Program Description
School-Based Health Center
HealthSource of Ohio

Welcome to the School-Based Health Center. The School-Based Health Center makes medical care available to all students when needed. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, or immunizations they can have it done in the School-Based Health Center.

How the School-Based Health Center works:

- You must complete the attached consent form and the other information pages and return them to the school nurse or school office.
- If the school staff sees your child is sick they will try to contact you. If your child needs a check-up, sports physical, or immunizations, the center will help you get a timely appointment at the School-Based Health Center, if it is not possible with your regular doctor.
- The Center will then contact the nurse practitioner and have your child seen as soon as possible.
- Your child will be examined and treated with respect and privacy. If necessary, a prescription will be written.
- After your child's visit with the provider, you will be contacted by telephone or in writing to discuss the plan of care and understand any concerns.
- **The School-Based Health Center does not take the place of your regular doctor and joining the program does not mean you are changing your child's doctor.** You will be encouraged to have any needed follow-up care with that physician and a summary of your child's visit at School Based Health will be sent to that office. However, if you do not have a regular doctor, we welcome that relationship here and can assist you in finding a primary care provider. If your child is already a patient of HealthSource of Ohio, you still have to sign this consent to be a part of the School-Based Health Center.
- Respectful and equal treatment, care, and accommodations are available regardless of race, age, ethnicity, creed, and sex.

The PRIMARY HEALTH CARE SERVICES we may provide include:

- Sick visits (for example, for sore throat, rash, an asthma attack) and follow-up for medical problems, including physical examination, tests and treatment/medications as needed.
- Minor injury evaluation, including first aid.
- Routine physical examination (including sports and work physicals) with immunizations, routine tests and treatments as needed.
- Health education and wellness promotion.
- Referral to outside agencies for further care that cannot be provided at the School-Based Health Center.

Regarding PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate **discounted fee**. However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on the HealthSource of Ohio sliding fee scale. This information will be kept strictly confidential.
- If you have private insurance, you should contact their customer service department to be sure your insurance pays for services at the HealthSource of Ohio. If your insurance does not cover HealthSource of Ohio, you will be responsible for the bill at the appropriate discounted fee based on your household income.
- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid, you can call the Outreach and Enrollment department of HealthSource of Ohio at 513-576-7000 x 3622.

Regarding the SHARING OF HEALTH INFORMATION:

- The School-Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the School-Based Health Center to your child's regular doctor/clinic.
- The School-Based Health Center and/or the West Clermont school nurse will share medical information with each other as needed.
- The child's medical and any other information will only be used in the treatment, payment and health care operations of the School-Based Health Center. All of your child's information will be kept strictly confidential according to all state and federal laws.
- The school has other community resources available, including mental health. If services for mental health are needed, the health center provider may initiate a referral to the mental health provider at your child's school or

a community site. The mental health provider will contact your for consent. The health center provider and the mental health provider will coordinate your child's care as needed. All information will be kept strictly confidential.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, School-Based Health Center or the HEALTHSOURCE OF OHIO may use and disclose protected health information, (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to HealthSource of Ohio's Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. HealthSource of Ohio reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to HealthSource of Ohio 5400 DuPont Circle Milford, Ohio 45150.

With my consent, School-Based Health Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, School-Based Health Center or HEALTHSOURCE OF OHIO may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that School-Based Health Center or HEALTHSOURCE OF OHIO restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to School-Based Health Center's uses and disclosure of my Protected Health Information to carry out treatment, payment and operation.

- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the School-Based Health Center may decline to provide treatment to me.

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*Please note that the School-Based Health Center is **completely optional.** School nursing and emergency services will still be provided as always whether you consent to the School-Based Health Center or not.

This consent will remain in effect until your child is no longer enrolled in West Clermont Schools. You **may revoke** this consent for treatment at any time by requesting the School-Based Health Center, in writing, to have your child removed from School-Based Health Center. Please notify us at the number below and in writing for any changes in guardianship.

Please keep this Program Description for your records.

The School-Based Health Center is an excellent way to keep your child healthy and in school. Please let us know if there is anything keeping you from enrolling your child. If you have any questions or need help with the application, please call the School Health Program 513-732-5082 or contact your school nurse.

West Clermont School-Based Health Center Consent

Please Complete, Sign and Return to the School Nurse

Patient's Name: _______________________________ DOB: __________ Gender: Transgender___ M __ F___

Patient's Social Security # (if known) ________________

Insurance Provider: _________________________________ Ins. #:_____________________________________

PRIMARY HEALTH CARE SERVICES:

_____ **YES,** I consent for my child to receive **MEDICAL CARE** including routine well childcare* (includes work, daycare, and sports physicals) appropriate immunizations, fluoride varnish and treatment for illness or injury including over the counter medications unless emergency services are needed. (*Note: well child care includes vision and hearing screening, urine and blood tests, immunizations as needed, and an external genital exam when appropriate)

_____ **NO,** I do not wish for my child to receive **MEDICAL CARE** at the school based health center (SBHC)

Please note that in Ohio minors may access confidential service for sexually transmitted infections and family planning, including provision of contraception such as condoms or birth control pills without parental consent.

VISION SERVICES:

_____ **YES,** I consent for my child to receive **EYE CLINIC SERVICES** at the Vision Center at SBHC, which may include comprehensive eye examinations including dilation, vision therapy, and the fitting and dispensing of vision correction. (Please see transportation section.)

_____ **NO,** I do not wish for my child to receive **EYE CLINIC SERVICES** at the Vision Center.

MENTAL HEALTH SERVICES:

_____ **YES**, I consent for my child to receive **MENTAL HEALTH CARE** including mental health assessment, behavioral health counseling and care coordination. I understand the risks and benefits of proposed services or lack of services. This consent does not include consent for alcohol and drug treatment. I understand I have the right to refuse consent and may withdraw consent at any time and HealthSource of Ohio will make efforts to collaboratively develop alternative approaches or plans and work with me to ensure I receive needed services.

_____ **NO**, I do not wish for my child to receive **MENTAL HEALTH CARE**.

TRANSPORTATION:

_____ **YES,** I consent for my child to be **TRANSPORTED/ACCOMPANIED** to and from medical or Vision Center services by a school designee. I, the parent or guardian of above named student, release HealthSource of Ohio and the West Clermont School, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

_____ **NO,** I do not wish for my child to be transported to or from school for these purposes.

By signing this consent, I agree to the terms and conditions regarding the PAYMENT FOR SERVICES & SHARING OF HEALTH INFORMATION as explained in the accompanying Program Description form. I have also received and agree with the **Patient Consent for Use and Disclosure of Protected Health Information** as explained in the Program Description form. I have received the **Notice of Privacy Practices,** which is attached separately.

_______________________________________ _________________________________

Parent/Guardian Signature **Date** **Parent/Guardian's Printed Name**

_______________________________________ _________________________________

Patient's Signature (if 18 or older) **Date** **Patient's Printed Name**

Please Complete, Sign and Return to the School Nurse

Please Complete and Return to School Nurse

Insurance Coverage Information

Primary Insurance Name: ____

Insurance ID Number: ____________________ Group Number: _____________

Insurance Subscriber's Name: ____

Relationship to Child: ____

Insurance Subscriber's Date of Birth: ______________________________________

Insurance Subscriber's Social Security Number: ____________________________

Insurance Subscriber's Address: ____

Secondary Insurance Name: ____

Insurance ID Number: ____________________ Group Number: _____________

Insurance Subscriber's Name: ____

Relationship to Child: ____

Insurance Subscriber's Date of Birth: ______________________________________

Insurance Subscriber's Social Security Number: ____________________________

Insurance Subscriber's Address: ____

Preferred Pharmacy

Pharmacy Name: ____

Pharmacy Telephone Number: ____

Please Complete and Return to School Nurse

HealthSource of Ohio

Patient Health History Form

Children Ages 12-17 years

Please Complete and Return to School Nurse

Legal Name: ____ Date of Birth: ______/________/________

Address:____

____

E-mail____ Telephone:______________________________

Mother's Name: ____

Father's Name: ____

Emergency Contact Name and Phone Number:____

Medical Conditions (such as Asthma, Allergies, Diabetes)

____

____

Allergies (Medications, Foods, Plants, etc.) Please note type of Reaction:

____

____

Current Medications: (please include vitamins, supplements, and over the counter medications)

Medication Name	Dose and How Often Taken	How long Taken

Family History

- O adopted no family history

Parents, brother/sister or grandparents had the following:

- O ADD/ADHD
- O Allergies
- O Asthma
- O Birth Defects
- O Cancer
- O Cardiovascular Disease
- O Coronary Artery Disease
- O Deafness
- O Depression
- O Developmental Delay
- O Diabetes
- O Eczema
- O Genetic Disease
- O Hyperlipidemia
- O Hemoglobinopathy
- O Hypertension
- O Learning Disability
- O Mental Retardation
- O Obesity
- O Renal Disease
- O Scoliosis
- O Seizure Disorder
- O Strabismus
- O Sudden infant death Syndrome
- O Thyroid Disorder
- O Other___________________________
- O Other___________________________
- O Other___________________________

Medical History

- O Abdominal Pain
- O Acne
- O ADD
- O ADHD
- O Allergic Rhinitis
- O Allergies
- O Anemia
- O Asthma
- O Birth Trauma
- O Concussion
- O Congenital Heart Disease
- O Constipation
- O Diabetes
- O Eczema
- O Fracture
- O GERD
- O Head Injury
- O Headache/Migraine
- O Micrognathis
- O Microtia
- O Otitis Media; recurrent
- O Pneumonia
- O Prematurity
- O Pyelonephritis
- O Seizure Disorder
- O Seizure , Febrile
- O Urinary Tract Infection

- Bleeding Disorder
- Bronchiolitis
- Bronchitis
- Chickenpox
- Hearing Problems
- Heart Murmur
- Menstrual Problems
- Vesicoureteral Reflux
- Other________________________
- Other________________________

Surgical History

- Adenoidectomy
- Appendectomy
- Blood Transfusion
- Dental Surgery
- Hernia repair, inguinal
- Hernia repair, umbilical
- Lymph node biopsy
- Tonsillectomy
- Other________________________
- Other________________________
- Other________________________

Social/ Home & Safety History

What School do you attend? _______________________________________ Grade in School __________

Do you play sports? Yes No what sports?____

How many hours a day do you exercise?______watch TV/computer games?______ Internet?_______

Do you eat a balanced diet with fruits and vegetables? Yes No

Do you wear a bike/skating helmet? Yes No

Do you wear a seat belt? Yes No

Do you Carbon monoxide detectors? Yes No

Do you have smoke detectors in home? Yes No

Do you have a pool/spa at the home? Yes No

Do you pets/animals in home? Yes No What type?____

Are there firearms in the home? Yes No Trigger guards? Yes No Unloaded for storage? Yes No

Ammunition stored separately? Yes No

Are there smokers in the home? Yes No

Do you drink alcohol? Yes No #drinks/week__________ Do you use any other drug? Yes No

Do you use a tobacco product? No Yes What type? Cigarettes Chewing Smokeless #______ per day

Some of the following questions may make you feel uncomfortable, our intent is to gather our patients history to give the best care possible.

Sex: Female Male (does this match your sex at birth) Yes No

Sexual Orientation

- Heterosexual/Straight
- Bisexual
- Homosexual/ Gay/ Lesbian
- Unsure
- Declined

Gender you Identify with

- Male
- Female
- Female to Male
- Male to Female
- Other
- Declined

My Sex partners have been (check all that apply)

- Male
- Female
- Transgender
- Male/Female

Are you sexually active? Yes No

Do you have sex only with your current partner? Yes No

Does your current partner only have sex with you? Yes No

Do you have any concerns with body image? Yes No

Birth control method? None Condoms Birth Control Pill Depo Provera IUD Other__________________

Are you being physically or emotionally abused? Yes No

Do you have a history of suicidal thoughts? Yes No

Do you have a history of homicidal thoughts? Yes No

Have you ever been diagnosed with a psychiatric problem? Yes No If yes please specify ________________________

FEMALE only

Age at which periods began ____________yrs.

First Day of last menstrual period _______________________

Period comes every __________ days and last ___________ days

Have you ever had a STD? Yes No

HealthSource of Ohio

Please Complete, Sign and Return to School Nurse

CONSENT TO MEDICAL/BEHAVIORAL/ VISION HEALTH TREATMENT

Patient Name: ________________________________

Date of Birth______________________

I (or____________________________ acting on behalf of the above named patient) am seeking medical, vision and/or behavioral health care and agree to receive this care from HealthSource of Ohio and the providers employed by HealthSource of Ohio. This care may include medically necessary diagnostic, medical, vision or behavioral healthcare services rendered by employed physicians, dentists, and allied health providers, including licensed providers such as social workers, nurse practitioners, optometrist, and clinical nurse specialists.

I understand that the practice of medicine, vision and behavioral health is not an exact science and acknowledge that treatment may involve risks such as life-threatening complications, including death, as well as benefits, and that there may be alternatives to recommended treatments. I acknowledge that no guarantees have been made to me about the results of examination and treatment by this office and HealthSource of Ohio.

I understand that:

a. Normally, except under emergency or extraordinary circumstances, no important procedures are performed on a patient unless and until he/she has had an opportunity to discuss them with the provider. Behavioral health patients will have an opportunity to discuss plans of care with the provider.
b. I should always ask my doctor or provider to explain any part of my care or treatment which I do not understand and I have the right to have my questions answered to my satisfaction.
c. I have the right to agree or to refuse any recommended procedure or course of treatment.
d. I will not take part in any experimental procedure, treatment or research without complete knowledge and agreement.
e. HealthSource of Ohio is a Federally Qualified Health Center and offers a reduced fee to eligible patients and their families based on family size and income. The physicians, providers and staff of HealthSource may be considered federal employees under the Federally Supported Health Centers Assistance Acts of 1992 and 1995.

I understand that there may be medical, nursing, vision, behavioral health and other healthcare personnel at this office who are still in training. I understand that they may be present and participate in my care.

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) FOR TREATMENT, PAYMENT & OPERATIONS

I understand that HealthSource of Ohio (HSO) creates, receives and maintains medical and healthcare information about me, or the patient above, as part of healthcare (PHI). Examples of this information include health history, test results, diagnoses, provider orders for treatment and referrals and documentation of office visits. This information is used for a number of purposes, such as:

1. Planning my care & treatment and communicating among the healthcare providers who care for me;

2. Documenting services for billing any insurance or government benefit program (Medicare or Medicaid) for costs of my care and payment for those costs;

3. HSO operations, including checking on the quality of my care, reviewing the way my providers care for me and sending data required by federal and state healthcare agencies.

4. I acknowledge that I have been given a copy of HSO's NOTICE OF PRIVACY PRACTICES, which has more information about how HSO uses and discloses my PHI and that I can review this Notice prior to signing this form. Since HSO can change this Notice, I can also request that HSO send me the latest copy of the Notice to review.

5. I consent to the use and disclosure of my PHI by HSO to affiliates, third parties, insurers, government healthcare programs, other healthcare providers and to other organizations to whom disclosure is permitted by the current HIPAA Privacy Rules at 45 CFR Parts 160 and 164 and as amended from time to time.

6. I give my permission for HSO to release my PHI to the following common organizations for services, payment for services, to meet government requirements or to assist in my referral for care by another provider. I understand that my health records may contain information about sexually transmitted disease testing and/or conditions, such as human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), substance abuse and behavioral/mental health treatment. I understand that this list does not cover every situation where my PHI may be used or disclosed:

   - Medicare or Medicaid offices and agents
   - My insurance company
   - Physicians, hospitals, home health agencies, long-term care and other healthcare facilities and services selected by me
   - School health officials as part of school health programs
   - County/state health departments and public health agencies
   - Women, Infants & Children (WIC) program and Maternal/Child Health Program

7. I understand that I may revoke (take back) this Consent in writing, by delivering written notice to HealthSource of Ohio at 5400 DuPont Circle, Suite A, Milford, OH 45150, Attn: Privacy Officer. Your decision will become effective thirty (30) days after we receive your notice. Information used and disclosed by HSO before your revocation was received is not covered by the revocation.

8. I acknowledge the consent for treatment form above has been fully explained to me and I understand all of the information as it applies to healthcare treatment by HealthSource of Ohio and the providers and staff of this office.
9. I understand and agree to abide by the above Healthsource of Ohio No-Show Policy.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received the HealthSource of Ohio Notice of Privacy.

No-Show Policy Acknowledgement

Your providers want to make sure that you and other area residents have access to high quality care when you need it. To ensure maximum access to services for all of our patients, please be aware of the following policy regarding appointments.

Scheduled Appointments: Although we will make every effort to remind you of your upcoming appointments by phone you are ultimately responsible for remembering your appointment date and time.

Cancelling Appointments: If you cannot make your scheduled appointments you must call us at least 4 hours in advance to let us know so that we can offer your appointment to another patient. Failure to provide at least a 4 hour notice counts as a missed appointment.

Missed Appointments: Because of the lack of access to services in our area, missed appointments are taken very seriously. If you miss four appointments in a calendar year this will result in your dismissal from the practice.

Please talk to any of the staff if you have questions about our No-Show Policy.

____

Patient, Parent, Guardian Signature   Date

____

Witness Signature

Please Complete, Sign and Return to School Nurse