Valley Professionals Community Health Center

Mobile School-Based Health Center (MSBHC)
CONSENT FOR TREATMENT

I give permission for _____
(please print) Student's Last Name First Name Middle Name

to receive health services from the MSBHC at my child's school. The school-based health center may not be able to take care of all the health needs my child may have. However, if he or she is not already under the regular care of a doctor or clinic, I will work with the MSBHC staff to choose one.

1. **I give consent for my child to receive MSBHC services**: I have read the information about the school-based health center and the release of information and understand what services the MSBHC will and will not provide. My consent will allow my child to receive health services (including behavioral and mental health counseling) while he/she is a student at this school. If I change my mind, I must write a letter to the MSBHC stating my intentions. It will also be my responsibility to notify the MSBHC staff about changes in the guardianship, address and phone numbers of my child.

2. **Information Privacy:** We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to your child's personal health information. The terms of the notice may change from time to time. The current notice will be posted at our facilities, on our website and copies will be available for you to take.

3. _____(Parents Initials) I acknowledge that I have received a copy of the MSBHC NOTICE OF PRIVACY PRACTICES

4. **Release of information:** I understand that services provided by the MSBHC are confidential. The MSBHC will use and disclose my child's personal health information to provide treatment, to receive payment for care (if applicable,) and for improvement of healthcare operations. My child's information may be shared with the school health office (with my child's doctor, my child's school nurse, school principal, school social worker or with my child's insurance provider), that may have my child as a patient. I also authorize the use of information from my child's medical record for the purposes of medical care, treatment, clinic administration and evaluation. In addition, I give my consent to the MSBHC to look at my child's school health record, including health history and vaccination records, in order to provide information that may assist the clinic staff in helping my child.

Signature of Parent/Guardian: _____ Date: _____

SERVICES WILL NOT BE PROVIDED WITHOUT PARENTAL CONSENT AS REQUIRED BY THE INDIANA STATE LAW

Valley Professionals Community Health Center

CONSENT TO PARTICIPATE IN TELEHEALTH
through Valley Professionals Community Health Center

Telehealth is the use of video conferencing to enable a licensed healthcare provider at a different location to provide health care treatment to your child without having to leave school. An explanation of services offered by telehealth is listed below. You do not have to be present for your child to be seen; however, this consent form must be signed by you in order for any services to be rendered.

DESCRIPTION OF SERVICES

Care for your child will be provided by a licensed healthcare provider. In our setting, this means that there will be two-way video conferencing between the healthcare provider and your child with the school nurse or assigned school official. Any exam that is requested by the healthcare provider will be accomplished by state-of-the-art technology, allowing high-resolution visualization of ears, throat, and skin as well as high fidelity sound of heart and lungs. This will allow almost any visit to the nurse's office to result in an accurate medical assessment without your child needing to leave school. When your child represents symptoms that are beyond the scope of care for a school nurse, your child will be seen virtually using diagnostic equipment via telehealth. An attempt to contact parents will be made prior to initiation of the primary care visit. Parents will also be given the option to transport children themselves and/or be present at all primary care visits that take place via telehealth.

Services that will be provided by telehealth for your child, include:

- Diagnoses and treatment for acute illnesses and minor injuries such as strep throat, ear infections, rash, and influenza
- Management and ongoing care of existing medical conditions such as asthma
- Behavioral health services and referrals

By signing this consent form, I give permission for the student noted below to participate in and receive services through telehealth.

_____

(please print) Student's Last Name First Name Middle Name

_____

Parent or Guardian's Signature Date

Valley Professionals Community Health Center

CONSENT TO PARTICIPATE in Behavioral Health Services through Valley Professionals Community Health Center

Matters discussed with the therapeutic relationship are confidential and protected by Indiana State law. The counselors maintain the highest possible ethical and legal standards regarding privacy and confidentiality. Your psychological records will be kept confidential in our electronic health record, which is not accessible by the medical staff. Only your therapist, his or her supervisor, and the medical director will have access to your records.

There are some instances, however, in which, by law, confidentiality must be broken. Such instances include, but are not limited to, threats of or suspected danger to yourself or others. If you become suicidal or homicidal, your family and/or a responsible designee will be contacted to attempt to ensure the safety of yourself or others. If safety cannot be ensured through contact with family or a responsible designee, law enforcement will be contacted to ensure safety. Your psychological services with Valley Professionals will likely be terminated, and referrals made to other treatment centers due to the level of care needed for homicidal and/or suicidal clients. Your therapist is also required by law to report instances of child abuse or neglect and instances of abuse or neglect of individuals who cannot care for themselves, such as elderly or disabled individuals.

If you desire information to be obtained, released, or exchanged with any other health care professional or individual, your written permission will be necessary. Appropriate release of information forms will be completed prior to the release of this information. You should discuss all requests for counseling information with your counselor before signing a release of information form.

By signing this consent form, I give permission for the student noted below to participate in and receive behavioral health services.

_____

(please print) Student's Last Name First Name Middle Name

_____

Signature of Parent/Guardian Date

Valley Professionals Community Health Center

Mobile School-Based Health Center (MSBHC)
Health History Form - Identifying Information

Student Name: _____ Sex: ☐ M ☐ F

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Valley Professionals is a Federally Qualified Health Center that receives government funding. The funding for the health center is based on the information you provide and is necessary for us to serve our patients. Please complete the following information for reporting purposes.

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Language: ☐English ☐Spanish ☐Other: _____ **Interpreter**: ☐Yes ☐No

Race: ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐Black or African American ☐White
☐American Indian or Alaska Native ☐More than one race ☐Choose not to disclose

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Choose not to disclose

Advanced Directive: ☐Yes ☐No *(If yes, select all that apply)*
☐Do Not Intubate ☐Health Care Representative Appointment ☐Living Will Declaration
☐Life Prolonging Procedures Declaration ☐Physician Ordered Scope of Treatment

Employment Status: ☐Full-time ☐Part-time ☐Unemployed ☐Self-employed ☐Student
☐Retired Employer: _____

Veteran: ☐Yes ☐No **Migrant Worker**: ☐Yes ☐No **Seasonal Worker**: ☐Yes ☐No

Homeless: ☐Yes ☐No *(If yes, select all that apply)*
☐Unknown ☐Street ☐Doubling Up ☐Transitional Housing ☐Homeless Shelter ☐Other

Number of People in Household _____ **Annual Income** _____

Contact information:

Does child live with: ☐Parent ☐Grandparent ☐Other relative ☐ Guardian ☐Other_____

Name _____

Home _____ Cell _____ Work _____

Name _____

Home _____ Cell _____ Work _____

Valley Professionals Community Health Center

Medical History:

Name of student's medical provider: _____

List any medications child is currently taking: _____

_____

List any allergies to food, medications, or insects: _____

_____

Pharmacy: _____
Name Location/Address

Our electronic medical record system allows us to collect and review your medication history. This list is collected from various sources, including your pharmacy, healthcare plan and other healthcare providers. Knowing your medication history allows our providers to treat you properly and avoid potential drug interactions. This information will become part of your medical record. You have the right to revoke this authorization, in writing, at any time by sending written notice to Valley Professionals.

List all medical conditions: _____

_____

Past surgeries: _____

Has your child had Chickenpox? ☐ Yes ☐ No

Any other medical information you feel necessary for us to know to treat your child:

_____

_____

Treatment of a Minor:

I give my permission for my child to be medically evaluated and treated at Valley Professionals in my absence. In addition, I give permission for the provider to share any relevant health information with the person accompanying my child. My child will be accompanied by:

☐ Himself or herself (only if 16 years or older)

☐ Relative/family member – Name _____ Relationship _____

☐ Other – Name _____ Relationship _____

Release of Information:

I hereby authorize Valley Professionals Community Health Center to release/discuss my child's protected health information with the following individuals:

Name: _____ Relationship: _____ Contact number: _____

Name: _____ Relationship: _____ Contact number: _____

I understand I have the right to revoke this authorization, in writing, at any time by sending written notice to Valley Professionals. If I revoke the authorization, this will not apply to any information that has already been released based on the authorization or to information that Valley Professionals has used based on the authorization. For questions on the use and disclosure of information, I can contact Valley Professionals.

Valley Professionals Community Health Center

Mobile School-Based Health Center
Health Insurance Information

Health Insurance: ☐ Yes ☐ No – see sliding fee scale information below

Please Note: Please fill out the following information in order for us to file your insurance. If we are not able to collect from your insurance, you will be responsible for any services that are rendered.

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder (Name on card): _____

Date of Birth: _____ Relationship to patient: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder (Name on card): _____

Date of Birth: _____ Relationship to patient: _____

Responsible Party (Person Responsible for bill)

Name: _____ Relationship to patient: _____

Address: _____ Apt #:_____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Home Phone: _____Cell: _____Work: _____

Insured's Employer: _____

Sliding Fee Scale

The sliding fee scale is available to assist those patients that have no insurance or are under insured by offering our services at a discounted rate. Patients are required to apply for the sliding fee scale on a yearly basis. In order to qualify for the sliding fee scale at VPCHC, patients and their families must have a combined income that falls within the U.S. Federal Poverty Guidelines. The determination of qualification is based on the number of members in the household and the following information:

- Most recent tax filing with the IRS and/or W2's from employer(s).
- A copy of Social Security or Disability Award letter(s) or unemployment statement(s).
- Pay stubs from all employers for the last 30-day period.
- If unemployed, no income and living with others, we require a signed and dated letter from the person providing support of the patient.
- Driver's license or state ID card.
- Any other income that is direct deposited.

Upon request, a sliding fee scale application will be provided and should be returned with the information above within 30 days of the mobile unit visit. Otherwise, patient will be responsible for the full amount of charges.