

**SCHOOL-BASED SUPPLEMENTAL
HEALTH SERVICES CONSENT FORM**



Mad River Local Schools (MRLS) partners with many community agencies to offer School-Based Supplemental Health Services. This one form replaces many of the different permission forms required to provide these services for your child. School nursing and emergency services will still be provided as always whether or not you choose to take part in these added services. Some Supplemental Services may not be available at all school buildings. (Check with your school nurse for questions about service ability).

These health services provide quality health care in a friendly and familiar school setting at a time that works for the student and family. We are not trying to replace your regular source of health care.

Student Information (Print all information in ink)

Patient/Student Name (First, Middle, Last)		Student Preferred Name	
Street Address	City	State	Zip Code
(Area Code) Phone Number	Student Date of Birth (Month-Day-Year)	Grade	School Name

Sex: Male Female Prefer to self-describe: _____ **Ethnicity:** Hispanic/Latino (check one) Yes No

Race: Please check **all that apply** for your child: Black or African American White Asian
 Native Hawaiian/Pacific Islander American Indian/Alaskan Native Other: _____

Student's Main Language: English Spanish Russian Turkish Kinyarwanda French Arabic Other: _____

Consent for Health Services Treatment

I consent to let providers participating in School-Based Supplemental Health Services perform the following services/treatment for my child: (Check each service that you want to have available for your child.)

<input type="checkbox"/> <u>Care and treatment for injury/illness</u> Physical examinations (well-child or sports) Influenza (flu) immunization	<input type="checkbox"/> Free Dental screening and sealants for 2nd/6 th grades (also includes a sealant check next school year and re-application if needed)
<input type="checkbox"/> Meningococcal immunization (required for 7 th & 12 th grades)	<input type="checkbox"/> Dental exam, dental filings
<input type="checkbox"/> Tdap immunization (required for 7 th grade)	<input type="checkbox"/> Mental/behavioral health counseling
Other immunizations (age-appropriate, following the American Academy of Pediatrics immunization schedule <input type="checkbox"/> DTaP/Td <input type="checkbox"/> Polio <input type="checkbox"/> Hepatitis B <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Hepatitis A <input type="checkbox"/> HPV <input type="checkbox"/> Pneumococcal conjugate <input type="checkbox"/> Hib	<input type="checkbox"/> Eye exam, including dilation (drops are used to make the pupil bigger), vision therapy, the fitting and dispensing of eyeglasses and corneal foreign removal (removing something from the clear, protective outer layer of the eye)
<input type="checkbox"/> Pregnancy testing	<input type="checkbox"/> Birth Control
<input type="checkbox"/> Sexually Transmitted Infection (STI/STD) testing, Education and/or treatment	

By signing this Consent for Health Services Treatment, I agree to the terms and conditions regarding Authorization to Release Information and Assignment of Insurance Benefits as explained in this consent form. 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 School-Based Supplemental Health Services Information for Parents & Students handout which is available on the CHCGD and FRHC website.

I understand that I will be notified of any services my child receives, as well as any abnormal findings and/or further treatment recommendations. I also understand I should contact the school nurse if I have questions about any necessary follow-up care or instructions. For services provided by the Health Centers, I understand I should call the phone number listed on the After Visit Summary which was sent home with my child. I understand this consent will remain valid as long as the child remains a student within Mad River Local Schools unless revoked by me. **I may revoke this consent for treatment at any time by requesting in writing that School-Based Supplemental Health Services remove my child from services.** I have received this handout, School-Based Supplemental Health Services Information for Parents and Students, which includes the agencies providing services, and I understand the services available. It is my responsibility to notify the school nurse of all updates or changes to my child's health condition(s), immunization records, medications or insurance coverage.

Privacy Practices & Authorization to Release Information

Notice of Privacy Practices Acknowledgement: I have been notified that I can ask for a copy of the Notice of Privacy Practices forms for Community Health Centers of Greater Dayton and Five Rivers Health Centers at any MRLS building. I know I also can view them online at www.communityhealthdayton.org and www.fiverivershealthcenters.org. Copies of the consent form are available at my child’s school and blank forms are also available at <https://www.madriver.schools.org/>

Authorization to Release Information: I hereby authorize CHCGD, FRHC, or MRLS to exchange information with insurers, compensation carrier, healthcare facility, welfare agency, healthcare provider, the MRLS school nurse(s), school counselor and/or school social worker, for the exclusive purpose of financial assistance, continuity of medical care, or care coordination. Administered immunizations will be entered into the statewide immunization information system (Ohio ImpactSIIS). Release of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987).

No disclosure of information regarding AIDS, HIV testing, or diagnosis of HIV/AIDS will be made. School-Based Supplemental Health Services may use student health records to evaluate the quality of care provided and the effectiveness of offering these services. My child’s records are protected and can only be accessed by authorized users with restricted access. I understand this authorization will remain valid as long as the child remains a student within Mad River Local Schools unless revoked by me. I may withdraw this authorization at any time by providing written notice to remove my child from these School-Based Supplemental Health Services.

Insurance Information: Insurance or other health care coverage programs are billed whenever possible to help cover the cost of care. Some School Based Supplemental Health Services are provided at no cost to families whether or not a student has insurance or the ability to pay. I give Community Health Centers of Greater Dayton and Five Rivers Health Centers the right to submit claims for reimbursement under any private health insurance policy, Medicare, Medicaid or any other programs that I identify for which a benefit may be able to pay for services provided to my child through School-Based Supplemental Health Services.

I AGREE to allow Community Health Centers of Greater Dayton and Five Rivers Health Centers access to my child’s individual academic, attendance and behavior records for the current and prior school years, so they can provide better services to my child.

I DO NOT AGREE to allow Community Health Centers of Greater Dayton and Five Rivers Health Centers access to my child’s individual academic, attendance and behavior records for the current and prior school years, so they can provide better services to my child.

This consent is valid until the child reaches the age of majority, or is no longer a student at a Mad River Local Schools. This consent may be revoked at any time by the parent/guardian authorized to act on behalf of the patient, except to the extent that all organizations have already taken action in reliance on this consent.

I understand that the 2 organizations will not discuss my medical care or billing information with anyone not listed on this consent. Below please list people that we may release information to.

Name	Relationship to Student	Name	Relationship to Student
1. _____		2. _____	
3. _____		4. _____	

Parent/Guardian Relationship to Student (if student/patient is less than 18 years old): Mother Father Legal Guardian

X	X	X	
Parent/Guardian <i>Printed Name</i>	Parent/Guardian <i>Signature</i>	Date	
	X	X	X
OR if student/patient is 18 years or older	Student/ <i>Signature</i>	Date	Student Phone

STUDENT NAME _____ **DOB** _____

PATIENT REGISTRATION FORM: (Complete all sections)


PATIENT INFORMATION:						
Last Name	First Name	MI	Nickname	Social Security #	Birthdate	Sex
Billing Address: of Patient or Responsible Party			Apt #	City	State	Zip
<input type="checkbox"/> Home Phone ()		<input type="checkbox"/> Alternate Phone ()		<input type="checkbox"/> Family Friend ()		
Email Address:						
RESPONSIBLE PARTY (Required for patients under 18 or whenever the guarantor is not the patient)						
Last Name	First Name	MI	Social Security #	Birthdate	Relationship	


HEALTH INSURANCE


Please check which insurance carrier covers your child or sign below if you don't think your child has insurance. Most School Based Supplemental Health Services are provided at no cost to families whether or not s student insurance or the ability to pay.

Medicaid Managed Care Plans (check one below):

Managed Care ID# _____

 CareSource

 Molina Healthcare



Ohio Medicaid # _____

Private Insurance (Other than Medicaid)

Insurance Company _____

Policy Holder Name _____

Relationship to the Student _____

Date of Birth _____

Effective Date _____

Co-Pay \$ _____

Policy # _____

Secondary Insurance

Insurance Company _____

Policy Holder Name _____

Relationship to the Student _____

Date of Birth _____

Effective Date _____

Co-Pay \$ _____

Policy # _____

New Patient History

STUDENT NAME _____ **DOB** _____

Primary Care Provider:	Provider Location:
Other Provider:	Other Provider Location:
Seen by other Providers for:	
Dentist:	Dentist Location:
Preferred Pharmacy:	Pharmacy Location:

Does your child have any allergies? Yes No (*Please check and explain*)

Allergies	Describe Reaction
All Surgeries since birth	

Family History:

Does anyone at home smoke or vamp?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indoors? <input type="checkbox"/> Yes <input type="checkbox"/> No	Outdoors? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Date of child's last physical or well-child exam _____	My child has <u>not</u> had a physical or well-child exam in the last 12 months
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Please list below all medical problems each family member has had.

Mother	Medical problems:
Father	Medical problems:
Grandmother	Mom side / Dad side (circle one) Medical problems:
Grandfather	Mom side / Dad side (circle one) Medical problems:
Brother	Medical problems:
Sister	Medical problems:

Medical Problems and Health Concerns (Check "Yes" or "No" for each item and explain below if necessary).

Chicken Pox disease (age: __) <input type="checkbox"/> Yes <input type="checkbox"/> No	History of Guillain-Barre Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness/fainting/passing out <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures (Epilepsy) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Date of last seizure: _____</i>
Psychological or mood problem* <input type="checkbox"/> Yes <input type="checkbox"/> No	Brain or nervous system problem* <input type="checkbox"/> Yes <input type="checkbox"/> No
Development problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery or admitted to the hospital In the last year <input type="checkbox"/> Yes <input type="checkbox"/> No	Cystic Fibrosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung or breathing problem* <input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Immune system problem * <input type="checkbox"/> Yes <input type="checkbox"/> No	GI or stomach problem* <input type="checkbox"/> Yes <input type="checkbox"/> No
Clotting disorder * <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disorder* <input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder or urinary problem* <input type="checkbox"/> Yes <input type="checkbox"/> No
Type 1 Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant (<i>girls only</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No
Type 2 Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Other problems/concerns* <input type="checkbox"/> Yes <input type="checkbox"/> No
Endocrine disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Please explain any above starred items	

Person Completing Form (print): _____ Date: _____

Signature: _____ Relationship to Child: _____

Billing Agreement

Health Insurance:

I am aware that it is my responsibility as the patient to give a copy of my insurance information to Community Health Centers of Greater Dayton and/or Five Rivers Health Centers.

Self-Pay (Uninsured or Underinsured):

I am aware that it is my responsibility to complete the Sliding Fee Application and return my proof of income within 30 days of my visit or I will be responsible for 100% of my bill.

Co-Pay/Nominal Fee:

I am aware that my co-pay/nominal fee is my responsibility. I may pay cash, check or credit card.

Statements:

I am aware that I will only receive two (2) statements and one (1) past due statement (a total of 3 statements) before my account is sent out to an outside collection agency. I am aware if Community Health Centers of Greater Dayton and/or Five Rivers Health Centers receives returned mail because I have not supplied a correct/updated billing address, I may be sent to an outside collection agency.

Payment Arrangements:

I am aware that if there is a balance due, I may set up a "Payment Arrangement" if I am unable to pay in full. I am also aware that if I do not set up a payment plan with Community Health Centers of Greater Dayton and/or Five Rivers Health Centers or I do not make my scheduled payments, I may be sent to an outside collection agency.

Collections:

I am aware that if I am sent to an outside collection agency two (2) times that I may be discharged from the practice and I will no longer be able to receive services at CHCGD and/or FRHC.

Financial Authorization and Release of Information

I authorize payment directly to CHCGD and FRHC and/or the physicians or their designees of the benefits herein specified and otherwise payable to me but not to exceed the regular charges. I understand I am responsible for all charges until the bills are paid in full and/or the balance of charges are not covered by insurance.

MEDICARE PATIENTS ONLY – I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I authorize any holder, including the physicians and/or their designees, of medical or other information about me to release to the Social Security Administration and/or the Medicare program any information needed for this or related Medicare claim. IF FOR ANY REASON MEDICARE (OR MY INSURANCE COMPANY) DENIES PAYMENT, I AUTHORIZE CHCGD and FRHC TO ACT ON MY BEHALF TO APPEAL FOR PAYMENT.

My signature, or that of my authorized representative, indicates that I have read, understand and agree the above conditions and this consent for care at CHCGD and FRHC supersedes any other financial consent that may have been signed.

Student's Name	DOB	Signature of Patient or Legal Representative or Agent	Date	Relationship to Student	Date
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Community Health Centers of Greater Dayton and Five Rivers Health Centers are Federally Qualified Health Centers. We are required to collect the incomes of our patient population. All information is confidential and we are only required to report numbers not patient names.

A family size is your immediate family who live in your home that you are legally responsible for and children you pay child support for that do not live in your home.

1. Circle your family size

2. Circle your income

Family Size	Annual Income Under	Annual Income Between	Annual Income Between	Annual Income Between	Annual Income Over
1	\$12,490	\$12,491- \$16,612	\$16,613- \$18,735	\$18,736- \$24,980	\$24,981
2	\$16,910	\$16,911- \$22,490	\$22,491- \$25,365	\$25,366- \$33,820	\$33,821
3	\$21,330	\$21,331- \$28,369	\$28,370- \$31,995	\$31,996- \$42,660	\$42,661
4	\$25,750	\$25,751- \$34,248	\$34,249- \$38,625	\$38,626- \$51,500	\$51,501
5	\$30,170	\$30,171- \$40,126	\$40,127- \$45,255	\$45,256- \$60,340	\$60,341
6	\$34,590	\$34,591- \$46,005	\$46,006- \$51,885	\$51,886- \$69,180	\$69,181
7	\$39,010	\$39,011- \$51,883	\$51,884- \$58,515	\$55,516- \$78,020	\$78,021
8	\$43,430	\$43,431- \$57,762	\$57,763- \$65,145	\$65,146- \$86,860	\$86,861

We will ask you to update this information **yearly**.

Student Name: _____

Date of Birth: _____

Today's Date: _____