Center Street Community Health Center
School Based Health Center—Consent and Acknowledgement

Do you give consent for your child to participate in Center Street Community Health Center's school-based services?

☐ YES, I will consent for the following services: Please mark which services below.

☐ NO, I do not wish for my child to receive any services.

Patient's First Name:	Patient's Last Name:	Patient's DOB:

Consent to Medical Treatment

☐ I authorize examination, diagnosis, and general treatment (including but not limited to, the use of non-invasive procedures such as diagnostic tests and lab tests), appropriate immunizations to be performed by the clinicians and staff of Center Street Community Health Center (CSCHC). I authorize the medical personnel to take cultures and use precautions deemed necessary for infectious cases. Any necessary prescriptions will be sent to our CSCHC pharmacy which provides delivery unless the parent requests a different pharmacy.
I understand and agree that CSCHC may provide certain services to me by remote means called "telehealth". I authorize the CSCHC to photograph, audiotape, or videotape as necessary for medical documentation or medical treatment. I understand use of such material will be limited to activities related to patient care and treatment. CSCHC will obtain additional consent. prior to any and all other uses of such material (including, but not limited to, media or publication).

☐ I do <u>not</u> authorize or consent to Medical Treatment.

Consent for Behavioral Health Treatment

☐ I voluntarily consent to behavioral health treatment at CSCHC for myself and/or my child. Services available include individual and family. Case management and coordination of services with other agencies are available and may be appropriate in my or my child's situation. Additional services may include psychiatric medication and/or psychological testing and evaluation. Licensed professionals will provide services either through traditional face-to-face meetings or via remote means called "telehealth". I understand that I may revoke consent at any time with no consequences from CSCHC. I understand that I am not obligated to use any or all of the center's services. C S C H C will explain the implications and potential outcomes of withdrawing or refusing to continue treatment.

☐ I do <u>not</u> authorize or consent to Behavioral Health Treatment.

Consent for Vision Services including mobile vision

☐ I voluntarily consent to vision services at CSCHC for myself and/or my child. Vision services may include comprehensive eye examinations including dilation, vision therapy, and the fitting and dispensing of vision correction.

☐ I do <u>not</u> authorize or consent to Vision Services.

Consent for Dental Services including mobile dental

☐ I voluntarily consent to dental services at the school based/mobile dental office include preventative care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals, if necessary. Sealants and other preventive procedures will also be provided. The treatment plan will be provided and approved by the parents/guardian PRIOR to starting treatment

☐ I do <u>not</u> authorize or consent to Dental Services.

Financial Responsibility and Assignment of Benefits

I hereby authorize CSCHC to furnish information from the patient's medical record and financial record to my insurer, compensation carrier or health care facility, which may be providing financial assistance for my or my child's care. I realize the bill is my responsibility. I assign and authorize payments to be made directly to CSCHC of all insurance benefits and agree to pay any deductible amount, co-insurance, or any other balance not paid by the insurance. By signing below, I have received or had the opportunity to review a copy of the RHCHC Financial Policy and agree to all the terms. Should I have questions regarding the policy, I will contact the CSCHC billing department.

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Patient's First Name:	Patient's Last Name:	Patient's DOB:

Consent for Use and Disclosure of Protected Health Information

I understand that confidentiality will be maintained by CSCHC in compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulations as part of CSCHC's Notice of Privacy Practices. By signing below, CSCHC may use and disclose my or my child's protected health information (PHI), in accordance with HIPAA, to carry out treatment, payment and healthcare operations. Please refer to CSCHC's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. C S C H C reserves the right to revise its Notice of Privacy Practices at any time. I may request a copy of the Notice at any time. Disclosures without additional consent will be permitted under state law for the following reasons that may apply to me or my child:

1. Client/Parent/Guardian gives permission in writing.	2. Disclosure is mandated by a court order
3. Disclosure in response to a patient medical emergency.	4. CSCHC program audits.
5. Mandated reporting of any suspected abuse towards children, elderly or the disabled.	6. Suspected or reported thoughts of harming oneself or others

By signing below, I hereby authorize CSCHC to furnish PHI from the patient's medical record to any health care provider whom my or my child's physician or provider deems necessary to provide for the continuity of medical care. I authorize CSCHC to furnish PHI to necessary school district staff including the school district's nurses, counselors, teachers, and social workers for purposes of my or my child's treatment. I acknowledge that other disclosures of my or my child's PHI will not be made without additional consent. I understand that I may revoke this authorization by request at any time by request to CSCHC.

Authorization to Communicate

☐ I understand that CSCHC uses various communication methods including voice calls, computerized test messages, secure email, fax and pre-recorded messaging for the purposes of sharing medical results, scheduling appointments, sending appointment reminders, satisfaction surveys, discussing financial responsibilities, and general communication. By signing below, I am granting permission for CSCHC to use all phone numbers and email addresses that I have supplied to contact me. I will be given the opportunity to opt out of future text, email, and phone communications at any time. Opting out of future communication will not affect my or my child's right to receive healthcare services from CSCHC.

☐ I consent for CSCHC to utilize my phone number to facilitate initial contact with me. I do not consent CSCHC to utilize all phone numbers and email addresses I have supplied to contact me thereafter.

Consent for Use and Disclosure of Personally Identifiable Information

I understand that confidentiality will be maintained by the Marion City School District (MCSD) in compliance with the Family Educational Rights and Privacy Act (FERPA). FERPA requires consent before MCSD can disclose education records containing you or your child's personally identifiable information (PII). By signing below, I consent to MCSD disclosing education records that may contain my or my child's PII with CSCHC in the event such disclosure is necessary for my or my child's treatment. Additionally, by signing below I acknowledge that, under FERPA, such education records may be disclosed by MCSD without consent in the event of an emergency insofar as such a disclosure would help to protect the health and/or safety of you, your child, or others.

By signing below, I have read, understand, and accept these terms for consent. If I refuse treatment or leave the facility, I hereby release the clinicians and CSCHC of all responsibility for my action. I am aware of the above contents and understand that I may revoke consent by requesting revocation in writing addressed to: Center Street Community Health Center, Attn: Privacy Officer, 136 W Center Street Marion, Ohio 43302.

Signature of Parent/Legal Guardian of Patient

Relationship to Patient

Printed Name of Parent/Legal Guardian of Patient

Date Signed