MASON COUNTY SCHOOLS

ON-SITE HEALTHCARE

Pleasant Valley Hospital is proud to provide medical care for students and employees at Mason County Schools.

Please take the completed form to your school office for delivery to the PVH Nurse Practitioner or email to schoolbasedhealth@pvalley.org.

MASON COUNTY SCHOOLS
ON-SITE HEALTHCARE

Pleasant Valley Hospital is proud to provide medical care for students and employees at Mason County Schools.

Pleasant Valley Hospital (PVH) is pleased to support the Mason County School System and their nursing staff by providing medical care to students and employees. Medical services are available on a rotating schedule during the school day. The FNPs work in collaboration with a PVH physician and are qualified to diagnose, treat illness and prescribe medications. The FNPs also work with your family physician and school nurse.

- Parents save valuable work time and expenses by not having to leave work or drive to school
- Mason County School employees save time
- Students don't have to miss school
- Prescriptions are called to your pharmacy of choice
- To access medical services onsite by a FNP from PVH, please take a few moments to complete the enclosed forms in this packet

<u>Services and treatments provided may include and are not limited to the following:</u>

- Minor illness and injuries like the following:
  - cold/flu
  - ear infection
  - minor wounds/abrasions
  - sinus infection
  - sore throat
  - sports physicals
- Annual well checks
- Counseling
- Health education
- Immediate care
- Preventive care

For more information, please call the Family Nurse Practitioner at 304.593.8822.

Locations

Ashton Elementary
Beale Elementary
Hannan Jr/Sr High School
Leon Elementary
Mason County Career Center
New Haven Elementary
Point Pleasant Intermediate
Point Pleasant Primary
Roosevelt Elementary
Wahama Jr/Sr High School

Better Together
CabellHuntington Hospital
MarshallHealth

ENROLLMENT AND CONSENT TO TREAT FORM

For Mason County School's School Based Medical Services

Sponsored by Pleasant Valley Hospital

FOR STUDENTS 17 YEARS OF AGE AND YOUNGER - A parent or legal guardian must complete these forms.
FOR STUDENTS AND EMPLOYEES 18 YEARS OF AGE AND OLDER - The patient must complete these forms.

STUDENT OR MASON COUNTY SCHOOL SYSTEM EMPLOYEE INFORMATION

Name: _____ Email Address: _____ Cell: _____

Address: _____City/State/Zip:_____ Grade: _____

Gender: _____ Race: _____ Preferred language _____

PARENT / GUARDIAN INFORMATION

Father: _____**Phone (H)**_____ **(W)**_____**(C)** _____**Email** _____

Mother: _____**Phone (H)**_____ **(W)**_____**(C)** _____**E-mail**_____

Guardian: _____**Phone (H)**_____ **(W)**_____**(C)** _____**E-mail**_____

Alternate Contact:_____**Phone (H)**_____ **(W)**_____**(C)** _____**E-mail**_____

CONSENT FOR TREATMENT: Consent is hereby given to the Pleasant Valley Hospital treating providers and/or staff to perform such services that are deemed necessary.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatment and/or examinations in the clinic.

FINANCIAL AGREEMENT: I accept responsibility for the payment of all charges and fees for the clinic and professional services covering treatment(s) provided of the patient listed above. I further authorize that any insurance benefits that are reimbursable for such services be paid directly to Pleasant Valley Hospital, Inc.

I acknowledge and understand that the ultimate responsibility for all charges incurred on my account is mine and agree to pay all deductibles, co-insurances, balances in full charges for non-covered or denied charges.

NOTICE OF PRIVACY PRACTICES: As part of your health care, it is necessary to create, maintain and (in certain situations) share medical information concerning your current health care services and health history. Our Notice of Privacy Practices (referred to as "NPP") describe how we may use and disclose your protected health information. You are being provided a copy of our Notice of Privacy Practices and have the right to review our Notice before signing this consent. By signing, you authorize consent to our use and disclosure of protected health information about your treatment, payment and health care operations and hereby acknowledge receipt of our Notice of Privacy Practices.

Confidentiality between the student, parents and the school health clinic is assured. By law, some information requires the student to have a signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions. I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact. I certify that a copy of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 was provided.

Authorization for use or disclosure of health information between medical providers and the school district: Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning privacy of such information. Failure to provide all information requested may invalidate this authorization.

Use and disclosure information: I understand, the undersigned, do hereby authorize Pleasant Valley Hospital to provide health information from the above named child's medical record to and from the Mason County School Nurses Samantha Knapp, RN; Lauri Johnson, RN; Lydia Gordon, RN; Helen Carry, RN; Faith Smith, RN; Mary Ann Parsons, LPN; Jill Thompson, LPN; Linda Ward, LPN. The Mason County School mailing address is 1200 Main Street Point Pleasant, WV 25550 – 304.675.4540. The disclosure of health information is required for the following purpose: vaccine information, requested information shall be limited to the following: all minimum necessary health information; and/or disease-specific information.

Duration: This authorization shall become effective immediately and shall remain in effect until August 31, 2017, or for one year from the date of signature, if no date entered.

Restrictions: Law prohibits the requestor from making further disclosure of my health information unless the requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

Your rights: I understand that I have the following rights with respect to this authorization: I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons that are listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance to this authorization.

Re-disclosure: I understand that the requestor will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the school district for providing safe, appropriate and least restrictive educational settings and school health services programs.

I have a right to receive a copy of this authorization. Signing this authorization may be required in order for this student to obtain appropriate services in the educational setting.

Pleasant Valley Hospital will not be responsible for any personal articles, which may be lost or during the discourse of treatment.

THE UNDERSIGNED HAS READ THE FOREGOING, UNDERSTANDS, AND ACCEPTS APPROVAL:

_____ _____

Signature of Parent or Legal Guardian if 17 years of age and younger
Signature of patient if 18 years of age and older

Date

_____ _____

Witness

Date

STUDENT OR MASON COUNTY SCHOOL SYSTEM EMPLOYEE INSURANCE INFORMATION

Please check all that apply and send a copy of the front and back of your insurance card(s)

Patient Name:	SS#	Marital Status:
Guardian's Cell Phone	Patient Phone or Cell Phone:	
Maiden Name:	Date of Birth:	
Primary Care (family) Physician and Phone:	Mother's first name:	
Employer's name and address:	Employer's Phone:	
Patient's Occupation:	Next of kin and relationship:	
Next of kin phone:	Next of kin Address :	

RESPONSIBLE PERSON (SUBSCRIBER) INFORMATION

Responsible Person's Name:	Responsible Person's SS#:
Responsible Person's Address:	Phone #:
Responsible Person's Employer Name and Address:	Responsible Person's Occupation:
Responsible Person's Date of Birth:	Employer Phone:

INSURANCE INFORMATION

Insurance Name: (**PRIMARY**)	Policy #
Subscriber's Name:	Group #
Insurance Address:	

Insurance Name: (**SECONDARY**)	Policy #
Subscriber's Name:	Group #
Secondary Insurance Address:	

_____ _____

Signature of Parent or Legal Guardian if 17 years of age and younger Date
Signature of patient if 18 years of age and older

Please attach a copy of the front and back of your insurance card(s).

MEDICAL HISTORY

NAME: _____

Please list any medical problems: _____
_____

Please list any previous surgeries: _____
_____

Please list any family history of medical problems (like diabetes, heart disease, cancer): _____
_____

Social History
Educational level _____ Years completed ____

Tobacco use
Yes ☐ How many packs per day ____ ☐ Never Used ☐ Considering Quitting ☐ Not considering quitting ☐ Secondhand Exposure

Alcohol use
☐ None ☐ 0-2 per day ☐ 2+ per day

Substance abuse
☐ None ☐ Cocaine/Crack ☐ Amphetamines ☐ Hallucinogens ☐ Tranquilizers/Sedatives ☐ Opiates ☐ Painkillers ☐ Cub/Designer drugs
☐ Inhalants ☐ Heroin ☐ Injection drugs ☐ Marijuana

Abuse: Physical Abuse ☐ Yes ☐ No Emotional Abuse ☐ Yes ☐ No Sexual Abuse ☐ Yes ☐ No

Allergies:_____

Current Medications (please include any over the counter and herb supplements)

Medication Name	**Strength/Route/Frequency**
_____	_____
_____	_____
_____	_____
_____	_____

Pharmacy_____ **Location**_____

The Pleasant Valley Hospital Family Nurse Practitioner will also provide annual/routine wellness exams for students and Mason County School Employees on-site at school locations.

_____ **Please initial here if your child has not had an annual/routine well child exam from his/her doctor and you would like the PVH Nurse Practitioner to provide your child with a well child exam.**

_____ **Please initial here if you are 18 years of age and older and have not had an annual/routine exam from your doctor and you would like the PVH Nurse Practitioner to provide you with an annual exam.**

_____ _____
Signature of Parent or Legal Guardian if 17 years of age and younger Date
Signature of patient if 18 years of age and older

Better Together · Cabell Huntington Hospital · PVH · Marshall Health

HIPAA - Notice of Privacy Practices of Pleasant Valley Hospital, INC. and other health care providers, which are members of our system, including the following: PVH Nursing & Rehabilitation Center, Pleasant Valley Therapy Center, PVH Home Health Services, Hospice & Private Duty, Medical, PVH Home Medical Equipment, Pleasant Valley Medical Group

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

WE HAVE A LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU

We are required to protect the privacy of health information about you and that can be identified with you, which we call "protected health information," or "PHI" for short. We must give you notice of our legal duties and privacy practices concerning PHI:

- We must protect PHI that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care.
- We must notify you about how we protect PHI about you.
- We must explain how, when and why we use and/or disclose PHI about you.
- We may only use and/or disclose PHI as we have described in this Notice.

This Notice describes the types of uses and disclosures that we may make and gives you some examples. In addition, we may make other uses and disclosures, which occur as a byproduct of the permitted uses and disclosures described in this Notice.

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain by first:
- Posting the revised notice in our offices;
- Making copies of the revised notice available upon request (either at our offices or through the contact person listed in this Notice); and
- Posting the revised notice on our website.

1. We may use and disclose PHI about you to provide health care treatment to you. We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription, to a laboratory to order a blood test, or to a home health agency that is providing care in your home.

2. We may use and disclose PHI about you to obtain payment for services.Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services provided to you. Before you receive scheduled services, we may share information about these services with your health plan(s). For example, if certain procedures are recommended, we may need to disclose information to your health insurer to get prior approval for the procedure. We may also disclose protected health information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan.

3. We may use and disclose your PHI for health care operations. We may use and disclose PHI in performing business activities, which we call "health care operations". These "health care operations" allow us to improve the quality of care we provide and reduce health care costs. Examples of the way we may use or disclose PHI about you for "health care operations" include the following:
- Quality assessment and improvement activities.
- Employee review activities.
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision.
- Accreditation, certification, licensing or credentialing activities.
- Reviewing and auditing, including compliance reviews, medical reviews, and legal services and maintaining compliance programs.
- Business management and general administrative activities.
- In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

4. We may use and disclose PHI under other circumstances without your authorization.
- We may use and/or disclose PHI about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object. Those circumstances include:
- When the use and/or disclosure is required by law.

For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.
- When the use and/or disclosure is necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- When the disclosure relates to victims of abuse, neglect or domestic violence.
- When the use and/or disclosure is for health oversight activities. For example, we may disclose PHI about you to a state or federal health oversight agency, which is authorized by law to oversee our operations.
- When the disclosure is for judicial and administrative proceedings. For example, we may disclose PHI about you in response to an order of a court or administrative tribunal.
- When the disclosure is for law enforcement purposes. For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- When the use and/or disclosure relates to decedents. For example, we may disclose PHI about you to a coroner or medical examiner for the purposes of identifying you should you die.
- When the use and/or disclosure relates to cadaveric organ, eye or tissue donation purposes.
- When the use and/or disclosure relates to medical research. Under certain circumstances, we may disclose PHI about you for medical research.
- When the use and/or disclosure is to avert a serious threat to health or safety. For example, we may disclose PHI about you to prevent or lessen a serious and eminent threat to the health or safety of a person or the public.
- When the use and/or disclosure relates to specialized government functions. For example, we may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations. For example, in certain circumstances, we may disclose PHI about you to a correctional institution having lawful custody of you.

5. You can object to certain uses and disclosures. Unless you object, we may use or disclose PHI about you in the following circumstances:
- We may share your name, your room number, and your condition in our patient listing with clergy and with people who ask for you by name. We also may share your religious affiliation with clergy.
- We may share with a family member, relative, friend or other person identified by you, PHI directly related to that person's involvement in your care or payment for your care. We may share with a family member, personal representative or other person responsible for your care PHI necessary to notify such individuals of your location, general condition or death.

• We may share with a public or private agency (for example, American Red Cross) PHI about you for disaster relief purposes. Even if you object, we may still share the PHI about you, if necessary for the emergency circumstances. If you would like to object to our use or disclosure of PHI about you in the above circumstances, please call our contact person listed on the cover page of this Notice.

6. We may contact you to provide appointment reminders. We may use and/or disclose PHI to contact you to provide a reminder to you about an appointment you have for treatment or medical care.

7. We may contact you with information about treatment, services, products or health care providers. We may use and/or disclose PHI to manage or coordinate your healthcare. This may include telling you about treatments, services, products and/or other healthcare providers. We may also use and/or disclose PHI to give you gifts of a small value.
8. We may contact you for fund-raising activities. We may use and/or disclose PHI about you, including disclosure to a foundation, to contact you to raise money for the hospital and its operations. We would only release contact information and the dates you received treatment or services at the hospital. If you do not want to be contacted in this way, you must notify in writing our contact person listed on the last page of this Notice.

**** ANY OTHER USE OR DISCLOSURE OF PHI ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION ****

Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose PHI about you. If you sign a written authorization allowing us to disclose PHI about you in a specific situation, you can later cancel your authorization in writing. If you cancel your authorization in writing, we will not disclose PHI about you after we receive your cancellation, except for disclosures which were being processed before we received your cancellation.

YOU HAVE SEVERAL RIGHTS REGARDING PHI ABOUT YOU
1. You have the right to request restrictions on uses and disclosures of PHI about you. You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in subsection 4 of the previous section of this Notice. You may request a restriction by contacting the Pleasant Valley Hospital Privacy Officer at 304-675-4340 Ext. 1161.

2. You have the right to request different ways to communicate with you. You have the right to request how and where we contact you about PHI. For example, you may request that we contact you at your work address or phone number or by email. Your request must be in writing. We must accommodate reasonable requests, but, when appropriate, may condition that accommodation on your providing us with information regarding how payment, if any, will be handled and your specification of an alternative address or other method of contact. You may request alternative communications by contacting the Pleasant Valley Hospital Privacy Officer at 304-675-4340 Ext. 1161.

3. You have the right to see and copy PHI about you. You have the right to request to see and receive a copy of PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. Instead of providing you with a full copy of the PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary or explanation. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. You may request to see and receive a copy of PHI by contacting the Pleasant Valley Hospital Privacy Officer at 304-675-4340 Ext. 1161.

4. You have the right to request amendment of PHI about you. You have the right to request that we make amendments to clinical, billing and other records used to make decisions about you. Your request must be in writing and must explain your reason(s) for the amendment. We may deny your request if: 1) the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and complete; or 4) you would not have the right to see and copy the record as described in paragraph 3 above. We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received PHI about you and who need the amendment. You may request an amendment of your PHI by contacting the Pleasant Valley Hospital Privacy Officer at 304-675-4340 Ext. 1161.

5. You have the right to a listing of disclosures we have made. If you ask our contact person in writing, you have the right to receive a written list of certain of our disclosures of PHI about you. You may ask for disclosures made up to six (6) years before your request (not including disclosures made prior to April 14, 2003). We are required to provide a listing of all disclosures except the following:
- For your treatment
- For billing and collection of payment for treatment
- For our health care operations
- Made to or requested by you, or that you authorized
- Occurring as a byproduct of permitted uses and disclosures
- Made to individuals involved in your care, for directory or notification purposes, or for other purposes described in subsection B.5 above.
- Allowed by law when the use and/or disclosure relates to certain specialized government functions relates to correctional institutions and in other law enforcement custodial situations (please see subsection B.4 above) and
- As part of a limited set of information which does not contain certain information which would identify you.

The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. If, under permitted circumstances, PHI about you has been disclosed for certain types of research projects, the list may include different types of information. If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee. You may request a listing of disclosures by contacting the Pleasant Valley Hospital Privacy Officer at 304-675-4340 Ext. 1161.

6. You have the right to a copy of this Notice. You have the right to request a paper copy of this Notice at any time by contacting the Pleasant Valley Hospital Privacy Officer at 304-675-4340 Ext. 1161. We will provide a copy of this Notice no later than the date you first receive service from us (except for emergency services, and then we will provide the Notice to you as soon as possible).

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you think we have violated your privacy rights, or you want to complain to us about our privacy practices, you can contact the Privacy Officer listed below:
Pleasant Valley Hospital - 2520 Valley Drive - Point Pleasant, WV 25550
Phone: 304-675-4340 ext. 1161 - E-mail: pbrooker@pvalley.org
You may also send a written complaint to the United States Secretary of the Department of Health and Human Services.
If you file a complaint, we will not take any action against you or change our treatment of you in any way.