The Wellness Center
A partnership between JCPS and Shawnee Christian Healthcare Center

Consent for Health Services

Please read carefully: In order for us to see the student at The Wellness Center please complete this form. The student's parent or legal guardian must **sign and date** in ink in the appropriate places. Students should return the completed form to their teacher or family resource center. Consent for services is provided for the student named while they attend the school specified. Consent may be revoked at any time by notifying SCHC.

Student/Patient Information

Select the student's school: ❑The Academy at Shawnee ❑ Atkinson ❑ Byck ❑ Dawson Orman ❑ DuValle Education Center ❑ Hazelwood ❑ Maupin ❑ McFerran ❑ Wheatley ❑ Whitney Young

Last Name: _____ First Name: _____ Middle: _____ SSN#_____

Date of Birth: _____/_____/_____ Student phone/cell phone (if applicable):_____

Home/Mailing Address: _____Apt#_____ Zip: _____

Student's Sex at Birth: ❑ Male ❑ Female ❑ Other _____ (ex. Intersex birth)

Race: ❑ Black American/ African American ❑ White/Caucasian ❑ American Indian/Alaskan Native ❑ Asian ❑Native Hawaiian ❑ Other Pacific Islander ❑ Prefer not to answer

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Prefer not to answer **Primary Language:** _____

Please indicate below only if you do NOT want to receive the listed services.

❑ No, please do not provide medical care for my child.
❑ No, please do not provide a wellness visit/school screening for my child.
❑ No, please do not provide dental services for my child.
❑ No, please do not provide services through telehealth/virtual visit

Student Insurance Coverage Information

Please complete the following insurance information for the student. This information is **required** for the student's health record to be complete but will ONLY be billed if services are provided at The Wellness Center.

Medical Insurance Information: Insurance Company Name: _____ ❑ The student does not have medical insurance

Member ID): _____ Policy Number:_____

Dental Insurance Information: Dental Insurance Company Name: _____ ❑ The student does not have dental insurance

Member ID: _____ Policy Number:_____

Policy Holder Information (if dependent is on parent insurance):

Name of Primary Insured (policy holder): Last Name: _____First Name: _____ Date of Birth_____/_____/_____

Social Security Number _____ Relationship to the student ❑Mother ❑ Father ❑ Legal Guardian ❑ Other _____

Home/Mailing Address (if different then student's): _____Apt#_____ City: _____ Zip: _____

Financial Assistance: You may be eligible for our sliding fee scale to receive discounts based on family size and income. The information you provide is confidential. SCHC serves all patients regardless of their ability to pay. You can see more on shawneechristianhealthcare.org

What is your family size? _____ **What is your annual income?** _____

Parent/Guardian Information

Last Name: _____First Name: _____Date of Birth: ___/_____/_____

Relationship to the student: ❑ Mother ❑ Father ❑ Legal Guardian ❑ Other _____

Contact: Home Phone: _____ Cell: _____ Preferred contact number: ❑ Home ❑ Cell

Do you allow SCHC to leave a voicemail if necessary? ❑ Yes ❑ No Do you allow text reminders? ❑ Yes ❑ No

Email address: _____

Housing Situation? ❑Not Homeless/ Permanent Housing ❑ Doubling up (staying with someone temporarily) ❑ Shelter ❑ Street ❑ Transitional Housing (temporary location) ❑ Other _____

If in permanent housing, is your housing ❑ Public Housing ❑Tenant Based Voucher (Section 8) ❑ Neither

Dvl LNelson 7/6/21, rev 9/8/21, rev 9/20/21, rev 1/26/22

Are you a Migrant Worker: ❑ No, I am not a Farm worker ❑ Yes, I am a Migrant worker ❑ Yes, I am a Seasonal Migrant worker

Emergency Contact

Name of Mother/ Legal Guardian_____

Home: _____ Cell: _____ Work: _____

Name of Father/ Legal Guardian: _____

Home: _____ Cell: _____ Work: _____

If Immediate Family is Not Available, Please Contact: Name and Relationship to Student: _____

Home: _____ Cell: _____ Work: _____

Consents for Treatment

Consent to Treat

I am requesting that health care services be provided to me (or the patient named above) at Shawnee Christian Healthcare Center (SCHC). I hereby give my permission to for the evaluation and treatment of the presented medical, dental, and/or behavioral health condition(s) ("health care services"). I voluntarily consent to all treatment and health care services that the caregivers at SCHC consider to be necessary for me (or the patient named above). These services may include diagnostic, therapeutic, imaging, need immunizations and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell my clinical team. Services may be performed in person or through virtual visit (telehealth). The main difference between telehealth and in-person care is the provider's inability to have direct, physical contact with the patient. Also, the quality of telehealth transmission might affect the quality of healthcare services. The patient may stop using telehealth at any time without jeopardizing access to future care, services or benefits. I understand that I can access additional information on Shawnee Christian Healthcare Center's website.

No guarantees have been made to me about the results of treatments, examinations, or services. I understand that SCHC provides integrated care services and that my care team will work together and communicate to address my needs. By signing, I agree and consent for a representative of Avesis Health Care to perform a sealant retention check on any dental sealant placed. This check may be completed at any time within 365 days of the date of consent. I consent for SCHC staff to access data on attendance and review/document on the Kentucky Immunization Registry and Infinite Campus for information to that will assist in providing care to the patient/myself. I consent for SCHC staff, Board of Education staff, school representatives and my primary care provider to communicate about my care on an as needed basis with the understanding that all information will be treated in a confidential manner.

Financial Responsibility and Assignment of Benefit

Subject to applicable law and the terms and conditions of any applicable contract between SCHC and a third-party payer and in consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I agree to be financially responsible and obligated to pay SCHC for any balance not paid by a third party. I assign to SCHC all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding SCHC's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by SCHC to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or another third-party payer. I understand that my current insurance must be on file with SCHC for my insurance to be billed and as such I will be expected to present my insurance card at each visit to verify my insurance coverage. If I do not provide SCHC with insurance information, I will be considered a self-pay patient and obligated to pay all fees associated with services rendered.

Notice of Privacy Practice and Patient Rights and Responsibilities

I acknowledge that I have read and agree with the Patient Rights and Responsibilities and the Notice of Privacy Practices. I consent to let SCHC use and disclose health information about me (or the above-named patient) as described in the Notice of Privacy Practices. In doing so, I consent to the release of my (or the above-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by SCHC, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent SCHC or provide assistance to SCHC for the purposes of securing payment from all parties who are potentially liable for payment for my (or the above-named patient's) health care, including for chemical dependency/substance abuse, mental health, and/or HIV/AIDS and STD, if applicable. I further consent to the disclosure of my protected health information in order for another provider or healthcare entity to conduct healthcare operations including quality assessment, evaluation and reviewing the competence of healthcare professionals.

Communication

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to SCHC or updated at a later time, text messages and/or telephone calls or other communications using live, prerecorded voices or any other computer-aided technologies from SCHC and its affiliates, clinical providers, and business associates, along with any billing services, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from SCHC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

I further attest that, as of the date of my signature, the income sources listed constitute all of my household income, and that the family members listed are all solely dependent on that income, or that the explanation provided to verify my income level is truthful. All information on this form is truthful to the best of my knowledge and if there are changes to my income, insurance status, or other information, I will inform Shawnee Christian Healthcare Center.

Signature of Parent/Guardian Print Name Date

Relationship to Student ❑Mother ❑ Father ❑ Foster Parent ❑Legal Guardian ❑Other _____

ONLY if parent/legal guardian signs with (X) or authorized person gives verbal consent, two signatures with names, addresses, and telephone numbers must be entered below.

1.Witness Last Name: _____ First Name: _____
Contact Number: _____ Address: _____
Witness Signature x _____Date: _____/_____/____

2. Witness Last Name: _____ First Name: _____
Contact Number: _____ Address: _____
Witness Signature x _____Date: _____/_____/____

Student Name: Student DOB:

Student's Medical History

The following information will aid The Wellness Center staff in making an accurate assessment of the student in case of illness or emergency. Please check the appropriate box if the student has ever had any of the following:

❑ Measles/Mumps	❑ Scarlet Fever	❑ Chest Pain	❑ Anaphylactic Episodes
❑ Diabetes	❑ Chicken Pox	❑ Anemia	❑ Unexplained Weight Gain or Loss
❑ Drug/Alcohol Use	❑ Asthma	❑ Birth Defects	❑ Unexplained Tiredness
❑ ADD/ADHD	❑ Exposed to Tuberculosis	❑Persistent Cough	❑ Sleep Problems
❑ Seizures	❑ Blood Transfusion	❑ Shortness of Breath	❑ Stomach or Bowel Disorders
❑ Joint/Muscle Pain or Stiffness	❑ Rheumatic Fever	❑ Head, Eyes, Ears, Throat Disorders	

If you answered yes to any of the above, please explain:

_____

_____

Does the student have any **allergies** to FOOD, MEDICATIONS, OR ENVIRONMENTAL POLLENS?

❑ YES	❑ NO

IF YES, PLEASE LIST: _____

Is the patient/student (if applicable): ❑ Pregnant ❑ Using Oral Contraceptives

Please list any Medications the student takes on a regular basis with dosage:

Medication	Dose	Frequency	Reason

****You will be asked to complete a separate form for JCPS Medication Consent if you desire the school nurse to administer this medication at school.**

Student's Pharmacy: _____ Address: _____

Check any Over the Counter medications below you DO NOT want the student to receive:

❑ Tylenol (Acetaminophen)	❑ Topical Antiseptic (Benzalkonium Chloride)
❑ Advil (Ibuprofen)	❑ Neosporin (Tiple Antibiotic Ointment)
❑ Orajel (Topical mouth, tooth pain reliever)	❑ Hydrocortisone 1% Cream
❑ Blistex, Chapstick (Lip Ointment)	❑ Eye Wash, Irrigating Solution
❑ Lotion	❑ Saline for Wound Cleaning
❑ Cough Drops	❑ Tums for Indigestion
❑ Sore Throat Spray	❑ Imodium for Diarrhea
❑ Benadryl (Diphenhydramine)	

Student's Primary Care Provider: _____Phone:_____

Address: _____Date of Last Medical Exam: _____

Has the student had:

	Reason:	Date:	Location:
❑ Operations/Surgeries			
❑ Hospitalizations			
❑ Serious Injuries or Illnesses			

Family Medical History:

Please check the appropriate space if any of the student's blood relatives (mother, father, brother, sister, grandmother, grandfather) has any of the following conditions.

❑ HIV/AIDS	❑ Alcohol/Substances	❑ Alzheimer's	❑ Arthritis
❑ Asthma	❑ Birth Defects	❑ Bleeding Disorders	❑ Cancer
❑ COPD/Emphysema/ Bronchitis	❑ Diabetes	❑ Epilepsy/Seizures	❑ Mental Illness (anxiety, depression)
❑ High Blood Pressure	❑ High Cholesterol	❑ Kidney Disease	❑ Liver Disease/ Hepatitis
❑ Heart Attack/ Stroke	❑ Osteoporosis	❑ Sickle Cell	❑ Thyroid Disorder
❑ Tuberculosis/ TB	❑ Dental Cavities	❑Other_____	

Immunization/Vaccine Status: Is the student up to date on immunizations? ❑ YES ❑ NO

OTHER:		
Do you have concerns about the student's health?	❑ YES	❑ NO
Is the student exposed to secondhand smoke?	❑ YES	❑ NO
Does the student smoke and/or use tobacco products	❑ YES	❑ NO
Does the student drink alcohol?	❑ YES	❑ NO
Has the student been exposed to lead in the home?	❑ YES	❑ NO

Student's Dental History

Please mark the box if the following conditions apply:

❑ Bleeding Gums	❑ Sensitive Teeth to Hot/Cold	❑ Sensitive Teeth to Sweet/Sour
❑ Pain in any tooth	❑ Jaw or Ear pain	❑ Sores or Lumps in Mouth
❑ Difficulty Opening or Closing Mouth	❑ Head, Neck, or Jaw Injury (Past or Present)	❑ Frequent Headaches
❑ Clicking Jaw	❑ Prolonged Bleeding	❑ Clenching or Grinding of teeth
❑ Difficulty Chewing	❑ Biting Lips or Cheeks Habit	

The student consumes sugary foods or drinks (juice, soft drinks, energy/sports drinks (select all that apply):

❑ primarily at mealtimes	❑ frequently between meals	❑ before bedtime

Student's Dentist: _____Address:_____

Last Dental Visit: _____

Notice of Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all medical and dental records and other individually identifiable information used or disclosed by us in any form are kept properly confidential and secure. HIPAA gives you rights to control how your health information is used and holds us accountable for how your Protected Health Information (PHI) is used. PHI is information about you including demographic information that may identify you and that relates to your past, present or future physical or mental health and related health care services. SCHC is required to abide by this notice and required by law to maintain the privacy of protected health information, provide you with notice of our legal duties with respect to privacy practices, and notify any affected individuals following a breach of unsecured protected health information.

How we use or may disclose your health information:

- **To treat you**
  - We can use your health information and share it with other professionals who are treating you. o Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- **To run our organization**
  - We can use and share your health information to run our practice, improve your care and contact you.
  - Examples:
    - We may use information in quality assessment and employee review to make sure you are receiving the best quality care.
    - We may use a sign-in sheet at the front desk and may call you by name when your doctor is ready to see you.
    - We may call your home and leave a message to remind you of an upcoming appointment, to schedule a new appointment or to call our office.
    - We may send post cards or letters.
    - We may share information with business associates that perform functions on our behalf or provide us with services.
- **To bill for services**
  - We can use and share your health information to bill and get payment from your insurance or other entities.
  - Example: We give information about you to your insurance plan so it will pay for your services.
- **For research purposes**
- **To coordinate your care with social service agencies and supportive services**
- **As required by law**
  - As required by law we may disclose public health issues, communicable diseases, abuse or neglect, helping with product recalls, preventing threat to health or safety.
  - We may disclose information related to legal proceedings, law enforcement and legal issues, coroners, funeral directors, organ donation, military activity or national security, workers compensation.
  - As required by the Secretary of Health and Human Services we may disclose information related to investigating or ensuring compliance with HIPAA.
- Other permitted and required uses and disclosures will be made only with your written authorization unless required by law. You can revoke this authorization at any time, in writing.

You have the right to:

- Get an electronic or paper copy of your medical record
  - This does not include therapy notes or information compiled in reasonable anticipation of or use in a criminal, civil, or administrative action or proceeding.
- Ask us to correct your medical record
  - If we deny your request, you have the right to file a statement of disagreement with us and we may prepare and provide you with a rebuttal to your statement.
- Request confidential communications, by asking us to contact you in a specific way
- Ask us to limit what we shar
  - This request may be denied if it will affect your care.
  - If you pay for a service in full, you can ask us not to share that information with your health insurer, family members or friends who may be involved in your care.
- Receive a record of certain disclosures we have made of your protected health information
- Get a copy of this notice privacy

We reserve the right to change the terms of this notice and will inform you of any changes in your patient packet and in the clinic lobby. You then have the right to object or withdraw as provided in this notice.

Complaints

If you have a complaint, believe your privacy rights have been violated, or have any question, you may contact the Shawnee Christian Healthcare Center Compliance Manager or the Secretary of Human Services. You may file a complaint by notifying the Compliance Manager at our office or through main telephone number.
The compliance manager is:

Stan Wardlaw Compliance and Risk Management Coordinator
Shawnee Christian Healthcare Center
234 Amy Ave, Louisville, KY 40212
Phone (502)-778-0001

This policy is effective as of June 26, 2018
Revised March 3, 2020, Approved April 6, 2020

Know Your Patient Rights

Civil Rights

1. Patients have the right to considerate and respectful treatment in an environment free of harm.
2. Patients seeking services shall not be denied, suspended, or terminated from services or have services reduced for exercising any of their rights.

Discrimination

1. Patients have the right to receive services regardless of age, sex, race, creed, color, religion, national origin, ancestry, marital or parental status, physical or mental disability, sexual orientation, gender identity or expression, veteran status, political affiliation or beliefs, or criminal record.
2. Patients may receive services without regard to one's ability to pay; if you are unable to pay the full fee for services, a sliding fee scale is available to you. You may examine and receive an explanation of your bill of services.
3. No recipient of services is presumed legally incompetent except as determined by a court.
4. Patients have the right to present any complaint or grievance on matters pertaining to services received, or any perceived or actual violation of rights.

Treatment

1. A recipient of services shall be provided with adequate and humane care and in the least restrictive environment, pursuant to an individualized service plan. When appropriate, a recipient's nearest kin or guardian shall be involved in the treatment/service plan.
2. Patients have the right to know of the variety of services that may be available and to participate in the planning of treatment.
3. Patients may refuse treatment at any time, and patients have the right to be informed of the consequences resulting from the refusal of treatment.
4. Seclusion will not be used as a means of intervention for any recipient services.

Confidentiality

1. Patients will receive confidential treatment; all clinical records and client information are protected by law, regulations and center policies. For the purposes of funding, certifications, licensure, audit, research or other legitimate purpose, your clinical record may be used by the person conducting the review to the extent that is necessary to accomplish the purpose of the review.
2. Patient information released to or requested from other sources requires your written consent. Patient records can be subpoenaed by court order and does not require your signature for release of information.
3. Patients have the right to review and obtain a copy of your clinical record in accordance with Shawnee Christian Healthcare Center's policy.