School-Based Health Center
Student Parental/ Court -Appointed Guardian Notice

HIGHLIGHTED AREAS MUST BE COMPLETED

Please read carefully and complete the following statement acknowledging that your son/daughter/ward may receive services at Family Health Services School-Based Clinic.

Please include a copy of the parent/court-appointed guardian identification (License), as well as a copy of the insurance card. Copies can be made at the school or send picture of license & insurance cards to clinicinfo@familyhs.org.

Student's Name:	**Birth Date:**
Address:	**Student's Social Security #:**
City: **Zip Code:**	**Student's Gender:** ☐ **Male** ☐ **Female** ☐ **Other:** _____

I acknowledge that my son/daughter/ward named above may receive the following services at the FHS School-Based Clinic:

- Comprehensive Health Inquiry
- Physical Examinations (general, sports, pre-employment)
- Diagnosis and treatment for minor illnesses and injuries
- Screening for select health problems (vision screening, hypertension, etc.)
- Care of certain chronic conditions such as asthma and seizure disorders
- Immunizations as needed (tetanus, rubella, etc.)
- Virtual/Telehealth visits
- Individual health and wellness education services
- Routine Lab Tests
- Prescription Medications
- Care for common pediatric/adolescent physical
- concerns (weight, acne, menstrual problems)
- Pregnancy Testing
- Diagnosis and treatment of sexually transmitted diseases
- Mental Health Assessments measles/mumps,
- Follow-up care as needed
- Transportation to school-based clinic at 3851 US Route 20 East, 3841 US Route 20 East, or other building if appt is pre-scheduled

Financial Responsibility: If you have insurance, FHS will bill your insurance company. Any co-pays **will** be billed. If you are uninsured, our FHS Outreach & Enrollment Coordinator will be contacting you to explore possible assistance options.

After Visit Summary: If your child/ward receives services in the FHS School-Based Clinic, you/your child will receive an After-Visit Summary in a sealed envelope, if requested.

Prescriptions: All prescriptions will be electronically prescribed and sent to your preferred pharmacy identified in the School -Based Health Center History Form. Controlled prescriptions will need to be picked up directly from one of FHS main locations located at 1912 Hayes Ave. in Sandusky or 265 Benedict Ave. in Norwalk.

I certify that I have read this notice and understand its content.

Signature of Parent/Court-Appointed Guardian: _____ **Date Signed:** _____

Relationship to Student: _____

TURN OVER

School-Based Health Center
Demographics and Insurance Information

HIGHLIGHTED AREAS MUST BE COMPLETED

Student/Patient Data

PLEASE PRINT LEGIBLY

School District:	**Western Reserve Local Schools**
School:	☐ **High School** ☐ **Middle School** ☐ **Elementary School**
Grade:	**Pre-K K** 1 **2** 3 **4 5 6** 7 **8** 9 **10 11 12**

First Name:	
Middle Name:	
Last Name:	
Language:	

Sex:	☐ **Male** ☐ **Female** ☐ **Other**
Race:	
Date of Birth:	/ / Month Date Year
Ethnicity:	☐ **Hispanic/Latino** ☐ **Not Hispanic/Latino**

Parent / Court -Appointed Guardian(s) Information

First Name:	
Last Name:	
Phone Number:	
Guarantor for Medical Payment?	**Date of Birth:**
Social Security No.:	
Employer:	
Employer Address:	
Email Address:	

First Name:	
Last Name:	
Phone Number:	
Guarantor for Medical Payment?	Date of Birth:
Social Security No.:	
Employer:	
Employer Address:	
Email Address:	

Insurance Information – Financial Responsibility: If you have insurance, FHS will bill your insurance company. Any co-pays will be billed. If you are uninsured/underinsured, FHS' Outreach & Enrollment Coordinator will contact you to explore possible payment options.

Do not have Insurance:	☐ **Yes** ☐ **No** If yes, complete boxes below
Subscriber Name:	
Plan Name:	
Address:	
Group Number:	
Subscriber ID:	

Primary Care Physician/Provider (PCP Data):

☐ DO NOT have a PCP	
PCP Name:	
PCP Address:	
PCP Phone Number	

ESTIMATED HOUSEHOLD ANNUAL INCOME:

☐ $0-$25,000 ☐ $25,000-$50,000 ☐ $50,000-$100,000
☐ $100,000-$150,000 ☐ $150,000+

TURN OVER

Family Health Services

School-Based Health Clinic History Form

STUDENT NAME:_____ **DATE OF BIRTH**: _____

PARENT/LEGAL GUARDIAN SIGNATURE:_____ **DATE**: _____
(Student 18 years old and older does not need parent/guardian signature)

(Please check ✓ all that apply)

ALLERGIES

☐ Food ☐ Seasonal
☐ Medications ☐ Animals
☐ Insects
☐ Reaction:_____

PAST MEDICAL HISTORY

☐ Allergies ☐ Heart Disease
☐ Asthma ☐ Neurological
☐ Ear Infections ☐ Behavioral
☐ Gastrointestinal ☐ Developmental
☐ Other (Please list): _____

CURRENT MEDICATIONS

Name of Medication	Dose	Amount Taken	Frequency Taken

PREFERRED RETAIL PHARMACY

Name	Address	Phone Number

(Please check ✓ all that apply)

FAMILY HISTORY	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other Please list
Alcohol/Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐	_____
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	_____
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	_____
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	_____
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	_____
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	_____
Cancer-Type?	☐	☐	☐	☐	☐	☐	☐	☐	_____
Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	_____
COPD	☐	☐	☐	☐	☐	☐	☐	☐	_____
Depression	☐	☐	☐	☐	☐	☐	☐	☐	_____
Developmental Problems	☐	☐	☐	☐	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	_____
Emphysema	☐	☐	☐	☐	☐	☐	☐	☐	_____
Gastrointestinal	☐	☐	☐	☐	☐	☐	☐	☐	_____
Heart	☐	☐	☐	☐	☐	☐	☐	☐	_____
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	_____
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	_____
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐	☐	_____
Psychiatric	☐	☐	☐	☐	☐	☐	☐	☐	_____
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	_____
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	_____
Thyroid	☐	☐	☐	☐	☐	☐	☐	☐	_____

TURN OVER

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Family Health Services
1912 Hayes Avenue
Sandusky, OH 44870

Phone: 419-502-2800
Fax: 419-502-2820

Patient:_____ Last 4 Digits of Patient's SSN: _____

School:_____ Date of Birth:_____/_____/_____

Telephone:_____ Current Address: _____

City:_____ State:_____ Zip: _____

For the purposes of this form, "my", and "I" mean the patient listed above whose record is maintained by Family Health Services.

I hereby authorize Family Health Services to release any and all health information that is contained in my patient records to the Western Reserve School District for treatment and as otherwise needed for my safety and education at the sole discretion of Family Health Services. **I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and/or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**

Once my health care information is released, the information may be re-disclosed by the recipient and may no longer be protected by law. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I agree to this authorization. I understand that the recipient of my health information may be charged for the service of releasing medical information.

This authorization form will automatically expire when Family Health Services is no longer providing school-based health care services to the students of the Western Reserve School District, when I am no longer a student of Western Reserve School District, or when I revoke this authorization, whichever occurs first. I may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, through written notice sent to: Administrator, Family Health Services, 1912 Hayes Avenue, Sandusky, Ohio 44870.

_____ _____/_____/_____

Signature of Patient/Patient's Personal Representative** Date Signed

_____ _____

Printed Name Relationship, if not Patient

*Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **must accompany the request (i.e., court-appointed guardian of the person, durable power of attorney for health care). Exception: Parent signing for a patient under the age of eighteen.

TURN OVER

Patient Acknowledgement and Consent Form

Patient Name:_____ **Date of Birth:** _____

On behalf of myself or my minor child or other patient named above, I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on Family Health Services.

Consent to Health Care Services: I am requesting that health care services be provided to me (or my minor child or the patient named above) at Family Health Services. I voluntarily consent to all medical treatment and health care-related services that the caregivers at Family Health Services consider to be necessary for me (or the patient named above). These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell my Family Health Services caregiver. My blood may be used to perform routine quality assurance testing. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments and examinations.

Financial Responsibility:

1. A. Subject to applicable law and the terms and conditions of any applicable contract between Family Health Services 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 Family Health Services for any balance not paid under the "Assignment of Benefits/Third Party Payers" paragraph below.
   OR, B. Subject to applicable law and the Family Health Services Sliding Scale Fee Policy, 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 Family Health Services for the patient balances due;

AND,

2. I authorize all clinical providers who have provided care to me, along with any billing services, collection agencies or other agents who may work on their behalf, to contact me on my cell and/or other phone using automatic telephone dialing system or other computer assisted technology.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I hereby assign to Family Health Services 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 Family Health Services' 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 Family Health Services 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 other third-party payers.

Patient Rights and Responsibilities: I have received a copy of the Family Health Services Patient Rights and Responsibilities handout.

Uses and Disclosure of Health Information: I have received Family Health Services' Notice of Privacy Practices. The Federal Privacy Standards explains how Family Health Services may use and disclose confidential health information that identifies me (or the above-named patient). I consent to let Family Health Services use and disclose health information about me (or the above-named patient) as described in the Federal Privacy Standards. 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 Family Health Services, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent Family Health Services or provide assistance to Family Health Services 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 substance abuse, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that Family Health Services has already relied on my consent.

Communication:

1. Family Health Services participates in one or more Health Information Exchanges. The Health Information Exchanges are electronic networks used to securely provide assess to your health records. I voluntarily consent to allow assess to my health information through the Health Information Exchanges. I can opt-out of this consent at any time in writing by notifying the Health Information Management Services/Medical Records Department.
2. I authorize Family Health Services to leave a message on my answering machine or voicemail regarding scheduled appointments, premedication and instruction appointments.
3. I authorize the following person(s) to obtain medical information about myself (or the above-named patient). Family Health Services is not responsible for the information provided if it is given to the below listed person(s).

    Name of Person Allowed Health Information: _____

    Date of Birth: _____

    Name of Person Allowed Health Information: _____

    Date of Birth: _____

_____ _____

Signature of Patient or Responsible Party **Date**

_____ _____

Printed Name of Patient or Responsible Party **Responsible Party's Relationship to Patient**