In-School Healthcare by Cura™

Cura School TeleHealth Program Packet

Please complete packet to participate in your school's Cura TeleHealth & Wellness Program

Attached Forms:
To get started right away, please complete all forms and return the information with your school enrollment packet.

- ❑ TeleMedicine Patient Information Form
- ❑ Insurance Information Sheet
  Please provide a copy of Insurance, Soonercare card and/or CDIB card (if applicable)
- ❑ Patient Bill of Rights & Responsibilities
- ❑ TeleMedicine Informed Consent Form

Child's Name: _____

Date of Birth: _____

Primary Care Information

Primary Care Provider_____

Primary Care Phone_____

A phone call will be placed before every virtual visit by the school nurse to inform you of your child's complaints and obtain verbal consent from you prior to initiating a Cura TeleHealth visit.

For more information, visit our website! cura.com

TeleMedicine Patient Information Form

Welcome to Wagoner Public Schools doctors and nurses at school - Through Cura TeleHealth! We will create a chart for your child a chart in the Cura TeleMedicine Program. You can gain access to this chart by record request just like any medical record. Later in the school year we will link your account and your minor children accounts together.

Child

Last Name:________________________________First Name:______________________Middle Initial:______
Birthdate:________________Age:_______Gender: M F Grade:_________Student ID#:_____________
Address:________________________________City:_________________________State/Zip:_________________
Race (circle one): 1-American Indian/ Alaskan Native 2-Asian 3-African American 4-White 5-Other________

Last Name:________________________________First Name:______________________Middle Initial:______
Birthdate:________________Age:_______Gender: M F Grade:_________Student ID#:_____________
Address:________________________________City:_________________________State/Zip:_________________
Race (circle one): 1-American Indian/ Alaskan Native 2-Asian 3-African American 4-White 5-Other________

Last Name:________________________________First Name:______________________Middle Initial:______
Birthdate:________________Age:_______Gender: M F Grade:_________Student ID#:_____________
Address:________________________________City:_________________________State/Zip:_________________
Race (circle one): 1-American Indian/ Alaskan Native 2-Asian 3-African American 4-White 5-Other________

Guarantor Information (Parent or Legal Guardian)

Last Name:________________________________First Name:______________________Middle Initial:______
Birthdate:________________Age:_______Gender: M F
Address:________________________________City:_________________________State/Zip:_________________
Home Phone#_(_____)_______-____________________Cell Phone#_(________)_______-________________
Email address:____
Race (circle one): 1-American Indian/ Alaskan Native 2-Asian 3-African American 4-White 5-Other________
Ethnicity (circle one): 1-Hispanic 2-Non-Hispanic Preferred Language:________________________________
Marital Status (circle one): S-Single M-Married D-Divorced W-Widow X-Legally Separated

Emergency Contact (who can be reached when parent/guardian can not)

Print Name: ____ Phone#: _(______)________-_________
Address:____Relationship: _________________________________
Mother Name:____ DOB:_____________Phone#____________
Address:____ City:________________State/Zip:____________
Father Name:____ DOB:_____________Phone#____________
Address:____ City:________________State/Zip:____________

Cura Digital Health Solutions, Inc. does not discriminate on the basis of age, sex, marital status, race, creed, color, national origin or the presence of any sensory, mental or physical disability

Insurance Information Sheet

Please provide a copy of card.

- ❑ Medicare
- ❑ SoonerCare
- ❑ CDIB Beneficiary Yes No
  Tribe:_____
- ❑ Other:_____
- ❑ Private Insurance Name:_____

City_____ State _____ ZIP_____
Insurance ID#_____ Group#_____

Primary Guarantor **(who carries Insurance)**

Social Security:_____
Last Name:_____First Name:_____Middle Initial:_____
Birthdate:_____Age:_____Gender: M F
Relationship to Patient: Self Spouse Parent Step-Parent

Assignment and Release **(Check one box)**

- ❑ I, the undersigned, clarify that I (or the dependent) have the insurance coverage listed above and assign Cura TeleHealth and Wellness all insurance benefits, in any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits.

- ❑ I, the undersigned, do not have insurance coverage and understand that I am financially responsible for all charges at the time services are rendered.

_____ _____
Responsible Party Printed Name Signature

_____ _____
Relationship Date

Note: If you do not have insurance and need help with payment arrangements please contact Cura at 888.910.2872. Your child's health is our priority and we want to make sure care is provided.

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kjy 10/17/2019

Patient Bill of Rights & Responsibilities

As a patient you have the right to:

1. The right to receive safe and quality care within the range of services that TeleMedicine provides.
2. The right to receive considerate, respectful and compassionate care regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
3. The right to be informed of the names of your doctors, nurses, nurse practitioner, and all health care team members directing and/or providing your TeleMedicine care.
4. The right to have a family member, support person, or other individual be present with you for emotional support during your treatment, unless the individual's presence infringes on other's rights, safety, or is medically or therapeutically contraindicated.
5. The right to be told by your doctor or nurse practitioner about your diagnosis, possible prognosis, benefits, risks of treatment, and the expected outcome of treatment, including unexpected outcomes.
6. The right to ask for a change of doctor, nurse practitioner, nurse or other health care team members or a second opinion.
7. The right to have your pain or illness assessed to be involved in decisions regarding your treatment. Parent, guardians, family members or others whom you may choose can speak for you if you cannot make your own decisions.
8. The right to receive privacy and confidentiality when you are receiving care.
9. The right to receive a copy of and details about your bill.
10. The right to know the TeleMedicine grievance process and share a concern or grievance about your care either orally or in writing and receive a timely notice of resolution. If you have a grievance or concern, please contact the Cura Compliance Officer at Compliance@cura.com.
11. The right to request an in-person consultation should you feel that the TeleMedicine consultation is less than adequate or otherwise unsatisfactory.
12. The right to receive information and ask questions related to the confidentiality of your TeleMedicine consultation and the use of your medical information.
13. The right to present concerns to the following: Compliance@cura.com
14. Be informed of the right to formulate an Advanced Directive and/or Do Not Resuscitate (DNR) order.

Patient responsibilities:

1. To provide complete and accurate information about yourself and your health including present complaints, past health problems and hospital visits, medications you have taken (including prescriptions, over-the-counter and herbal medicines), and any other information you think your care givers need to know.
2. Expected to ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for telling your doctor or nurse practitioner. You are responsible for outcomes if you do not follow the care, treatment, and service plan.
3. To follow the instructions of nurses and other health professionals who are carrying out physicians or nurse practitioner orders.
4. Expected to provide correct and complete information about your financial situation as best you can and promptly meet any financial obligations agreed to with the clinic.
5. Expected to treat your doctors, nurse practitioner nurse, nurses and other health care team members with respect.

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TeleMedicine Informed Consent Form

Patient Information

Patient Name: _____ Date of Birth_____

Patient's School:_____

Provider Location:__Cura TeleHealth & Wellness_____

Introduction

You or your child are consenting to have a clinical visit using videoconferencing technology. You or your child will be able to see and hear the provider and they will be able to see and hear you, just as you were in the same room. Since 1994, the technology has connected tens of thousands of patients and providers. The information may be used to diagnose, therapy, follow-up, and/or education.

Expected Benefits:

- Improved access to care by enabling a patient to remain within the facility and obtain services from providers at distant sites.
- Patient remains closer to home where local healthcare providers can maintain continuity of care.
- Reduced need to travel for patient or another provider.
- This consent is to be effective beginning October 8, 2019 – July 1, 2020.

The Process:

You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider or any TeleMedicine staff in the room with you, if you are unsure of what is happening. If you are not comfortable with you or your child seeing a provider on videoconference technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being implemented to ensure that this videoconference is secure, and no part of the encounter will be recorded.

Possible Risks:

There are potential risks associated with the use of TeleMedicine which include, but may not be limited to:

- A provider may determine that the TeleMedicine encounter is not yielding sufficient information to make an appropriate clinical decision and recommend a face-to-face visit.
- Technology problems may delay medical evaluation and treatment for today's encounter.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By Signing this form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to Tele-Medicine, and that no information obtained in the used of TeleMedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw my consent to the use of TeleMedicine in the course of my or my child's visit any time, without affecting my or their right to future care or treatment.
3. I also understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may, at any time stop the TeleHealth visit and schedule a face-to-face visit.
4. I understand that I may expect the anticipated benefits from the use of TeleMedicine in my care, but that no results can be guaranteed or assured.

Patient/Guardian Consent to the Use of TeleMedicine: (please check box)

❑ I have read and understand the information provided above regarding TeleMedicine, and of my questions have been answered to my satisfaction. I hereby give my informed consent to the use of TeleMedicine in my or my child's care.

Promissory Note and Authorization to Pay: (please check box)

❑ I understand that I am financially responsible for all charged incurred as a result of the treatment I or my child receives at the TeleMedicine clinic site.

Patient Rights and Responsibilities: (please check box)

❑ I further acknowledge I have received a copy of the patient rights and responsibilities

I hereby authorize Cura TeleHealth and Wellness to use TeleMedicine in the course of my or my child's diagnosis and treatment.

Signature of Patient (or guardian):_____Date: _____

If guardian, relationship to patient:_____