SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM

Dayton Public Schools (DPS) 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).

Community Health Centers of Greater Dayton

Five Rivers Health Centers

DAYTON PUBLIC SCHOOLS

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.)

□	Care and treatment for injury/illness Physical examinations (well-child or sports) Influenza (flu) immunization		□	**Free** Dental screening and sealants for 2nd/6th grades (also includes a sealant check next school year and re-application if needed)
□	Meningococcal immunization (required for 7th & 12th grades)		□	Dental exam, dental filings
□	Tdap immunization (required for 7th grade)		□	Mental/behavioral health counseling
	Other immunizations (age-appropriate, following the American Academy of Pediatrics immunization schedule □ DTaP/Td □Polio □Hepatitis B □ MMR □ Varicella □ Hepatitis A □ HPV □ Pneumococcal conjugate □ Hib		□	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)
□	Pregnancy testing		□	Birth Control
□	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 Community Health Centers of Greater Dayton (CHCGD) and Five Rivers Health Centers (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 Dayton Public 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 DPS 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 www.dps.k12.oh.us

Authorization to Release Information: I hereby authorize CHCGD, FRHC, or DPS to exchange information with insurers, compensation carrier, healthcare facility, welfare agency, healthcare provider, the DPS 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 Dayton Public Schools unless revoked by me. I may revoke 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 Dayton Public 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 *Printed Name*	**Parent/Guardian** *Signature*	Date	
	X	**X**	**X**
OR If student/patient is 18 years or older	**Student/** *Signature*	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
□ Home Phone ( )		□ Alternate Phone ( )		□ 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. 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. You may get a bill for some services if not covered by insurance. (See the *School-Based Supplemental Health Services Information for Parents and Students* sheet).

Medicaid Managed Care Plans (check one below):

Managed Care ID# _____

☐ buckeye health plan

☐ CareSource

☐ PARAMOUNT ADVANTAGE | MEDICAID Affiliate of ProMedica

☐ MOLINA HEALTHCARE

☐ UnitedHealthcare

☐ 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 vape?	□ Yes □ No	Indoors? □ Yes □ No	Outdoors? □ Yes □ No

Date of child's last physical or well-child exam _____	□ My child has **not** had a physical or well-child exam in the last 12 months

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

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

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 balances of charges are not covered by insurance.

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

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: _____