Penn Highlands' School-Based Telemedicine Program

Penn Highlands is excited to be working with Brockway Area School District to offer parents and students a new option for pediatric care. Through high-definition telemedicine video and communications equipment, the school nurse can connect with a Penn Highlands physician for evaluation. This will make healthcare for children more convenient and accessible, avoid delays in treatment, and enhance learning by decreasing absenteeism.

How does this program work?

With the parent's consent, a physician from Penn Highlands will perform an assessment alongside the school nurse. The school nurse will first evaluate the student in person. If the nurse determines the child could benefit from further evaluation, they will contact the parent to obtain verbal consent to proceed with a telemedicine visit and invite them to participate if available. The physician will complete an assessment of the student. The school nurse will assist the physician during the evaluation through the use of special equipment. The provider will have the ability to listen to heart and lungs with a digital stethoscope. The physician can closely examine the student's ears, throat, rash, or abrasions with high – definition cameras.

Upon completion of the evaluation, the physician will give instructions for follow-up care and submit an order to your pharmacy of choice for prescription medications, if needed. A record of your child's visit will be kept in their medical record at Penn Highlands for future reference.

Who is eligible?

All students in the Brockway Area School District are eligible to enroll in the school-based telemedicine program.

What are examples of conditions that could be evaluated?

- Earaches
- Fever
- Coughs and colds
- Rashes and minor skin infections
- Abrasions and scrapes
- Strep throat and Influenza
- Headaches
- Pinkeye

There are medical needs that will require an in-person evaluation by a medical provider. You may be asked to schedule an appointment with your child's primary care physician directly if evaluation by telemedicine isn't sufficient for diagnosis.

How do I enroll my child in this program?

The first and most important step is to complete the required informational and consent forms to enroll your child in the school-based telemedicine program. Forms must be filled out for each student that attends Brockway Area School District. Completed paper forms should be given to the school nurse.

What is the cost?

There is no cost to enroll in this program. If your child has a visit, Penn Highlands will bill your insurance and any required co-pay amounts after the visit.

When will health services be available?

Medical services will be provided during the school day with the exception of school closures.

How will I know if my child has a telemedicine visit?

When a student presents to the school nurse's office, the nurse will assess the student's condition and contact the parent or legal guardian to discuss if it is appropriate to have a telemedicine visit. For a telemedicine visit to take place, the required forms should have already been completed and on file at the nurse's office. Parents/guardian will also give verbal consent to the nurse to proceed with a telemedicine visit.

Does a parent/guardian have to be present for the telemedicine visit?

Parents are welcome and encouraged to attend virtually but it is not required. Parents that are able and want to participate will be sent a link to join the video visit.

Will my child still be seen by the school nurse if I choose not to participate in the program?

Yes, if you choose NOT to sign your child up for the School-based telemedicine program, they will continue to receive all school nursing services currently being provided at your child's school.

Please return the following documentation to your school nurse or complete electronically:

1. Telemedicine Consent and Acknowledgements – Authorizes a Penn Highlands' Provider to evaluate and treat your child by telemedicine.
2. Registration Form – Demographic and insurance information for your child.
3. Patient Information and Medical History Form – Medical history and general health information for your child that the Penn Highlands provider will reference during your child's visit.
4. Notice of Privacy Practices – Detailed handout regarding Penn Highlands' Privacy Practices for parent/guardian to keep. *Do no need to return*.

1. Telemedicine Consent and Acknowledgements

By signing this form, I 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 me or 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 visit at any time without affecting their right to future care or treatment.
3. I also understand that if the provider believes my child would be better serviced by a traditional face –to-face encounter, they may, at any time stop the telemedicine visit and recommend a face-to-face visit.
4. I understand that I may expect the anticipated benefits from the use of telemedicine in my child's care, but that no results can be guaranteed or assured.

Patient/Guardian Consent to the Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, and my questions have been answered to my satisfaction. I hereby give my informed consent to the use of telemedicine in my child's care.

Promissory Note and Authorization to Pay:

I authorize Penn Highlands Healthcare to release information to insurance carriers concerning my child's illness and treatments for the purpose of payment. I accept all payments for medical services rendered my child. I understand I am responsible for any amount not covered by my insurance including co-pays, deductibles, and non-covered services.

Patient Rights and Responsibilities:

I further acknowledge I have received a copy of Penn Highlands Healthcare's Notice of Privacy Practices.

I hereby authorize Penn Highlands Healthcare to use telemedicine in the course of my child's diagnosis and treatment.

Student Name: _____

Date of Birth (MM/DD/YYYY): _____

Signature of Parent/Guardian: _____

Printed Parent/Guardian Name: _____

Relationship to patient: _____ Date: _____

Signature of Patient (18-year old or emancipated minor): _____

Date: _____

2. Registration Form

Patient Information

Child's Name: Last Name: _____ First Name: _____ MI: _____

Date of Birth (MM/DD/YYYY) _____ Age: _____ Sex: ☐ Male ☐ Female

Child's Address:

Preferred Pharmacy: _____ Pharmacy Phone No: _____

Student Grade: _____

Parent/Guardian Information:

Name of Mother: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Mother's Email Address: _____

Name of Father: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Father's Email Address: _____

Name of Other Guardian: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Other Guardian's Email Address: _____

Best Emergency Contact (if the above can't be reached): _____

Relationship to child: _____ Phone: _____

Insurance Information: I hereby give my permission for Penn Highlands Healthcare to bill my insurance as follows:

Primary Insurance Information

Insurance Name: _____

Insurance Address: _____

Insurance Phone: _____

Policy Holder Name: _____

Policy Holder's Relationship to Child: _____

Policy Holder Date of Birth (MM/DD/YYYY): _____

Insurance ID: _____

Group Number: _____

Secondary Insurance Information

Insurance Name: _____

Insurance Address: _____

Insurance Phone: _____

Policy Holder Name: _____

Policy Holder's Relationship to Child: _____

Policy Holder Date of Birth (MM/DD/YYYY): _____

Insurance ID: _____

Group Number: _____

3. Patient Information and Medical History

Patient Name: _____ DOB (MM/DD/YYYY):_____

Primary Care Physician: _____ PCP Phone: _____

ALLERGIES

As far as you know, is your child allergic to any medications? YES ☐ NO ☐

If YES, which medications, and what kind of reactions has he or she had? _____

_____

_____

Any milk or food allergies? _____

HEALTH HISTORY (please check all that apply):

- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes mellitus
- ☐ Headache
- ☐ Hearing loss
- ☐ Meningitis
- ☐ Obesity
- ☐ Otitis media
- ☐ Seizures
- ☐ Sickle cell anemia
- ☐ Strep throat (recurrent)
- ☐ UTI
- ☐ HIV/AIDS
- ☐ Other _____

SURGICAL HISTORY (please check all that apply):

- ☐ Abdominal surgery
- ☐ Appendectomy
- ☐ Ear tubes
- ☐ Meckel's diverticulum
- ☐ Tonsillectomy
- ☐ Umbilical hernia

☐ Eye surgery ☐ VP shunt

☐ Fracture surgery ☐ Lymph node biopsy

☐ Other _____

Please tell us about any health conditions marked on the prior list or any other concern's you may have about your child's health:

_____

_____

_____

CURRENT MEDICATIONS: Name Dosage How Often Taking

_____

_____

_____

_____

In signing this form, I am stating that the following information that I have provided is accurate and up-to-date.

Parent Signature: _____

Date: _____

4. Notice of Privacy Practices

Your copy – Do not need to return

Penn Highlands Healthcare

NOTICE OF PRIVACY PRACTICES

EFFECTIVE SEPTEMBER 1, 2021

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.

If you have any questions about this notice, please contact our System Director of Compliance at 814-375-6178.

WHO FOLLOWS THIS NOTICE OF PRIVACY PRACTICES

A list of entities that follow this Notice of Privacy Practices can be found on the Penn Highlands Healthcare website at www.phhealthcare.org under the Notices and Policies section. This Notice of Privacy Practices is followed by the members of our medical staff (including your physician), departments, units, staff in all PHH facilities, all health care professionals permitted by us to provide services to you, students, trainees, volunteers and others involved in providing your care. As permitted by law, these places and people may share your health information with each other for the treatment, payment or health care operations that are described in this Notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that your medical information is personal. We are committed to protecting the privacy and security of your medical information. We create a record of the care and services you receive at PHH facilities. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated at any of the PHH facilities, whether made by PHH personnel or your personal doctor. You may receive similar notices from non-employed physicians on our medical staff regarding their use and disclosure of your medical information created in their doctor's office or clinic. This notice explains the ways in which we may use and disclose your medical information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

The law requires us to:

- Make sure that your medical information is kept private;
- Give you this notice of our legal duties and privacy practices with respect to your medical information; and
- Follow the terms of the notice currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe different ways that we use and disclose medical information. For each category we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed; however, all of the ways we are permitted to use and disclose information will fall in one of the categories.

Treatment – We may use your medical information to provide you with medical treatment or services. We may disclose your medical information to doctors, nurses, technicians, medical students, interns, or other personnel who are involved in taking care of you during your visit with us. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different PHH facilities also may share your medical information in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose your medical information to others outside of PHH facilities who may be involved in your medical care after you leave, such as family members, or others you select to provide services that are part of your care. (i.e. visiting nurses, medical equipment suppliers, ambulance services, etc.)

Payment – We may use and disclose your medical information so that the treatment and services you

receive at our facilities may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received so your health plan will pay us for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also disclose your medical information to other entities to bill and collect payment for the treatment and services you receive from them.

Health Care Operations – We may use and disclose your medical information for health care operational purposes. These uses and disclosures are necessary to run our facilities and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many hospital patients to decide what additional services PHH should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other hospitals to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Business Associates – We may share your medical information with our "business associates" to carry out treatment, payment, or health care operations. We will obtain written agreements with our business associates that they will appropriately safeguard your information.

Appointment – Reminders We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at one of our facilities.

Treatment Alternatives – We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services – We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Fundraising – We may contact you as part of our fundraising efforts. We may use contact information, such as your name, address, phone number, department of service, treating physician, and the dates you received treatment or services to contact you. We may use and share this information with a Business Associate. If you receive a communication from us for fundraising purposes, you will be told how you can opt out of any further fundraising communications and we will make all reasonable efforts to comply with your request.

Marketing and Online Services – We will not use or disclose medical information for the purpose of marketing non-PHH products or services without your authorization. We will not sell or distribute your medical information to third parties.

PHH and you may agree to use a third-party website, application or electronic messaging service in order to receive remote health care services. These third-party services may have separate terms and conditions and privacy policies in addition to PHH that need to be accepted.

Patient Directory – We maintain limited information about you in a "directory" while you are a patient. This information may include your name, location in the facility, your general condition (e.g., fair, stable, serious, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you and generally know how you are doing. You also have the right to tell us not to include your information in the directory.

Individuals Involved in Your Care or Payment for Your Care – We may release your medical information to a friend or family member who is involved in your ongoing medical care, unless you tell us in advance not to do so. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in

our facility. In addition, we may disclose your medical information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. You also have the right to tell us of any person(s) whom you do not want your protected health information shared with.

Research – We may use and share your health information for research 1) if the researcher obtains permission from an outside committee that decides the request meets certain standards required by law; or 2) if you provide us with your written permission to do so. You may choose to participate in a research study that requires you to obtain related health care services. In this case, we may share your health information 1) to the researchers involved in the study who ordered the hospital or other health care services; and 2) to your insurance company in order to receive payment for those services that your insurance agrees to pay for. We may use and share your health information with an outside researcher if certain parts of your health information that would identify you are removed before we share it with the researcher. This will only be done if the researcher agrees in writing not to share the information, will not try to contact you, and will obey other requirements that the law provides. We may also share your health information with a Business Associate who will remove information that identifies you so that the remaining information can be used for research.

Required By Law – We will disclose your medical information when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety – We may use and disclose your medical information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Organ and Tissue Donation – If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans – If you are a member of the armed forces, we may release your medical information as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation – We may release your medical information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Inmates – If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your medical information to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Public Health Risks – We may disclose your medical information for public health activities. These activities generally include the following:

- Prevent or control disease, injury or disability;
- Report births and deaths;
- Report child abuse or neglect;
- Report certain reactions to medications or problems with products;
- Notify people of recalls of products they may be using;
- Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities – We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes – If you are involved in a lawsuit or a dispute, we may disclose your medical information in response to a court or administrative order or rule. We may also disclose your medical

information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

Law Enforcement – We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors – We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities – We may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
Protective Services for the President and Others
We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Exceptions to the Above Additional authorization may be required to release behavioral health or drug and alcohol records outside of those specific facilities.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Request a Copy – You have the right to inspect and request a copy of your medical information. Usually, this includes medical and billing records, but does not include psychotherapy notes. You have the right to request your electronic medical record in electronic form. Your request must be in writing. The Authorization Form is available on our website with additional instructions. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend – If you feel that your medical information is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Penn Highlands Healthcare. To request an amendment, your request must be made in writing and submitted to the Director of Medical Records. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for one of our facilities;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures – You have the right to request an "accounting of disclosures." This is a list of disclosures we made of your medical information. Disclosures made for treatment, payment or health care operations and disclosures authorized by you or your legal representative are not included in the accounting of disclosures. To request this list or accounting of disclosures, you must submit a request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years from the date of the request. Your request should indicate in what form you want the list (for example, on paper, electronically).

Right to Request Restrictions – You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. You also have the right to request a restriction to disclose your medical information to a health plan if the purpose of the disclosure is: (i) to carry out payment or health care operations; (ii) the disclosure is not required by law; and (iii) the medical information pertains to a health care item or service that you or someone other than the health plan has paid PHH in advance for the services to be provided. To request restrictions, you must make your request in writing to the Director of Medical Records. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications – You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Director of Medical Records. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Notice in the Event of a Breach – You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of unsecured protected health information involving your medical information. Notice will be provided directly from Penn Highlands Healthcare or one of its Business Associates.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may also obtain a copy of this notice at our website.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

COMPLAINTS

If you believe we have violated your privacy rights, you may file a complaint directly with us by calling the Confidential Message Line at 1-855-737-6788 or by contacting the Secretary of the Department of Health and Human Services. All complaints to the Secretary of the U.S. Department of Health and Human Services must be in writing and addressed to:

U.S. Department of Health and Human Services
200 Independence Ave. S.W.
Washington, DC 20201

You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facilities and it is also available on our PHH websites. The notice will contain, on the first page, the effective date. In addition, each time you register at any of our facilities for treatment or health care services as an inpatient or outpatient, we will make available to you a copy of the current notice in effect.

ADDENDUM TO THE NOTICE OF PRIVACY PRACTICES

HEALTH INFORMATION EXCHANGE (HIE)

We may share your health information using various Health Information Exchanges (HIEs) that PHH

participates in both on a regional and national basis. By participating in an HIE, your provider may share aspects of your medical record including, but not limited to: general laboratory results, pathology results, medical imaging results, diagnosis lists, immunizations, allergies, medication history, progress notes, consultation notes, discharge summaries and instructions, medical history information, and operative reports.

Information about you may be shared with an HIE unless you "opt-out." If you choose to opt-out of these exchanges, your health information will no longer be provided through the exchange. However, your decision will not affect the information that was exchanged prior to the time you chose not to participate. If you choose not to participate in an HIE and wish to join at a later date, you may do so by contacting your PHH provider listed on the Penn Highlands Healthcare website at www.phhealthcare.org under the Notices and Policies section.

LIST OF ENTITIES FOLLOWING PENN HIGHLANDS HEALTHCARE'S NOTICE OF PRIVACY PRACTICES

Penn Highlands Brookville 100 Hospital Road, Brookville, PA 15825	**Penn Highlands Elk** 763 Johnsonburg Road, St. Marys, PA 15857
Penn Highlands Clearfield, *A Campus of Penn Highlands DuBois* 809 Turnpike Avenue, Clearfield, PA 16830	**Penn Highlands Huntingdon** 1225 Warm Springs Avenue, Huntingdon, PA 16652
Penn Highlands Connellsville 401 East Murphy Avenue, Connellsville, PA 15425	**Penn Highlands Mon Valley** 1163 Country Club Road, Monongahela, PA 15063
Penn Highlands DuBois 100 Hospital Avenue, DuBois, PA 15801	**Penn Highlands Tyrone** 187 Hospital Drive, Tyrone, PA 16686