School-Based Wellness Centers

Baltimore County Public Schools/Baltimore County Health Department

Wellness Centers

A Wellness Center:

- Is a school-based health center.
- Provides preventive care, such as check-ups and immunizations.
- Treats acute and chronic health problems.
- Does not replace the child's primary care provider.

Services offered include:

- Physical examinations, health screenings
- Sport physicals
- Evaluation and treatment of acute illnesses and injuries, like ear infections and sore throats
- Referrals for specialty care
- Management of chronic illnesses, like asthma
- Mental health screenings

To get an appointment and/or for more information:

- Contact your child's school nurse at _____**.**
- Read and complete the consent form to allow your child to be seen and to authorize billing of medical insurance, if available.
- Fill out the student health history form.

Fees for services:

- The center bills medical assistance and all other health insurances.
- A sliding fee scale is applied to students without health insurance. If your child does not have health insurance, we offer help with applying for medical assistance.
- For more information, please call 443-809-6368.

This Center is supported by the Baltimore County Department of Health and Baltimore County Public Schools.

"Health and learning go hand in hand"

8/2021

Safeguarding Your Protected Health Information

BCDH is committed to protecting your health information. BCDH is required by law to maintain the privacy of your health information, and to provide you with this notice of our legal duties and privacy practices with respect to your health information, and to follow the privacy practices described herein.

BCDH reserves the right to change our privacy practices and the terms of this Notice at any time, and to apply the provisions of the revised notice to your health information that we obtained before revising the Notice. If this occurs, we will post the current version on our website and make it available to you at our service locations. You may obtain a copy of the Notice currently in effect by calling 410-887-2077. The current Notice is also posted on our website: **www.baltimorecountymd.gov/go/hipaa**

To Report a Problem about our Privacy Practices

If you believe your privacy rights have been violated, you may file a complaint.

- You can file a complaint with the Privacy Officer by calling 410-887-2077.
- You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may call the County's Privacy Officer for the contact information.

Notice of Privacy Practices

Baltimore County Department of Health (BCHD) and Associated Entities

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.**

Effective Date: September 23, 2013

You have the right to:

Breach Notification: You have the right to be notified of a breach involving your information.

Request Restrictions: You have a right to request a restriction or limitation on the health information BCDH uses or discloses about you. BCDH may accommodate your request, if possible, but is not legally required to agree to the requested restriction. If BCDH agrees to a restriction, BCDH will follow it except in emergency situations. You have the right to request that we not share your information about a particular visit with your insurance company as long as you have paid the entire charge yourself.

Request Confidential Communications: Our normal method of contacting you is by mail to your home address and via the phone numbers you provide. You have the right to ask that BCDH send you information at an alternative address or by alternative means. BCDH must agree to your request as long as it is reasonable for us to do so.

Review and/or Request a Copy: You have a right to review or request a copy of your health information. If your health information or a portion thereof is in paper-only format, there may be a copying and postage fee. You have a right to request what portions of your information you want copied and receive an estimate of the cost. If your records are in electronic format, you may request your information in electronic form and additionally may request that we transmit a copy of that information to a third-party. The request for electronic copy and transmittal to a third party must be requested in a clear, conspicuous and specific manner. We may charge a fee based on cost of labor to produce the electronic copy.

Request Amendment: You may request in writing that BCDH correct or add to your health record. BCDH may deny the request if BCDH determines that the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; or (3) not permitted to be disclosed. If BCDH approves the request for amendment, BCDH will change the health information and inform you, and will inform others that need to know about the change in health information.

Accounting of Disclosures: You have a right to request a list of the disclosures made of your health information for the six year period prior to the date on which the accounting is requested. Exceptions are health information that has been used for treatment, payment, and operations. In addition, BCDH does not have to list disclosures made to you, to others when based on your written authorization, when provided for national security, or when provided to law enforcement officials and correctional facilities. Additionally, BCDH will provide an accounting for disclosures made through an electronic health record for treatment, payment, and health care operations, but information is limited to the three year period prior to date of request. There will be no charge for up to one such list each year.

Notice: You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request. You have the right to request this Notice in alternate format by contacting the Office of Communications and Constituent Services by calling 410-887-6092.

How to exercise your rights:
Submit your request in writing to:

Privacy Officer
Baltimore County Department of Health
6401 York Road, Third Floor
Baltimore, MD 21212

Other important information: If you have questions and would like more information, you may contact the Privacy Officer at 410-887-2077. TTY users, call via Maryland Relay.

How BCDH May Use and Disclose Your Protected Health Information

All services you receive from BCDH programs, regardless of type or location, are legally considered a single record. BCDH employees will only use your health information when doing their jobs. For use and disclosures beyond those described in this Notice, BCDH must have your written authorization. If you give such authorization you may revoke it by notifying the Privacy Officer at the address listed at the end of this section. This revocation shall apply except where we have already used or disclosed information in accordance with the authorization. The following are some examples of our possible uses and disclosures of your health information.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations:

For Treatment: BCDH may use or share your health information to provide treatment or arrange for health-related services. Some examples are:

- provide a screening, examination, or immunization at a clinic;
- make a home visit to assess your needs or provide nursing care;
- provide case management services by phone to oversee and coordinate your care;
- arrange for services from various county, state, or private organizations;
- arrange for transportation to a medical appointment;
- share your vaccination information with the State Immunization Registry (IMMUNET); or
- use your information to contact you regarding services offered by the Health Department; but you have the right to refuse additional services that you may not want at the time.

To obtain payment or make arrangements for payment of a health service: BCDH may use and share your health information in order to obtain an authorization from your insurance company or to submit a health care claim. We may also coordinate health insurance benefits between insurance carriers. In certain cases, we may pay for certain medications or other supplies or services.

For Health Care Operations: BCDH may use and share your health information to evaluate the quality of services we provide and to help maintain the high quality of those services. For example, we may use your information to evaluate our treatment and services which have been provided. We may combine health information about many individuals to research health trends, to determine what services should be offered, or for other similar uses. We may also share your health information with state or federal auditors, as required by law or regulation.

Other Uses and Disclosures of Health Information Required or Allowed by Law:

Vaccination Documentation Required for School Entry: We may share your vaccination information with a public or private school after obtaining your verbal permission.

Public Health Authority: BCDH operates as a Public Health Authority as well as a health care provider. In our role as a Public Health Authority, we may use your health information to investigate and track diseases as required by law. This function is exempt from the Health Insurance Portability and Accountability Act (HIPAA) requirements.

Information Purposes: Unless you provide us with alternative instructions, BCDH may send appointment reminders and other materials about a particular program to your home.

Required by Law: BCDH may disclose health information when a state or federal law requires us to do so.

Public Health Activities: BCDH may disclose health information when BCDH is required to collect or report information about disease or injury, or to report vital statistics to other divisions in the department and other public health authorities.

Health Oversight Activities: BCDH may disclose your health information to other divisions in the department and other agencies for oversight activities required by law. Examples of these oversight activities are audits, inspections, investigations, and licensure.

Coroners, Medical Examiners, Funeral Directors, and Organ Donations: BCDH may disclose health information relating to a death to coroners, medical examiners, or funeral directors, and to authorized organizations relating to organ, eye, or tissue donations or transplants.

Research Purposes: In certain circumstances, and under supervision of an Institutional Review Board or other designated privacy board, BCDH may disclose health information to assist medical research.

Avert Threat to Health or Safety: In order to avoid a serious threat to health or safety, BCDH may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

Abuse and Neglect: BCDH will disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or some other crime. BCDH may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Specific Government Functions: BCDH may disclose health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

Families, Friends, or Others Involved in Your Care: BCDH may share your health information with people as it is directly related to their involvement in your care or payment of your care. BCDH may also share health information with people to notify them about your location, general condition, or death.

Workers' Compensation: BCDH may disclose health information to workers' compensation programs that provide benefits for work-related injuries or illnesses without regard to fault.

Lawsuits, Disputes, and Claims: If you are involved in a lawsuit, a dispute, or a claim, BCDH may disclose your health information in response to a court or administrative order, subpoena, discovery request, investigation of a claim filed on your behalf, or other lawful process.

Law Enforcement: BCDH may disclose your health information to a law enforcement official for purposes that are required by law or in response to a subpoena.

Contact the Privacy Officer:

Privacy Officer
Baltimore County Department of Health
6401 York Road, Third Floor
Baltimore, MD 21212

BALTIMORE COUNTY PUBLIC SCHOOLS
TOWSON, MARYLAND 21204

BALTIMORE COUNTY DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND 21212

PARENTAL CONSENT FORM FOR SECONDARY WELLNESS CENTER

I am granting permission for my child to enroll in the School-Based Wellness Center and consent to them receiving health related services which can include physical examinations, health screenings, limited diagnostic tests, education, counseling, referrals, and administration of necessary medications. I understand the school nurse may participate in coordinating follow-up care and will have access to the Wellness Center records. You have my permission to release any Wellness Center health information to any health or mental health professional providing services to my child through the Wellness Center, school health suite, or school counseling office. You have my permission to release any educational information to any health or mental health professional who needs this information to care for my child through the Wellness Center.

- My signature on this consent certifies that I have received Baltimore County Department of Health Notice of Privacy Practices.
- I understand that Maryland Law allows a minor to receive treatment and/or advice about sexually transmitted disease, pregnancy, contraception, drug use, and mental health (12 years of age or older).
- I understand that I am responsible for medical care if follow-up outside the school-based center is recommended.
- I authorize the release of any medical or other information necessary to process insurance claims, if applicable.
- I authorize payment of medical benefits to Baltimore County for services rendered at the Wellness Center.
- I agree that if I receive payment from my insurance company for services rendered at a Wellness Center, I will endorse the check and forward it to the Wellness Center. I understand that if my child has health insurance through Medical Assistance, with or without a Managed Care Organization (MCO), they can still receive care from the Wellness Center.
- I understand that my child's immunization record will be entered on the Maryland registry, ImmuNet, if vaccines are given.

Print Child's Name_____ Birth Date_____ Grade_____
Address_____ Zip_____
Child's Social Security Number_____ ☐ Male ☐ Female
Child's Health Care Provider_____ Telephone_____
Print Name of Parent/Guardian_____ Mother's Maiden Name _____
Relationship to Student_____ Telephone (H) (W)_____
Signature of Student_____ Date_____

Signature of Parent/Legal Guardian_____ Date_____

IF YOUR CHILD HAS ANY FORM OF HEALTH INSURANCE, PLEASE PROVIDE A COPY OF THEIR INSURANCE CARD.

IF YOUR CHILD HAS MEDICAL ASSISTANCE, PLEASE COMPLETE THE FOLLOWING INFORMATION:
Child's Medical Assistance Number: _____
Child receives MA services through an MCO?_____YES _____NO
If YES, name of MCO_____ Policy/Contract#_____ Effective Date:_____

IF YOUR CHILD'S HEALTH CARE IS COVERED BY PRIVATE INSURANCE, PLEASE COPY <u>ALL</u> THE FOLLOWING INFORMATION <u>DIRECTLY</u> FROM YOUR INSURANCE CARD:

1. Insurance Company's Name & Address_____
   _____ City_____ Zip_____
   Insurance Company's CLAIMS (Billing) Address (if different from above)_____
   _____ City_____ Zip_____
   Insurance Company's Phone Number_____
2. Name of Individual listed on Insurance Card_____
   Policy Number of Insured Listed on Card _____
   Group Number Listed on Health Insurance Card_____
3. List the name of the Policy Holder (person whose name the insurance policy is under)_____
   Social Security Number of Policy Holder_____
   Place of Employment of Policy Holder_____
   _____ Work Phone Number (___)_____
   Relationship of Policy Holder to Child_____
   Home Address of Policy Holder_____

IF YOUR CHILD HAS <u>NO</u> HEALTH CARE COVERAGE, PLEASE INDICATE BY PLACING A (√)HERE( ) AND COMPLETE BELOW.

Please indicate Annual Income:_____ **Number of Family Members:** _____

If you need help with Medical Assistance, please call the Maryland Health Connection 1-855-642-8572

Wellness Center Health/Family History Questionnaire
(To be completed by Parent/Guardian)

Date of child's last physical examination:_____/_____/_____

Student Name:	**Date of Birth:**	**Sex: (circle)** Male Female Other
Forms Competed by:	**Relationship:**	**Today's Date:**

PREGNANCY AND BIRTH HISTORY

Illnesses/medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug use? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Did child stay in intensive care nursery after birth?
No ☐ Yes ☐
Why?_____
Type of Delivery? Vaginal ☐ C-Section ☐
If C-section, why_____

PSYCHOSOCIAL HISTORY

Who lives in household? Mother ☐ Father ☐
Siblings ☐ Grandparent/s ☐ Other children ☐
Other Adults ☐ How many?_____
Rent? ☐ Own? ☐ Shelter? ☐
Who cares for child during the day?_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care?_____ Dates:_____
Other Languages?_____

FAMILY HISTORY

Has anyone in the family (parents, grandparents, aunts/uncles, sisters/brothers) had:

	Yes	No	Who?
Allergies(List)_____	☐	☐	_____
Asthma	☐	☐	_____
TB/Lung Disease	☐	☐	_____
HIV/AIDS	☐	☐	_____
Suicide Attempts	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure/Stroke	☐	☐	_____
High Cholesterol	☐	☐	_____
Blood Disorders/Sickle Cell	☐	☐	_____
Diabetes	☐	☐	_____
Seizures	☐	☐	_____
Mental Illness/depression	☐	☐	_____
Cancer	☐	☐	_____
Birth Defects	☐	☐	_____
Hearing Loss	☐	☐	_____
Speech Problems	☐	☐	_____
Kidney Disease	☐	☐	_____
Alcohol/Drug Abuse	☐	☐	_____
Hepatitis/Liver Disease	☐	☐	_____
Thyroid Disease	☐	☐	_____
Learning Problems/ Attention Deficit Disorder	☐	☐	_____
Family Violence	☐	☐	_____
Any other family health history concerns:_____	☐	☐	_____

YOUR CHILD'S MEDICAL HISTORY

Has your child ever had:

	Yes	No	Comments
Allergies (eg. Medications) List_____	☐	☐	_____
Asthma	☐	☐	_____
Chicken Pox (Month/Yr) _____	☐	☐	_____
Frequent Ear Infections	☐	☐	_____
Vision/Hearing Problems	☐	☐	_____
Skin Problems/Eczema	☐	☐	_____
TB/Lung Disease	☐	☐	
Seizures/Epilepsy	☐	☐	_____
CP/Meningitis	☐	☐	_____
High Blood Pressure	☐	☐	_____
Heart Defects/Disease	☐	☐	_____
Liver Disease/Hepatitis	☐	☐	_____
Diabetes	☐	☐	_____
Kidney Disease/Bladder Infections	☐	☐	_____
Speech or Learning Disabilities	☐	☐	_____
Physical Limitations	☐	☐	_____
Bleeding Disorders/Hemophilia	☐	☐	_____
Sexually Transmitted Infections	☐	☐	_____
Emotional or Behavioral Problems	☐	☐	_____
Depression/Suicidal Thoughts	☐	☐	_____
Hospitalizations/Surgeries	☐	☐	_____
Physical/Emotional/Sexual Abuse	☐	☐	_____
Bone or Joint Injuries	☐	☐	_____
Obesity/Eating Disorders	☐	☐	_____
Other:_____	☐	☐	_____

Current Medication(s): (List) _____

Reviewed by:	**Date of Review:**