HUDSON HEADWATERS
HADLEY-LUZERNE STUDENT HEALTH

STUART M. TOWNSEND
ELEMENTARY SCHOOL

PO BOX 200
27 HYLAND DRIVE
LAKE LUZERNE, NY 12846-0200

518-824-2580
FAX: 518-824-2579

WWW.HHHN.ORG

Dear Parent/Guardian,

Hudson Headwaters Health Network has been providing care to children and teens in the North Country for over three decades. We are thrilled to now be partnering with the Hadley-Luzerne School District to bring high-quality primary care to students at the new school-based health center, Hadley-Luzerne Student Health. We'd like to share some information, so you and your child know what to expect.

Opening and Hours of Operation:
The health center is open every day that school is in session from 8:00 a.m. to 12:00 p.m. You will be able to reach a member of our pediatric health care team by phone until 5:00 p.m.

Services:
Primary care services provided to students may include annual physicals, sports physicals, illness or injury referred by the school nurse, vaccinations, chronic disease management, women's health or other care not routinely provided by the district's nurse.

Consent and Participation:
All students in the Hadley-Luzerne School District (including **both** Hadley-Luzerne Junior/Senior High School and the Stuart M. Townsend Elementary School) are eligible to enroll in the school-based health program.

To receive services, parents must complete the enclosed enrollment forms. Additionally, these forms are available at the school or online at www.hhhn.org. Enrollment in the program can be completed at any time.

All parents are encouraged to enroll their child in the program, even if they already have a primary care provider. Enrolling your child gives you the option of using the school-based health center if needed. The school-based health center team will work with your family doctor to provide back-up care when necessary and to help monitor chronic conditions.

Eligibility, Insurance, Payment:
There are no income or insurance requirements to participate in this program. Services are provided with **no out of pocket costs** to families. If your child has insurance, we will bill your insurance company if applicable. Should your child need additional services **outside** of Hadley-Luzerne Student Health, we offer financial and billing assistance through budget agreements, a Sliding Fee discount for medical, dental and other services, and RX Assist for financial assistance with ongoing prescription needs. For more information about our financial assistance programs please call 518-824-8640 or visit our website.

Appointments:
Students may access services from the health center through direction from the school nurse if they are enrolled in the program. Parents will also be able to schedule appointments for their children at this location.

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If your child becomes ill at school, the school nurse will determine if it is necessary for your child to receive care. We will always attempt to contact you by phone if your child is seen for an acute illness or injury and will send home a written explanation of the care given and the necessary follow-up. Medications and prescriptions will not be sent home with your child. Prescriptions will be sent to the pharmacy of your choice.

If your child is ill, **please do not** send him/her to school. If you would like your child to be seen at Hadley-Luzerne Student Health, please call and make an appointment for your child to be seen. Parents are always welcome to come to their child's appointment. If you are unable to attend the appointment, we can see your child during the school day and call you before and after their appointment.

If needed, transportation from the Hadley-Luzerne Junior/Senior High School to Hadley-Luzerne Student Health will be provided by the school.

After Hours/Urgent Care:
When school is not in session and your child is ill, please contact your child's primary care provider. If you do not have a primary care provider for your child, please contact our Pediatric and Adolescent Health office at 518-798-6400.

Hudson Headwaters also offers **urgent care** for health concerns that arise suddenly but are not life-threatening at two of our facilities, the Health Center on Broad Street in Glens Falls and the Warrensburg Health Center seven days a week with evening hours. Please visit our website for more information.

Patient Portal:
As a parent or legal guardian, you can manage your child or teen's personal health information on our secure online health portal. Our portal allows you to access medical information you need like medications, immunizations, and appointment summaries from the convenience of your computer or mobile device. To register, select "yes" on the enrollment form and share your email address. You may also register for the patient portal by calling the health center.

Meet the Hadley-Luzerne Student Health Team:
Our team of experienced pediatric providers and medical assistant, Lauren Eckard, will work closely with the school nurse, Annie Horn to make sure your child receives the high-quality healthcare they need. Our team is available should you have any questions or concerns. We look forward to caring for the students of the Hadley-Luzerne School District.

Irene Flatau, M.D.
Pediatrician

Krysta Brown, PNP
Pediatric Nurse Practitioner

Lia Braico, FNP
Family Nurse Practitioner

www.hhhn.org

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Hadley-Luzerne Student Health Enrollment and Consent Form

Please complete the front and back of this form and return to the health center.

Student and Guardian Information:

Student's Name: _____ **Date of Birth**: _____ /_____ /_____ **Grade:** _____

Social Security #: _____ **Gender Identity:** ☐Female ☐Male ☐Other, please specify: _____

Preferred Language: _____ **Ethnicity:** ☐Hispanic/Latino ☐Not Hispanic or Latino ☐Refuse to Report

Race: ☐Native-Hawaiian ☐Black/African American ☐White American ☐Indian/Alaska Native ☐Asian
☐Unreported/Refuse to Report ☐Other _____

Student Address: _____

Parent/Guardian First and Last Name: _____ **Relationship to Student:** _____

Phone #: _____ **Cell #:** _____ **Work #:** _____

E-Mail Address: _____ **Would you like to register for our patient portal? YES NO**

Who is your child's primary care provider? ☐Hudson Headwaters Health Network

Practice Name: _____ Provider Name: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Emergency Contact:

Name: _____ Relationship to Student: _____

Home Phone #: _____ Cell Phone #: _____

Insurance Information:

Does your child have health insurance: **YES NO**

If your child does not have health insurance, would you like to be contacted by an enrollment specialist from Adirondack Health Institute who can assist you with obtaining free or low-cost health insurance? YES NO

Insurance Company: _____ Phone #: _____

Address to submit claim to: _____

Policy/ID #: _____ Group #: _____

Name of Policy holder: _____ Date of Birth: _____

Social Security #: _____ Employer: _____

(*over*)

HUDSON HEADWATERS
HADLEY-LUZERNE STUDENT HEALTH

Consent for Health Services

I give my consent for my child to receive applicable medical services provided by the staff of Hudson Headwaters Health Network Hadley-Luzerne Student Health, including;

- Comprehensive physical exams, including those for school sports
- Lab test when necessary to detect illness or infection (ie: strep throat)
- Immunizations
- First aid and assessment of acute illness, injuries and emergency care
- Prescriptions and medication administration when necessary
- Referrals to an outside agency for services not provided at Hadley-Luzerne Student Health
- Health Education Counseling

I give consent for, _____to receive the above healthcare services provided by the professional staff of Hudson Headwaters Health Network Hadley-Luzerne Student Health.

I further give consent to the staff of Hadley-Luzerne Student Health to examine my child's full medical and school records including any information that may assist them in helping my child. In addition, if necessary, you may contact our family physician or any other healthcare provider to share information regarding my child's treatment.

I also authorize the release of any medical information necessary to process any insurance claim to my designated insurance carrier and made payable directly to Hudson Headwaters Health Network Hadley-Luzerne Student Health.

I understand that when necessary every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. New York State law does not require parental consent for treatment or advise about drug abuse, alcoholism, sexually transmitted disease, reproductive health or outpatient mental health services.

All care provided will be in collaboration with your child's Primary Care Provider.

The staff of Hadley-Luzerne Student Health considers parental involvement very important. Accordingly, the staff will encourage every student to involve his/her parents or guardian in counseling and medical care decisions. We encourage parents to visit or call the center at any time.

Date: _____ Signature: _____

Print Name: _____

Relationship to student: _____

Please complete the front and back of this form and return to the health center.

HUDSON HEADWATERS HEALTH NETWORK

Today's Date: ____ / ____ / _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: ____ / ____ / _____
Gender: ☐ Female ☐ Male ☐ Other _____

Please take a few moments to answer these questions about your past medical history. This will help us to serve you better. This information will be kept **CONFIDENTIAL**. Thank you.

ALLERGIES: Please list any medication allergies, reactions, and other allergies.

_____
_____
_____
_____

MEDICATIONS: Please list any prescription, over-the-counter medications, herbals and/or vitamins you are taking. Include dose, frequency and prescribing provider.

_____
_____
_____
_____

IMMUNIZATIONS/VACCINES: Please include a copy of child's immunization and vaccination history including facility, provider and date.

MEDICAL ILLNESSES: Please list any hospitalizations or medical illnesses. Note year.

_____
_____
_____
_____

SURGERY: Please list any operations you have had. Note year and provider name.

_____
_____
_____
_____

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Name: _____
Date of Birth: ____ / ____ / _____

SOCIAL HISTORY:
Parents' Name(s): _____
Parents' Marital Status: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced ☐ Other _____
Home situation: ☐ Both parents ☐ Mother ☐ Father ☐ Relatives ☐ Adoptive parents
☐ Foster parents ☐ Other _____
Do you have siblings? ☐ Yes ☐ No If yes, names and date of birth: _____
_____
Do you have pets? ☐ Yes ☐ No
Childcare: ☐ None ☐ Relative ☐ Private sitter ☐ Daycare/Preschool

Date of Last Dental Visit: ____ / ____ / _____ Year in school: _____
Date of Last Eye Exam: ____ / ____ / _____

Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Diabetic ☐ Other _____

Do you exercise regularly/play sports? ☐ Yes ☐ No

How much caffeine or sweetened drinks do you consume per day? _____

How much screen time do you have per day? _____

Do you live with someone who smokes? ☐ Yes ☐ No

Are there smoke and carbon monoxide detectors in your home? ☐ Yes ☐ No

Do you use your seat belt or car seat routinely? ☐ Yes ☐ No

Do you use sunscreen routinely? ☐ Yes ☐ No Do you use insect repellent routinely? ☐ Yes ☐ No

Are there guns in your home? ☐ Yes ☐ No If yes, are they secure? ☐ Yes ☐ No

FAMILY HISTORY: Please note their health status and age, or age at death and cause.
Father: _____
Mother: _____
Siblings: _____

PREVIOUS PEDIATRICIAN/PRIMARY CARE PROVIDER: Include facility address and phone number.
_____
_____

OTHER DOCTORS YOUR SEE: Include reason, facility address and phone number.
_____
_____
_____
_____

Hudson Headwaters Health Network

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

NEW YORK STATE DEPARTMENT OF HEALTH

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

_____

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
STAFF PERSON'S NAME AND TITLE SIGNATURE DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

HUDSON HEADWATERS HEALTH NETWORK
RELEASE OF INFORMATION

I understand that my health information may be used or disclosed for the purposes of treatment, payment, and operations in accordance with state and federal regulations for privacy and security. I understand that this may include disclosures of information to my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to Hudson Headwaters Health Network for medical services rendered to myself and/or my dependents. I am responsible for understanding the limitations of my insurance coverage and to present any co- pay (co- insurance, deductible) or other personal obligations at the time service is rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I give Hudson Headwaters Health Network permission to disclose to a relative or friend my location and general condition, or other information directly relevant to that person's involvement in my care, to those I have named below: (please note: Certain medical conditions may require a separate release.)

_____	_____
(First and last name)	*(Relationship with patient)*
_____	_____
(First and last name)	*(Relationship with patient)*
_____	_____
(First and last name)	*(Relationship with patient)*
_____	_____
(First and last name)	*(Relationship with patient)*
_____	_____
(First and last name)	*(Relationship with patient)*

X_____ X_____

Patient's Signature or Parent/Guardian's Signature Date

☐ Patient or Parent/Guardian refused to sign.

Please complete the front and back of this form and return to the health center.

HUDSON HEADWATERS HEALTH NETWORK
ASSIGNMENT OF BENEFITS

Because Hudson Headwaters Health Network receives funding from the Federal Government, we are required to collect information about income ranges. **Please determine family size and check the appropriate income category box.**

Family Size	CATEGORY 1: ☐	CATEGORY 2: ☐	CATEGORY 3: ☐	CATEGORY 4: ☐
1	$0 - $12,490	$12,491 - $18,735	$18,736 - $24,980	$24,981 +
2	$0 - $16,910	$16,911 - $25,365	$25,366 - $33,820	$33,821 +
3	$0 - $21,330	$21,331 - $31,995	$31,996 - $42,660	$42,661 +
4	$0 - $25,750	$25,751 - $38,625	$38,626 - $51,500	$51,501 +
5	$0 - $30,170	$30,171 - $45,255	$45,256 - $60,340	$60,341 +
6	$0 - $34,590	$34,591 - $51,885	$51,886 - $69,180	$69,181 +
7	$0 - $39,010	$39,011 - $58,515	$58,516 - $78,020	$78,021 +
8	$0 - $43,430	$43,431 - $65,145	$65,146 - $86,860	$86,861 +

☐ Patient or Parent/Guardian refused to indicate income category.

X_____ X_____

Patient's Signature or Parent/Guardian's Signature — Date

☐ Patient or Parent/Guardian refused to sign.

Please complete the front and back of this form and return to the health center.

HUDSON HEADWATERS HEALTH NETWORK
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand and have been provided with a copy of Hudson Headwaters Health Network Privacy Practices that provides a more complete description of how the Network may use and disclose my protected health information in accordance with state and federal regulations for privacy and security. I further understand that Hudson Headwaters Health Network reserves the right to change its privacy practices. In the event of a change, a copy will be posted in a prominent location in the practice site, or upon my request, a copy will be sent to the address I have provided.

I,_____, date of birth_____, understand,
Patient First and Last Name Date of birth

that as part of my health care, Hudson Headwaters Health Network originates and maintains paper and/or electronic records describing health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means to facilitate coordination of care among the health professionals, including referrals, who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for healthcare options of the Network such as assessing quality of care and reviewing competence of healthcare professionals.

I understand that Hudson Headwaters Health Network may send test results and correspondences associated with my care to the address I have provided. We may also leave messages at the telephone numbers I have provided either to confirm appointments or to request I call on medical, dental or billing items.

If you require a restriction on the above please see a staff member at the desk.

X_____ X _____
Patient's Signature or Parent/Guardian's Signature Date
☐ Patient or Parent/Guardian refused to sign.

(over)

HUDSON HEADWATERS HEALTH NETWORK
9 Carey Road, Queensbury, NY 12804 · www.hhhn.org

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how your medical information may be used and disclosed and how you can get access to this information. For more information please contact our Risk Management and Compliance department at 518-761-0300 ext. 31350 or compliance@hhhn.org

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➢ *For more information on these **rights** and **how to exercise them**, please see your nearest health center*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➢ *For more information on these **choices** and **how to exercise them**, please see your nearest health center*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➢ *For more information on these **uses and disclosures**, please see your nearest health center*