Primary Health Care, Inc. School Based Health Clinic 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 public schools. One consent form per student must be signed and on file at the health center for the student to receive these services in the public school building. This consent is also valid at other PHC locations.

By signing below, I consent to the above named person to 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, integrated behavioral health care, 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[1].**
I give the SBHC access to above named person's health records from other medical clinics through the Electronic Health Records EPIC. This would include records at UnityPoint, McFarland, and University of Iowa. Please date and initial here if you **do not** want staff to access records in these systems. Initial:

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 (Complete as applicable):

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

SSN# of student_____

Policy Holder's name & DOB _____ Employer_____

Policy Holder's Address_____

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

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, behavioral health, ear infections, rashes, administer immunizations and make appropriate referrals to other providers as needed. PHC will provide care for minor injuries but will not provide emergency services. 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, or our sliding fee program, if eligible.

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 PHC. Parents/guardians will be notified of appointments via text message, unless you have opted out of this service. Typically, phone calls are made ahead of time too. PHC staff will send information regarding the appointment home with your child. 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. 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 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. https://phciowa.org/patients/#forms
- By signing this form, you are consenting for PHC staff to check your child's prescription refills history electronically. If you decline please initial here:
- **This Authorization expires 15 months after signing or when I revoke this consent.**
- **I do not want my child to receive the following services. Please list services, sign, and date.**

- **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 Student** _____

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. It can be viewed here: https://phciowa.org/wp-content/uploads/2024/01/Privacy-Notice-2023.pdf

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

Signature of Parent/Guardian

Date

[1] Except Covid vaccine. Covid vaccines will not be given unless a parent/guardian is present.

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Student's allergies (medicines, pollen, food, stinging insects):	**Student's past surgical procedures:**
Student's past and current medical conditions:	
Student's Medicines and Supplements: List all current prescriptions, over-the-counter medicines and supplements (herbal and nutritional)	
Anything else you want our school based clinic to know:	

Informed Consent for Telehealth Services

I consent to having my student_____ use telehealth at the SBHC at Primary Health Care, Inc.
(Print student name here)
as a part of the medical treatment and behavioral health treatment. I understand that: a) telehealth services may include assessment, consultation, treatment planning. mental health evaluation, and therapy (*your child will not receive therapy without your knowledge and consent*), b) patient and provider do not have to be in the same physical location, promoting more consistent visits and easier access to care. Telehealth will occur primarily through interactive audio and video communications.
By signing this consent, I am verifying that I understand the following:

1. I have the right to revoke my consent for telehealth services at any time. This will not impact any future care or treatment I receive at PHC.
2. Confidentiality. Your provider will ensure that your sessions are private and confidential to the extent possible. However, there may be challenges with confidentiality using telehealth including: the potential for others to overhear sessions on the patient's end and technology-related issues (e.g., others accessing your private conversations or stored information without your knowledge). It is recommended that you are in a private and quiet place during your session to increase privacy.
3. I give consent for my student to be interviewed by a PHC provider. I also understand that other individuals may be present to operate the telehealth equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.
4. **For Medical visits:** I understand that a limited examination may take place during the videoconference and that I and my student have the right to ask my healthcare provider to discontinue the conference at any time. I understand that some parts of the exam may be conducted by individuals at my location at the direction of the consulting healthcare provider.
5. **For Behavioral Health:** I understand that there are limitations to videoconference and that I and my student have the right to ask my healthcare provider to discontinue the conference at any time. I understand that our behavioral health services are provided as part of our medical services and our medical records are combined.
6. I agree that in certain situations the provider might recommend an in-person visit based on the results of the visit.
7. I have read this document and understand the risk and benefits of the telemedicine services and have had my questions regarding the services explained and I hereby consent to participate in a telehealth visit under the conditions described in this document.

_____ _____ _____ _____
Patient/Client/Legal Representative **Signature** **Relationship to student** **Date**
(Please print name)

Communication Consent
I give my permission to Primary Health Care, Inc (PHC) to communicate information concerning my student's healthcare (medical, dental and integrated behavioral health) and financial/insurance information to the person's listed below.

Name 1_____ Relationship _____Phone number_____

Name 2_____ Relationship _____Phone number_____

Name 3_____ Relationship _____Phone number_____

I understand that mental health (therapy), substance abuse treatment and/or HIV information will not be disclosed pursuant to this form. I understand if there are exceptions to the communications permitted pursuant to this form, it is my responsibility to inform PHC.
I agree to allow PHC to contact me with the following methods regarding my student's private health information, evaluation and treatment. I authorize PHC to leave messages for me when I am not available.

My phone voicemail ☐ Yes ☐ No Preferred phone number_____ Is this a cell phone ☐ landline ☐ work ☐

It is okay to send text message ☐ Yes ☐ No Email ☐ Yes ☐ No _____
(Standard text message rates apply)

_____ _____
Signature of Parent or Legal Guardian **Date**