Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_\_

To give your child permission to receive medical/dental/behavioral health care at [*COMMUNITY HEALTH CENTER NAME*], please complete this consent form and return it to school or health center staff as soon as possible. Information on privacy practices, policies, and procedures are available at the end of this form, and at the school office and/or clinic.

As the Parent and/or Legal Guardian, I hereby give my student consent to receive services offered by [*COMMUNITY HEALTH CENTER NAME*] at my child’s designated school under the following terms and conditions:

1. I have been informed of the services offered at the [*HEALTH CENTER NAME*] and I understand that these services are routine health care services and that treatment will be limited to:

**Medical**

* Diagnosis and treatment of minor and acute illnesses and first aid for minor injuries
* Physical examinations (general, sports, pre-employment)
* Laboratory services
* Vision & hearing screenings
* Immunizations
* Prescription and over-the-counter medications
* Diagnosis, treatment, & prevention of sexually transmitted infections
* Pregnancy testing, prescription for contraception, and referral for prenatal care
* Nutrition assessment and counseling
* Health education about a variety of topics such as drugs and alcohol, healthy relationships, sexually transmitted infections, HIV, pregnancy prevention, and stress management

**Dental**

* Dental screening and fluoride varnish
* Dental examinations, diagnostic procedures (x-ray and pictures), and treatment
* Use of local anesthetics
* I understand that there is the chance for allergic response or muscle soreness due to local anesthetic used during a procedure.

**Behavioral Health**

* Individual and or group counseling relating to topics such as drugs and alcohol, physical and sexual abuse, suicide, grief and loss, sexuality, school, family, and general mental health.
1. I have listed below those services that I DO NOT WANT my child to receive at the School-Based Health Center:

However, I understand that California State Law permits the provision of the following services to a minor who has attained 12 years of age with or without parental consent:

* Diagnosis and treatment of sexually transmitted diseases
* Pregnancy testing, contraceptives and referral for prenatal care
* Crisis mental health counseling by [*HEALTH CENTER NAME*]
* Alcohol and substance abuse counseling
1. I understand my consent covers only those services provided at the [*HEALTH CENTER NAME*] School-Based Health Centers and does not authorize services to be provided at any other private or public facility.
2. I authorize the [*HEALTH CENTER NAME*] to exchange information regarding treatment of my child with school district partners and/or other medical providers for any reason in accordance with medical practice and what is legally allowed through patient privacy laws.
3. I understand that no student or family will be charged for services at the School-Based Health Center. However, it is the School-Based Health Center’s policy to cover expenses by billing possible third-party sources such as Medi-Cal and Family Pact. Students may be asked to register for Medi-Cal. Family income is usually not a factor in determining eligibility; rather eligibility depends on the type of medical or mental health service utilized by the student. The School-Based Health Center may be required to release information regarding treatment to third-party payers, such as Medi-Cal or Family Pact for the purpose of billing.
4. All information between your child/guardian and [*HEALTH CENTER NAME*] services is held strictly confidential unless (1) you authorize the release of information, (2) the disclosure is allowed by a court order, (3) the student presents a physical danger to her/him self or to others, or (4) child or elder abuse/neglect is suspected. In cases of potential abuse or neglect, NAHC staff is required by law to inform the proper authorities so that the protective measures can be taken. If your student/family is receiving services through more than one [*HEALTH CENTER NAME*] services partner, relevant information may be shared between program staff in order to coordinate services. Staff should discuss with you such conversations and their relevance.
5. NOTIFICATION OF PARTICIPATION IN A COUNTY-WIDE EVALUATION OF SCHOOL-BASED HEALTH CENTERS In order to improve our services, we are participating in a County-wide evaluation of School-Based Health Centers. The evaluation is being conducted by the University of CA, San Francisco (UCSF). As part of this evaluation, we collect information on clients who use our services and share this information confidentially with UCSF. UCSF will never share your name or your child/ward’s name or other personally identifying information in any evaluation reports.
6. I authorize the Oakland, San Leandro or Alameda unified School District to grant [*HEALTH CENTER NAME*], the on-site health provider at my child’s designated school to review my child’s pupil records. [*HEALTH CENTER NAME*] agrees not to disclose the pupil records to any other person or entity without first obtaining written permission.

All participants are accepted into the program on a nondiscriminatory basis, and are accorded equal treatment and services without regard to race, color, sex, sexual orientation, gender identity, religion, nation of origin or ancestry. Your rights include, but are not limited to the following:

* Services that are courteous, dignified and reliable.
* A safe and comfortable environment.
* To be informed by NAHC of the provisions of laws regarding complaints and procedures for registering complaints including, but not limited to, the address and telephone number of the appropriate person.
* To discontinue services.

Name of Parent/Legal Guardian (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **PATIENT INFORMATION** |
| Last Name & Suffix (Jr., Sr., III) | First Name: | Middle Name: |
| Home Address: | City | State: | Zip: |
| Social Security Number: | Date of Birth: | Gender Assigned at Birth:r Male r Female | Mother’s Maiden Name: |
| **Preferred Language:** | **Marital Status:** | **Are you a Student?** | **Are you a Veteran?** |
| Language Barrier? r Yes r NoHearing Impaired? r Yes r No | r Married r Widowedr Single r Divorcedr Domestic Partner | r No r Yes - If Yes:r Full Time r Part Time | r No r Yes |
| **PREFERRED CONTACT (check one)** |
| r Home: *Confidential Msg OK?*  r Yes r No | r Cell Phone: *Confidential Msg OK?*  r Yes r No | r Do Not Call |
| **Home Phone:** | **Cell Phone** | **Alternative Phone Type:** |
|  |  | *Confidential Msg OK?*  r Yes r No |
| **Email Address:** |
| *Is this a personal email where you can receive private health information?*  r Yes r No |
| **Do you currently live in a Public Housing?** | **Are you Homeless?** | **Are you a Migrant Worker?** |
| r No r Yes - If Yes: (check one)r Public Housingr Tenant Based Voucherr Other | r No r Yes - If Yes: (check one)r Shelter r Street r SRO r Staying with Family/Friendsr Transitional/Program Program Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | r No r Yes - If Yes: (check one)r Regularr Seasonal |
| **Self-Identified Ethnicity:** | **Self-Identified Race:** |
| r Hispanic/Latinor Non-Hispanic/Latinor Unknown | r American Indian or Alaskan Native r Middle Eastern or Africanr Asian r Native Hawaiian or Pacific Islanderr Black or African American r Whiter Latino or Hispanic r Unknown or Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **MEMBER INSURANCE INFORMATION** |
| Do you have **MEDI-CAL?**r No r Yes - If Yes:Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(example: 123456789F)*  | Have you ever been enrolled in **Health Pac**?r No r Yes - If Yes:Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Have you ever been enrolled in HEALTHY SF?r No r Yes - If Yes:Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Private Insurance Group/Plan Name: | Group/Plan Policy Number: | Insurance Phone Number: |
| Name of Policy Holder: | Date of Birth: | SSN: | Relationship to Member: |
| **RESPONSIBLE PARTY (check one)** r **Self**  r **Parent**  r **Guardian** |
| Full Name – First and Last: | Date of Birth: | SSN: | Relationship to Member: |
| Responsible Party/Parent/Guardian Address: | City: | State/Zip: |
| Source of Income: | Family Size: | Monthly Income: | Phone: |
| EMPLOYER Name & Address: | City: | State/Zip: | Employer Phone: |
| **MEMBER EMERGENCY CONTACT or Secondary Parent** |
| Name, Address, City, State, Zip: | Relationship: | Phone Number: | Alternative Phone Number: |
| Is it okay to send email regarding your health care to your emergency contact address in an attempt to reach you? r No r Yes |

**PLEASE TURN OVER AND COMPLETE**

[*HEALTH CENTER NAME*] follows rules and regulations set by Indian Health Services (IHS) and the State of California. **Members are financially responsible for all Medical and Dental services rendered at [*HEALTH CENTER NAME*], as [*HEALTH CENTER NAME*] is not a free clinic. Counseling services are free in the Community Wellness Department.**

I request [*HEALTH CENTER NAME*] to provide me and/or my family with health care services. I agree to pay for treatment and services rendered. [*HEALTH CENTER NAME*] may release billing information to appropriate third-party payers (e.g., insurance companies, County) to collect payment. I understand that my insurance carrier may pay less than the actual bill, and agree to be responsible for the cost of all services not covered. I understand that [*HEALTH CENTER NAME*] reserves the right to bill me for 100% of charges if I fail to prove my eligibility for an assistance program. I understand that my treatment may be performed by a student/resident and I have the right to request not to be seen by a student/resident.

[***HEALTH CENTER NAME***] will refuse to treat persons under the influence of drugs and alcohol. Members must call within 48 hours to reschedule appointments. If a member fails to keep a scheduled appointment three times, all of their future appointments will be cancelled and they will only be seen on an emergency basis.

The information on this form is correct to the best of my knowledge.

**I hereby agree to abide by [*HEALTH CENTER NAME*] policy, and I understand the terms explained on this form.**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Member/Parent/Guardian/Responsible Party Date

*Describes how medical information about you may be used and shared and how you can get access to this Information. Please review it carefully.*

**Our Pledge Regarding Health Information:**

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive at the health center. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the health center whether made by the health center personnel or your doctor. This notice will tell you about the ways in which we may use and share medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

**How we may use and share health information about you:**

We may use your health information to provide you with medical treatment, and to arrange and coordinate your health care; to obtain payment for our services; and to conduct our health care operations, including quality assurance, fundraising, and general management and administration. We may disclose your health information for a variety of purposes in the public interest, as required or permitted by law. We will obtain your written authorization to use or disclose your health information for other purposes. There are circumstances when health information about you will not be shared unless you first give your permission for it to be shared; such as when you receive services in a substance abuse treatment agency.

**Your Health Information Rights:**

You have a right to inspect, copy, and/or amend your health information. You also have a right to know with whom we have shared your medical information. You have a right to request restrictions on the disclosure of health information to others. You have a right to confidential communications about your treatment or services.

**Who Will Follow This Notice:**

This summary describes our health center’s practices and that of:

* Any health care professional authorized see or enter information into your medical chart.
* All sites, locations, departments and units of the health center.
* All employees, staff, consultants, volunteers and other health center personnel

**We are required by law to:**

* **Make sure that medical information that identifies you is kept private.**
* **Give you this notice of our legal duties and privacy practices**
* **Follow the terms of the notice that are currently in effect**

**If you believe that your privacy rights have NOT been maintained**, you can file a complaint with the Secretary of the US Department of Health & Human Services, or with the health center’s HR Director/HIPAA Privacy Officer. Submit your complaint in writing to 2950 International Blvd., Oakland CA 94601, or by phone: (510) 747-3030.

*This is a summary prior to your review of the complete Notice of Privacy Practices (attached).*

*You may also view the Notice of Privacy Practices on our website at* [*HEALTH CENTER WEBSITE ADDRESS*]

I acknowledge that I have received a copy of the [*HEALTH CENTER NAME*]’s Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Signature Date

Consent for Services: As described on page one of this packet, **your signature on this form gives your consent** to voluntarily receive behavioral, dental and/or medical health care services at [*HEALTH CENTER NAME*] as provided by [*HEALTH CENTER NAME*]’s service providers. If you are a beneficiary’s legal representative, your signature below gives that consent on behalf of your beneficiary.

Informing Materials: Your signature also means that the materials/topics listed below were discussed with you in a language and manner that you understand and that you were given the Member Informing Materials packet for your records. You may request an explanation and/or copies of the materials again, at any time:

* Membership Agreement / Informed Consent to Treatment
* Member’s Rights & Responsibilities r Tribal Affiliation
* Consent to Follow Up r Advanced Directive
* Notice of Privacy Practices r Member Feedback/Grievance Procedure

**In initialing then signing below, I agree to, and acknowledge, the following:**

\_\_\_\_\_ I give my informed consent to receive treatment at [*HEALTH CENTER NAME*].

\_\_\_\_\_ I agree to actively engage in treatment while abiding by [*HEALTH CENTER NAME*] membership agreements. I understand that participation in services is voluntary.

\_\_\_\_\_ I consent to receiving follow-up care contact from [*HEALTH CENTER NAME*].

\_\_\_\_\_ I have been offered enrollment into the [*HEALTH CENTER NAME*] Member Portal. I understand I can give verbal consent for enrollment at any time when I choose to enroll. I must provide a private and confidential email address where I may receive protected health information about my health care in order to qualify for enrollment.

\_\_\_\_\_ I have received and acknowledge the Patient Portal terms and conditions, included in my Member Informing Materials packet.

\_\_\_\_\_ I understand that information about my health is confidential.

\_\_\_\_\_ I understand it is my responsibility to change my Medi-Cal managed care assignment to [*HEALTH CENTER NAME*] to access primary medical services.

\_\_\_\_\_ I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by or in [*HEALTH CENTER NAME*]. I authorize any holder of medical or other information about me to release such needed information to Medicare and its agents to determine if these benefits or benefits for related services apply to me.

\_\_\_\_\_ I understand that my health information may need to be shared for safety, treatment, payment, operational, health registry, billing, or legal reasons.

\_\_\_\_\_ I have received a copy of [*HEALTH CENTER NAME*]’s Notice of Privacy Practices.

\_\_\_\_\_ In the event of my death, I give my consent for [*HEALTH CENTER NAME*] to share information with the community about my funeral or memorial services.

\_\_\_\_\_ I agree to receive email communications from [*HEALTH CENTER NAME*] regarding public news, events and programs. I understand that I can unsubscribe at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member’s Full Name Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Name Signature Date

Dear Members,

[*HEALTH CENTER NAME*] has changed our practice management system and has joined the OCHIN collaborative. This means that, [*HEALTH CENTER NAME*] is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at <http://www.ochin.org> www.ochin.org. As a business associate of [*HEALTH CENTER NAME*], OCHIN supplies information technology and related services to [*HEALTH CENTER NAME*] and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record system. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by [*HEALTH CENTER NAME*] with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

\_\_\_\_\_ My electronic submission is acknowledgement of consent in lieu of in-person signature.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Name

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Parent/Guardian Date

I consent to the following related to Telephone visits and Video visit:

1. I understand my health care provider will be at a different location from me. I will connect to the visit from a private space by telephone or cell phone.
2. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, and the healthcare provider. I will give my verbal permission prior to the entry of the additional personnel.
3. I understand that I have the option to refuse telephone/video health service at any time without affecting the right to future care or treatment and without risk of losing benefits.
4. I understand that if I do not choose to participate in a telephone or video appointment, no action will be taken against me that will cause a delay in my care and that I may still pursue face- to-face visits.
5. Telephone and video visits have its limitations. There is no guarantee this type of visit will not eliminate the need for me to see a provider in person.

\_\_\_\_\_ My electronic submission is acknowledgement of consent in lieu of in-person signature.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Name

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Parent/Guardian Date