Niswonger Children's Network School-Based Virtual Health Clinic

A school-based service provided by Ballad Health Medical Associates Urgent Care

We can see you now.

Niswonger Children's Network has partnered with Ballad Health Medical Associates Urgent Care to provide students and staff with a convenient option to access high-quality care using virtual health technology while at school.

With permission, a school nurse will use live video technology to connect the student or staff member with an off-site Ballad Health Medical Associates Urgent Care doctor, physician assistant or nurse practitioner. The urgent care provider will have the ability to diagnose, listen to the patient's heart and lungs, order basic labs and send any needed prescriptions to the patient's pharmacy – all without leaving the school nurse's office.

Our goal is to provide quality healthcare that reduces time away from school or work.

BalladHealth™ Niswonger Children's Network

BalladHealth™ Medical Associates

Frequently asked questions

How does a school-based virtual health visit work?

With the help of technology, an off-site provider can receive information related to a patient's medical condition.

With the assistance of the school nurse, the off-site provider will interact live with the patient through the computer, view images of their throat/mouth, ears, eyes, skin rashes and so forth, listen to the child's heart and lungs, as well as order basic labs and send prescriptions to the patient's pharmacy, if needed.

Our virtual health providers are doctors, physician assistants and nurse practitioners employed by Ballad Health Medical Associates Urgent Care

What is offered through this school-based virtual health service?

We offer primary care services to students and staff, including the diagnosis and treatment of:

- Fever
- Sore throat/strep
- Allergy symptoms
- Ear pain
- Nausea/diarrhea
- Abdominal pain
- Skin irritation/rash/wound
- Inflammation
- Limb sprains/strains/contusions
- Pink eye
- Cold/flu symptoms (cough, runny/ stuffy nose, etc.)

As a parent or guardian, can I attend the visit?

Yes, we encourage a parent/guardian to attend the visit in-person or remotely. The school nurse will contact you to invite you to the visit, and provide a link if you prefer to join remotely. If you have completed the proper paperwork and can't be reached in a timely manner, we will proceed with the virtual visit.

What happens after a telemedicine visit?

Our providers will follow up with the parent/guardian after the visit. If your child needs further treatment, this will be communicated to the parent/guardian by the school nurse. We will also fax or send an electronic copy of the report to the patient's primary care provider using our electronic health record system (EPIC) if this is indicated on the enrollment paperwork.

If prescriptions are needed for treatment, the provider will electronically prescribe them to your preferred pharmacy.

When can a virtual visit be scheduled?

This service will be available Monday through Friday during normal school hours.

Will my child be able to stay at school after a virtual health visit, and will a doctor's note be provided?

Whether your child will be able to finish the day at school depends on your child's medical condition and symptoms. If applicable, a doctor's note will be sent to the attendance records office.

Does my insurance cover the virtual health visit?

We will bill your insurance, if your child does not have insurance, we offer a flat rate of $49 per visit. We can also work to determine if he/she is eligible for the state health insurance plan.

Please note that there is an additional cost for flu, COVID, and/or strep tests. Self-pay patients can expect the following prices for lab tests (flu – $6.60, strep – $3.30, and COVID – $6.21).

If I don't want my child to use this service, can he/she still see the school nurse?

Yes; simply disregard the enrollment forms. If your child becomes ill at school, he/she cannot use this service if the enrollment forms have not been completed.

How do I sign up?

Complete, sign and return all of the enrollment forms (patient information form, consents and history) in your back-to-school packet, or contact your school nurse. Please include a copy of your insurance card (front and back).

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Patient name: _____

Date of birth: _____

Consent for Care and Treatment

Ballad Health Medical Associates has partnered with your school to develop a collaborative school-based virtual health service. Our goal is to provide quality healthcare to staff and students in the convenience of the school setting. We aim to positively affect students' health, school attendance and academic performance. For more information, please refer to our "frequently asked questions" or contact the school nurse at your child's school.

In order for your child to receive school-based virtual health services, you must consent to the following and complete/sign this form where indicated.

- I give my consent for Ballad Health Medical Associates, its physician(s) and other healthcare providers (providers) to examine (student's name)_____ and to provide care and treatment, which may include the evaluation, diagnosis, consultation and treatment of my child's medical condition using advanced telecommunications technology (telemedicine services.)
- I understand that if my child requires telemedicine services, reasonable attempts will be made to contact me and invite me to join the medical visit by phone or video technology. If I cannot be reached in a timely manner, I understand and give consent for my child to be seen by providers in my absence and to provide me with a summary of the visit upon my request.
- I understand that telemedicine services may include audio, video or other electronic media and providers may: (1) be located off-site; (2) examine my child face-to-face via telemedicine technology and/or review health information transmitted via telemedicine technology; and (3) rely on information provided by my child and/or other on-site healthcare professionals.
- I understand and agree that providers shall not be held liable for factors beyond their control (such as technology failures, incomplete or inaccurate data provided by others, or distortions of images due to electronic transmission.) I understand that reasonable steps will be taken to protect the confidentiality of patient data, but the security of electronic information cannot be guaranteed.
- I understand that other individuals may be present during the visit to operate telemedicine equipment and technology, and I consent and authorize audio/video recording or photography to be taken in order to provide the telemedicine services to my child. These recordings or photographs may become part of my child's medical record.
- I understand that if a provider believes that further healthcare services are required or would benefit my child, a referral or recommendation for follow-up care may be made.

I have read this form or had it read to me, and I understand its contents. By signing below, I affirm that: (1) I agree to all of the statements above, and (2) I authorize telemedicine services to be provided to my child during the _____ school year.

_____ _____

Signature of parent or legal guardian Date

BalladHealth™

Medical Associates

Patient Name: _____

Date of Birth: _____

Assignment & Authorization To Bill Insurance

In order for your child to receive school-based virtual health services, you must consent to the following and complete/sign this form where indicated.

- I authorize and grant to Ballad Health Medical Associates permission to bill my insurance company or other applicable third-party payor(s) for healthcare services provided to my child. I also authorize direct payment from my insurance company to Ballad Health Medical Associates for the healthcare services provided to my child.
- I assign and convey directly to Ballad Health Medical Associates my rights under the applicable insurance and/or benefit policies, so that Ballad Health Medical Associates may obtain payment for healthcare services provided to my child. I assign to Ballad Health Medical Associates: (1) the right to claim payment for goods and services provided to my child by Ballad Health Medical Associates; (2) the right to any settlements or legal remedies; and (3) the option (but not the obligation) to appeal or pursue any denied or delayed claims.
- I authorize Ballad Health Medical Associates to release information – which relates to the healthcare services provided to my child – to my insurance company, applicable third-party payor(s), and/or their representatives. I also authorize my insurance plan and other applicable third-party payor(s) to release information to Ballad Health Medical Associates regarding benefits, coverage and settlement information.
- I understand and agree that I am fully responsible for any unpaid bills not covered by my insurance policy, including co-payments, deductibles, and/or other out-of-pocket costs, in accordance with Ballad Health Medical Associates' fee schedule. If I do not have insurance coverage, I understand that I will be billed directly for Ballad Health Medical Associates' services to my child. I agree to promptly pay any such out-of-pocket amounts for the healthcare services provided by Ballad Health Medical Associates to my child.

I have read this form or had it read to me, and I understand its contents. By signing below, I affirm that I understand, acknowledge and agree to all of the statements above.

_____ _____

Signature of parent or legal guardian Date

_____

Printed name of parent or legal guardian

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Medical Associates

Medical Record/CI#: _____

Patient Name: _____

Date of Birth: _____

Registration Consents and Acknowledgements
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Privacy Acknowledgement

1. May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results?* ◯ Yes ◯ No
   If no, is there another number at which we may try to reach you? _____
2. May we mail to the address you provided information regarding your appointment or test results?
   ◯ Yes ◯ No If no, is there another address at which we may send you information?
   _____
3. Do you wish us to share health information regarding you with a family member or friend?
   ◯ Yes ◯ No If yes, please provide name of person(s). _____
4. May we contact you via e-mail with information about our practice, educational programs and general health information? ◯ Yes ◯ No If yes, I understand that email transmissions may not be secure and will not be used for the purpose of communicating my personal health information.

Note: To protect your information, we reserve the right to use professional judgment and discretion when communicating information/test results which may be "sensitive" in nature.

☐ I acknowledge I have received a copy of Ballad Health's "Notice of Privacy Practices for Protected Health Information," which describes how Ballad Health Medical Associates uses and discloses health information.

Referrals for services

This practice is an affiliate of Ballad Health. Ballad Health is committed to honoring those we serve by delivering the best possible care. Consistent with the Ballad Health-wide mission and shared values of our employed physicians, our physician employees agree to refer their patients to providers, practitioners and suppliers within the Ballad Health system whenever their patients need medical services not available at this practice and whenever such referral is in the individual patient's best interest, not contrary to the patient's express choice and not inconsistent with the requirements of the patient's insurance.

Medicare and Medicaid information

I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare/Medicaid claim. I further certify that I have provided any required information concerning any other liability for medical practice charges in order to complete the Medicare Secondary Payor (MSP) form. I request that payment of authorized benefits be made on my behalf. I authorize Ballad Health Medical Associates to secure information from the Department of Human Services regarding my qualification for Medicaid.

_____ _____

Signature of parent or legal guardian Date

BalladHealth™

Medical Associates

Patient Name: _____

Date of Birth: _____

Health Questionnaire

Instructions for parents: please complete this form on your child's behalf, and attach a copy of your insurance card.

General health

Does your child have any known allergies (foods, medications, etc.)? ◯ Yes ◯ No

List all known allergies: _____

_____

Is your child currently being treated for any health problems? ◯ Yes ◯ No
Specify who is providing the treatment:

If yes, explain: _____

_____

Does your child take daily medications? ☐ Yes ☐ No

Please list all medications, the dosage, and when given:

Name of medication	Dosage	When given	Name of medication	Dosage	When given

Name of pediatrician/primary care provider _____

Please share any additional pertinent health information for your child.

_____

_____

_____

_____

_____

_____

Do you, your child, or anyone in the home:

Smoke ◯ Yes ◯ No

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Patient Information Form

Instructions for parents: please complete this form on behalf of your child.

Patient information

Child's name (last name, first name, middle name):_____

Date of birth (month/day/year): _____/_____/_____ Male: (☐) Female: (☐) SSN #: _____- _____- _____

Child's street address: _____

Child lives with (check all that apply): ☐ Mother ☐ Father ☐ Guardian/Other: _____Phone #:_____

Preferred pharmacy name:_____ Preferred pharmacy street address: _____

Preferred pharmacy phone:_____ City, State, Zip:_____

School name:_____ School district:_____

Pediatrician/Primary care provider:_____ Physician/Primary care provider phone/fax #:_____

Race/Ethnicity (please select appropriate group):

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Other
☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ Latino / Hispanic ☐ Decline to answer

Parent/Guardian information

Mother's/Guardian's name: _____ Father's/Guardian's name: _____

Primary phone: _____ Alternate phone: _____ Primary phone: _____ Alternate phone:_____

Employer:_____ Work phone: _____ Employer: _____ Work phone: _____

Date of birth: _____ Email: _____ Date of birth: _____ Email: _____

Emergency contact - In case of an emergency, who should we contact?

Name: _____ Relationship:_____ Phone: _____

Ballad Health Medical Associates may disclose medical and billing information to this contact: ◯ Yes ◯ No

Self-pay ☐ I will pay the flat fee of $49 per visit, please do not file with my insurance.

Insurance information

Is your child covered by insurance? ☐ Yes ☐ No

Person(s) responsible for bill: ☐ Mother ☐ Father ☐ Other: _____ Street address: _____

Primary phone number: _____ Cell phone number:_____

Primary insurance

Policy holder: ☐ Child ☐ Mother ☐ Father ☐ Other:_____ Date of birth:_____

Insurance name: _____ Insurance phone #:_____

Insurance ID#:_____ Insurance group #:_____

Secondary insurance

Policy holder: ☐ Child ☐ Mother ☐ Father ☐ Other:_____ Date of birth:_____

Insurance name: _____ Insurance phone #:_____

Insurance ID#:_____ Insurance group #:_____

I certify that the information contained on this form is true and correct. Furthermore, I understand that it is my responsibility and duty to inform Ballad Health Medical Associates if any information on this form changes in the future.

_____

Printed name of parent/legal guardian Signature Date

400 N. State of Franklin Road
Johnson City, TN
tel 423.547.5222

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BH3766_20231121