07/14/2021

Dear Parent/Guardian of Pontotoc County School Students,

For more than 40 years, ACCESS Family Health Services has provided family healthcare to our local communities through our Community Based Health Clinics in Smithville, Tremont, Nettleton, Tupelo, and Houlka.

Over the past couple years, we partnered with the Pontotoc County School District to provide **ACCESS School Health Services** – a School-Based Health Clinic (SBHC) located **on each campus**. Our licensed Family Nurse Practitioner (FNP) provides a variety of healthcare services to your child *without them having to leave campus and missing valuable classroom instruction, and without interrupting your busy day*. You are not required to be present at your child's visit, however **you must sign and return the attached forms before services can be provided – our healthcare provider cannot treat your child without your consent**. Before your child is seen, the nurse or provider will contact you to discuss treatment options.

If you have insurance, it will be billed after your child is treated at the School-Based Health Clinic. **If you do not have insurance**, we offer a patient assistance program (based on household income and family size) which applies a discount to the cost of treatment. Also, information will be made available for students who qualify for Medicaid/CHIP programs.

If you would like your child to receive care at the School-Based Health Clinic, please complete the attached forms **at your earliest convenience.**

The following forms are attached:
- Consent Form *(return to school)*
- Pontotoc County Students Health Information Summary *(return to school)*

If you mark option 2 on the consent form we will send a link to your cell phone to complete all the necessary information required for your child to see the Nurse Practitioner.

If you have any questions or concerns, please contact us at either of the numbers below, or visit **accessoncampus.com** for forms, discount program information, an online patient portal, and more.

ACCESS Family Health Services
Administrative Office
662-651-4686

ACCESS Family Health Services
Tupelo Medical Clinic
662-690-8007

We look forward to keeping your student **healthy** & **happy** this school year!

Sincerely,

Marilyn Sumerford
Chief Executive Officer

Frequently Asked Questions

What is a School-Based Health Clinic?
A School-Based Health Clinic (SBHC) is a regular medical clinic within a school. The purpose of having a SBHC is to allow students, faculty, and staff to stay at school as much as possible, which maximizes instruction time and productivity.

Who will be caring for my child?
Each clinic has a Family Nurse Practitioner (or physician), a nurse, and a receptionist whose top priority is the health, safety, and wellbeing of your child.

Who can use the School-Based Health Clinic?
All students, faculty, and staff are eligible for routine medical care at the clinic **if we have a signed consent**. Students **must** have a signed consent **from a parent or guardian.**

What are the hours?

North Pontotoc	Monday, Wednesday, every other Friday	7:30a – 4:00p
South Pontotoc	Tuesday, Thursday, every other Friday	7:30a – 4:00p

Am I required to register my child to receive services?
Not at all. However, certain forms are required **by the school** for all students. For example, children without a signed SHBC consent can still visit the school nurse, as usual.

What happens if treatment is needed other than what the school nurse can provide and I have not signed the consent?
The child may have to be picked up and taken to another healthcare facility to receive the needed treatment.

If I sign the consent, can my child still visit their regular pediatrician/provider?
Absolutely. The School-Based Health Clinic is not meant to replace pediatricians or other primary care providers.

May I be present at my child's visit?
You certainly may. Simply inform the nurse or receptionist that you want to be present. When you arrive on campus, be sure to check-in at the school office before proceeding to the clinic.

How will you communicate with me?
Every effort will be made to contact you; typically, by phone call before your child is seen by the Nurse Practitioner. An alternate method of communication is the Patient Portal. Having a portal account allows you to receive Patient Care Summaries for each visit, view vitals & lab results, securely communicate with your child's healthcare team, and much more.

Will I be charged for the visit?
No money will be collected from students. Visits will be billed to the insurance we have on file (Medicaid, CHIP, or private insurance). If a student does not have insurance, the visit will not be charged, but the parent/guardian will be assisted with filing for Medicaid, CHIP, or the Access Assistance Program. You may be asked for proof of Medicaid application or denial. **No student will be denied access to the school nurse.**

Faculty & staff will pay their co-payment, co-insurance, and deductible, as usual.

Visit **accessoncampus.com** for more information.

RETURN this form to school

Consent for Treatment & Release of Health Information

_______________________ ____/____/____ **Your relationship to patient:**

PATIENT First & Last Name *(please print)* **Date of birth** ☐ Self ☐ Mother ☐ Father

_______________________ ☐ Legal Guardian:____________

PARENT | GUARDIAN First & Last Name *(please print)* (not required if *Self*) (specify)

(Check one) **The patient named above may receive treatment from:**

☐ **Option 1:** the school nurse only (**not** Access School Health).

☐ **Option 2:** both the nurse practitioner/physician of Access School Health Services and the school nurse.

By checking "Option 2," *I give my consent, permission, understanding, acknowledgement and/or agreement to Access School Health Services (ASHS) & Access Family Health Services, Inc. (AFHSI) for the following:*

Authorization for Diagnosis & Treatment

- medical examination, treatment, and procedures, which may be performed during the office visits, including, but not limited to, a comprehensive history and physical examination, health screenings, health education and prevention programs, prescriptions, referrals, referral follow-ups, lab work, injections, and immunizations, as may be advisable or necessary by the nurse practitioner or attending physician of ACCESS Family Health Services, Inc (AFHSI). I understand that no guarantees have been made as a result of examination and treatment in the clinic. This authorization remains valid unless otherwise directed in writing.

Assignment of Benefits

- AFHSI may provide Medicare, Medicaid, or my insurance carrier with any information necessary to receive payment for services rendered to me or other persons listed on the patient registration form.

Notice of Privacy Practices

- I have reviewed AFHSI's *Notice of Privacy Practices*, which describes how information about me may be used and disclosed and how I can get access to this information. I may obtain a copy of the *Notice of Privacy Practices* upon request or at **accessoncampus.com**.

Patient's Bill of Rights & Responsibilities

- I have reviewed and agreed with the AFHSI *Patient Bill of Rights & Responsibilities*. I may obtain a copy of the Patient's Bill of Rights and Responsibilities upon request or at **accessoncampus.com**.

Communications

- I authorize all clinical providers who have/will provide care or interpret my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me via mobile or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices/services, or other computer assisted technology, or by email, text message, or any other form of electronic communication. This communication may also include appointment reminders, clinic services, and/or clinic surveys.

Financial Agreement

Care/treatment received at Access School Health Services is a partnership between you and the staff of AFHSI. We rely on the fees paid by you and your insurance carrier(s) to keep these clinics operating. AFHSI is not responsible for any charges incurred from hospitals, other physicians, or any other services outside of an AFHSI facility. I understand that failure to cooperate with AFHSI billing, third party collection services, or with the insurance company could result in losing eligibility to receive services provided by our School-Based Health Clinics.

Patients without insurance agree:

- to apply for the Patient Assistance Program (Sliding Fee) as recommended by AFHSI staff. I understand that failure to provide proof of income will result in my being responsible for 100% of the charges. I agree that I will pay all charges for which I am responsible at the time of service or make payment arrangements with the Billing Department.

Patients with insurance agree:

- AFHSI will bill the most current insurance in my file. I agree to provide current insurance information at each visit and upon request by AFHSI staff, and to notify AFHSI with any changes in coverage. **I agree to pay: my co-payment, my deductible, and for services not covered by my insurance plan. If necessary, I will contact my insurance carrier to ensure payment for services that I have received. I understand that if I fail to pay my bill, AFHSI reserves the right to limit services to me.**

Disclosure of Protected Health Information (PHI)

AFHSI will not discuss your PHI without your authorization, except with those allowed under Federal & State law.

List the name, relationship, & phone number of anyone you authorize us to discuss your Protected Health Information with.

NAME	RELATIONSHIP	CONTACT NUMBER
		( ) -
		( ) -
		( ) -

By signing below, I acknowledge that I read, understand, and consent to the terms above.

_______________________ ____/____/____

Patient • Parent • Guardian **SIGNATURE** Date

_______________________ ____/____/____

Staff Witness Date

PONTOTOC County Schools
Health Information Summary Form

May acetaminophen, antacids, and ibuprofen be given at school? ❐Yes ❐No

I, ______________________________, give Pontotoc County Schools permission to administer emergency
*(**Printed** name of Parent/Guardian)*

treatment to ________________________________, and I assume all necessary expenses.
*(**Printed** name of Student)*

Name	**Grade**	**Teacher**
Date of Birth / /	**Race**	**Gender**
Address	**Phone** *(incl. area code)*	
Father/Guardian	**Place of Work**	**Phone** *(incl. area code)*
Mother/Guardian	**Place of Work**	**Phone** *(incl. area code)*
Mother's Cell #	**Father's Cell #**	
Allergies	**Problems**	

Emergency Contacts (not listed above)	**Name (1)**	**Relationship**	**Phone** *(incl. area code)*
	Name (2)		

Health History

Condition	Yes	No	Condition	Yes	No
Diabetes			Bone Fractures		
High Blood Pressure			Hearing		
Strokes			Vision		
Seizures			Emotional/Behavioral		
Kidney Problems			Surgery		
Asthma/Breathing Problems			Cancer		
Sickle Cell			Other		

If yes, marked on any of the above, please explain: ____

____

____

Parent/Guardian Signature
Date