Hazel Health Consent Form

Our school is partnering with Hazel Health to provide access to quality health care services for all students. The school health representative can initiate a video visit with a Hazel Health provider while your student is at school. **To ensure your student has access to this service, complete BOTH pages of this form.**

Student's First Name ____________ Student's Last Name ____________ Student's Birthdate (Month / Day / Year) ____________

Student ID Number ____________ Student's Address ____________ City/State/Zip ____________

Parent / Legal Guardian #1 Name ____________ Relationship to Student ____________ Mobile Phone ( ) ____________ Email ____________

Parent / Legal Guardian #2 Name ____________ Relationship to Student ____________ Mobile Phone ( ) ____________ Email ____________

Required Insurance Information

Hazel Health has partnered with your school to cover your cost of services so that **there is no cost to your family.**

Why is insurance information needed if a Hazel visit is at no cost to me? Hazel Health bills insurance for services to ensure that the visit cost is covered by your health plan, and there are no out-of-pocket costs for the family. Having insurance information also helps Hazel to better coordinate care for your student, such as referrals and prescriptions. Once a visit is completed, you may receive an explanation of benefits (EOB) in the mail. If you receive an EOB, this is NOT a bill, it is simply a record indicating a visit occurred and was submitted to your insurance. No action is needed. Your insurance information is always kept confidential and stored securely. By providing your insurance information you are empowering Hazel to continue its mission, ensuring every child is seen, heard and cared for.

What if my student does not have insurance? Any student, regardless of insurance status, can use Hazel Health. Hazel will review and confirm the student's insurance status when a visit is scheduled or delivered.

For more information about insurance, please see our FAQ's at www.hazel.co/faq.

Please provide your student's insurance information and complete all sections below. If you would like to provide a picture of your insurance card, complete this form online by scanning the QR code at the top of the page.

Insurance Company ____________ Member ID Number ____________ Group Number (if applicable) ____________

Policy Holder First Name ____________ Policy Holder Last Name ____________ Policy Holder Birthdate ____________ Relationship to Student ____________

☐ **By checking this box, I attest that my student does not have health insurance coverage at this time.**

I have read the Hazel Health Services Authorization and Privacy Policy and: (Please check one box below)

☐ I **GIVE** permission for my student to receive health care services from Hazel Health providers.

☐ I **DO NOT give** permission for my student to receive health care services from Hazel Health providers.

Parent / Legal Guardian / Legal Representative Signature (Required) ____________ Date ____________

PLEASE CONTINUE TO PAGE 2 TO INPUT KNOWN ALLERGIES & OTHER HEALTH INFORMATION

This consent will remain valid unless revoked by the parent / legal guardian / legal representative.

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Month / Day / Year

Student's First Name | Student's Last Name | Student's Birthdate

Does your student have any allergies?

☐ YES ☐ NO Medication allergies Please List:

☐ YES ☐ NO Food allergies Please List:

☐ YES ☐ NO Seasonal/Environmental allergies Please List:

Is your student currently taking any medications?

☐ YES ☐ NO Please List:

If recommended by Hazel's licensed medical provider, can the following medications (age/weight appropriate) be administered to your student at school?

YES	NO	
☐	☐	Tylenol™ / Acetaminophen (pain, fever)
☐	☐	Advil™ / Motrin™ / Ibuprofen (pain, fever)
☐	☐	Children's Pepto™ / Calcium Carbonate (upset stomach)
☐	☐	Liquid Pepto-Bismol™ / Bismuth Subsalicylate (nausea, indigestion, upset stomach)
☐	☐	Liquid Antacid / Aluminum Hydroxide / Magnesium Hydroxide, Simethicone (upset stomach)
☐	☐	Throat Lozenge / Benzocaine / Menthol (cough, sore throat)
☐	☐	Cough Syrup (cough)
☐	☐	Sudafed™ / Phenylephrine (congestion)
☐	☐	Hydrocortisone Cream (inflammation, itch)
☐	☐	Benadryl™ / Diphenhydramine (allergic reaction)
☐	☐	Zyrtec™ / Cetirizine (allergies, allergic reaction)
☐	☐	Zaditor™ / Ketotifen (allergy eye drops)
☐	☐	Antibiotic Ointment / Bacitracin / Neomycin / Polymyxin B (cuts, infections)

Has your student ever had any of the following health conditions or health concerns?

YES	NO	
☐	☐	Acid Reflux (Heartburn)
☐	☐	ADD/ADHD (Attention Deficit Disorder)
☐	☐	Anxiety
☐	☐	Asthma
☐	☐	Autism spectrum disorder
☐	☐	Cognitive/Intellectual delay or disability
☐	☐	Congenital Heart Defect
☐	☐	Constipation
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Eczema
☐	☐	Genetic disorder
☐	☐	High Blood Pressure
☐	☐	Kidney disease
☐	☐	Migraine Headaches
☐	☐	Seizure Disorder
☐	☐	Sickle Cell Disease
☐	☐	Speech/language delay or disorder
☐	☐	Surgery: Appendix removed
☐	☐	Surgery: Ear Tubes
☐	☐	Surgery: Tonsils removed
☐	☐	Other (please explain): ________

Does your student have a primary care doctor?

Hazel uses this information to coordinate with your student's doctor and inform them of any Hazel visit. Providing the fax number will allow Hazel to send a visit summary to your student's doctor.

☐ YES ☐ NO

Student's Doctor | Phone | Fax

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Hazel Health Services School Health Center Authorization

For purposes of this Notice, when we refer to “you” or “your,” we mean you as a patient (meaning you meet your state criteria for age of majority, emancipated minor, or unaccompanied minor) or you as the provider of information about a minor patient (meaning you are an authorized legal guardian or authorized legal representative of the child).

Understanding that you may need healthcare treatment, behavioral healthcare, or healthcare screenings at the school or outside the school, you hereby authorize Hazel Health Services, through the Hazel Health Services telehealth service, to initiate and administer such first aid or other medical or behavioral health examination and treatment as shall be deemed appropriate under the circumstances, and you consent to receive such treatment. You understand that you have the right to refuse treatment. Hazel Health will not provide emergency services. In the event of an emergency, the School will follow appropriate protocol to have you treated by a duly qualified medical practitioner. You understand that Hazel Health Services may not always be available due to capacity or other reasons. You authorize Hazel Health Services or its delegates to contact and leave a voicemail, text message, and/or email, leaving protected health or personally identifiable information, such as a diagnosis of you, and/or information that is relevant to Hazel Health's product, services, and partnerships, using the contact information provided by you and/or the School. You may opt out of receiving Hazel texts by replying with the word STOP from the mobile device receiving the text messages or by contacting Hazel Health Services by phone at 1-800-764-2935, by email at support@hazel.co, or in writing at 8300 Esters Blvd., Ste. 900, Irving, TX 75063. You also understand that the transmission of personal health and/or personally identifiable information may not be secure and may be illegally accessed by a third party. Any medical or demographic information provided to the School may be shared with Hazel Health and Hazel Health Services. Consent is further given to the School to share any student records related to the medical treatment and/or diagnosis to Hazel Health Services.

1. **PURPOSE.** The purpose of this form is to obtain your consent to participate in a telehealth consultation. This consent will authorize medical information about you, including personally-identifiable medical information, to be disclosed to your school District, Health Information Exchanges, Hazel Health and Hazel Health Services and its contractors and medical professionals, administrative staff, and employees of Hazel Health and Hazel Health Services for the purposes of treatment, analysis, research or general administration. This disclosure will also authorize the sharing of information containing personally-identifiable medical information for informational purposes to the School, school District and its employees. You also authorize Hazel Health or Hazel Health Services to use personally-identifiable information for the development and improvement of software, hardware, and related tools designed to improve services provided by medical professionals, administrative staff, contractors and employees of Hazel Health and Hazel Health Services. This consent will also authorize the disclosure of information, diagnosis, and records containing or related to your protected health information for the purposes of billing commercial and insured healthcare payors, state and/or federal healthcare payors, including but not limited to state Medicaid plans. The purpose of the disclosure is to obtain information and/or renumeration for reimbursable medical services.

a. Texas residents: By signing this form, you expressly authorize Hazel Health, Hazel Health Services, and any of its contractors, vendors or affiliates to bill Medicaid and any other payors for the specific services performed for you as outlined in your current Admission, Review and Dismissal/Individualized Education Program (“ARD/IEP”) plan, including under the School Health and Related Services (“SHARS”) program.tions.

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Your ability to receive services outside of the school setting will not be impacted. You may withdraw this consent at any time by emailing support@hazel.co. You understand that you may choose your provider and you have no obligation to select Hazel Health or Hazel Health Services as a healthcare provider for you. You understand that you are responsible for any out-of-pocket patient responsibility that is not covered by your healthcare payor or other agency. You will have access to all medical information resulting from the telehealth services as provided by applicable law for patient access to medical records.

2. **NATURE OF TELEHEALTH CONSULTATION.** During the telehealth consultation, the following may occur:

a. Details of your medical and behavioral health history, examinations, x-rays, and tests may be discussed with other health professionals when medically necessary.

b. Physical examination and behavioral assessment of you may take place via a remote medical practitioner through the mobile application, utilizing audio, videos, or photos when medically necessary to deliver care. Not all conditions can be treated by a telehealth consultation.

c. Non-medical personnel including school staff, Hazel Health Services employees and/or translators may be present to aid with language and technical implementation of the consultation. You authorize school personnel, including the nurses and non medical personnel to administer medications including over the counter medica

3. **POINT-OF-CARE TESTING.** I consent to point-of-care testing at school when medically indicated.

a. Potential complications of point-of-care testing may include temporary discomfort, minor irritation or localized trauma to the affected area.

4. **MEDICAL INFORMATION AND RECORDS.** All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Additionally, dissemination, beyond the potential uses listed in this consent, of any patient-identifiable images or information from this telehealth interaction will not occur without your explicit consent except you authorize Hazel Health Services to disclose protected health information about you to school designees, school nurses, physicians, Hazel Health or other healthcare providers and payors for treatment, administration, and billing purposes. You also authorize Hazel Health to maintain and save your medical records consistent with applicable laws and regulations. To obtain a copy of your medical records or access your medical information, please submit your request to support@hazel.co or by calling 1-800-76-HAZEL.

a. Nevada residents: Pursuant to N.R.S. 629.051, all healthcare records may be destroyed after a period of five (5) years.

5. **CONFIDENTIALITY.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risk associated with the telehealth consultation, and all existing confidentiality protections under federal and state law apply to information disclosed during this telehealth consultation.

6. **RIGHTS.** You may withhold or withdraw consent to telehealth consultations, to the disclosure of personally identifiable information to any state or federal agency or other third party, or to any other services at any time. You acknowledge that you have been advised of your right to receive a copy of this authorization as signatory to the authorization.

7. **RISK, CONSEQUENCES AND BENEFITS.**

You are aware of any potential risk, consequences, limitations, and benefits of telehealth. You understand the inherent risks associated with electronic and telecommunication and the potential for technology failure. You have had an opportunity to ask questions about this information and all questions have been answered. You understand the written information provided above. You are choosing to enroll in Hazel Health Services and are not being forced to utilize this program.

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8. NOTICE TO CLIENT REGARDING COMPLAINTS.

a. California residents: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

b. Texas residents: Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018. Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353. For more information, please visit our website at www.tmb.state.tx.us.

9. AGE OF MAJORITY, EMANCIPATED MINOR, OR UNACCOMPANIED MINOR.

a. California residents: You represent and warrant that you are an emancipated minor in California as defined by Emancipation of Minors Law Div 11. Part 6, Chapter 1, 7000, an unaccompanied minor under California law, or of the age of majority in the state of California, or have other legal authority under California law and have the capacity to sign this consent.

b. All other states: You represent and warrant that you are an emancipated minor in the state that you reside or an unaccompanied minor under the law of the state that you reside, of the age of majority in the state that you reside or have other legal authority under the laws of the state that you reside and have the capacity to sign this consent.

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Notice of Privacy Practices - Hazel Health Services Affiliated Covered Entity

For purposes of this Notice, when we refer to "you" or "your," we mean you as a patient or you as the provider of information about a minor patient.

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.

This Notice of Privacy Practices (the "Notice") describes how Telehealth Services USA or Telehealth Services South d/b/a Hazel Health Services and the members of its Affiliated Covered Entity (collectively "we" or "our") may use and disclose your protected health information to carry out treatment, payment or business operations and for other purposes that are permitted or required by law. An Affiliated Covered Entity is a group of health care providers under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The members of the Hazel Health Services Affiliated Covered Entity will share protected health information with each other for the treatment, payment, and health care operations of the Hazel Health Services Affiliated Covered Entity and as permitted by HIPAA and this Notice of Privacy Practices. For a complete list of the members of the Hazel Health Services Affiliated Covered Entity, please contact the Hazel Health Services Privacy Office.

"Protected health information" or "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical health or condition, treatment or payment for health care services. This Notice also describes your rights to access and control your protected health information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by our health care providers, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to support our business operations, to obtain payment for your care, and any other use authorized or required by law.

TREATMENT:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a health care provider to whom you have been referred to ensure the necessary information is accessible to diagnose or treat you.

PAYMENT:

Your protected health information may be used to bill or obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for your services, such as: making a determination of eligibility or coverage for insurance benefits and reviewing services provided to you for medical necessity.

HEALTH CARE OPERATIONS:

We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities include, but are not limited to, improving quality of care, providing information about treatment alternatives or other health-related benefits and services, development or maintaining and supporting computer systems, legal services, and conducting audits and compliance programs, including fraud, waste and abuse investigations.

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USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION:

We may use or disclose your protected health information in the following situations without your authorization. These situations include the following uses and disclosures: as required by law; for public health purposes; for health care oversight purposes; for abuse or neglect reporting; pursuant to Food and Drug Administration requirements; in connection with legal proceedings; for law enforcement purposes; to coroners, funeral directors and organ donation agencies; for certain research purposes; for certain criminal activities; for certain military activity and national security purposes; for workers' compensation reporting; relating to certain inmate reporting; and other required uses and disclosures. Under the law, we must make certain disclosures to you upon your request, and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). State laws may further restrict these disclosures.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless permitted or required by law. Without your authorization, we are expressly prohibited from using or disclosing your protected health information for marketing purposes. We may not sell your protected health information without your authorization. Your protected health information will not be used for fundraising. If you provide us with an authorization for certain uses and disclosures of your information, you may revoke such authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION:

You have the right to inspect and copy your protected health information.

You may request access to or an amendment of your protected health information.

You have the right to request a restriction on the use or disclosure of your protected health/personal information. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, except if the requested restriction is on a disclosure to a health plan for a payment or health care operations purpose regarding a service that has been paid in full out-of-pocket.

You have the right to request to receive confidential communications from us by alternative means or at an alternate location. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

You have the right to request an amendment of your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to our statement and we will provide you with a copy of any such rebuttal

.You have the right to receive an accounting of certain disclosures of your protected health information that we have made, paper or electronic, except for certain disclosures which were pursuant to an authorization, for purposes of treatment, payment, healthcare operations (unless the information is maintained in an electronic health record); or for certain other purposes.

You have the right to obtain a paper copy of this Notice, upon request, even if you have previously requested its receipt electronically by e-mail.

Please contact privacy@hazel.co to request any of the aforementioned items.

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REVISIONS TO THIS NOTICE:

We reserve the right to revise this Notice and to make the revised Notice effective for protected health information we already have about you as well as any information we receive in the future. You are entitled to a copy of the Notice currently in effect. Any significant changes to this Notice will be posted on our website.

BREACH OF HEALTH INFORMATION:

We will notify you if a reportable breach of your unsecured protected health information is discovered. Notification will be made to you no later than 60 days from the breach discovery and will include a brief description of how the breach occurred, the protected health information involved and contact information for you to ask questions.

COMPLAINTS:

Complaints about this Notice or how we handle your protected health information should be directed to our HIPAA Privacy Officer at privacy@hazel.co. If you are not satisfied with the manner in which a complaint is handled you may submit a formal complaint to the Department of Health and Human Services, Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov. We will not retaliate against you for filing a complaint.

We must follow the duties and privacy practices described in this Notice. We will maintain the privacy of your protected health information and to notify affected individuals following a breach of unsecured protected health information. If you have any questions about this Notice, please contact us at (415) 424-4266 and ask to speak with our HIPAA Privacy Officer or e-mail at privacy@hazel.co.

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