



Kenton County School District | *It's about ALL kids.*

**THE KENTON COUNTY BOARD OF  
EDUCATION**

1055 EATON DRIVE, FORT WRIGHT, KENTUCKY  
41017

TELEPHONE: (859) 344-8888 / FAX: (859) 344-1531

WEBSITE: [www.kenton.kyschools.us](http://www.kenton.kyschools.us)

Dr. Henry Webb, Superintendent of Schools

**KCSD ISSUE PAPER**

**DATE:**

September 24, 2020

**AGENDA ITEM (ACTION ITEM):**

Consider/Approve the Memorandum of Understanding with Summit Medical Group, Inc. dba St. Elizabeth Physicians to provide telehealth services for students and faculty in the Kenton County School District, for one year with the option for automatic renewal.

**APPLICABLE BOARD POLICY:**

01.1 Legal Status of the Board

**HISTORY/BACKGROUND:**

In January of 2020, the Kenton County School District entered into initial discussions with St. Elizabeth to provide video telehealth services in our school district. Video telehealth services would allow our students and faculty access to a physician, through the virtual environment, when sick. This service will reduce barriers for our families by allowing sick students to have a video telehealth appointment in 30 minutes or less and not having to wait for an appointment after presenting with symptoms. Parents/guardians are also allowed to participate in the video telehealth visit with their child through a link or onsite. St. Elizabeth will bill insurance for individual telehealth visits.

**FISCAL/BUDGETARY IMPACT:**

None

**RECOMMENDATION:**

Approval of the Memorandum of Understanding with Summit Medical Group, Inc. dba St. Elizabeth Physicians to provide telehealth services for students and faculty in the Kenton County School District, for one year with the option for automatic renewal.

**CONTACT PERSON:**

Paula Rust, Health Services Director

Principal/Administrator

District Administrator

Superintendent

Use this form to submit your request to the Superintendent for items to be added to the Board Meeting Agenda.

Principal –complete, print, sign and send to your Director. Director –if approved, sign and put in the Superintendent's mailbox.

**Kenton County Board of Education**

Board Members: Carl Wicklund, Chairperson Karen L. Collins, Vice Chairperson Carla Egan Shannon Herold Jessica Jehn  
"The Kenton County Board of Education provides *Equal Education & Employment Opportunities.*"

**MEMORANDUM OF UNDERSTANDING  
BETWEEN**

**Kenton County School District  
And  
Summit Medical Group, Inc. dba St. Elizabeth Physicians**

This Memorandum of Understanding ("MOU"), effective on this \_\_\_\_ day of \_\_\_\_\_, 2020 ("Effective Date"), is entered into and between Kenton County School District ("the School") and Summit Medical Group, Inc. dba St. Elizabeth Physicians ("SEP");

**WHEREAS**, the School desires that SEP perform telehealth services for its students and faculty;

**WHEREAS**, SEP employs physicians and advanced practice providers who are qualified through training and experience to provide telehealth services ("Providers") to School's students and faculty upon certain terms and conditions;

**WHEREAS**, the parties agree that utilization of such telehealth services will provide the School medical coverage and assist in addressing current health needs for participant students and faculty but not intended to serve as the sole primary care provider;

**NOW, THEREFORE**, in consideration of the following mutual promises, covenants, and conditions, the parties hereto agree as follows:

**RESPONSIBILITIES OF SEP:**

1. SEP shall provide the School with health-based services via a telehealth platform by Providers in a timely manner during the hours of 7:30am and 4:00pm on scheduled school days. Health-based services in this context are limited to acute illnesses and chronic illness management for enrolled students and specifically excludes, without limitation, vaccinations, behavioral health services, and wellness visits.
2. In the event that telehealth consultation is unavailable in a timely manner, either due to equipment or connection problems, or due to Provider time constraints, SEP shall provide telephone communication as appropriate and provide guidance to the School nurse/telepresenter to determine the next steps.
3. SEP shall ensure that the School nurse/telepresenter is appropriately trained in the telehealth platform.
4. SEP shall maintain, own and be the sole custodian of its records generated by this Agreement, including, patient records, data and information. SEP shall be responsible for complying with all state and federal laws pertaining to patient confidentiality. Records of patients that are owned and maintained by SEP are not student records and are not subject to FERPA.

5. SEP shall bill insurance or any other applicable health care coverage program for a participant for the cost of care provided by SEP.

#### **RESPONSIBILITIES OF THE SCHOOL:**

1. The School shall ensure that each student and faculty member who participates in a telehealth service has completed the required Consent and SEP paperwork and it has been submitted to SEP. Required forms are attached as Exhibit A ("Required Forms").
2. The School shall supply the necessary hardware and network connectivity to enable use of the telehealth platform. The hardware and technical requirements are set forth on the attached Exhibit B.
3. The School nurse/telepresenter shall facilitate the telehealth service, including operation of the telehealth platform and obtaining the Required Forms.

#### **TERM:**

The term of this MOU is one year and will auto renew each school year unless written notice is given by either party. Either party may terminate this MOU at any time for any reason upon 30 days' of written notice to the other party.

#### **MISCELLANEOUS:**

1. The Parties acknowledge and agree that SEP's relationship to the School is that of an independent contractor and that SEP shall provide the services to School and participants using SEP's independent skill and judgment. Nothing herein will be deemed to create any form of partnership, principal-agent relationship, employer-employee relationship, or joint venture between the parties hereto. Neither Party has any authority to bind or obligate the other Party in any manner whatsoever. This MOU does not constitute either Party as an agent of the other Party. Neither Party shall be responsible in any way for any obligation or liability incurred or assumed by the other Party. Neither Party shall hold itself out to any third Party as a partner of, joint venturer with, agent of, or in any other capacity with regard to the other Party except as specifically described in this Agreement.
2. The School shall indemnify, defend, and hold harmless SEP and its affiliates, directors, officers, agents and employees from any and all claims, demands, actions, suits and other proceedings, whether civil, criminal, administrative, investigative or otherwise, together with all judgments, damages, fines, losses, costs, expenses and other amounts, including reasonable attorneys' fees due to losses arising or alleged to have arisen out of any breach of this Agreement, negligent or unauthorized act, willful misconduct, violation of law, or error or omission by

School or its directors, officers, employees or agents related to or resulting from the performance of the duties and responsibilities of School pursuant to this Agreement.

3. Both parties agree they will comply with all applicable federal, state and local laws, rules and regulations.
4. The parties warrant that they are not engaged in a joint enterprise or joint venture, and that the benefits and obligations arising under this MOU inure exclusively to the School and SEP and that there are no third party beneficiaries, intended or unintended, under this Agreement. Neither party may assign the benefits or obligations under this MOU.
5. SEP agrees to hold harmless and indemnify the School from any third party claims, damages, complaints, or actions from the services in this agreement provided by SEP to the School. The School agrees to hold SEP harmless from any third party claims, damages or complaints arising from the maintenance or safety of the space provided by the School and School procedures related to the operation of the school based health center.
6. Neither party waives any legal defenses conferred to them under either state or federal law, including defenses of legal immunity.
7. This Agreement shall be governed and construed under the laws of the Commonwealth of Kentucky, with jurisdiction lying in the Kenton County Circuit Court.

Summit Medical Group, Inc. dba St. Elizabeth Physicians      Kenton County School District

BY: \_\_\_\_\_

BY: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

## Exhibit A – Required Forms

1. School Based Telehealth Parental Consent Form
2. New Patient Packet – Viewable [here](#)

#### Exhibit B – Hardware and Technical Requirements

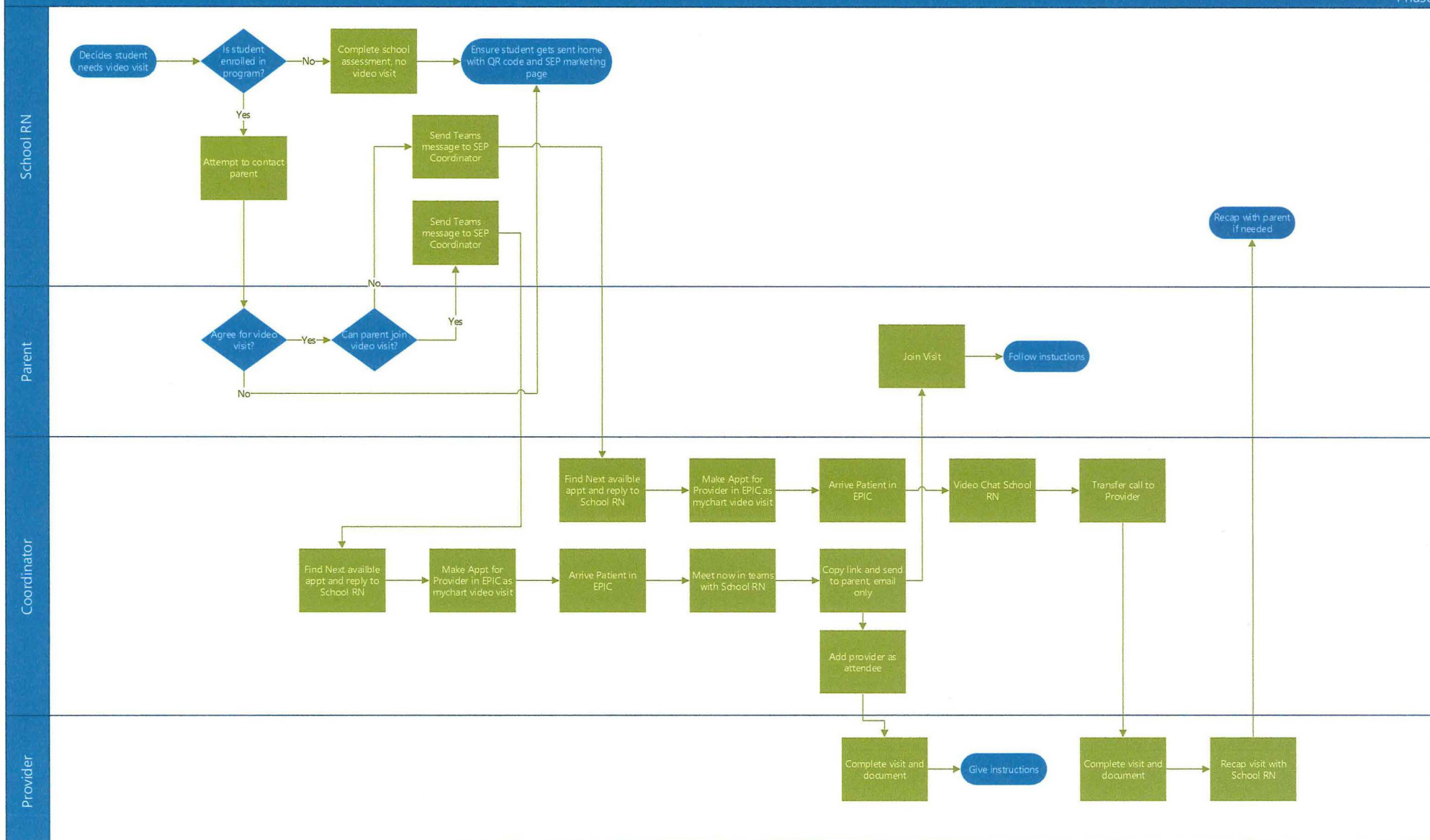
1. Laptop/Desktop/Chromebook with working Camera and microphone and USB ports
2. Telehealth provided through Microsoft teams
  - a. Must be able to download the Microsoft teams app

## Exhibit C – School Locations

Beechgrove Elementary  
Caywood Elementary  
Hinsdale Elementary  
River Ridge Elementary  
Ft. Wright Elementary  
Ryland Heights Elementary  
Taylor Mill Elementary  
Kenton Elementary  
Piner Elementary  
Whites Tower Elementary  
Summit View Academy  
Twenhofel Middle School  
Turkey Foot Middle School  
Woodland Middle School  
Dixie Heights High School  
Simon Kenton High School  
Scott High School

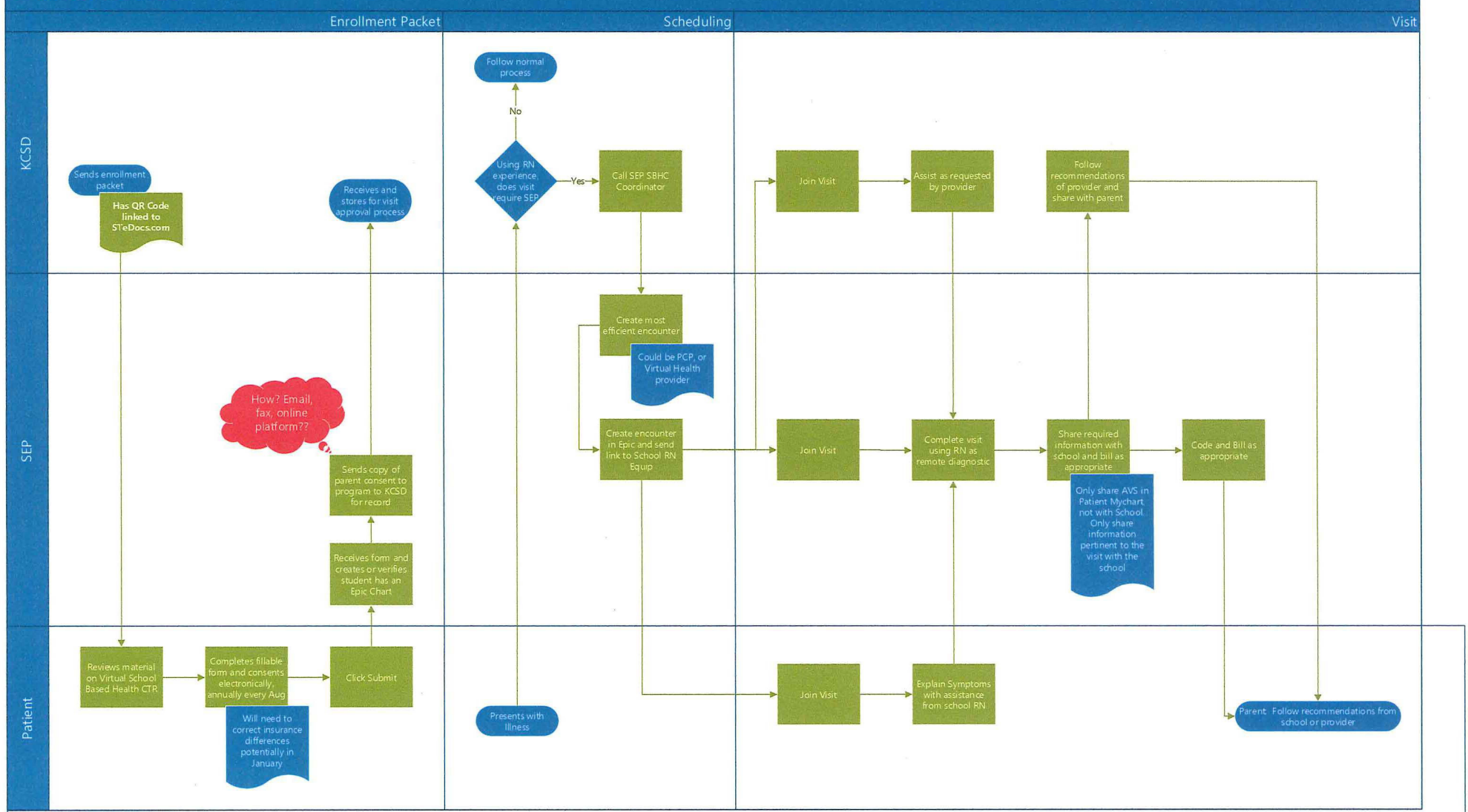
# Scheduling Appointment

Phase





# Virtual SBHC Process



## School Based Telehealth Parental Consent Form

### Introduction

The Kenton County Board of Education partners with Summit Medical Group, Inc. dba St. Elizabeth Physicians ("SEP") to offer School-Based Telehealth Services. These telehealth services do not take the place of your regular doctor and participating in this program does not mean you are changing your child's doctor. You are encouraged to have any needed follow-up care with that physician and a summary of your child's telehealth visit with SEP will be sent to your child's doctor.

### Student Information

Student Name: \_\_\_\_\_

Student Date of Birth: \_\_\_\_\_

Student Grade: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Student's School: \_\_\_\_\_

Is your child currently a patient of St Elizabeth Physicians? Yes ☐ No ☐

Student's Primary Care  
Provider: \_\_\_\_\_

### Consent to Treat

By signing this Consent for Health Services, I agree to the terms and conditions regarding Authorization to Release Information and Assignment of Insurance Benefits as explained on Page Two of this Consent. I also acknowledge that I have received information about how to receive Notice of Privacy Practices as explained in this Consent. I also have received and understand available services as described in the [~ title of materials ~] which accompanied this Consent.

I voluntarily give my consent for my child identified above to receive telehealth services through SEP. I authorize any physician or advanced practice provider working with SEP to provide such care. I understand that this consent will remain valid throughout the 2020 – 2021 academic year unless revoked by me. **I may revoke this consent for treatment at any time by requesting in writing that the District remove my child from services.** I understand that additional verbal consent will be attempted to be obtained prior to each appointment except in the event my child is emancipated or able to consent for treatment without the consent of a parent or legal guardian as permitted in applicable Kentucky law. I understand that I will be notified of any services my child receives except in the event my child is emancipated or able to consent for treatment without the consent of a parent or legal guardian as permitted in applicable Kentucky law. I also understand that I should contact the school nurse if I have questions regarding any necessary

follow up care or instructions. It is my responsibility to notify the school nurse of all updates or changes to my child's health conditions or insurance coverage.

#### Notice of Privacy Practices

I have been notified that I can ask for a copy of the Notice of Privacy Practices for SEP at any District school building. I know I can also view them online by clicking [here](#) or visiting Stedocs.com.

#### Authorization to Release Information

I hereby authorize SEP to share information with the District school nurse the exclusive purposes of treatment and care coordination. This specifically includes authorization for the District school nurse to participate in the telehealth visit with my child and SEP. I understand that this consent will remain valid throughout the 2020 – 2021 academic year unless revoked by me. **I may revoke this consent for treatment at any time by requesting in writing that the District remove my child from services.**

#### Insurance Information

Insurance or other health care coverage programs are billed for the cost of care provided by SEP. I authorize SEP to submit claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other program that I identify for which a benefit may be available to pay for services provided to my child.

If you do not have health insurance for your child, you will be responsible for the bill in accordance with standard SEP billing practices.

I affirm that I have the right to consent as the parent or legal guardian of the minor child identified in this form. I understand that it is my responsibility to notify SEP about changes in my legal guardianship.

\_\_\_\_\_  
Name of Parent or Legal Guardian

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_  
Date



# St. Elizabeth PHYSICIANS

## PATIENT REGISTRATION / Consent to Treat

Please print the information below and have your insurance card and legal photo ID available for the receptionist to scan.

### PATIENT INFORMATION

Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Ext. \_\_\_\_\_ Email: \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 (Name) (Relationship)  
 Patient Employer \_\_\_\_\_ Emp. Address \_\_\_\_\_ Emp. Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Pharmacy most used by patient \_\_\_\_\_ Pharm. Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Referring Provider (Specialist office only) \_\_\_\_\_

### PERSON WHO SHOULD RECEIVE THE BILL - RESPONSIBLE PARTY (Guarantor)

Relationship to Patient: Self Parent Spouse Other \_\_\_\_\_  
 Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Ext. \_\_\_\_\_ Email: \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Employer \_\_\_\_\_ Emp. Address \_\_\_\_\_ Emp. Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

### PRIMARY INSURANCE COMPANY NAME

**No Insurance**

(Circle if applicable)

Subscriber Relationship to Patient: Self Parent Spouse Other \_\_\_\_\_  
 Subscriber Name: \_\_\_\_\_ Date of birth \_\_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Employer \_\_\_\_\_ PCP \_\_\_\_\_ Copay \_\_\_\_\_

### SECONDARY INSURANCE COMPANY NAME

Subscriber Relationship to Patient: Self Parent Spouse Other \_\_\_\_\_  
 Subscriber Name: \_\_\_\_\_ Date of birth \_\_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Employer \_\_\_\_\_ Copay \_\_\_\_\_

I understand that I am responsible for payment for all services rendered. I authorize St. Elizabeth Physicians to act as my agent in helping me obtain payment from my insurance companies. I authorize payment be made directly to St. Elizabeth Physicians. I authorize release of information to all my insurance companies which may be necessary to collect any payments. I further authorize release of medical information to any and all providers involved in my care. I permit a copy of this authorization to be used in the place of the original. I authorize the use of "signature on file" to be used on all of my insurance submissions. I understand that I am responsible for notifying the office of any precertification or referral needed for my insurance. According to recognized coding rules, you may receive separate charges for procedures, physicals and/or other problems during a single visit.

**I further authorize the access of my clinical and medication information for treatment by my Primary or Specialty Care Provider and to any and all providers directly involved in my care.**

Signature X \_\_\_\_\_ Date \_\_\_\_\_  
 (Signature of patient or patient representative)

Witness \_\_\_\_\_

**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.**

**Our Commitment to Your Privacy:** We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and comply with legal requirements. This notice applies to all of the records of your care that we maintain. We are required by law to keep medical information about you private, to give you this notice of our legal duties and privacy practices with respect to medical information about you and to follow the terms of the notice that is currently in effect.

**Organized Health Care Arrangement:** St. Elizabeth Physicians participates in a clinically integrated care setting in which patients typically receive health care from more than one health care provider. This arrangement is called an Organized Health Care Arrangement (or OHCA) under the federal laws governing the privacy of patient health information. This means that when you receive services at St. Elizabeth Physicians, you may receive certain professional services from physicians on our Medical Staff, residents, and/or medical students who are independent practitioners and not employees or agents of St. Elizabeth Physicians. These independent practitioners have agreed to abide by the terms of this Notice when providing services at St. Elizabeth Physicians. Therefore, this Notice applies to all of your health information that is created or received as a result of being a patient at St. Elizabeth Physicians.

**Who will follow this notice?** The privacy practices in this notice will be followed by any health care professional that treats you at any of our locations, by all departments and units of our organization and by all employed associates.

**Changes to this Notice.** We may change our policies at any time. Changes will apply to information we already hold, as well as new information after the change occurs. If we make a material change in our policies that affects this notice, we will change our notice and post the new notice in our facilities and on our Web site at [www.stelizabethphysicians.com](http://www.stelizabethphysicians.com). You may receive a copy of the current notice at any time. The effective dates are listed just below the title. You will be offered a copy of the current notice when you register. You will also be asked to acknowledge in writing that you were offered the notice.

**How we may use and disclose medical information about you.** Under certain circumstances, we are entitled to use or disclose your medical information without obtaining your written authorization. Some examples of when we are permitted to do this are presented below:

**Treatment.** We will use or disclose medical information about you for treatment purposes to doctors, nurses, technicians, and other caregivers in accordance with the Medical Authorization and Release that you signed and provided to us. We will make health information about you available through an electronic medical record system to healthcare providers who treat you. For example, your primary care provider may refer you to a specialist who will need to know about your medical conditions in order to treat you appropriately. A nurse or diabetic counselor may discuss your medical condition with your physician.

**Payment.** We will use and disclose your medical information as necessary for payment purposes, in accordance with the Medical Authorization and Release that you signed and provided to us. For instance, we may forward information regarding your medical treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment. We may use and disclose your medical information to another entity or health care provider for payment of the entity that receives the information. For instance, we may forward information to your insurance company so they can prepare a bill.

**Health Care Operations.** We may use and disclose medical information about you to support our health care operations. For example, we may use or disclose your medical information in order for us to review our services and to evaluate our staff's performance. We may also use or disclose your medical information to obtain a medical consultation regarding your care or treatment.

**Unless you tell us otherwise**, we may disclose your medical information to a family member, friend and others whom you have identified as being involved with your care. If family members or friends are present while care is being provided, we will assume you are comfortable with your companions hearing the discussion, unless you state otherwise. In a disaster situation, we also may disclose relevant protected health information to disaster relief organizations to help locate your family members or friends or to inform them of your location, condition or death.

We may use or disclose medical information about you for **fundraising** efforts in support of our organization, **unless you tell us otherwise**. We also may contact you for **appointment reminders** or to tell you about or recommend **possible treatment options and other health-related benefits, classes or services** that may be of interest to you.

Subject to certain requirements, we are **permitted or required by law** to make certain other uses and disclosures of your medical information without your authorization.

For instance, we will release your medical information if we suspect child abuse or neglect, if we believe you to be a **victim of abuse, neglect, or domestic violence**, and as required by law to report wounds, injuries and crimes. We may disclose your medical information for **public health purposes** such as reporting births and deaths, and reporting information to prevent and control disease. We may disclose your medical information to a health oversight agency such as the Department of Health and Human Services for **health oversight activities** including, but not limited to, conducting an audit or inspection of our facility. We may also disclose your medical information to **coroners and funeral directors**, as well as to **organ donation agencies** (to facilitate organ and tissue donation and transplantation).

We may disclose medical information about you for **workers' compensation** purposes if you are injured on the job. We may also disclose medical information **when permitted or required by law**, such as in response to a request from **law enforcement officials** in specific circumstances, and in response to valid judicial, administrative, or court orders. We may also disclose information about you in certain **emergencies** or to **avert or lessen a serious threat to the health and safety** of a person or the public. We may release your medical information if you are a member of the military as required by armed forces services, or if necessary for **national security or intelligence activities**. We may also disclose medical information for purposes of medical **research studies** when such use has been approved by an Institutional Review Board.

**For Health Information Exchange.** We may participate in one or more health information exchanges (HIEs) and may electronically share your health information for treatment, payment and healthcare operations purposes with other participants in the HIEs. HIEs allow your health care providers to efficiently access and use your pertinent medical information necessary for treatment and other lawful purposes. For example, we may participate in quality improvement projects with the Greater Cincinnati Health Council, HealthBridge, Inc. and/or the Health Improvement Collaborative of Greater Cincinnati in an effort to improve care and treatment related to certain diseases such as adult diabetes and pediatric asthma. If you do not opt-out of this exchange of information, we may provide your health information to the HIEs in which we participate in accordance with applicable law.

**Other uses of medical information.** Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require your written authorization. In any other situation not covered by this notice, we must receive your written authorization before using or disclosing your medical information. If you choose to authorize use or disclosure, you have the right to later revoke that authorization by notifying us in writing of your decision.

#### **Your rights regarding your medical information.**

In most cases, **you have the right to receive a copy and/or inspect the medical information** we retain about you, upon written request. After the first request for copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request, you may submit a written request for a review of that decision. In some circumstances, another licensed health care professional chosen by St. Elizabeth Physicians may review your request and denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. However, in some circumstances, our denial of a request by you to inspect and/or receive copies of your information is not subject to review.

**You have the right to request that we amend your medical information**, by submitting a request in writing that provides your reason for requesting the amendment. We have the right to deny your request if the information was not created by us, if it is not part of the medical information maintained by us, if it is not part of the information which you would be permitted to inspect and copy, or if in our opinion that record is accurate. If we deny your request, we will provide you with a written statement of the basis for the denial and a description of how you may file a written statement of disagreement. If you do not file a written statement of disagreement, you may request that your request for amendment and our written denial be provided with any future disclosures of your medical information.



**You have the right to a list of those instances where we have disclosed your medical information** when you submit a written request. This list will not include: disclosures made for treatment, payment or health care operations; disclosures made directly to you; disclosures you authorized pursuant to a signed authorization; disclosures for facility directory purposes or to persons involved in your care; and disclosures made to correctional institutions and for other law enforcement purposes. The request must state the time period desired for the accounting, which must be less than a 6-year period and start after April 14, 2003. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free. Additional requests may be provided for a fee. We will inform you of the fees before you incur any costs.

**You also have the right to be notified if there is a breach of your unsecured protected health information.**

If this notice was sent to you electronically, **you have the right to a paper copy of this notice.**

**You have the right to request that medical information about you be communicated to you in a confidential manner**, such as sending mail to a P.O. Box instead of your home address, by notifying us in writing of the specific way or location for us to use to communicate with you. We will not ask you the reason for your request. We will accommodate all reasonable requests, but we may not be able to agree to your request.

**You may request, in writing, that we not use or disclose medical information about you** for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. You are entitled to a restriction to not disclose information to your health plan for health care services that we provided for which you paid us directly in full when the purpose of the disclosure is for the health plan's payment or health care operations. We are not required to agree to other types of requests. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**All written requests or appeals should be submitted to:**

**Corporate Privacy Officer  
St. Elizabeth Physicians  
334 Thomas More Parkway, Suite 200  
Crestview Hills, KY 41017**

#### **Complaints**

If you are concerned that your privacy rights may have been violated, or if you disagree with a decision we made about access to your records, you may lodge a written complaint with our Corporate Privacy Officer in writing. Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights. Our Corporate Privacy Officer can provide you with the address. Under no circumstance will you be penalized or retaliated against for filing a complaint.

#### **Privacy Officer**

If you have questions or need further assistance regarding this Notice, please contact the Corporate Privacy Officer at St. Elizabeth Physicians, 334 Thomas More Parkway, Suite 200, Crestview Hills, KY 41017 (866)-669-5124 or by Fax line (859) 344-5553

**Receipt of Notice of Privacy Practices**  
**ALTERNATE COMMUNICATION REQUEST FORM**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Print full name)

I wish to be contacted in the following manner (check all that apply):

☐ By home, cell or work phone listed in my registration as below.

Home – Cell - Work			Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O.K. to leave message on voice mail _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O.K. to leave message with individual _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leave message with call-back number only _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do not leave message _____

☐ Written Communication

☐ O.K. to mail to my home address

☐ O.K. to fax to this number \_\_\_\_\_

☐ O.K. to mail to my work/office address

☐ O.K. to e-mail to address listed in my registration

☐ O.K. to mail text me

I, \_\_\_\_\_ give permission to the following individuals to obtain the indicated  
(Name of Patient or Responsible Party)  
information:

\_\_\_\_\_ whose relation to me is \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
(Name of person) (Relationship to Patient)

\_\_\_\_\_ whose relation to me is \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
(Name of person) (Relationship to Patient)

\_\_\_\_\_ whose relation to me is \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
(Name of person) (Relationship to Patient)

\_\_\_\_\_ whose relation to me is \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
(Name of person) (Relationship to Patient)

\_\_\_\_\_ Prescription refills on my behalf

\_\_\_\_\_ Test results on my behalf

\_\_\_\_\_ Set up appointment/ or cancel on my behalf

\_\_\_\_\_ Speak to the doctor/MA either in person or by telephone on my behalf

\_\_\_\_\_ Pick up prescriptions, doctor's orders, or other needs on my behalf with a photo ID.

Effective Date \_\_\_\_\_ Expires \_\_\_\_\_ Revoked \_\_\_\_\_

***Please note: This form does not apply to pregnancy, sexually transmitted diseases, contraception, chemical dependency/substance abuse, or psychiatric/psychological conditions.***

***It is the responsibility of the patient to notify the physician's office if there is a change in this information.***

***\*\*Scan original in chart, copy may be given to patient\*\****

*By signing this waiver I release St. Elizabeth Physicians and its staff therein, from any liability for release of information pertaining to my medical care as designated above and I acknowledge that I have received a copy of St. Elizabeth Physicians **Notice of Privacy Practices**. The effective date of the notice is: 09/23/13*

Signature of patient or responsible person \_\_\_\_\_

Relationship of Representative to Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of witness \_\_\_\_\_ Date \_\_\_\_\_





**AUTHORIZATION FOR USE OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION  
ST. ELIZABETH PHYSICIANS  
Pt. MRN \_\_\_\_\_**

HealthPort Office # \_\_\_\_\_

Printed Name of Patient \_\_\_\_\_ Patient's Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

X  
Signature of Patient or Patient's Representative \_\_\_\_\_ Relationship of Representative to Patient \_\_\_\_\_ Expiration Date or 90 days \_\_\_\_\_

X  
Signature of Witness \_\_\_\_\_

**MUST HAVE COMPLETE INFORMATION BEFORE THIS REQUEST CAN BE PROCESSED.**

I hereby authorize the use and disclosure (release) of my Medical Record information:

From: \_\_\_\_\_ To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The information to be released includes: \_\_\_\_ Entire Medical Record \_\_\_\_ Other \_\_\_\_\_

The Medical Record Information will be used and/or disclosed for the following purposes:

- ☐ At the request of the individual ☐ Changing Primary Care Physician ☐ Changing/seeing Specialist  
☐ Other (write purpose here) \_\_\_\_\_

I acknowledge and agree that the term Medical Record information may include: notes by the provider and other personnel, results, reports, correspondence, x-rays and other diagnostic imaging films, as well as claims, billing, and payment information. I expressly authorize the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions unless specifically excluded.

**Please exclude the following information, if it is part of my Medical Record information (Check any or all you want excluded from this authorization for use or disclosure):**

- ☐ Chemical Dependency/Substance Abuse ☐ Psychiatric/psychological conditions  
☐ Sexually Transmitted Diseases ☐ Alcohol ☐ Drugs ☐ N/A

I understand that this Authorization shall remain in effect for a period of **90 days**. I further understand that I may revoke this Authorization at any time by notifying St. Elizabeth Physicians in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by St. Elizabeth Physicians before receiving my revocation.

I understand that I have the right to restrict disclosure of my PHI to a health plan, if the disclosure is for payment or healthcare operations and pertains to a healthcare item or service for which I have paid out-of-pocket in full. I have the right to an accounting of disclosures of any and all breach notifications of my unsecured PHI upon my written request to the SEP Privacy Officer. I also understand I have the option to "opt-out" of receiving communications from my provider should I choose to do so as long as I provide them with the request in writing.

**A PHOTO IDENTIFICATION WILL BE REQUIRED TO PICK UP MEDICAL RECORDS**

\_\_\_\_\_ I am designating \_\_\_\_\_ to pick up my medical record. I understand my designee or I will need to produce a picture I.D. in order to obtain the records.

Refusal to sign this authorization in no way affects my treatment, payment, or eligibility for benefits. Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Patient received free copy YES NO, dates included \_\_\_\_\_ to \_\_\_\_\_ Chart in MZ Storage YES NO  
Return chart to: MZ Storage Office \_\_\_\_\_ Box # \_\_\_\_\_ Chart # \_\_\_\_\_



### **Patient Financial Expectations**

Thank you for choosing St. Elizabeth Physicians as your preferred provider. We are committed to providing our patients with comprehensive and compassionate care that improves the health of the community we serve. This communication was developed to provide detailed information regarding patient insurance and financial responsibility for services rendered.

1. **Insurance** – St. Elizabeth Physicians (SEP) participates with most insurance plans, including Medicare. Please use the website at [www.stedocs.com](http://www.stedocs.com) when searching for a provider or a participating insurance carrier.
2. **Proof of insurance** – All patients are responsible for providing the correct insurance information at each visit. The patient service representative at the office will scan and store a copy of the most current insurance card. If the patient is not insured by a plan SEP participates with, the charges for the visit may be denied and become the patient's responsibility. If the patient is insured by a participating plan but does not have an up-to-date insurance card, SEP will attempt to verify coverage. If unable to do so, the balance may become the patient's responsibility.
3. **Insurance coverage changes** – If there is a change in insurance, the patient is responsible for notifying the patient service representative upon arrival at the office. Failure to provide the correct insurance information within 30 days of the visit may result in the total balance becoming patient responsibility. At any point, changes in insurance may also be submitted to SEP by calling (859) 344-5555 or by sending a message through the online patient portal, MyChart.
4. **Co-payments** – All co-payments are due at the time of service. This arrangement is a contractual obligation with the patient and their insurance company. SEP accepts cash, check, Visa, MasterCard, Discover and American Express.
5. **Outstanding balances** – Patients with an outstanding balance will be notified of such balance at the time of appointment scheduling, arrival of the appointment as well as checking out after the appointment. If unable to pay the balance in full, a payment plan can be arranged with the patient service representative or the Central Billing Office by calling (859) 344-5555.
6. **Appointment scheduling** – Patients with an outstanding balance will be requested to make a payment at the time of scheduling an appointment. If the patient cannot make the required payment, they will be asked to set up a payment plan before the appointment will be scheduled. After the payment plan has been arranged, the patient will be eligible to schedule their appointment.
7. **Financial Assistance** – Financial assistance is available to all patients based on need. The patient service representative at the office can provide the necessary paperwork or it can be downloaded from the website at [www.stedocs.com](http://www.stedocs.com) by clicking on Resources, Financial Assistance Programs.

8. **Non-covered services** – Not all services received may be covered by insurance. The provider's office will attempt to determine if a procedure will be covered or not. If a service is deemed to be "non-covered", the patient will be notified. The charge for the service and amount owed by the patient will be explained prior to receiving the service. The patient must approve the service and acknowledge the amount owed before the service will be rendered. Payment will be due after the insurance has processed the claim and upon receipt of your statement. If unable to pay the balance in full, the patient may set up a payment plan by calling the Central Billing Office at (859) 344-5555.
9. **Payment plan arrangements** – SEP may approve a monthly payment plan arrangement if special circumstances prevent the patient from making full payment. Payment plans may be arranged by patient service representatives in the SEP offices or by Central Billing Office (CBO) associates. CBO associates are available Monday through Thursday from 8:00 a.m. to 5:30 p.m. and Friday 8:00 a.m. to 4:00 p.m. They can be reached by calling (859) 344-5555 or toll free at (877) 687-3303. Inquiries can also be made through the online patient portal, MyChart. Failure to meet the agreed arrangement of the payment plan may result in the patient's account being referred to a third party collection agency.
10. **Claims submission** – SEP will bill all applicable insurances and assist in any way reasonable to help get the claims paid. If the claim is denied, SEP will follow up with the payor and appeal the denial, if appropriate. If the appeal is overturned, the balance may become the patient's responsibility. At times, the insurance company may request certain information directly from the patient, it is the responsibility of the patient to comply with their request. If the information needed is not supplied, the balance could become the patient's responsibility.
11. **Statements** – Statements will be mailed to the patient's address on file once the balance has been deemed to be the patient's responsibility. Statements under \$10 are not mailed but the amount due may be requested from an SEP patient service representative at any point.
12. **ECA (Extraordinary Collection Activities)** – Statements are mailed to the patient monthly. If the account is over 90 days past due, the status of Final Notice will appear on the billing statement. The outstanding amount will be due in 10 days. Partial payments will not be accepted unless otherwise negotiated. If a balance remains unpaid, SEP may refer the account to a third party collection agency. Accounts will not be referred to an agency when the insurance denied payment due to an error by SEP nor will the patient be referred to a collection agency while their Financial Hardship application is in process.

Thank you for your understanding and adherence to the SEP patient financial responsibility expectations. If you have any questions or concerns, our associates are here to help. Please contact us at (859) 344-5555.