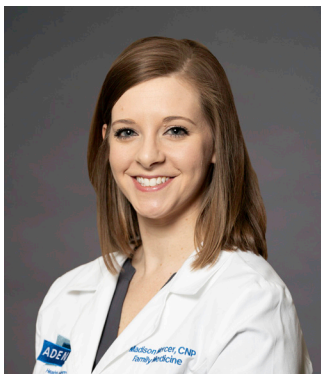
Adena Family Medicine - Ironmen Clinic

A convenient walk-in clinic for students, staff and community.

Services offered through the Ironmen Clinic

- Treatment of acute illness such as ear/sinus infection, cold, flu, cough, sore throat
- Chronic Disease Management such as diabetes and asthma
- Behavioral Health Treatment: anxiety, depression, and ADHD/ADD
- Comprehensive annual wellness visits and sports physicals
- Immunizations and disease prevention
- On Site Testing: blood sugar, strep, flu, hearing, vision
- Lab specimen collection (including blood draws)
- Reproductive health



Madison Mercer, CNP

Hours:

Monday | 7:30 a.m. to 3:30 p.m.
Tuesday | 7:30 a.m. to 3:30 p.m.
Wednesday | 7:30 a.m. to 12:30 p.m.
Thursday | 7:30 a.m. to 3:30 p.m.
Friday | 7:30 a.m. to 2:30 p.m.

New location!

Adena Family Medicine - Ironmen Clinic
109 Trago Street, Jackson, 45640

740-286-7869

ADENA HEALTH

Adena Family Medicine- Ironmen Clinic
Overview of Services

Adena Family Medicine-Ironmen Clinic was created from a partnership between Adena Health System ("Adena") and Jackson City Schools to provide access to medical experts in a familiar school setting. The clinic offers a convenient location that removes barriers such as transportation, missed work days, and appointment delays. Case studies show that school-based clinics help students reduce the amount of time away from school, and thereby improve academic performance.

Who can be seen? The Adena Family Medicine- Ironmen Clinic welcomes everyone from the school and the public.

Where is the clinic? The Adena Family Medicine- Ironmen Clinic is located at the Jackson Middle School. However, transportation services will be available from all other schools, if a signed authorization is returned to the school. This authorization will allow a designated school employee to transport your child to and from their office visit. Student drivers will be permitted to drive themselves, if the student driver consent is signed and on file.

What services are offered through the Ironmen Clinic? Just imagine a family medicine clinic, but on a smaller scale. The nurse practitioners of the Ironmen Clinic provide the following services:

- Treatment of acute illness such as ear/sinus infection, cold, flu, cough, sore throat
- Chronic Disease Management such as diabetes, asthma
- Behavioral Health Treatment: anxiety, depression, and ADHD/ADD
- Comprehensive annual wellness visits & sports physicals
- Immunizations and disease prevention
- On Site Testing: blood sugar, strep, flu, hearing, vision
- Lab specimen collection (including blood draws)
- Reproductive health

What are the clinic's hours of operation? We are open Monday, Tuesday and Thursday from 7:30 am – 3:30 pm, Wednesday 7:30 am – 12:30 pm and Friday from 7:30 am to 2:30 pm. The Ironmen Clinic will remain open year round.

Do I need to make an appointment? Appointments can be made, but are not required. Walk-in visits will be seen on a first come, first serve basis. If you would like to have an annual wellness visit performed, simply make the selection on the attached paperwork and your child's visit will be worked in during regular hours.

Am I required to be present at my child's visit? Although we encourage a parent or guardian to be present during the visit, it is not required. However, a signed consent for treatment must be on file or a parent/legal guardian must be available to provide consent over the telephone (except for the instances discussed later in this document where a minor can consent for treatment). If your child is in class, they will be asked to come to the office and will be sent back to their classroom when the visit is over. If the illness is contagious, your child will stay in the Nurse's office until a parent or guardian picks them up.

How much will the visit cost? All visits will be billed to the student's insurance. The fee for the visit is exactly the same as any other clinic visit at Adena. As with all office visits, the cost will vary depending on the complexity of the visit, and the procedures performed. No money will be collected at the time of the visit, and billing will be processed per Adena's usual processes. Adena is committed to serving our community, regardless of their ability to pay. To apply or learn more about Adena's financial assistance programs, please contact a Financial Counselor at 740-779-8786 or visit adena.org and search for "financial assistance".

Adena Family Medicine- Ironmen Clinic

Overview of Services

How will I get information about the appointment? If the visit is a "sick" visit, a care team member will contact you at the number provided to discuss the diagnosis and plan for treatment. If they cannot reach you, a message will be left requesting you to call the clinic back at your convenience. For all visit types (including wellness visits), a visit summary will be given to your child. We also strongly encourage you or your child to use Adena's patient portal which allows you to view all visit notes, test results, and your child's medication list. Additionally, you can correspond to your child's provider through the portal, and can request appointments and medication refills. Medical records may be obtained by parents/legal guardian if the child is a minor. We recommend discussing this with your child so they are aware that his or her visit information may be accessed or shared with you.

If medications are prescribed, how will I receive them? All prescriptions will be electronically sent to your pharmacy of choice (indicated on the Patient Demographic form), except for controlled substances (ADHD/ADD medication), which will have to be picked up from the clinic.

What paperwork needs completed? The following forms can be accessed on the Jackson City Schools' webpage, and are also available in each of the JCS offices. These documents/authorizations must be signed by a parent or legal guardian, and returned to the school who will facilitate sending to the clinic:

1. Adena Family Medicine- Ironmen Clinic School-Based Health Center Consent
2. Treatment/Finance Consent (Adena's standard consent)
3. Patient Demographic Form (includes insurance information)
4. Medical History Questionnaire
5. Student Driver Consent/Transportation Consent
6. Authorization for Release of Information (*If you would like us to be able to share pertinent information with school officials*)
7. Notice of Privacy Practices (does not need returned)

**If consent is not on file, a parent/guardian must be available to provide consent over the telephone.*

Can my child get treatment without my consent? There are a few instances in which we can provide treatment and/or testing to your minor child without parent/legal guardians consent under Ohio law. Provided below are those instances:

- STD testing and treatment, *HIV/AIDS is limited to testing only
- Drug or alcohol abuse and treatment
- Mental health services if 14 years or older and only for a limited period of time, *not including medication.
- Sexual assault examination

Although minors may be able to consent to the above treatment, this doesn't mean it will necessarily be kept confidential. Medical Records, with limited exceptions, may still be obtained by the parent/legal guardian and the child's insurance will still be billed.

Adena Family Medicine - Ironmen Clinic
109 Trago St.
Jackson, Ohio 45640
740-286-7869

Adena Family Medicine- Ironmen Clinic

School-Based Health Program Consent Form

Jackson City School District ("JCSD") and Adena Health System ("AHS") are partnering to offer a school based health program to JCSD students via the Adena Family Medicine-Ironmen Clinic ("AFM-IC"). The goal of this program is to help improve the health and well-being of students so that they can be successful in school. The purpose of the school based health program is to provide quality healthcare in a friendly and familiar school setting at a time that is convenient to the student and family. Although we are happy to fill the need of a Primary Care Provider, you are not required to transfer your care to AHS prior to or after being seen. JCSD will still provide school nursing and emergency services as always whether you consent to participate in this program or not.

Patient / Student Information:

Patient/Student, First and Last Name

Parent/Legal Guardian, First and Last Name

Street Address City State Zip Code

( ) --

Area Code Phone Number Date of Birth (Month-Day-Year) School & Grade Level

Consent for Medical Care/Treatment:

I wish to have **ALL** applicable services / treatments available for the above referenced patient/student.

☐ **YES** ☐ **NO** (If no, make selections of services/treatments you do consent to have available below)

	Care and treatment for any injury/illness		Pregnancy Testing
	Mental/Behavioral Health Treatment		Birth Control
	Physical Examinations / well-child (i.e. sports, work, school) **Note:** Well-child includes vision and hearing screening, urine and blood tests, and an external genital exam when appropriate		

Consent for Vaccinations:

I wish to have **ALL** vaccines available for the above referenced patient/student.

☐ **YES** ☐ **NO** (If no, make selections of vaccines you do consent to have available below)

Required Vaccines* for School Attendance in Ohio		Recommended Vaccines* **but not required by the Ohio Department of Health**	
	DTaP / Tdap / Td		Influenza (flu)
	Meningococcal / Men B		Human Papilloma Virus (HPV)
	Measles Mumps Rubella (MMR)		Hepatitis A
	Varicella		Pneumococcal
	Polio		Hib (Haemophilus influenzae type B vaccine)
	Hepatitis B	*Age appropriate, following the American Academy of Pediatrics vaccination schedule	

Adena Family Medicine- Ironmen Clinic

School-Based Health Program Consent Form

There are a few instances in which we can provide treatment and/or testing to your minor child without parent/legal guardians consent under Ohio law. Provided below are those instances:

- STD testing and treatment, *HIV/AIDS is limited to testing only
- Drug or alcohol abuse and treatment
- Mental health services if 14 years or older and only for a limited period of time, *not including medication.
- Sexual assault examination

Although minors may be able to consent to the above treatment, this doesn't mean it will be kept confidential. Medical Records, with limited exceptions, may still be obtained by the parent/guardian and the child's insurance on record will still be billed.

By signing this consent, I am authorizing AFM-IC to provide the services to my minor child outlined in this form and to bill me/my insurance for any services rendered to my child at AFM-IC. I understand that this consent for treatment will remain valid until my child is no longer enrolled in JCSD, unless I revoke or makes changes sooner. I understand that I may make changes at any time to this consent or revoke it entirely by making a written request to AFM-IC. I understand that even if I revoke my consent, as a parent of a minor child, my minor child may still consent to the treatment for which they are allowed to by law as described above. I have reviewed the AFM-IC Overview of Services and understand the services available. It is my responsibility to tell AFM-IC about changes in insurance coverage or changes to my child's health condition(s), immunization records, or medications. Additionally, I authorize AFM-IC to request medical records/information from any health care provider or facility where my child has been seen and to send results of any treatment to my child's regular doctor/clinic. Furthermore, by signing below I am attesting that I am the parent/legal guardian of the above named child and understand that a new consent form must be signed by a legal guardian if this would change. Finally, I understand that if I am not this child's birth parent that I must provide documentation or an explanation of my ability to sign this consent on behalf of the minor child and have attached such documentation to this consent.

X Parent/Legal Guardian *Printed* Name (If student is less than 18)	**Parent/Legal Guardian *Signature***	**Date/Time**
X Student *Printed* Name (if student is 18+)	**Student *Signature***	**Date/Time**

TREATMENT/FINANCE CONSENT

CLI.1066 (Rev. 02/19)

ADENA HEALTH

MAIN HOSPITAL NUMBER
(740) 779-7500

BUSINESS OFFICE
(740) 779-4200
800-975-7541

Consent to Medical Care and Treatment: I* acknowledge hereby authorize my provider to perform all tests or procedures relative to my illness, injury or examination necessary for my care and treatment. (* Throughout this document the use of the term "I" will refer to "I and/or my parents or guardians." The use of the term "me" "myself" or "my" shall refer to the patient. The use of "Adena" will refer to Adena Health System, its attending doctors, other doctors, or agents of Adena.) I acknowledge that this authorization enables the provider to obtain preadmission or continued length of stay certifications. I authorize Adena to take photos, video, or audio recording of me for diagnostic, teaching, identification, care conferencing, and quality improvement purposes. I acknowledge that no guarantee has been made about the outcome of the care rendered. I recognize that providers furnishing services to me may be independent contractors.

Release of Information: I authorize Adena to share, release, or exchange all medical information to:

- my providers, including referring providers;
- agencies needed to facilitate continuity of care;
- my insurance company, or its authorized representative, or medical assistance agency;
- any collection agency Adena uses to collect payment for the services rendered; and
- any government authority when required to do so by law.

This authorization includes any information concerning diagnosis of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or testing for Human Immunodeficiency Virus (HIV). In the event of a work-related illness/injury, I hereby authorize the release of all pertinent medical information to the Adena Occupational Health Center and any other party with an interest in the claims defined by Ohio law.
Assignment Insurance Benefits: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. If applicable, I authorize any holder of medical or other information about me to release this information to CMS and its agents. I request that payment of authorized benefits be made directly to Adena, on my behalf. I authorize Adena to bill Medicare Lifetime Reserve Days, as necessary. I assign the benefits payable for provider services to the provider or organization furnishing services. If assignment is accepted, I authorize the provider or organization furnishing the services to submit a claim to Medicare and/or commercial insurance carriers for payment. I also assign the benefits payable for private and attending provider services to my private/attending provider or his/her private practice organization; provided, however, that should my provider not accept this assignment for his or her services, this assignment for private and attending provider services shall be null and void.

Financial Agreement: I (or my guarantor, if applicable) understand that I am financially responsible for all services provided, including charges not covered by insurance.

Consent to Contact: I grant permission and consent to Adena and its agents and assignees (1) to contact me by phone at any number associated with me; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text messages or emails using any email addresses I provide; and (4) to use pre-recorded/artificial voice messages and/or an automatic dialing device (an auto dialer) in connection with any communications made to me or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services from Adena.

Disclosure of Charges: I acknowledge that I am entitled, upon request, to a list of the charges for common medical and surgical procedures.

Notices: I have been advised Adena participates in a Health Information Exchange (HIE). My healthcare provider can use this electronic network to securely provide access to my health records for a better picture of my health needs. Unless I have previously opted out by executing a separate opt-out form, I acknowledge that Adena will allow access to certain health information through the HIE for treatment, payment, or other health care operations. I have been advised I may opt out of such exchange or opt back in at any time by contacting our Health Information Management Services/Medical Records Department. I have been informed that Adena is not responsible for loss or damage to my valuables and personal items. I have been informed that all Adena properties are tobacco free and that tobacco cessation information is available upon request. I have been informed that interpretive services, if needed, are available and will be provided at no cost to me. I acknowledge that Adena's Notice of Privacy Practices and Patient Rights has been made available to me at this or another AHS location. If not, a copy is available upon my request.

Signature: By signing my name below, I certify that I have read and agree to all terms explained in this registration consent form. My questions, if any, have been answered to my satisfaction.

☐ By checking this box, I have indicated that I do not wish to be included in the facility directory.

SIGNATURE:
By signing my name below, I certify that I have read and agree to all terms explained in this registration consent form.

_____ / _____ / _____

PATIENT (GUARANTOR, IF PATIENT IS A MINOR) **DATE/TIME** **WITNESS**

PATIENT IS UNABLE TO CONSENT BECAUSE _____

I, THEREFORE, CONSENT FOR THE PATIENT _____

_____ / _____ / _____

RELATIONSHIP **DATE/TIME** **WITNESS**

Adena Family Medicine-Ironmen Clinic

Patient Demographic Information

Student Name (Last, First, M.I.) _____ **DOB**_____

School Attended:_____**Grade Level**_____

Home Street Address_____**City**_____

State_____ **Zip** _____ **Email**_____

Home Ph._____ **Cell Ph.**_____ **Work Ph.**_____

Would you like to be signed up for the patient portal to access your medical records electronically? ☐ **Yes** ☐ **No**

What is your preferred method of contact? ☐ **Phone** ☐**Cell Ph.** ☐ **Pt. Portal** ☐ **Text**

Sex: ☐ **M** ☐ **F** **Race**_____ **Ethnicity**_____ **Language**_____

Mother's Name _____

Father's Name _____

Legal Guardian's Name (if applicable)_____

**Please attach a copy of proof of legal guardianship if it hasn't been previously provided to the clinic.*

Primary Care Provider/Pediatrician (name & Clinic) _____

Emergency Contact: _____

Emergency Contact Address_____

Emergency Contact Phone_____ **Relationship**_____

Insurance Name_____ **Subscriber Number**_____

Group Number_____ **Group Name**_____

Insured Name_____ **Relationship to Patient**_____

Local Pharmacy_____

Mail Order Pharmacy_____

_____ _____

Signature of Person Completing this Form **Date**

(Should be completed by parent/legal guardian)

Adena Family Medicine- Ironmen Clinic

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient/Student Name:_____**DOB:**_____

Current Family Medicine Provider/Pediatrician:_____

Date of last Wellness Exam:_____

Would you like a Comprehensive Wellness Exam Performed □ Yes □ No

**Insurance companies, including Medicaid, pay for an annual wellness exam, at no expense to you*

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

**Attach additional page if necessary*

Name of Medication	Strength/Dosage	Frequency Taken

Medical History *Please check all that apply.*

Heart Problems	Never Had	Have Now	Had in the Past
Irregular Heart Beat (arrhythmias)			
Heart Failure			
High Blood Pressure			
Other, Specify			

Lung Problems	Never Had	Have Now	Had in the Past
Asthma			
Bronchitis			
Other, Specify			

Bone & Joint Problems	Never Had	Have Now	Had in the Past
Arthritis			
Fracture of the Hip, Wrist, Spine, Arm, Leg (circle which one)			
Other, Specify			

Gland Problems	Never Had	Have Now	Had in the Past
Diabetes			
Thyroid, Overactive (High)			
Thyroid, Underactive (Low)			
Other, Specify			

ENT	Never Had	Have Now	Had in the Past
Chronic Allergies			
Congestion			
Difficulty Swallowing			
Other, Specify			

Kidney and Urinary Problems	Never Had	Have Now	Had in the Past
Kidney Disease			
Frequent Bladder or Kidney Infections			
Urinary Incontinence (wetting)			
Other, Specify			

GI Problems	Never Had	Have Now	Had in the Past
Chronic Constipation			
Diarrhea			
Indigestion			
Vomiting			
Chronic Abdominal Pain			
Other, Specify			

Mental/Behavioral Health Problems	Never Had	Have Now	Had in the Past
Anxiety			
Depression			
Learning Disabilities			
Other, Specify			

Eyes: □ Wears Glasses □ Contacts □ Vision Changes

Date when vision changes occurred_____

Allergies to Medications

Name of the Medication	Reaction you had

Surgical History

Year	Reason/Diagnosis	Hospital

Hospitalizations

Year	Reason/Diagnosis	Hospital

Childhood Illnesses: □ Measles □ Mumps □ Rubella □ Chicken Pox □ Rheumatic Fever □ Polio

Family History of Illnesses (mark those that apply):

	No History	Mental Health	Diabetes	Heart Disease	Hypertension	COPD	Asthma	Cancer
Mother								
Father								
Brother								
Sister								
Grandmother								
Grandfather								

Women Only

Age at onset of menstruation:_____Date of last menstruation:_____Period every ___days

Heavy periods, irregularity, spotting, pain, or discharge? □ Yes □ No

Number of pregnancies _____ Number of live births _____

Are you pregnant or breastfeeding? □ Yes □ No Date of last pap smear:_____

Men Only

Do you usually get up to urinate during the night? Yes No If yes, # of times _____

Do you feel pain or burning with urination? □ Yes □ No Any blood in your urine? □ Yes □ No

Do you feel burning discharge from penis? □ Yes □ No

Do you have any problems emptying your bladder completely? □ Yes □ No

Any testicle pain or swelling? □ Yes □ No

Please list any medical or behavioral health history that was not specially asked, but that would be pertinent to the student's/patient's care.

1. _____
2. _____
3. _____

_____ _____

Signature of Person Completing this Form **Date**
(Should be completed by parent/legal guardian)

TRANSPORTATION BY PRIVATE VEHICLE

Date of Trip During enrollment at Jackson City Schools Time of Trip As determined by health care needs and transportation availability

Reason for the transportation Seeking health care services at Adena Family Medicine- Ironmen Clinic

The following student(s) _____

_____ will be transportated to Jackson Middle School & the Adena Family Medicine- Ironmen Clinic

from Current school building attended by Designated School Employee

Vehicle Description: Provide Student Driver Information (if applicable)

Make _____

Model & Year _____

License Tag Number _____

Insurance Coverage/Carrier _____

Signature of Parent _____ Date _____

Signature of Student Driver _____ Date _____

Signature of Student Passenger _____ Date _____

According to Jackson City Board of Education guidelines, the person approved for the transportation of students in a private vehicle must be:

- an employee of this Board, a student of this District, or the parent of a student enrolled in this District;
- the holder of a current valid license to operate a motor vehicle in the State of Ohio;
- the holder of automobile liability insurance and personal injury insurance.

Any private vehicle used for the transportation of students must be owned by the approved driver or the spouse of the approved driver; have the capacity to hold not more than nine (9) persons; and must conform to registration requirements of the State.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____

Date of Birth:_____

I hereby authorize Adena Family Medicine – Ironmen Clinic ("AFM-IC") and Jackson City School District ("JCSD") to share/release/exchange my health information with school nurses, school counselors, school social workers, school athletic trainers and/or teachers and school administrators about my/my child's physical and/or mental condition, including, but not limited to, information regarding services provided to me/my child at school for treatment and care coordination purposes

I understand that this authorization will be effective as of the date signed below and will remain valid throughout my enrollment at JCSD, unless I revoke this authorization sooner. I may revoke this authorization at any time by providing written notice of my intent to revoke to the AFM-IC. If I choose to revoke this authorization, I understand that the revocation will not apply to any information that has been released in good faith prior to the receipt of the written revocation. Any information use and/or disclosed in accordance with this authorization may be subject to re-disclosure by the person or entity receiving the information, and such re-disclosure may no longer be protected by federal privacy laws or regulations.

I also understand that I am not required to sign this authorization and that AFM-IC will not condition participation in the school based health services program, treatment, payment, or eligibility for benefits on this signed authorization, and I have received a copy of the this authorization.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient or Patient's Representative Date

If signed by patient's representative, relationship to patient: _____

(If signed by patient's representative, provide documentation or explanation of your authority to act for the patient. Attached copy, if applicable)