Eagle Point High School School-Based Health Center (SBHC)
Parent/Guardian Consent for Student Health Care Services
203 North Platt Street, Eagle Point, OR 97524
Eagle Point SBHC is operated by Rogue Community Health (RCH) in collaboration with Eagle Point School District

Patient/Student Name: _____ Grade: _____ Date of Birth: _____

Address: _____ City: _____ Home Phone: _____

Who does student live with: _____ Preferred Spoken Language: _____

Your Student may be asked to participate in a satisfaction survey and a health questionnaire every school year

Agreement: Please read carefully and sign at the bottom.

Consent for Treatment:
I consent to treatment necessary for care. I authorize release of all medical records to referring health care providers and to my insurance company, if applicable. I allow fax transmittal and/or HIPAA secure electronic submission of medical records, if necessary.

I give permission to the SBHC Registered Nurse, Medical Assistant, or front office staff to provide over-the-counter medication (such as Tylenol, etc.) to my child/student: ☐ **No** ☐ **Yes** ***Initial:***_____

Allergies: *My child has no allergies* ☐, *or* **My child is allergic to**: _____

Financial Responsibility:
All patients with self-pay accounts or co-pay requirements are asked to bring in payment at each visit. Patients that have made payment arrangements and/or received a monthly statement are asked to make a payment within thirty days of the statement date. If you have payment concerns, please notify the billing department. We will bill your insurance for you. However, your account remains your responsibility.

Insurance Information: ☐ No Medical Insurance ☐ Private Health Insurance ☐ OHP ☐ Unknown

Name of Insurance Policy holder: _____ Date of Birth: _____

Name of Medical Insurance: _____ ID#: _____ Group #: _____

Insurance Address: _____ Phone #: _____

If not insured, would you like to be contacted by someone for no-to-low-cost health coverage for children 0 to19 years old? ☐ Yes ☐ No

Insurance Authorization: I understand the financial policy above and accept financial responsibility. By signing below, I assign RCH all payments due from my insurance company for services rendered.

NO ONE IS TURNED AWAY FOR INABILITY TO PAY. Students will receive many services without a fee.

Medical Home
Rogue Community Health (RCH) has a model of care called a Patient Centered Medical Home. This means the clinic is my health care setting where I work in partnership with my care team to address all of my health care needs.

- Does the patient have a regular doctor or Primary Care Physician? ☐ Yes ☐ No
  If yes, please provide the doctor's name: _____
- I would like RCH/SBHC to be my child's/student's primary medical provider. ☐ Yes ☐ No

Release of Information: Do we have your permission to:

- Leave message on your home phone regarding the child/student listed above? ☐ Yes ☐ No
- Leave a message on your cell phone? (cell #)_____ ☐ Yes ☐ No
- Leave a message at your place of employment? (work #) _____ ☐ Yes ☐ No
- Discuss your child's medical condition with any member of your household? ☐ Yes ☐ No
  If yes, ☐ Anyone ☐ Specific: _____

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. These agreements will remain in effect while the student is enrolled at Eagle Point High School or until revoked by me in writing. If revoked, I understand the authorization will not affect any use or disclosure of information that has already occurred.

_____
Signature of Parent or Guardian — Parent or Guardian (Please print)

_____
Relationship to Student/Patient — Date

Medical Record Number (MRN): *To be filled out by SBHC Staff* _____ *Updated 3/2018*