Now Available: On-site Medical Care through Nemours Telehealth Program

Through generous funding from Winter Park Health Foundation (WPHF), Winter Park Day Nursery and Nemours Children's Health have partnered to provide on-site medical services to the children in our care with your consent and active involvement.

How does this program work? If a child is sick and requires non-emergent medical attention, the school will contact the child's parents or guardians to offer this service. Once permission is granted, the school will initiate a video visit with a Nemours pediatrician. Through an iPad and secure technology, the provider will virtually examine the child and determine safe and necessary care. If a prescription is needed, it will be sent electronically to your local pharmacy for pickup.

Parents or guardians will be asked to join the online visit through a secure link sent to them via text or email. They can also join in-person if they are present with their child at school. Parents will also receive an email with instructions to download and sign up for the **Nemours app** to access their child's after visit summary. A copy of the visit notes will also be sent to your child's doctor if this information is provided. This service is available to children at school during school hours only.

How much will this service cost? There is no cost to enroll in this program. Payments are due only if care is provided.

- If insurance is used, the cost will be the same an in-person urgent care visit (out-of-pocket fees, copays, and deductibles).
- If insurance is NOT used, the cost of the visit is only $79.

WPDN has put aside grant funds to support families in need to help cover the visit cost (family income dependent).

How do I sign up? This program is optional; however, we highly encourage enrolling early - before your child needs it.

To enroll your child(ren), please complete the forms provided. Return the packet to the front desk. The forms will cover visits for the entire 2022-2023 school year. Each child needs his/her own forms filled out.

- Student and Family Information with Insurance Form
- Telemedicine Consultation Consent and Authorization for Release of Information
- Patient Presents for Appointment Without Legal Representative Authorization for Treatment
- Financial Responsibility

If you have any questions about the forms, call the school office at (407) 647-0505.

Winter Park Health Foundation

NEMOURS CHILDREN'S HEALTH

Nemours. Children's Hospital

Patient Name:
MRN:
DOB:

CareConnect Student & Family Information with Insurance

Date_____Grade_____Homeroom_____School year _____

Patient Information

Name_____Social Security Number_____

Sex: Male / Female / Other Race _____Date of Birth _____ Patient Weight _____

Any known Allergies _____

Street Address_____

City_____State_____Zip Code_____County_____

Student Resides With _____

Mother's/ Legal Representative's Information

Name _____

Street Address_____

City_____State_____Zip Code_____County_____

Date of Birth_____Employer_____Work Number/Extension_____

Home Phone_____Cell Phone_____Email_____

Father's /Legal Representative's Information

Name _____

Street Address_____

City_____State_____Zip Code_____County_____

Date of Birth_____Employer_____Work Number/Extension_____

Home Phone_____Cell Phone_____Email_____

Person to Notify in Case of Emergency (other than parent/legal representative)

Name_____Relationship to patient_____

Street Address _____

City_____State_____Zip Code_____County_____

Home Phone_____Cell Phone_____

Nemours. Children's Hospital

Patient Name:
MRN:
DOB:

CareConnect Student & Family Information with Insurance

Primary Care Physician

Name_____

Address_____

Phone Number_____Fax Number_____

Date Last Seen_____

Pharmacy

Name_____

Address_____

Phone Number_____Fax Number_____

Primary Insurance Information

Name of insurance company_____Telephone Number _____

Claims address_____City _____ State_____ Zip code_____

Effective date_____ Expiration date_____ Group name _____

Policy number_____Group number_____Co-Pay_____

If visit is due to an accident, accident date_____

Subscriber's name_____

Subscriber's date of birth_____ Relationship of subscriber to patient_____

Name of subscriber's employer_____Occupation_____

Employer's address _____

City_____State_____ Zip code_____

Subscriber's work telephone number_____Employment status_____

Subscriber's Social Security number_____

Patient Name:
MRN:
DOB:

CareConnect Student & Family Information with Insurance

Other or Secondary Insurance Information (if applicable)

Name of insurance company_____ Telephone number_____

Claims address_____City_____ State_____ Zip code_____

Effective date_____ Expiration date_____ Group name_____

Policy number_____Group number_____Co-Pay_____

If visit is due to an accident, accident date_____

Subscriber's name_____

Subscriber's date of birth_____ Relationship of subscriber to patient_____

Name of subscriber's employer_____Occupation_____

Employer's address _____

City_____State_____ Zip code_____

Subscriber's work telephone number_____Employment status_____

Subscriber's Social Security number_____

Guarantor Information (person financially responsible for services provided)

Name_____

Relationship_____ Home telephone number_____ Work number_____

Address_____ City_____ State_____Zip code_____

Sex_____Date of birth:_____Social Security number_____

Employer's name_____Employer's address_____

City_____ State_____Zip code_____

o Full time o Part time o Student part time o Student full time o Unemployed
o Retired

Guarantor language_____How did you hear about us?_____

NEMOURS CHILDREN'S HEALTH

Patient Name:
MRN:
DOB:

200001

Telemedicine Consultation Consent and Authorization for Release of Information

- I understand that my healthcare provider wishes for me to engage in a telemedicine consultation with a Nemours* consulting health care provider.

- I understand that my healthcare provider may electronically transmit information to Nemours for diagnosis, treatment, follow-up and/or patient education, including:
    - Patient medical records;
    - Medical images;
    - Interactive audio, video, and/or data communications; and/or
    - Output data from medical devices, sound, and video files.

- I understand that individuals other than my healthcare provider and the Nemours consulting health care provider may also be present and have access to my child's medical information in order to assist with the telemedicine equipment.

- I understand that visual and physical examination may take place and some parts of the exam may be conducted by individuals at my treating provider's location at the direction of the Nemours consulting health care provider.

- The telemedicine equipment and electronic systems being used incorporate network and software security protocols to protect the confidentiality of my child's medical information. I understand that there is a slight risk that the security protocols could fail, causing a breach of privacy of my child's confidential medical information.

- I understand that there are limits to the telemedicine technology being used (e.g., poor resolution of images or sound quality, dropped connections, or audio interference) and the information being transmitted may not be sufficient to allow for appropriate medical decision making by the Nemours consulting health care provider. This could result in delays in medical evaluation and treatment or a determination by the treating physician and/or Nemours consulting health care provider to discontinue the telemedicine consult.

- I have the right to withhold or withdraw my consent to the use of telemedicine during the course of my child's care at any time. I understand that my withdrawal of consent will not affect any future care or treatment from Nemours.

- I understand that information, including recordings (photographs, video, electronic or audio media), may be collected, used, and disclosed as necessary for one year from the date signed for:
    - Coordinating treatment with healthcare providers;
    - Eligibility, billing, claims management, medical necessity, and utilization review;

Telemedicine Consultation Consent and Authorization for Release of Information

- Required reporting of diseases or injuries such as communicable diseases
- Required reporting to registries such as cancer and immunization; and
- Inclusion in Health Information Exchanges.

I acknowledge:

- If this is my first visit to Nemours that I have received a copy of the Notice of Privacy Practices, or
- If this is not my first visit, I am aware the Notice of Privacy Practices can be obtained from our website www.nemours.org, or from my treating physician.
- My privacy rights are fully explained in the Nemours Notice of Privacy Practices.

I hereby give my consent for the use of telemedicine consultation in my child's medical care and the above terms and conditions.

By signing below, I certify that I am either the parent or legal representative of the patient, or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I certify that I have read and understand that above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____ _____ _____ AM PM
Signature of Patient or Patient's Legal Representative Date Time

_____ _____
Printed Name of Patient or Patient's Legal Representative Relationship to Patient

INTERPRETER'S SIGNATURE: (To be completed only when appropriate)

I certify that I am fluent in English and the native language of the person indicating consent on the above form. I certify that I have accurately and completely interpreted the contents of this form, and that the patient and/or adult legally responsible for the minor child has indicated their understanding of the contents of this form.

_____ _____ _____ AM PM
Interpreter's Signature &/or Telephone Identification Number Date Time

_____
Interpreter's Name (Print)

*Nemours includes: The Nemours Foundation, a Florida not-for-profit corporation, its operating divisions and sites, and its affiliates and subsidiaries, including Nemours Children's Hospital, Delaware; Nemours Children's Hospital, Florida; Nemours Children's Hospital, Surgery Center, Bryn Mawr; and Nemours Children's Hospital, Surgery Center, Deptford; and all entities operating under the name Nemours Children's Health.

Nemours.

Patient Name:
MRN:
DOB:

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

To provide timely and accurate payment to Nemours* for any services furnished the patient listed above by Nemours physicians and health care providers:

- I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.
- I assign my right to receive payment of authorized benefits to Nemours.
- I request that payment of authorized benefits be made on my behalf to Nemours for any services furnished the patient listed above by Nemours physicians and health care providers.
- I authorize Nemours to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided.
- If my Health Insurance Plan will not direct payment to Nemours, I agree to forward to Nemours all health insurance payments which I receive for the services rendered by Nemours and its health care providers.
- I authorize Nemours or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

I further acknowledge and agree:

- That I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
- That I agree to pay all charges which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
- I further agree that, if permissible by law, I will reimburse Nemours for all costs, expenses and attorney's fees that may be incurred by Nemours to collect those charges.
- That this financial form with assignment of benefits applies and extends to subsequent visits and appointments at Nemours

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____	_____	_____
Patient/Legal Representative	**Relationship to Patient**	**Date**

INTERPRETER'S SIGNATURE: (To be completed only when appropriate)

I certify that I am fluent in English and the native language of the person indicating consent on the above form. I certify that I have accurately and completely interpreted the contents of this form, and that the patient and/or adult legally responsible for the minor child has indicated their understanding of the contents of this form.

_____	_____	_____	_____ AM
Interpreter's Signature	Interpreter's Name (Print)	Date	Time PM

*Nemours includes: The Nemours Foundation, a Florida not-for-profit corporation, its operating divisions and sites, and its affiliates and subsidiaries, including The Alfred I. duPont Hospital for Children Surgery Center, Bryn Mawr, and all entities operating under the name Nemours duPont Pediatrics.

NEMOURS CHILDREN'S HEALTH

Patient Name:
MRN:
DOB:

PATIENT PRESENTS FOR APPOINTMENT WITHOUT LEGAL REPRESENTATIVE CONSENT FOR TREATMENT

Quality health care requires a team approach between the parent/legal representative and your child's health care provider. *Nemours encourages the parent/legal representative to be present with their child at all visits. The presence of the parent/legal representative ensures good two-way communication to make certain your child's health care needs are understood and addressed. Nemours understands, however, that occasionally minor children live with and/or are well cared for by members of their extended families or others. As a result, on occasion a minor requiring treatment will not be accompanied by the parent/legal representative, and efforts by Nemours to communicate with the minor's parent/legal representative at the time of the visit may not be desired by the parent/legal representative.

I represent that I am the parent/legal representative and have the legal authority to consent to the examination and treatment of: _____by Nemours health care providers and associates.

I understand that the examination and treatment may include the use of x-rays, laboratory tests (including routine HIV(human immunodeficiency virus) testing, when applicable), medications, DNA analysis, and other diagnostic procedures and tests normally provided in a pediatric health care environment, but does not include consent to surgery, general anesthesia, provision of psychotropic medications or other extraordinary procedures for which a separate written informed consent as provided by law is required.

During the course of my/my child's care at Nemours, it may be medically necessary to obtain a blood, urine, stool, tissue, or other type of biological specimen for analysis. This analysis *will not* involve the examination of your DNA to identify the presence and composition of genes in your body. After an analysis has been performed and the biological specimen is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state, and federal requirements. It may also be the case that a biological specimen from you/your child may be deposited on medical instruments, bedding, clothing, or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Nemours to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

I understand that information, including recordings (photographs, video, electronic or audio media), may be collected, used, and shared with others only as necessary for:

- Coordinating treatment with healthcare providers;
- Ensuring providers we refer you to have all the necessary health information;
- Eligibility, billing, claims management, medical necessity, and utilization review;
- Required reporting of diseases or injuries such as communicable diseases;
- Required reporting to registries such as cancer and immunization; and
- Inclusion in Health Information Exchanges (HIE).

PLEASE NOTE: I understand I have the right to request a restriction on the sharing of my child/ward's health information. Visit www.Nemours.org for restriction request form. To opt out of Nemours' sharing health information with HIE partners, except in life-threatening emergencies, send an email to HealthExchange@nemours.org.

I consent to the examination and treatment by Nemours health care providers and associates of the patient above. I agree that Nemours will not be responsible for the medical care, services, and treatment delivered by physicians and allied healthcare providers not employed by Nemours. I understand that this consent applies and extends to subsequent visits and appointments at Nemours, even if my child is not accompanied by me, and is valid for one year.

I understand it is my obligation to know when my child is examined and treated at Nemours, to know who accompanied my child to the visit, if anyone, and to take steps promptly following the visit to make sure I understand the recommendations and plans instituted by Nemours to address my child's health needs. I understand the recommendations and plans instituted by Nemours to address my child's health needs will be shared with the person who accompanied my child to the visit, and that I may obtain the recommendations and plans from that person or by communicating with the Nemours provider who examined and treated my child.

NEMOURS CHILDREN'S HEALTH

Patient Name:
MRN:
DOB:

PATIENT PRESENTS FOR APPOINTMENT WITHOUT LEGAL REPRESENTATIVE CONSENT FOR TREATMENT

Person(s) Accompanying Patient	**Relationship to Patient**
Print Name (Patient/Legal Representative)	**Signature (Patient/Legal Representative)**
Date **Time (am/pm)**	**Relationship to Patient**

INTERPRETER'S SIGNATURE: (To be completed only when appropriate)

I certify that I am fluent in English and the native language of the person indicating consent on the above form. I certify that I have accurately and completely interpreted the contents of this form, and that the patient and/or adult legally responsible for the minor child has indicated their understanding of the contents of this form.

Interpreter's Signature	Interpreter's Name (Print)	Date	Time	AM PM
_____	_____	_____	_____	AM

Key: DNA: Deoxyribonucleic Acid

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