Hornet Health Clinic

A doctor's office on a school campus

Bryant School District wants to support the health, well-being and academic success of our students, enabling them to thrive in the classroom and beyond.

1. What is the Hornet Health, and what services are provided?
   Hornet Health is on campus doctors' office, located beside Bryant Elementary. The Bryant School District has partnered with Arkansas Pediatric Clinic (APC) to staff the clinic.
   The HHC can provide the following types of care and more:
   - Primary Care for wellness/ sickness
   - Injury
   - Laboratory test
   - Prescription Medications
   - Health Promotion and Prevention Programs
   - Vaccines/ Immunizations

2. Will my child see the doctor without my permission?
   Absolutely not! Parents must enroll their child in the school-based health center before the child will be seen. We will make every attempt to contact the parent before the child is seen for their appointment, upon request we will inform you about everything that occurs in the appointment.

3. Will my student have a ride to HHC, if I am not able to come?
   Yes, any student enrolled in Bryant, and needs or has an appointment at the clinic, they will be transported by a district employee or walked by an employee. Too and from their building.

4. Will my child leave with their medications?
   Absolutely not! No child will leave the HHC with medication or a written prescription. All student prescriptions will be called into the parents' pharmacy of choice.

5. Will my child have to pay at the time of visit, what about insurance?
   Students that are transportation to HHC, will not be expected to pay the co-payment. APC will send a statement to the guardian for payment.
   Insurance will be billed by the doctor for the services rendered in at HHC. If your child already as a PCP but wants to see the doctor at the clinic, every attempt will be made to secure a referral from your PCP. We might ask for your help in receiving the referral.

Why choose us?
Parents appreciate the HHC because:

- Parents miss less work.
    - When a child is sick, the parent must miss work to take the child out of school and to be seen at the nearest health care facility once an appointment is secured.
- HHC services help their child to stay healthy and in school. Services include those for physical and mental health.
- Staff enhance the school's health education program.

What do I need to do for my child to be apart of HHC?
Students needing services must have parental consent forms on file in order to access services. All students needing services during the school day and does not have an appointment for the day, must visit the school nurse prior to receiving services. If it is determined by the school nurse that a student needs services, the parent will be notified prior to the appointment. No student will be sent directly to HHC during school hours, unless an appointment is made or an assessment from the school nurse or counselor.

2022-2023 HORNET HEALTH CENTER
STUDENT REGISTRATION & PERMISSION FORM

1215 Woodland Dr. Building 35
Bryant, AR 72022
501-653-5040
Brittany Rothwell, Coordinator

STUDENT INFORMATION SCHOOL ATTENDING:

Name (Last, First, Middle)	Birth Date / /	Gender ☐Male ☐Female	Primary Language Spoken if Not English

Does the child have a regular doctor or other medical provider? ☐Yes ☐No Name of Provider or Clinic:

If the child does not have a regular doctor or other medical provider, I would like information on how Arkansas Pediatric Clinic, can become my child's Primary Care Provider (PCP) ☐Yes ☐No

I **Only** want my child to receive immunizations/vaccines in the clinic? ☐Yes ☐No

My child will need transportation to and from the clinic. ☐Yes ☐No

I would like Arkansas Pediatric Clinic to become the child's Primary Care Provider (PCP) ☐Yes ☐No

** Please complete the Primary Care Physician (PCP) form change form.*

Does the child have a regular dentist or dental clinic provider? ☐Yes ☐No Name of Dentist or Dental Clinic:

Does the child have a regular optometry or eye clinic provider? ☐Yes ☐No Name of Optometry or eye clinic:

PARENT / COURT ORDERED LEGAL GUARDIAN INFORMATION

Name Date of Birth		Relationship to Student	Does the student live with you? ☐Yes ☐No
Street Address		City, State, Zip	
Daytime Phone #	Work phone # and ext.	Other Phone (cell phone) #	Email Address
In Case of Emergency Contact/Relationship to Student		Phone #	Other Phone (cell phone) #

Has there been any change in your child's health during the past year? ☐Yes ☐No **If yes, explain.**

Has this child had a recent complete physical exam? ☐Yes ☐No **If yes, when? / /**

If no, would you like for your child to receive a complete physical in the Hornet Health Center? ☐Yes ☐No **If yes, please sign the statement below:**
I give permission for my child to have a complete physical exam at the Hornet Health Center – signature: _____

I would like to be present for my child's exam. ☐Yes ☐No We will contact you before and after the appointment.

Last eye exam? / / Any eye concerns? ☐Yes ☐No **If yes, explain.**

Last dental exam? / / Any dental concerns? ☐Yes ☐No **If yes, explain.**

Has your child ever had any serious sports-related injuries? ☐Yes ☐No **If yes, give the age it occurred and describe injury.**

If your child receives a sports physical in the Hornet Health Center; do you consent to releasing a copy of your child's completed sports physical forms to the school for sports participation purposes? ☐Yes ☐No

Is there anything else you would like for the school health center to know about your child?

HOUSEHOLD INFORMATION

Please name the people living in your household: Example: Father/Mother, Stepfather/mother, Sisters, Uncle, etc.

Does anyone in the household smoke? ☐Yes ☐No

NOTICE AND ACKNOWLEDGMENT OF PRIVACY PRACTICES

Dear Parent/Guardian,

By signing this consent form, you have acknowledged that you have received/been made aware of our Notice of Privacy Practices. Our job here at the clinic is to provide your child with the best possible care. Our goal is to get students back to class as soon as possible, based on the diagnosis from Dr. Duke. If you do not sign this Consent Form, Hornet Health Center/ Arkansas Pediatric Clinic (APC) has the right to refuse to provide treatment unless a licensed healthcare professional has determined emergency treatment is necessary, in which case we are required by law to provide treatment. Hornet Health Center/APC is required to document any circumstances in which we do not obtain your consent yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent Form. You understand that photographs, videotapes, digital, or other images may be recorded to document care, and consent to this. Images that identify you will be released and/or used outside the institution only upon written authorization from you or your legal representative.

Thanks!
Hornet Health Center Staff

INSURANCE INFORMATION* Please send a copy of your insurance cards with this form or send the original **(we will make a copy and return the card to you)**

Is the student covered by Medicaid? ☐ Yes ☐ No ☐ Pending Medicaid ID#:	Would you like information about Medicaid? ☐ Yes ☐ No Do you have another child in the home on Medicaid? ☐ Yes ☐ No

Is the student covered by insurance? ☐ Yes ☐ No			Would you like information about how you could get insurance? ☐ Yes ☐ No
Private Insurance	Name of Policyholder	Date of Birth	Relationship to student
Insurance Company Address (to mail medical claims – check on the back of your insurance card)			Insurance Phone #
ID Number (Policy #)	Group Number		Social Security # **(for insurance purposes only)**
Date Coverage Began			
Policyholder's Employer	Employer Address		

1. I give consent for my child to receive any of the available services at the Hornet Health Center. The Hornet Health Center provides medical, dental, mental health, nutrition, and social work services to enrolled students who have completed registration, including written consent and signature of the parent or legal guardian. Staff will inform parents of significant findings and treatment recommendations for minor children, for conditions other than those exempted by state law.
2. I authorize the release to my child's primary care provider & the school health nurse any medical information pertinent to my child's general health and care while they are at school. I authorize the release of information from my child's primary care provider, school nurse, and Student Support Services to the Hornet Health Center for coordination of care.
3. I authorize the release of any medical information, including information on behavioral health and communicable diseases, necessary to process an insurance claim for payment of medical benefits to the Hornet Health Center.
4. I authorize payment of insurance benefits for services rendered at the Hornet Health Center, through APC. I understand that I am financially responsible for all charges and any co-pays or deductible amount not covered by my insurance. I further understand I am responsible for understanding my own insurance plan and whether services are covered or require pre-authorization. If services require pre-authorization, I understand this is my responsibility.
5. I understand my student will not be required to pay at the time of services, but understand it is my responsibility to pay all cost associated with visit. If I do not pay all such costs, APC has the authority to freeze my child's account.
6. I understand that APC operates in the Hornet Health Center, and I must contact APC to make special payment arrangements if I am unable to pay the bill in full.
7. I understand that my child's medical, mental health, nutrition, and all other records will be strictly confidential, in compliance with state and federal laws, and will be maintained at the Hornet Health Center. Information will only be shared with the school's Student Support Services and will not share with teachers, principals, or other students.
8. I confirm that all information given is complete and accurate.
9. I understand that providers are located on the Bryant Elementary Campus, and it may be necessary for a student to be transported to the Hornet Health Center from another campus. I give my permission for my child to be transported via a school vehicle by an employee of the Bryant School District to/from the Hornet Health Center as needed.
10. I understand that by signing this form, I authorize my child to receive all services available from the Hornet Health Center. I understand that this consent is voluntary and is valid for the entire time that my child is enrolled in school. I understand that I may revoke my consent at any time. I understand that it is my responsibility to provide up-to-date information on the insurance coverage I carry on my child, including Medicaid.

Please sign the following declaration: **I certify that the information provided on this form is accurate and complete to the best of my knowledge.**

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date: _____/_____/_____

NO STUDENT WILL BE DENIED HEALTH SERVICES BASED ON THEIR PARENT OR LEGAL GUARDIAN'S INABILITY TO PAY

ARKANSAS PEDIATRIC CLINIC

MIDTOWN
500 South University Avenue
Suite 317
Little Rock, AR 72205

BRYANT
1412 Woodland Drive
Bryant, AR 72022

MAUMELLE
11749 Maumelle Boulevard
North Little Rock, AR 72113

WEST
16115 St. Vincent Way
Suite 320
Little Rock, AR 72223

Anthony D. Johnson, M.D.
Anton L. Duke, M.D.
Stacy L. Sax, M.D.
Paige Fenner, APRN

Lori E. Montgomery, M.D.
Scott M. Sanders, M.D.
Sarah C. Bone, M.D.
Jodi Haltom, MNSc, APRN, FNP-C

Eugene Lu, M.D.
Kristi M. Hawkins, M.D.
Deena Garner, APRN

Patient Information Form

Patient's Full Name: _____ Date of Birth: _____ (Male)☐ (Female)☐

Race (please circle one): ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White

Ethnicity (please circle one): ☐Hispanic or Latino ☐Not Hispanic or Latino

Address _____
Street Apt # City State Zip Code County

Cell phone number: (_____)_____ Alternate phone number: (_____)_____

Email Address (please print clearly):_____

I (mother/father) of _____ authorize medical records to be emailed to the above email address.
☐Yes ☐No

Primary Care Physician: _____

Responsible party:_____

Father's name:_____ Mother's Name:_____

Social Security No:_____ Social Security No:_____

Date of Birth:_____ Date of Birth:_____

Marital Status: (Married)____ (Divorced)_____ (Single)_____ Mother's Maiden Name:_____

Please list the names of other children and date of birth:

_____

_____

_____

Emergency Contact (not living at same address as patient):

Name:_____ Relation to child:_____

Telephone No: ( )_____ Address:_____

I give permission for Arkansas Pediatric Clinic to treat my child._____
Signature Date

Initial Intake Form

Today's Date: _____

Hornet Health Clinic
412 Woodland Dr
Bryant, AR 72022
501-653-5040

Patient Name: _____ DOB: ____/____/_____ Male / Female Age:_____

Name of person completing form: _____ Relationship to patient: _____

Is your child presently taking any medications? YES NO

If yes, please list with dosage and prescribing physician's name: _____

_____

BIRTH HISTORY HOSPITAL: _____

Birth Weight _____lbs ___oz Term or Premature (_____wks) Vaginal birth or c-section

Y (details) _____ Blood type _____

Complications	Yes	No			
Hearing screen passed	Yes	No	Not Known		
First Hep B given	Yes	No			
Circumcision	Yes	No	N/A	When_____	Details _____
Hospitilization	Yes	No		When_____	Details _____
Surgeries	Yes	No		Details	_____

Does your child have a history of any of the following problems?

Developmental Delay	ADD/ADHD	Cerebral Palsy	Prematurity
Allergic Rhinitis / Hay Fever	Diabetes	Ear Infections	PT / OT / Speech Therapy
Asthma/Wheezing	Eczema	Seizure Disorder	NONE OF THESE
Behavior/Emotional Problems	GE Reflux	Urinary Tract Infections	

FAMILY HISTORY Have any family members (including natural parents, grandparents, aunts, uncles, siblings) had any of the following?

Heart Disease < 55 yrs	High Cholesterol	Allergies	ADD / ADHD	Mental Health Issues
Seizure Disorder	Diabetes	Asthma	Substance Abuse	

Additional Family History: _____

SOCIAL HISTORY Please list all those living in the child's home.

Name	Relationship to child	Birthdates	Health Problems

What is the parent's marital status? Single Married Divorced Unmarried/Living Together

Does anyone in the home smoke? YES NO

If yes, who in the home smokes? _____

Preferred Pharmacy: _____

Pharmacy Address:_____

City:_____ State: AR Zip:_____

Phone:_____ Fax:_____

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Little Rock, AR 72223

Authorization for Alternate Consent

EVEN IF YOU DO NOT WANT ANYONE ON THE LIST, PLEASE GO AHEAD AND SIGN/DATE THIS FORM.

I, _____ am the [mother, father, or legal guardian]
(Parent or Legal Guardian's Name)

of _____ Date of Birth: _____
(Child's Name)

By signing below, I hereby authorize Arkansas Pediatric Clinic to provide medical services to my child as deemed necessary by the physicians at Arkansas Pediatric Clinic upon obtaining this written consent of anyone of the following individuals that I have listed below:

_____ _____
(Name of person you are allowing to bring the child in) (Relationship to the child)

_____ _____
(Name of person you are allowing to bring the child in) (Relationship to the child)

_____ _____
(Name of person you are allowing to bring the child in) (Relationship to the child)

_____ _____
(Name of person you are allowing to bring the child in) (Relationship to the child)

_____ _____
(Name of person you are allowing to bring the child in) (Relationship to the child)

_____ _____
(Name of person you are allowing to bring the child in) (Relationship to the child)

I agree to pay for the charges billed for any and all services provided to my child by Arkansas Pediatric Clinic based upon the consent of anyone of the above named individuals. I understand and agree that this authorization will remain in effect until I revoke this authorization by a delivered written notice of such revocation to Arkansas Pediatric Clinic.

_____
(Signature of Parent or Legal Guardian)

_____
(Print Name of Parent or Legal Guardian)

_____
(Date)

[SEAL]
STATE OF ARKANSAS

County of _____

Subscribed and sworn to before me, a Notary Public, this _____ day of _____, 20_____

_____
(Notary Public)

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Arkansas Pediatric Clinic Policies

Patient Name: _____ Date of Birth: _____

Insurance Information

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts, included but not limited to co-payments and deductibles due under my insurance plan, incurred by my child for services received from Arkansas Pediatric Clinic whether covered by insurance or not. I also understand that if I have a primary insurance, I will still be responsible for all charges not covered by the secondary insurance including Medicaid.

Primary Insurance: _____

Secondary Insurance: _____

Signature: _____ Date: _____

Appointment Policy

We appreciate the trust you have placed in us and will provide the quality of medical care you expect for your child. Our office procedures have been designed for your comfort. We take great pride in our ability to provide your child with optimal medical care.

We understand that circumstances occur that interfere with you keeping certain appointments; however, we do kindly ask that you give our office two hour notice prior to your appointment if you will be unable to attend making it available for another patient. After three or more missed appointments Arkansas Pediatric Clinic reserves the right to terminate our doctor-patient relationship. Please feel free to contact our office at any time should you have any questions or concerns. We look forward to seeing you again and serving your child's medical needs.

Signature: _____ Date: _____

HIPAA Agreement

By my signature below, I acknowledge that I have received a copy of the Arkansas Pediatric Clinic, PLLC Notice of Privacy Practices.

Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

Patient Name: _____ **Date of Birth:** _____

1. **Physician/Facility** authorized to disclose the information? **Name:** _____
   Complete Address: _____
   Phone Number: _____ **Fax Number:** _____

2. Who is authorized to receive the information? **Name: Arkansas Pediatric Clinic**
   Complete Address: 500 S. University Ave., Ste 317, Little Rock, AR 72205
   Phone Number: 5 01-664-4117 Fax Number: 501-664-1137

3. The specific information to be requested or released is:
   List dates of service: _____

   - ☒ All Medical Records
   - ☐ Clinic Visit Notes
   - ☐ Lab
   - ☐ Physical
   - ☒ Shot Record
   - ☐ Other: _____

4. The information is needed for:
   - ☐ Camp
   - ☐ School/Daycare
   - ☐ Insurance
   - ☒ Continuity of Care
   - ☐ Legal Reasons
   - ☐ Other: _____

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by these regulations.

6. I understand that Arkansas Pediatric Clinic will be paid for the costs of copying the information to be released.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.

8. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Arkansas Pediatric Clinic except to the extent that action has been taken in reliance on this authorization. This authorization expires: **One year from date signed.**

9. I understand Arkansas Pediatric Clinic will release the requested information only to the entity listed above.

PLEASE PRESENT A COPY OF A PHOTO ID

_____ _____
Signature of Patient or Representative Date

_____ _____
Phone Number Relationship to Patient

ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM
PRIMARY CARE PHYSICIAN SELECTION AND CHANGE FORM

Member Information:

First Name _____ Last Name _____ Middle Initial _____

Medicaid ID# _____ Social Security # _____

Birth Date (mm/dd/yyyy) _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email address: _____

Requested New Doctor (Primary Care Provider):

I have picked the three (3) physicians named below in order of my preference to be my primary care physician. I understand only one (1) of them will be my primary care physician.

1. Anton Duke
   Doctors first and last name _____ Medicaid Provider ID# _____ Date of assignment
2. Kristi Hawkins
   Doctors first and last name _____ Medicaid Provider ID# _____ Date of assignment
3. Eugene Lu
   Doctors first and last name _____ Medicaid Provider ID# _____ Date of assignment

Reason for Request to Assign/Change Doctor (Primary Care Provider)
Choose all that apply. Select at least one.

- ☐ New Member – made 1st time selection
- ☐ Already patient with requested PCP
- ☐ Requested PCP already sees family member
- ☐ Member preference
- ☐ Member moved
- ☐ PCP hours didn't fit member need
- ☐ Quality of care
- ☐ Office wait times are too long
- ☐ Takes too long to get an appointment
- ☐ Office too far away/ hard to get to
- ☐ Language / communication barrier
- ☐ Other (please specify) _____

Signatures:

✓ Member Signature (or Legal Guardian if a minor) _____

✓ Printed Name of Member (or Legal Guardian if a minor) _____

Date (mm/dd/yyyy) _____