PRIVACY PRACTICE/CONSENT FORM

(Consent to treatment and authorization to release information and assignment of benefits)

The Union County Board of Education has joined in partnership with Union General Hospital, Inc. and other primary care providers to develop a comprehensive school-based collaborative healthcare center. Medical services will be provided via telemedicine and includes diagnosis and treatment of acute illnesses and minor injuries, management of chronic illnesses, management/maintenance of monthly medications, health education/promotion, and referrals to medical subspecialists and community agencies. The primary focus of the center is to provide quality, accessible health care to the children of Union County, in order to have a positive impact on the children's health, school attendance, and academic performance.

In order for your child to receive services at the health center, this consent form must be completed and proper documentation of insurance obtained.

I hereby voluntarily give my consent for ____ to receive health services at
(Insert child's name)
Union General Hospital SBHC. I further authorize any physician or designated healthcare provider (nurse practitioners, physician assistants, college student interns, etc) working for the clinic to provide such medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of my child's health. Furthermore, I agree to actively participate in the primary health care of my child by accompanying him/her to center appointments as often as possible and attending educational programs developed for parents/guardians.

________ I authorize release of information from my son or daughter's medical record of the family doctor or primary care provider designated by me whenever necessary for his or her care including referrals and/or emergency services.

________ I give consent to the Union General Hospital SBHC to examine my son or daughter's full school record, including attendance and other information that may assist the staff in helping my son or daughter.

________ I authorize Union General Hospital SBHC to release information regarding treatment to third party payers such as Medicaid or other insurers for the purposes of billing or for any other reason in accordance with acceptable medical practice pursuant to the law.

If patient is seen at Blue Mountain Family Practice, charges for services rendered to students not insured and as HMO insured patients choosing to use our services out of network will be based on a sliding fee scale. No students will be denied services because of inability to pay at Blue Mountain Family Practice.

______ I understand the Union General Hospital SBHC is permitted to disclose protected health information about my child for the purposes of payment, continued care or treatment, and healthcare operations.

______ If my child's protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS), drug or alcohol abuse and/or mental illness, I hereby give consent to the disclosure of this information by these clinics only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I also understand that I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

_____ I understand that my signing this consent allows the physician and professionals at Union General Hospital SBHC staff to provide comprehensive health services. I also understand that I have the right to withdraw this consent at any time upon written notice to the school and / or clinic staff.

I have read and understand the above information and give permission for my child's care as described. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the school nurse.

____________________________________	____________________________________
Name of Parent or Legal Guardian	Name of Student
____________________________________	____________________________________
Signature of Parent/Legal Guardian	Relationship to Student

Date:________________________________

Authorization to Bill Insurance

Patient's Name: ____

Patient's Birth Date: ___-___-_____ Patient's Social Security # ______-______-________

Primary Insurance Company: ____
Name of person insured if patient is a dependent: _____________________________________
Insured's birth date ___-___-_____ Insured's Social Security # _____-_____-_______
Group # ____
Policy or Member # ____

Secondary Insurance Company: ____
Group # ____
Policy or Member # ____

Responsible Party:
Name: ____ Date of Birth: __________________
Social Security # : ________-_________-__________ Employer: ___________________________

Authorization
The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

1. Grant permission to all physicians, therapist, laboratories, and any other professionals to perform and administer care and treatment of the patient, or designated other qualified health care provider for such services.
2. Grant permission to release to the third party payor (or payers), Medicare, Medicaid, their representatives and/or other physician(s) involved in the patient's care, any information in connection with any care rendered to patient.
3. Grant permission to bill third party payor or (payers) with benefits paid directly to the appropriate provider when assignment is accepted.

Letter of Responsibility:
I understand that I am responsible for any unpaid bills not covered by Medicaid, Medicare, and any other private insurance companies. The physicians will not accept any retroactive Medicaid cards on paid accounts. Thus, I will not be entitled to any refunds of Medicaid payments.

______________________________ ______________________
(Signature of parent/guardian) (Date)

____
(Student's Name)

We appreciate you for placing your confidence in us by choosing our staff for your medical needs. Our physicians and staff are dedicated to serving you.

STUDENT INFORMATION PACKET

Date_______________ Grade___________Homeroom__________________________ School year _________

Patient Information

Name ___________________________________ Social Security Number______________________________

Sex: M / F Race____________ Date of Birth_________________ Age______________

Street Address____

City____________________ State _____ Zip Code__________ County ______________________________

Student Resides With ____

Mother's/Guardian's Information

Name ____

Street Address____

City ________________________ State_________ Zip Code_____________ County_____________________

Employer______________________________ Work Number/Extension___________________________

Home Phone_______________________ Cell Phone____________________ Other______________________

Father's /Guardian's Information

Name ____

Street Address ____

City________________________ State_________ Zip Code_____________ County_____________________

Employer _____________________________ Work Number/Extension___________________________

Home Phone_______________________ Cell Phone____________________ Other______________________

Person to Notify in Case of Emergency (other than parent/guardian)

Name _______________________________Relationship to patient___________________________________

Street Address ____

City________________________ State_________ Zip Code_____________ County_____________________

Home Phone__________________ Cell Phone________________________ Other______________________

In order for your child to receive services at Union General Hospital SBHC, this consent form must be completed and proper documentation of insurance obtained.

I hereby voluntarily give my consent for my child listed above to receive telehealth services through Union General Hospital SBHC. I authorize any physician or designated health/mental health professional working with Union General Hospital SBHC to provide care. I understand that additional consent will be obtained prior to each appointment.

I prefer for my child to be seen by the following healthcare provider affiliated with Union General Hospital SBHC if possible:

❑ Blue Mtn Family Practice *(Accepting new patients)* ❑ Dr. Breedlove *(Must be a patient of this practice)*

❑ Dr. Thompson ❑Dr. Nunn *(Must be a patient of these practices)*

❑ Dr. M. Wiles *(Age 18 and over only)* ❑ Dr. E. Wiles *(Age 18 and over only)*

**If a visit with the preferred healthcare provider cannot be accommodated, the visit will be defaulted to Blue Mountain Family Practice. If the patient is seen by Blue Mountain Family Practice, and this is not their primary care provider, then a summary of the visit will be forwarded to the patient's primary care provider listed.*

Parent/Guardian Signature____ Date______________