School- Based Clinic Information

What is a School-Based Clinic?

The clinics are located at Orchard Elementary School and Medicine Crow Middle School. They are school-based locations of RiverStone Health Clinic. The school-based clinics provide:

- Routine well child check-ups with immunizations
- Sports physicals
- Urgent care
- Behavioral health services
- Help with chronic illnesses such as diabetes or asthma
- Dental care is also available at Orchard School Clinic

These clinics are not open to the public, but are intended to serve people who already access the school buildings. For that reason, the usual school security process applies to clinic access.

Who can use the School-Based Clinics?

- The clinic is open to all students enrolled in School District 2 and their family members.

When are the School-Based Clinics open?

- The clinics are open during the school year and follow the school calendar.

Is there a charge for the clinic’s services?

- The School-Based Clinics accepts Medicare, Medicaid, Healthy Montana Kids and most insurance plans. If you have insurance, we will directly bill your insurance company. You will be responsible for co-pays and unmet deductible amounts. We also have a sliding fee scale that is based on income and family size.

How do I enroll in the School-Based Clinics?

There an enrollment process that is required before we are able to see your child in the clinic. **Children cannot be seen in the clinic without your consent and completion of the enrollment process.**

- Call the School-Based Clinics at 406-247-3210 or email schoolclinic@riverstonehealth.org to request an enrollment packet or pick up an enrollment packet at your school.

If you have any questions or would like more information, please call 406-247-3210 or email schoolclinic@riverstonehealth.org

May 10, 2019
Patient Health Information – School Based Health Clinic

Name: ___________________________ Date of Birth: ___/___/____

Do you have ANY ALLERGIES or SENSITIVITIES:  Yes  No  If yes, please list below:

____________________________________________________________________________________________________________________________________________________________________________________

Medications: List medicines, birth control pills, herbal supplements or vitamins you take with or without a prescription:

____________________________________________________________________________________________________________________________________________________________________________________

Illnesses: Please ☑ where you or members of your family (parents, grandparents, siblings) have had the following diseases or problems:

<table>
<thead>
<tr>
<th>Patient</th>
<th>Family</th>
<th>Who</th>
<th>Patient</th>
<th>Family</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>ADHD</td>
<td>☑ ☑</td>
<td>______</td>
<td>High Blood Pressure/Hypertension</td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Alcoholism</td>
<td>☑ ☑</td>
<td>______</td>
<td>Kidney/Bladder Problems</td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Anxiety</td>
<td>☑ ☑</td>
<td>______</td>
<td>Liver Disease, Hepatitis, Yellow Jaundice</td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Asthma</td>
<td>☑ ☑</td>
<td>______</td>
<td>Mumps, Measles, Chicken Pox</td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Bleeding Disorder or Blood Clots</td>
<td>☑ ☑</td>
<td>______</td>
<td>Mental Illness</td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Cancer or Tumor</td>
<td>☑ ☑</td>
<td>______</td>
<td>Stroke</td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Diabetes</td>
<td>☑ ☑</td>
<td>______</td>
<td>Suicide Attempt</td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Domestic Violence</td>
<td>☑ ☑</td>
<td>______</td>
<td>Thyroid Disease</td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Drug Abuse</td>
<td>☑ ☑</td>
<td>______</td>
<td>Tobacco Use</td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Eczema</td>
<td>☑ ☑</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Emphysema</td>
<td>☑ ☑</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Epilepsy/Seizures</td>
<td>☑ ☑</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Eye Problems</td>
<td>☑ ☑</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Glaucoma</td>
<td>☑ ☑</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>HIV/AIDS</td>
<td>☑ ☑</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>☑ ☑</td>
<td>______</td>
<td>Heart Disease</td>
<td>☑ ☑</td>
<td>______</td>
<td></td>
</tr>
</tbody>
</table>

Other Illnesses:

____________________________________________________________________________________________________________________________________________________________________________________

__________________________________________  ____________________________________
Patient/Guardian Signature                        Date
## School Based Health Clinic
### Patient Information Form

### STUDENT INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student’s Last Name</td>
<td>_________________________________</td>
</tr>
<tr>
<td>Student’s First Name</td>
<td>____________________________________________</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>_____<em><strong><strong><strong>/</strong>____<strong><strong>/</strong></strong></strong></strong></em> Month Day Year</td>
</tr>
<tr>
<td>School:</td>
<td>____________________________________________</td>
</tr>
<tr>
<td>Sex:</td>
<td>☐ Male ☐ Female Grade _________________</td>
</tr>
<tr>
<td>Student Address:</td>
<td>____________________________________________</td>
</tr>
<tr>
<td></td>
<td>__________________ _________________________</td>
</tr>
<tr>
<td></td>
<td>City                           State                    Zip Code</td>
</tr>
</tbody>
</table>

**Does the student communicate in a language other than English?**
- ☐ No ☐ Yes: Language ________________________________

**Who is the student’s regular doctor?**
- Name: ____________________________________________

**Is the student currently experiencing homelessness?**
- ☐ No ☐ Yes

**Racial Group:**
- ☐ White ☐ African American ☐ Native American
- ☐ Asian ☐ Pacific Islander ☐ More than One Race

**Ethnicity:**
- ☐ Hispanic/Latino ☐ Not Hispanic/Latino

### PARENT/GUARDIAN INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>Last Name: ___________________ First Name: ______</td>
</tr>
<tr>
<td></td>
<td>Cell Phone # __________________________________</td>
</tr>
<tr>
<td>Father</td>
<td>Last Name: ___________________ First Name: ______</td>
</tr>
<tr>
<td></td>
<td>Cell Phone # __________________________________</td>
</tr>
<tr>
<td>Legal Guardian, If Applicable</td>
<td>Last Name: ___________________ First Name: ______</td>
</tr>
<tr>
<td></td>
<td>Relationship of legal guardian to student</td>
</tr>
<tr>
<td></td>
<td>☐ Grandparent ☐ Aunt or Uncle ☐ Other: __________</td>
</tr>
</tbody>
</table>

**Contact Information for parent or guardian**
- Home Tel: ______________ Work Tel: ______________
- Cell: ________________________________

**Additional Emergency Contact**
- Name: ________________________________
- Relationship to Student: ________________________________
- Home Tel: ______________ Work Tel: ______________
- Cell: ________________________________

### INSURANCE INFORMATION

**Does your child have Medicaid or HMK/CHIP?**
- ☐ No ☐ Yes: Medicaid ID # ________________________________

**Does your child have coverage through your employer or any other type of health insurance?**
- ☐ No ☐ Yes: Health Plan: ________________________________

- Member ID/Policy Number: ________________________________

**If your child does not have health insurance, would you like a Certified Application Counselor to contact you to enroll into health insurance?**
- ☐ No ☐ Yes

### PREFERENCES

**Does your child have a regular dentist?**
- ☐ No ☐ Yes: Name ________________________________

**Preferred Pharmacy:**
- Name: ____________________________________________

- Location: __________________________________________

**Do you wish to apply for our sliding fee scale which is based on income and family size?**
- ☐ No ☐ Yes
  - If yes: Household Annual Income ________________
  - Number of people in home ________________

Updated 11-1-2017
I authorize RiverStone Health to disclose to _______________ School the following protected health information (“protected health information”) of _______________ (the “Student”), including all of the following unless otherwise indicated below:

- Information required by law;
- Conditions which may require emergency treatment;
- Conditions which limit the Student’s daily activities; and
- Conditions which require the Student to be absent from school.

By signing this authorization, I understand that I am authorizing the RiverStone Health to use or disclose the Student’s protected health information to the School Based Health Clinic for the purpose(s) I have identified. I understand I can revoke this Authorization in writing at any time and doing so will stop future use or disclosure of the Student’s protected health information; but I understand that RiverStone Health can act on this Authorization until either I revoke my authority in writing or until the expiration date in this authorization. If I want to revoke this Authorization, I will send written notice of revocation to RiverStone Health at 123 South 27th Street, Billings MT 59101 Attn: Medical Records.

I understand I can refuse to sign this Authorization and I am signing it of my own free will. I understand that if I should decide to not sign this Authorization there will be no retaliation from RiverStone Health, nor will there be any effect on the Student’s treatment or payment for services.

I understand I can see and copy my protected health information as described in RiverStone Health’s Notice of Privacy Practices. I understand RiverStone Health cannot control any further disclosure of my protected health information by the School Based Health Clinic after it is disclosed as allowed by this Authorization, and that my protected health information may not be subject to continued protection under federal law once it is received by the recipient.

Unless I indicate at an earlier time below, this Authorization expires on the date the Student is no longer enrolled in the School Based Health Clinic. Date of earlier expiration of Authorization: _______________ (Leave blank if no earlier date is desired)

I have read and understand the release of protected health information described in this Authorization. My signature indicates my consent to release protected health information as specified.

Signature: ___________________________________________ Date: _______________

Parent/Guardian

Printed Name of Parent or Guardian: ________________________________

Updated 11/1/2017
RIVERSTONE HEALTH SCHOOL-BASED CLINIC
CONSENT FOR TREATMENT /ASSIGNMENT OF BENEFITS

Child’s (Patient) Name (Please Print) ______________________________________________

Parent/Guardian Name (Please Print) ______________________________________________

Child’s Primary Care Doctor ______________________________________________________

I consent, request and authorize RiverStone Health Clinic to assess, evaluate, and provide care and
 treatment, including behavioral health ("Treatment") to the patient listed above, including any
 Treatment rendered via telehealth. Documentation of my Treatment will be a part of my RiverStone
 Health medical record. I understand that a licensed clinical pharmacist may also participate in my
care and as part of my care team to provide, among other benefits, drug therapy management. I
may also receive Treatment from students and residents of academic programs who are receiving
 training at RiverStone Health, including, but not limited to, medical or dental students and medical
 or dental residents who may participate in my care under applicable supervision requirements. If I
do not wish to receive Treatment from a resident or student, I understand it is my responsibility to
 communicate this wish to my provider

______ (Initial Here) I authorize my health care provider and public health agency to collect and
 enter immunization records into the Montana Department of Public Health and Human Services’
 confidential Immunization Information System registry. I understand that information in the registry
may be released to a public health agency as well as to my health care providers to assist in my
medical care and treatment. In addition, children’s immunization information may be released to
child care facilities and schools to comply with State immunization requirements. I understand that I
can revoke this authorization and have my record removed at any time by contacting my local health
department.

I authorize RiverStone Health to access my prescription history from outside sources, including but
not limited to SureScripts.

I further understand that I am responsible for the cost of my care. I understand that RiverStone
Health Clinic offers a Sliding Fee Scale based on family income; if I qualify for the Sliding Fee Scale,
I acknowledge that I remain responsible for the remaining balance for my care. I hereby assign any
of my health insurance benefits to be paid directly to RiverStone Health Clinic. I hereby authorize
the release of medical information related to the payment of those insurance benefits. If the patient
listed above is enrolled in the Montana Medicaid Passport program, I authorize RiverStone Health
to contact my Passport provider for authorization.

I acknowledge that RiverStone Health Clinic is a Patient Centered Medical Home. I will be asked to
select a primary care provider and understand that I will be an active participant in my care.

Signature: ____________________________ Date: ____________________________

1/7/2019
Patient Name _______________________________      Date of Birth: _________________________

We are committed to protecting your personal health information in compliance with the law. You have been provided RiverStone Health’s Notice of Privacy Practices dates 7/1/2017 and acknowledge receipt of it. The Notice of Privacy Practices identifies and outlines, among other things:

- RiverStone Health’s obligations under the law with respect to your personal health information.
- How RiverStone Health may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- RiverStone Health’s rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in the Notice of Privacy Practices.
- The person to contact for further information about RiverStone Health’s privacy practices.

We are required by the law to provide the Notice of Privacy Practices to you and this document is your written acknowledgement that the Notice of Privacy Practices has been offered to you in paper form. You can also access a copy of our Notice of Privacy Practices on our website: www.riverstonehealth.org

Patient Acknowledgement

I acknowledge I have been provided a copy of RiverStone Health’s Notice of Privacy Practices.

Patient’s Signature _______________________________      Date _________________________

Signature of Patient’s Representative _______________________________      Date _________________________
### Patient Bill of Rights & Responsibilities

<table>
<thead>
<tr>
<th>As a patient, you have the right to:</th>
<th>As a patient, you have the responsibility to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have access to information about your rights and responsibilities. Your family or guardian may exercise your rights if you are judged incompetent or are a minor.</td>
<td>Provide correct and complete information about your medical problems, past illnesses, medications, advance directives and other health issues. Keep the agency informed of changes in name, address, phone number or financial information.</td>
</tr>
<tr>
<td>Be treated without regard to race, color, religion, sex, handicap, gender preference, national origin, or decision regarding advance directives.</td>
<td>Agree to accept all caregivers without regard to race, color, religion, sex, handicap, gender preference, or national origin.</td>
</tr>
<tr>
<td>Be given information about charges for services, including your eligibility for sliding fee scale with income verification.</td>
<td>Be complete and honest in providing income and insurance information. Keep your financial commitments.</td>
</tr>
<tr>
<td>Not be physically abused or exploited. Be treated with respect, consideration, dignity and privacy.</td>
<td>Treat staff and other patients with respect and consideration.</td>
</tr>
<tr>
<td>Be given information about services available and participate in decisions regarding your care.</td>
<td>Participate in your care. Let your provider know if you do not understand something. Ask questions.</td>
</tr>
<tr>
<td>Be given name and job title of each staff member who provides services to you.</td>
<td>Let us know ahead of time if you are unable to keep an appointment.</td>
</tr>
<tr>
<td>Participate in decisions regarding your care including decisions about your treatment. You have the right to refuse to participate in experimental research.</td>
<td>Follow your treatment plan. Let your provider know if you are unable to keep your plan.</td>
</tr>
<tr>
<td>Be told of the consequences of your actions, if you communicate to your provider that you are refusing treatment.</td>
<td>Accept the consequences if you refuse treatment or if you choose not to follow your treatment plan.</td>
</tr>
<tr>
<td>Have protected health information be handled in a private manner and be able to receive a copy of your clinical record if requested.</td>
<td>If you request a copy of your record, there is a fee for this service.</td>
</tr>
<tr>
<td>Choose your provider or change your provider at RiverStone Health. Choose or change the provider you are referred to outside of RiverStone Health.</td>
<td>Follow your treatment plan as agreed with your provider. Take medications as directed by your provider. Keep your provider informed of changes in your health.</td>
</tr>
<tr>
<td>Voice complaints or suggestions without discrimination or fear of reprisal. Complaints may be made orally or in writing to the Program Manager.</td>
<td>Let the agency know of any problems or if you are unhappy with care or services.</td>
</tr>
<tr>
<td>Be informed about making an advance directive (what you want to happen at end of life if you are unable to express your wishes).</td>
<td>Give your provider a copy of your advance directives.</td>
</tr>
<tr>
<td>Know what to do in an emergency or after hours.</td>
<td>Take steps to maintain your health when you can. Provide a responsible adult to transport you home from the facility and remain with you for 24 hours, if required by your provider.</td>
</tr>
</tbody>
</table>

**I have received a copy of the Patient Bill of Rights.**

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Patient Signature or Guardian

Date
RiverStone Health Clinic

Service Locations:

RiverStone Health Clinic- Billings
RiverStone Health Clinic- Bridger
RiverStone Health Clinic- Worden
RiverStone Health Clinic- Joliet
Orchard School Clinic
Medicine Crow School Clinic
RiverStone Health Dental
RiverStone Health Healthcare for the Homeless – St. Vincent DePaul
RiverStone Health Healthcare for the Homeless – Montana Rescue Mission
RiverStone Health Healthcare for the Homeless – The Hub

After Hours:

After hours coverage is available for special problems by calling 247-3350 and following the instructions given. Patients with medical emergencies should call 911 or go to a local Emergency Room.

Questions or Concerns Regarding Services:

If you have questions regarding services or have concerns regarding the care or services you received, you have the right to contact the following individuals, in the order listed, to voice such questions or concerns:

RiverStone Health Clinic- Billings (406) 651-6470
RiverStone Health Clinic- Bridger (406) 651-6424
RiverStone Health Clinic- Worden (406) 651-6424
RiverStone Health Clinic- Joliet (406) 651-6424
RiverStone Health - Dental- (406) 651-6432
RiverStone Healthcare for the Homeless (406) 651-6470
Orchard School Clinic (406) 651-6424
Medicine Crow School Clinic (406) 651-6424

Updated 11/1/2017