid? Yes: _____ No: _____
If so, please provide a copy of the insurance card, Medicare Card, or State Medicaid to the receptionist.

Have you applied for KY State Medicaid: Yes: _____ NO:_____

This information must be updated each year, and anytime your income, household size and/or medical insurance status changes.

I understand that the information I provide on this form is subject to verification by APlus Family HealthCare. I certify that the above information is true and correct to the best of my knowledge.

_____ _____
Patient/Guardian Signature Printed Name Date

_____ _____
Signature of A Plus Representative Discount % to be applied: Date

MEDICAL HISTORY

I, parent/guardian, understand it is my responsibility to provide APFHC School Based Clinic with my child's medical records, including prescriptions and medical provider orders, for APFHC School Based Clinic to provide required treatments and medications ordered by my child's healthcare providers. Providing APFHC School Based Clinic access to diagnoses and current medications, treatment plans, and care instructions after an injury, illness, surgery or hospitalization can ensure consistency in health services for your child. Requests from a parent/guardian to change a prescribed medication or treatment will not be accepted without the documentation from the prescribing healthcare provider.

MEDICAL HISTORY

The following list of medications will be on hand at the APFHC School Based Clinic to be administered after your child's complaint has been evaluated. Please review the list and place a check mark by the ones you will allow your child to have:

- ❑ Tylenol (Acetaminophen)
- ❑ Advil (Ibuprofen)
- ❑ Cough Drops
- ❑ Sore Throat Spray
- ❑ Robitussin (Tussin)
- ❑ Orajel
- ❑ Allergy Eye Drops
- ❑ Antacids (Liquid/Chewable)
- ❑ Aloe Vera Gel
- ❑ Chapstick
- ❑ Benadryl (Diphenhydramine)
- ❑ Calamine Lotion
- ❑ Hydrocortisone 1% Cream
- ❑ Triple Antibiotic Ointment
- ❑ Glucose Gel/Tablets

The following information will aid the School Based Clinic in making an accurate assessment of your child in case of illness or emergency. Please check the appropriate box if your child has ever had any of the following:

- ❑ Measles
- ❑ Mumps
- ❑ Anemia
- ❑ Chicken Pox
- ❑ Leukemia
- ❑ Head, Eyes, Ears, Throat Problems
- ❑ Chest Pain
- ❑ Scarlet Fever
- ❑ Birth Defects
- ❑ Rheumatic Fever
- ❑ Exposed to Tuberculosis
- ❑ Blood Transfusion
- ❑ Persistent Cough
- ❑ Stomach or Bowel Problems
- ❑ Diabetes
- ❑ Asthma
- ❑ Shortness of Breath
- ❑ Anaphylactic Episodes
- ❑ Other: _____

CURRENT MEDICATIONS:

_____
_____
_____
_____
_____

ALLERGIES:

_____
_____
_____
_____
_____

CHRONIC ILLNESSES/SURGICAL HISTORY:

DOES YOUR CHILD USE ANY OF THE FOLLOWING:

❑ Alcohol ❑ Tobacco ❑ Drugs

NAME OF YOUR CHILD'S PRIMARY CARE PROVIDER:

_____

DATE OF LAST VISIT: _____

NAME OF YOUR CHILD'S DENTIST:

_____

DATE OF LAST VISIT: _____

ANY INFORMATION REGARDING YOUR CHILD'S MEDICAL HISTORY NOT LISTED ABOVE:

_____

_____

_____

FAMILY MEDICAL HISTORY

Please specify if any of the student's family members have had any of the health problems listed below

Cancer: _____ Anemia: _____ Kidney Disease: _____

Heart Disease: _____ High Blood Pressure: _____ Stroke: _____

Birth Defects: _____ Epilepsy: _____ Diabetes: _____

PEDIATRICIAN/PRIMARY CARE PROVIDER

In the event of an emergency, it may be necessary for us to contact your child(s) Pediatrician or Primary Care Provider (PCP). Please list the name and contact information for that primary care provider or facility along with any/all medical facilities where the child has been given immunizations.

Pediatrician/Primary Care Provider: _____

Address *(if unsure of complete mailing address, please just list City and State):*

_____

Street

_____

City State Zip

Office Phone Number: _____

APFHC HIPAA NTICE OF PRIVACY PRACTICES 2020

THIS FORM DOES NOT CONSTITUTE LEGAL ADVICE AND COVERS ONLY FEDERAL, NOT STATE, LAW

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice available upon re quest. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Receptionist, Danielle Meredith. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

(a) Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and/or business operations. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. There may be a fee charged for copies, based upon the amount of information requested and the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

(b) Right to Request Restriction of PHI: You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which out facility has been paid out of pocket in full.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. There may be a fee charged for copies, based upon the amount of information requested and the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore, these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (*Example: If you request information on May 15, 2004 the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Breach Notification Requirements: Beginning September 23, 2009, in the event unsecured protected information about you is "breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform the United States Department of Health & Human Services (HHS) and take any other steps required by law.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision, we made regarding your access to your health information, you can complain to us, in writing, by requesting a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with HHS.

HOW TO CONTACT US: Practice Name: A Plus Family HealthCare **Privacy Officer:** Ashley Graham
Ph: 270-975-4050 **Address:** 210 S Main Street Ste 101, Brownsville, KY 42210 **Fax:** 866-809-8145