Primary Health Care, Inc. School Based Health Center Consent to Treat Form

Name of Student Date of Birth Grade

I understand that the School Based Health Center (SBHC) can provide health service for students enrolled in the Des Moines Public Schools. One consent form per student must be signed and on file at the health center for the student to receive these services. By marking yes I consent to the following services:

☐ **Yes.** I consent to having my child receive **medical care** through the SBHC. I acknowledge that such medical care may include, without limitation: physical exams, drawing blood, evaluation of injuries, vaccinations, chronic disease management, and referrals as well as other services as described below. **Please note: all required and recommended vaccinations will be given unless otherwise specified by the parent or guardian.**

☐**Yes.** I consent to my child being transported to appointment by Des Moines Public Schools Transportation to the SBHC.

I understand that this Consent Form may be revoked in writing at any time and that the revocation will take effect on the day it is received by Primary Health Care, Inc. at the School Based Health Center.

Parent/Guardian Information

Mother/Guardian _____DOB _____Primary Phone _____Other Phone _____

Father/Guardian _____DOB _____Primary Phone _____Other Phone _____

Parent/Guardian Address _____

Parent/Guardian email:_____

Health Insurance (Please circle and complete, if applicable):

Medical & Dental Insurance: Uninsured Medicaid/Hawk-I ID#_____ Private Insurance ID/Group#_____ SSN#_____

Policy Holder's name & DOB _____ Employer_____

Policy Holder's Address_____

****NOTE: Primary Health Care, Inc. will treat patients regardless of their ability to pay.**

School Based Health Centers

The SBHC will be available at your child's school or nearby school. The SBHC will be staffed and operated by Primary Health Care, Inc (PHC). PHC will be able to test for, diagnose and treat many common conditions such as sore throats, headaches, ear infections, as well as other infectious disease such as hepatitis, tuberculosis and sexually transmitted infections. [NOTE: Iowa state law (Iowa Code § 139A.35) allows students to choose whether or not a parent will be notified of a student's care related to sexually transmitted infections]. PHC will provide care for minor injuries but will not provide emergency services. PHC will also provide services such as immunizations, contraceptive services and make appropriate referrals to other providers as needed. PHC will attempt to coordinate care with your child's primary care provider as long as PHC has been provided information on such primary care provider. If you have private health insurance or Medicaid/Hawk-I, PHC will provide services and submit the bill to your insurance carrier. If you do not have such coverage, PHC staff will work with your family to help enroll your child(ren) in Medicaid/Hawk-I, if eligible.

Primary Health Care, Inc. - Consent to Treatment & Release of Information

To enroll your child at the SBHC, and in order for the Des Moines Public School (DMPS) District to give PHC staff confidential information to help with diagnosis and treatment, this signed and completed Consent form must be on file at DMPS and PHC. PHC staff will typically attempt to contact you to inform you of the reason for your child's visits and the services provided. By signing this enrollment and consent form, you consent to the following:

- I authorize the sharing of information regarding my child between the Primary Health Care, Inc., Dental Connections, and Des Moines Public Schools.
- I authorize PHC to examine and treat my child at the SBHC, and I understand that no guarantee has been made as to the results of such examinations and treatments.
- I authorize DMPS and any of its certificated staff, including the school nurse at my child's school, to communicate and share information to assist PHC to treat my child, including my child's family and emergency contact information, attendance records and disciplinary information, immunization history, results of health screenings such as hearing and vision, psychological evaluations, special education (IEP-MDT) records, Section 504 Accommodation Plan, and any health conditions such as seizures or asthma.
- I authorize PHC staff members to release any medical records required by the insurer or other payer to obtain payment. Following applicable legal requirements, PHC staff members may use and share my child's medical information for: 1) treatment of my child's health condition and maintaining the continuity of my child's care, 2) payment for health services provided to my child, and 3) routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. A Notice of Privacy Practices document is available to me at the location my child receives his/her health care services and on the PHC website.
- **Unless otherwise revoked, this Authorization expires <u>12 months</u> after the date of my signing this form.**

By signing this consent, I confirm I am the parent/legal guardian of the above listed student and am authorized to give this consent.

Parent/Guardian signature_____Relationship to Child_____

Date _____

About Our Notice of Privacy Practices

We are committed to protecting your child's personal health information in compliance with the law. The Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your child's personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient's Signature

_____

Date

Signature of Parent or Patient's Representative (if applicable)

_____

Date

Description of Legal Authority to Act on Behalf of Patient

Medicine, Allergies, & Health History
(Please mark all that apply with an [X])

Is your child allergic to any of the following?

[ ]Anesthetics [ ]Sulfa [ ]Latex [ ]Aspirin [ ]Codeine

[ ]Penicillin/Amoxicillin [ ]Other Medicines:_____

_____

[ ]Foods:_____

[ ]Environmental:_____

[ ]Other:_____

General Provider and Pharmacy Information

Who is your child's Primary Care Provider (PCP)?

When was your child's last visit with his/her PCP?
Date (or approximate date):

Who is your child's Dental Provider?

When was your child's last dental visit?
Date (or approximate date):

Please list any other Providers your child regularly sees?
(i.e. ENT, Psychiatrist, Cardiologist, etc.):

What Pharmacy do you use? What is the address (or cross-streets)?

Please circle **YES** or **NO** to the following questions

Is your child taking medicine? NO / YES-please list:

Have you taken your child to the hospital recently?
NO / YES-Where and Date:

Has your child been to any clinics or urgent care centers for any health problems recently? **NO / YES-Where and Date:**

Any issues with the pregnancy or birth of your child?
NO / YES-please explain:

Medical and Mental Health Conditions:
(Please mark all that apply with an [X])

[ ] ADHD	[ ] High Blood Pressure
[ ] Allergies	[ ] HIV/AIDS
[ ] Anemia	[ ] Hearing Impairment
[ ] Anxiety	[ ] Heart Condition
[ ] Arthritis	[ ] Hepatitis
[ ] Asthma	[ ] Liver Condition
[ ] Autism	[ ] Kidney Condition
[ ] Behavioral Concerns	[ ] Muscular Dystrophy
[ ] Bladder Problem	[ ] Orthopedic Condition
[ ] Bowel Problem	[ ] Seizure
[ ] Celiac Disease	[ ] Sickle Cell Anemia
[ ] Cerebral Palsy	[ ] Skin Condition
[ ] Cystic Fibrosis	[ ] Spina Bifida
[ ] Depression	[ ] Thyroid Condition
[ ] Diabetes	[ ] Tuberculosis
[ ] Dizziness/Fainting	[ ] Vision Impairment
[ ] Downs Syndrome	[ ] Wears glasses/contacts
[ ] Epilepsy	[ ] Other:

Any past Serious Injuries or Accidents? **NO / YES-Please list:**

Has your child ever been in the hospital? **NO / YES-When and Why:**

Has your child ever had surgery? **NO / YES-When and Why:**

General Health

Do you consider your child to be in good health? **NO / YES**

Has your child ever had a head or mouth injury? **NO / YES**

Do you think your child has any cavities or toothaches? **NO / YES**

Does your child need medicine before dental treatment because of heart or other medical conditions? **NO / YES-Why:**

Is your child pregnant? **NO / YES / MAYBE**

Are there any concerns with your child's physical, mental, and or emotional development? **NO / YES-please explain:**

Any concerns regarding your child's school performance?
NO / YES-please explain:

Family History

Does your child's biological **mother** have any medical problems?
(example: asthma, diabetes, heart disease, etc.) **NO / YES-please explain:**

Does your child's biological **father** have any medical problems?
(example: asthma, diabetes, heart disease, etc.) **NO / YES-please explain:**

Does your child's biological **siblings** have any medical problems?
(example: asthma, diabetes, heart disease, etc.) **NO / YES-please explain:**

Which do you consider your child?

[ ] White [ ] Hispanic-Latino [ ] African-American

[ ] Asian [ ] American-Indian [ ] Other

Does your child qualify for free/reduced lunch at school? **NO / YES**

Who Lives at Home?

Mother	**NO / YES**	Name:
Father	**NO / YES**	Name:
Sister(s)	**NO / YES**	How many?
Brother(s)	**NO / YES**	How many?
Other People	**NO / YES**	How many?

Home Environment

Do you have enough food at home? **NO / YES**

Does someone else care for your child?
(daycare, after school care, family member, etc.) **NO / YES**

Does anyone smoke inside the home? **NO / YES**

Do you live in your own home/apartment? **NO / YES**

Or do you stay at someone else's place? **NO / YES**

Do you feel safe in your home? **NO / YES**

Is there any other information about your home environment that would be helpful for us to know when caring for your child?
NO / YES-please explain:

Is there any other information you would like to share with your provider?

PHC
primary health care

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Your Health Record/Information

Each time you visit the Primary Health Care, Inc. School Based Clinics (Clinics), a record of your visit is made. Usually this record has your symptoms, exam, test results, diagnosis, treatment, and a plan for future care or treatment. This information is often called your health or medical record. It serves as a:

- Basis to plan your care and treatment.
- Way the health professionals who care for you communicate with each other.
- Legal document describing the care you received.
- Way you and /or your insurance company can be sure that services billed were actually services performed.
- Source of data for facility and service planning.
- Source of information to improve the care and services we give to our patients.
- Source of information for public health officials who have the goal of improving the health of the nation.

Understanding what is in your record and how your health information is used helps you to be sure your health information is correct, know who, what, when, where, and why others may have your health information and make better decisions when allowing disclosure to others.

Privacy Rights of Minors

Most of the time, parents or guardians of minors have the privacy rights described in this Notice. However, there are times when minor patients may make decisions about their own care and have the rights described in this Notice. When minor patients are allowed by law to make decisions about their own medical care, they can usually control the release of their medical information even to their parents/guardians. If you have questions or concerns about whether your parent will have access to your medical information, you should talk to your health care provider.

Your Rights Regarding Your Health Information

Although your health record belongs to the Clinics, the information in it belongs to you. You have the right to:

- Look at and /or ask for a copy of your health record. An appointment is required to view the record with your health care provider. We may deny your request to inspect and copy in certain very limited circumstances. You may request that the denial be reviewed in most circumstances.
- Ask to restrict certain uses and disclosures of your record. If we deny your request, we will tell you in writing why we do not agree.
- Ask for a correction or change to your health record. We do not have to make the change you request. If we deny your request you can write a statement of disagreement with the denial that we will keep with your medical record.
- Get a list of when and to whom your health information has been sent for reasons other than treatment, payment, or health operations as of April 14, 2003.
- Ask us to communicate your health information to you by other means or to another location. For example, you can ask that we only contact you through use of a certain telephone number.

Our Responsibilities

Primary Health Care, Inc. School Based Clinics have a duty to:

- Keep your health information private.
- Give you this Notice of Privacy Practices and to seek your written acknowledgement of your receipt of this notice.
- Abide by our current Notice of Privacy Practices. We will not use or give out your health information without your permission, except as described in this notice.
- Tell you if we are unable to agree to your request to change or correct your health record or to restrict certain disclosures of your record.

How We Use Health Information

Treatment, Payment, and Health Operations

Treatment. For example, the laboratories conducting your lab tests will receive your health information necessary to conduct the test. Also, the information the health care provider gets about you will be put in your record in either paper form or electronic form. Your health record is used to decide the best course for treatment for you and to provide continuity of care should you get a different health care provider. We have policies and procedures in place to protect the confidentiality of your health information contained in either the paper or electronic record.

Payment. For example, if you have insurance that may cover the cost of your visit a bill may be sent to your insurance company. The information that goes to the consultant who helps us bill insurance companies and the bill sent to your insurance company may include information that identifies you, your diagnosis, procedures, and supplies used.

Regular Health Care Operations. For example, members of our clinical staff, a quality improvement or auditing team may use information in your health record to assess the care and outcome in your case and others like it. This information will then be used to improve the quality and effectiveness of the health care and service we provide.

Patient Communications. We may contact you to remind you of appointments and we may contact you about health-related services that may be of interest to you. Normally we contact you at the telephone number and address you give us. You may ask us to communicate with you in other ways or at another location. We will agree to your request if it is reasonable.

Other Disclosures Not Requiring Your Permission

Required by Other Law. We may disclose health information when required by other federal, state or local laws. For example, other laws require us to report minor neglect, physical or sexual abuse and health information necessary to follow laws relating to workers' compensation or other similar programs established by law.

Legal Process. We may disclose health information in response to court orders, subpoenas or other legal documents.

Public Health. We may disclose your health information for public health purposes such as birth reporting, to prevent or control disease, injury or disability, to let a person know if they were exposed to a disease or may be at risk for getting or spreading a disease or condition, or to report problems with medicines or other products.

Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement, transplantation, or to an organ donation bank. We may also release health information to a coroner, medical examiner, or a funeral director.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensing. These activities are needed for the government to oversee the health care system.

Specialized Government Functions. If you are a member of the armed forces or a foreign military, or become an individual at a correctional institution, we may share health information as required by law. We may also disclose your health information to authorized federal officials for activities authorized by law related to national security.

Law Enforcement. If we believe you have been the victim of abuse, neglect or domestic violence, we must report it to law enforcement. If you are emancipated, we will get your permission first. Other situations are when a crime occurs at the clinic, or when it is necessary to prevent a serious health and safety threat to you, another person or the public. Research. We may use of share your health information for research purposes as allowed by law or if you have given permission.

Disclosures Requiring your Permission

Other uses and disclosures will be made only with your written permission. You may cancel that permission in writing at any time. If you cancel your permission, we will no longer use or share your health information for the reasons on your written permission. Of course, we are unable to take back any disclosures we have already made with your permission.

Questions or Complaints

If you have questions, please contact Primary Health Care's Compliance Director at **515-248-1445**. If you believe your privacy rights have been violated let the Compliance Director know. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be treated differently by Primary Health Care, Inc. school based clinic staff if you make a complaint.

Changes to this Notice

We must follow the terms of the Notice of Privacy Practices. We can change this Notice of Privacy Practices, however, and reserve the right to make the new notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in this clinic. The effective date of this notice is listed on this page.