Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

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

Mobile School-Based Health Center

Health History Form - Identifying Information

Student Name: ____ Sex: ☐ M ☐ F (please check)

Address: ____ Apt #:_________

City: ______________________ State: _____ Zip: ____________ Date of Birth: ________________

School: _________________________________ Grade: _______ Teacher: ____________________

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

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

No. of People in Household: ________ *Annual income:* ______________________

Race: ☐ Multi-Race ☐ American Indian/Alaskan ☐ Black/African American

☐ Asian ☐ White/Caucasian ☐ Pacific Islander or Native-Hawaiian

Ethnicity: Hispanic/Latino ☐ Yes ☐ No *Migrant Worker:* ☐ Yes **X** No *Homeless:* ☐ Yes **X** No

Primary Language at Home: ☐ English ☐ Spanish *Do you need an Interpreter?* ☐ Yes ☐ No

Military Service: **X** Non-veteran ☐ Veteran ☐ Active

Contact information:

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

Name ____

Home __________________ Cell __________________ Work __________________

Name ____

Home __________________ Cell __________________ Work __________________

Medical History:

Name of student's medical provider: ____

List any medications child is currently taking: ____

____

List any allergies to food, medications or insects: _____________________________________

____

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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:

____

____

____

MSBHC Behavioral Health Services - Confidentiality and Consent

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 in 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 VPCHC 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.

Signature of Parent/Guardian: ________________________________ Date: ___________

Vermillion-Parke
Community Health Center
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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: __________________

SS#: __________________________________ 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.