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

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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

Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

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
CARING PROFESSIONALS IN YOUR COMMUNITY.

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** _____

Gender Identity: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Additional Category ☐Choose Not to Disclose

Sexual Orientation: ☐Straight ☐Gay or Lesbian ☐Bisexual ☐Something Else ☐Don't Know ☐Choose Not to Disclose

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
CARING PROFESSIONALS IN YOUR COMMUNITY.

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
CARING PROFESSIONALS IN YOUR COMMUNITY.

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.

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 Warren, CEO
Valley Professionals Community Health Center, Inc.
777 South Main Street
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 bringing pets into the facility.

NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: April 14, 2003
Revised Date of this Notice: September 23, 2013

Valley Professionals Community Health Center

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	1810 Lafayette Rd Crawfordsville, IN 47933	727 N Lincoln Rd Rockville, IN 47872

Mobile School Based Health Center

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal, and we are committed to protecting your privacy. We create a record of the care and services you receive at this facility. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all records of your care generated by this facility whether in paper of electronic form.

How We May Use and Disclose Your Medical Information

The following categories describe different ways that we use and disclose medical information. Information may be disclosed in writing, orally or electronically. Not every use or disclosure in each category will be listed; however, all of the ways we are permitted to use and disclose information will fall within one of the categories.

1. For Treatment:

   We will use your medical information to provide you with quality treatment or services. Your information may be accessed by various people who are involved in your care (example: doctors, nurses, technicians, students, clerks, laboratory personnel, ect…). Different departments may share medical information about you in order to coordinate the different things you need. For example: a doctor will share your medical information with another physician if you are referred for specialized care. We may also share your medical information with a family member or friend who will assist with your care outside this facility.

2. For Payment:

   We will use and disclose your medical information so that we can bill for the services you received and collect payment. For example, we may share information with your insurance company to obtain prior approval for treatment when applicable, or to bill and receive reimbursement for treatment you received.

3. For Operations:

   We may use and disclose your medical information as necessary to run our facility and provide our patients with quality care. Examples of uses and disclosures include, but are not limited to, the following:

   - To send you appointment reminders;
   - To inform you about or recommend possible treatment options or alternatives that may be of interest to you;
   - To provide you with information about health-related benefits and services that may be of interest to you;
   - To review our services, evaluate our performance, and decide what additional services we should offer;
   - To volunteers who assist our patients;
   - For research purposes under certain circumstances;
   - To outside organizations called our Business Associates who perform a task on our behalf, such as an outside billing agency;
   - For fundraising efforts, but you have the right to opt out of such communications;
   - To doctors, nurses, students and other personnel for review and learning purposes.

4. As required by Law:

   - We may use and disclose our medical information as required in the following situations:
   - To prevent a serious threat to your health and safety or the health and safety of another person or the public;
   - To report public health activities or risks, such as infectious disease or abuse cases;
   - To report births or deaths;
   - For health oversight activities, which could include audits, investigations, inspections and licensure;
   - To a court or in response to an administrative order, subpoena, discovery request or other process if you are involved in a lawsuit or dispute;
   - To law enforcement officials in response to a criminal investigation, warrant, ect.;
   - To federal officials for intelligence and other national security activities authorized by law;
   - To coroners, medical examiners or funeral directors;
   - To worker compensation programs when applicable;
   - To organ donation or procurement programs when applicable;
   - To provide legally required notices of unauthorized access to or disclosure of your health information; and
   - To military command authorities, as applicable, if you are a member of the Armed Forces.

5. Your Written Authorization is Required for Other Uses and Disclosures:
   The following uses and disclosures of your medical information will be made only with your written authorization:
   - Uses and disclosures of psychotherapy notes;
   - Uses and disclosures of your medical information for marketing purposes; and
   - Disclosures that constitute a sale of your medical information.
6. Other Uses of Medical Information:
   Other uses and disclosures of medical information not covered by this Notice or law will be made only with your written permission. If you provide us permission to use or disclose your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we may have already made while we had your permission, and that we are required by law to retain our records of the care we provided to you.

Your Rights Regarding Your Medical Information

1. Right to Inspect and Copy:
   As a patient of ours, you have the opportunity to review your information or receive copies of your records. This includes medical and billing records, but does not include psychotherapy notes. If you request a copy of your records, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. To review or request a copy of your record, contact the medical records department at (765) 828-1003 for the Valley Professionals Community Health Center.
2. Right to Amend:
   If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, contact Terry J. Warren, CEO, at (765) 828-1003. They will give you the appropriate form to complete which must include the reason for your request. We will deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition, we may deny your request if it is deemed that our information is accurate and complete.
3. Right to Accounting of Disclosures:
   You have the right to request an accounting of disclosures, that is, a list of the persons to whom we sent some or all of your medical information. This accounting can begin no earlier than our HIPAA Privacy Standards compliance effective date of April 14, 2003, and can include a maximum of six-year period. Contact Terry J. Warren, CEO at (765) 828-1003 to begin this process. We will charge you for the cost of providing more than one accounting during a 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any charges are incurred.
4. Right to Get Notice of a Breach:
   You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
5. Right to Request Restrictions:
   You have the right to request a restriction or limitation of the medical information we use or disclose about you for treatment, payment or other health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in our care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about this visit. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, contact Terry J. Warren, CEO at (765) 828-1003. You will be given the appropriate form to complete your request which must include:
   - What information you want to limit;
   - Whether you want to limit our use, disclosure, or both; and
   - To whom you want the limits to apply, for example, disclosures to your spouse

   You have the right to restrict certain disclosures of PHI to your health plan when you agree to pay out-of- pocket in full for the healthcare item or services.
6. Right to Request Confidential Communications:
   You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. You may request confidential communication during your registration process. Any request made after you have been registered, should be made to Terry J. Warren, CEO at (765) 828-1003.
7. For More Information or to Report a Problem
   If you have questions or would like additional information about our privacy practices or this Notice, you may contact our Compliance Department during normal business hours at 765-828-1003. If you believe your privacy rights have been violated, you can file a complaint with the Compliance Department, at:

VPCHC	Office of Civil Rights
777 S. Main St., Suite 100	233 N Michigan Ave, Suite 240
Clinton, IN 47842	Chicago, IL 60601
Phone: 765-828-1003	Fax: 312-866-1807

You will not be penalized for filing a complaint.

Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

_____

Please Print: First Name M.I. Last Name

Acknowledgment of Receipt of Patient Bill of Rights

By my signature below, I acknowledge that I have received the Patient Bill of Right.

_____ _____

Signature Date

_____ _____

Relationship to patient (if not signed by patient) Staff initials

Acknowledgment of Receipt of Notice of Privacy Practice

By my signature below, I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signature Date

_____ _____

Relationship to patient (if not signed by patient) Staff initials

3.17.14