



School-Based Health Clinic Information

What is a School-Based Health 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 health clinics provide:

- Routine well child check-ups with immunizations
- Sports physicals
- Urgent care (sore throats, tummyaches, colds, fevers)
- Behavioral health services (ADHD, developmental screenings, anxiety, depression)
- Help with chronic illnesses such as diabetes or asthma
- Lab tests
- Dental Education
- Referrals to community resources

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 Health 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 Health Clinics accept 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 Health Clinics?

There is 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 Health Clinics at 406.247.3210 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.



RIVERSTONE HEALTH CLINIC CONSENT FOR TREATMENT /ASSIGNMENT OF BENEFITS

Patient Name: _____ **Birth Date:** ____/____/____

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 my health care providers to assist in 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 prescription history from outside sources, including but not limited to SureScripts.

I further understand that I am responsible for the costs 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 authorize the release of medical information related to the payment of those insurance benefits.

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:** _____



School-Based Health Clinic Patient Information Form

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____ / _____ / _____
Month Day Year

School: _____

Sex: Male Female Grade _____

Student Address: _____

_____ *City State Zip Code*

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

Mother

Last Name: _____ First Name: _____

Cell Phone # _____

Father

Last Name: _____ First Name: _____

Cell Phone # _____

Legal Guardian, If Applicable

Last Name: _____ First Name: _____

Relationship of legal guardian to student

Grandparent Aunt or Uncle Other: _____

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 _____

RiverStone Health provides high-quality healthcare. Everyone is welcome, regardless of ability to pay.

- We are **accepting new patients**
- **Sliding fee scale** based on income & family size
- We **accept** private insurance, Medicare & Medicaid
- **Signup help** for Health Insurance Marketplace, Medicaid & Healthy Montana Kids. **Call: 406.651.6540**
- **Same day appointments** for urgent care
- Schedule **TeleHealth** visits from home
- **Pharmacy** offers curbside pickup & mailed prescriptions
- **Dental Clinic** provides dental care & TeleDental visits
- **Behavioral Health** for stress, family issues, job loss, substance abuse, or other counseling
- **School-based clinics** at Orchard Elementary and Medicine Crow Middle School. **Call: 406.247.3210**

RiverStone Health Clinic Call us at 247.3350	 Medical Care	 Dental Care	 Behavioral Health	 Pharmacy
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WIC Signup: WIC offers help for pregnant women, new moms, infants and kids under 5. **Call: 247.3370.**

Immunization Clinic: Stay current on infant, childhood and adult immunizations. Open by appointment. **Call: 247.3382.**

RiverStone Health Healthcare for the Homeless: 2424 First Ave. North. Walk-ins welcome. **Call: 671.8731**

For general questions about COVID-19, visit covid.RiverStoneHealth.org or call **406.651.6415**

123 South 27th Street, Billings MT • 406.247.3200 • RiverStoneHealth.org

Please fill out and return bottom half



RiverStone Health Clinic Dental Survey



Child's Name: _____

Parent/Guardian Name: _____

Does your child have a dentist?

Yes: Name _____ No

Has your child been to the dentist in the last year?

Yes No

Are you interesting in having your child see Riverstone Health providers for dental exams, cleanings and sealants?

Yes No



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:

Patient	Family	Who		Patient	Family	Who	
<input type="checkbox"/>	<input type="checkbox"/>	_____	ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure/Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney/Bladder Problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver Disease, Hepatitis, Yellow Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mumps, Measles, Chicken Pox
<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding Disorder or Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental Illness
<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer or Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Suicide Attempt
<input type="checkbox"/>	<input type="checkbox"/>	_____	Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	_____	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	_____	Eczema				Other Illnesses: _____ _____ _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Emphysema				
<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	
<input type="checkbox"/>	<input type="checkbox"/>	_____	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	

Patient/Guardian Signature

Date

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

1. Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You have the Right to:

Get a copy of your paper or electronic medical record	<ul style="list-style-type: none">• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Correct your paper or electronic medical record	<ul style="list-style-type: none">• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.• We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communication	<ul style="list-style-type: none">• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.• We will say “yes” to all reasonable requests.
Ask us to limit the information we share	<ul style="list-style-type: none">• You can ask us not to use or share certain health information for treatment, payment, or our operations.<ul style="list-style-type: none">○ We are not required to agree to your request, and we may say “no” if it would affect your care.• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.<ul style="list-style-type: none">○ We will say “yes” unless a law requires us to share that information.
Get a list of those with whom we’ve shared your information	<ul style="list-style-type: none">• You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice	<ul style="list-style-type: none"> You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	<ul style="list-style-type: none"> If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you believe your privacy rights have been violated	<ul style="list-style-type: none"> You can complain if you feel we have violated your rights by contacting us using the information on page -6. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

2. Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want to do, and we will follow your instructions.

In these cases, you have both the right and the choice to tell us to:	<ul style="list-style-type: none"> Share information with your family, close friends, or others involved in your care Share information in a disaster relief situation Contact you for fundraising efforts <p><i>If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.</i></p>
In these cases, we <i>never</i> share your information unless you give us written permission:	<ul style="list-style-type: none"> Marketing purposes Sale of your information Most sharing of psychotherapy notes
In the case of fundraising:	<ul style="list-style-type: none"> We may contact you for fundraising efforts, but you can tell us not to contact you again.

3. Our Uses and Disclosures

How do we typically use or share your information? We typically use or share your health information in the following ways:

Treat you	<ul style="list-style-type: none">• We can use your health information and share it with other professionals who are treating you. <p><i>Example: A doctor treating you for an injury asks another doctor about your overall health condition.</i></p> <p><i>Example: A doctor treating you looks up your health information in the Big Sky Care Connect health information exchange (HIE) or another health information exchange system to obtain information about health services you received from other providers, including labs, radiology, and other tests.</i></p>
Run our organization	<ul style="list-style-type: none">• We can use and share your health information to run our practice, improve your care, and contact you when necessary. <p><i>Example: We use health information about you to manage your treatment and services</i></p>
Bill for your services	<ul style="list-style-type: none">• We can use and share your health information to bill and get payment from health plans or other entities. <p><i>Example: We give information about you to your health insurance plan so it will pay for your services.</i></p>

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, go to

<https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html>

Help with public health and safety issues	<ul style="list-style-type: none">• We can share health information about you for certain situations such as:<ul style="list-style-type: none">○ Preventing disease○ Helping with product recalls○ Reporting adverse reactions to medications○ Reporting suspected abuse, neglect, or domestic violence○ Preventing or reducing a serious threat to anyone’s health or safety
Do research	<ul style="list-style-type: none">• We can share or use your information for health research

Comply with the law	<ul style="list-style-type: none"> • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	<ul style="list-style-type: none"> • We can share health information about with you with organ procurement organizations
Work with a medical examiner or funeral director	<ul style="list-style-type: none"> • We can share health information with a coroner, medical examiner, or funeral director when an individual dies
Address workers' compensation, law enforcement, and other government requests	<ul style="list-style-type: none"> • We can use or share health information about you: <ul style="list-style-type: none"> ○ For workers' compensation claims ○ For law enforcement purposes or with a law enforcement official ○ With health oversight agencies for activities authorized by law ○ For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	<ul style="list-style-type: none"> • We can share health information about you in response to a court or administrative order, or in a response to a subpoena

4. Special Rule for Substance Abuse Records

Confidentiality Requirements	<ul style="list-style-type: none"> • Federal law and regulations protect the confidentiality of patient records related to drug and alcohol abuse diagnosis and treatment. If you receive care or treatment from our drug and alcohol abuse program providers, we will use and disclose information and records related to your drug and alcohol abuse treatment only as permitted by federal law and regulations. These laws and regulations are found at 42 U.S.C. 290dd-2; 42 U.S.C. 290ee-3 and 42 CFR Part 2. • RiverStone Health is a mixed-use integrated care setting. 42 Part 2 applies only to records created, received, or acquired by providers who are part of RiverStone's Part 2 program. • Records created, received, or acquired by RiverStone's primary care medical providers are not subject to the protections for drug and alcohol abuse/treatment, even if you receive treatment for substance abuse disorders or substance abuse related conditions from our primary care medical providers.
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General Rule	<ul style="list-style-type: none"> • Generally, we may not say to a person outside our drug and alcohol abuse program that you participate in or are treated by the program or disclose any information identifying you as a participant in the program unless: <ul style="list-style-type: none"> ○ You consent in writing; ○ The disclosure is allowed by a court order; or ○ The disclosure is made to medical personnel in a medical emergency or to qualified personnel providing services to the program or to qualified personnel providing research, audit, or program evaluation.
Reporting Violation	<ul style="list-style-type: none"> • Violation of the law protecting drug and alcohol abuse records is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.
Information related to a Crime	<ul style="list-style-type: none"> • Information about drug and alcohol abuse records related to a crime or threat of a crime, either on the premises of our program or against personnel of our program, is not protected and may be communicated to appropriate authorities.
Information Related to Child Abuse or Neglect	<ul style="list-style-type: none"> • Information about suspected child abuse or neglect is not protected and will be communicated to appropriate authorities as required by state law.

5. Health Information Exchange

Big Sky Care Connect (BSCC)	<ul style="list-style-type: none"> • We participate in the Big Sky Care Connect health information exchange (HIE). • BSCC gives qualified medical professionals access to accurate, current patient information, and helps them provide better quality care. Providers who are caring for you can access your data on a secure, controlled, and private network. • If you have any concerns about your information being shared in the BSCC you should discuss those with us. • You can find more information about the policies and your ability to decide how your health information is shared through the BSCC HIE on the BSCC website:
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<https://www.mtbscc.org/patients>

Other HIE Networks

- We may participate in other health information exchange systems or networks from time to time. Health information about you may be disclosed from these HIE systems for your treatment or for payment purposes. If you have questions about any HIE systems or disclosures, you should discuss those with us.
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6. Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

7. Additional Information

- RiverStone Health provides healthcare services as part of its larger organizational obligations, which include serving as the public health entity for Yellowstone County. This Notice of Privacy Practices applies only to the activities and services of the RiverStone Health that are covered by the HIPAA regulations and may not apply to certain clinical services provided by RiverStone Health's public health staff.
- The effective date of this Notice is January 1, 2023.
- If you have questions about this notice, you can contact our privacy official by mail, telephone, or email:

Privacy Officer
123 South 27th Street, Billings, MT 59101
406-247-3384
compliance@riverstonehealth.org

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been offered a copy of RiverStone Health's Notice of Privacy Practices that is in effect as of January 1, 2023, in electronic or paper form. I understand I can access a copy of our Notice of Privacy Practices at www.riverstonehealth.org

Patient Signature

Date

Signature of Patient's Representative

Date



RiverStone Health Clinic

Service Locations:

RiverStone Health Clinic- Billings
RiverStone Health Clinic- Bridger
RiverStone Health Clinic- Joliet
RiverStone Health Clinic- Worden
Medicine Crow School Clinic
Orchard School Clinic
RiverStone Health Dental
RiverStone Health Healthcare for the Homeless – HCH Base Clinic
RiverStone Health Healthcare for the Homeless – St. Vincent DePaul

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 or concerns regarding the care or services you received, you have the right to contact the following:

RiverStone Health Clinic- Billings (406) 651-6470
RiverStone Health Clinic- Bridger (406) 247-3264
RiverStone Health Clinic- Joliet (406) 247-3264
RiverStone Health Clinic- Worden (406) 247-3286
Medicine Crow School Clinic (406) 651-6424
Orchard School Clinic (406) 651-6424
RiverStone Health - Dental- (406) 651-6432
RiverStone Healthcare for the Homeless (406) 651-6575