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

Valley Professionals Community Health Center
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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

CONSENT TO PARTICIPATE in Behavioral Health Services

Valley Professionals Community Health Center
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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
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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

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 _____

Medical History:

Valley Professionals Community Health Center
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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.

Mobile School-Based Health Center

Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

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.

Valley Professionals Community Health Center

Patients' Bill of Rights and Responsibilities

Valley Professionals Community Health Center ("VPCHC") is committed to improving patient care by providing comprehensive and continuous medical care that is fair, responsive, and accountable to the needs of our patients and their families. We are committed to providing our patients and their families with a means to not only receive appropriate health care and related services, but also to address any concerns they may have regarding such services.

EVERY PATIENT HAS A RIGHT TO:

1. Receive comprehensive, quality care based on professional standards of practice delivered through a personal provider and care team, regardless of his or her (or his or her family's) ability to pay for such services.

2. Obtain services without discrimination on the basis of race, ethnicity, national origin, sex, age, religion, physical or mental disability, sexual orientation or preference, marital status, socio-economic status or diagnosis/condition.

3. Be treated with courtesy, consideration and respect by all VPCHC staff, at all times and under all circumstances, and in a manner that respects his or her dignity and privacy.

4. Participate in the development and implementation of his or her care plan.

5. Receive a complete, accurate and easily understood, explanation of any diagnosis, possible treatment with prognosis, and alternatives (including no treatment) along with associated risks/benefits.

6. Make decisions regarding his or her care based on information provided about his or her health status, including involvement in care planning, request for or refusal for treatment.

7. Receive information regarding the coordination of care with specialty groups, home health care or hospitals as well as the availability of support services that are community based and/or clinic based, including translation, transportation and education services.

8. Receive an itemized copy of the bill for his or her services, an explanation of charges, and description of the services that will be charged to his/her insurance.

9. Request any additional assistance necessary to understand and/or comply with the VPCHC's administrative procedures and rules.

10. File a grievance or complaint about the VPCHC or its staff without fear of discrimination or retaliation and have it resolved in a fair, efficient and timely manner. To file a complaint, write out your concerns and deliver them to:

    Terry J. Warren, CEO
    Valley Professionals Community Health Center, Inc.
    777 South Main Street, Suite 100
    Clinton, IN 47842

EVERY PATIENT IS RESPONSIBLE FOR :

1. Providing accurate personal, financial, insurance, and medical information (including all current treatments and medications) prior to receiving services from the VPCHC and its health care providers.

2. Following all administrative and operational rules and procedures of VPCHC.

3. Supervising his or her children while in the VPCHC facility(s).

4. Refraining from abusive, harmful, threatening, or rude conduct towards other patients and/or the VPCHC staff.

5. Not carrying any type of weapon or explosives into the VPCHC facility(s).

6. Keeping all scheduled appointments and arriving on time. Patients that arrive more than 15 minutes late for an appointment may be required to reschedule their appointment.

7. Notifying VPCHC no later than 24 hours (or as soon as possible within 24 hours) prior to the time of an appointment that he/she cannot keep the appointment as scheduled. Failure to follow this policy may result in being charged for the visit and/or being placed on a waiting list for the next visit.

8. Participating in and following the treatment plan devised in conjunction with his or her personal provider and working with the care team to achieve desired health outcomes.

9. Informing his or her personal provider and/or care team of any changes or reactions to medication and/or treatment.

10. Asking questions if he or she does not understand diagnosis, care plan or treatment and informing personal provider if unable to follow plan/treatment.

11. When a fee is charged, making a good faith effort to meet financial obligations, including promptly paying for services provided.

12. Advising VPCHC of any concerns, problems, or dissatisfaction with the services provided or the manner in which (or by whom) they are furnished.

13. Not bring pets into the facility.

NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: April 14, 2003
Revised Date of this Notice: November 15, 2024
Reviewed by the Board of Directors: November 20, 2024

Valley Professionals Community Health Center, Inc.

777 S Main St, Ste 100 Clinton, IN 47842	703 W Park St Cayuga, IN 47928	201 W Academy St Bloomingdale, IN 47832	1530 N 7th St, Ste 201 Terre Haute, IN 47807	8000 Education Dr, Rm E148A Terre Haute, IN 47802	
1702 Lafayette Rd Crawfordsville, IN 47933	727 N Lincoln Rd Rockville, IN 47872	4757 S 7th St Terre Haute, IN 47802	601 W National Ave W Terre Haute, IN 47885	1792 E. SR 163 Clinton, IN 47842	Mobile School Based Health Center

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Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Valley Professionals Community Health Center, Inc. (VPCHC) is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a revised copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice and on VPCHC's website.

You have the right to authorize other uses and disclosures - This means we will only use or disclose your PHI as described in this Notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes or substance use disorder counseling notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or VPCHC has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination designated by you (i.e., cell phone number, alternative address, etc.). You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. Since your health record is maintained in electronic format, you also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information* - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if VPCHC discovers a breach of

your unsecured PHI and determines through a risk assessment that notification is required.

How We May Use or Disclose Protected Health Information

The following are examples of uses and disclosures of your PHI that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose your PHI as needed to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office. We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - We may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine, based on our professional judgment, that it is in your best interest. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc.); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Prohibited Uses/Disclosures - Substance use disorder treatment records received from Part 2 programs, or testimony relaying the contents of such records, will not be used or disclosed in any criminal investigation, to initiate or substantiate criminal charges, or in civil, criminal, administrative or legislative proceedings against you without your authorization or a court order with accompanying subpoena or similar legal mandate compelling disclosure. PHI that is potentially related to reproductive health care is prohibited from being disclosed for purposes of investigating or imposing liability on any person for the mere act of seeking, obtaining, facilitating, or providing lawful reproductive health care.

Attestation - Any person requesting disclosure of PHI potentially related to reproductive health care for purposes of health oversight, law enforcement, judicial or administrative proceedings, or about decedents to coroners or medical examiners will be required to submit an attestation signifying that the PHI will not be used for prohibited purposes (see above section).

Privacy Complaints - You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

*You may ask questions about your privacy rights, file a complaint, or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by our office or by notifying our Privacy Officer, Tiffani Martin, at 765-828-1003 or 777 S. Main St., Suite 100, Clinton, IN 47872. You may contact the Office of Civil Rights at 233 N. Michigan Ave, Suite 240, Chicago, IL 60601 or by fax at 312-866-1807.

Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

*****By signing below, I confirm that the information provided is correct to the best of knowledge:**

_____

Parent/Guardian Signature Date

*****By my signature below, I acknowledge that I have received the Patient Bill of Rights and a Notice of Privacy Practice.**

_____

Parent/Guardian Signature Date