MRN: _____ *to be completed by SBHC Staff*

School-Based Health Center Consent for Student Health Care Services

ALL *SBHCs are operated by Rogue Community Health (RCH) in collaboration with the School Districts*

School Name: _____ Grade: _____

Patient Name: _____ DOB: ___/___/____ Primary Phone: _____

Patient Address:_____
Street or P.O. Box City State Zip

Person Completing Consent: (please circle one): Parent/Guardian Self/Student **(if 15 years or older)** Sex (circle): M F Other: _____
Preferred Language Spoken: (circle): ENGLISH SPANISH OTHER: _____

Allergies: Student has □No **allergies** **OR** □Yes, Student **has allergies** Please Describe: _____(If changes, notify SBHC)

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

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

Consent for Treatment: I consent to treatment necessary for the care of the above named patient. I authorize release of all medical records to referring health care providers and to my insurance company, if applicable. I authorize fax transmittal and/or HIPAA secure electronic submission of my medical record, if necessary. Please Initial: _____

Financial Responsibility: All insurance co-pays are due at the time of the visit. All patients with self-pay accounts must bring cash payment at each visit. Patients that have made payment arrangements and/or received a monthly statement must 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. If you have payment concerns, please notify the billing department (541-618-4414).

No student will be turned away for inability to pay

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

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**

Name of Medical Insurance: _____ ID#: _____ Group #: _____
Name of Policy Holder: _____ Employer Name: _____ DOB: ___/___/____
Insurance Address: _____ Phone: _____

Insurance Authorization: I understand the financial policy above and accept financial responsibility. By this agreement, I assign Rogue Community Health all payments due from my insurance company for services rendered.

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 my health care needs.
Does the student have a regular Primary Care Physician? □Yes □No Rogue Community Health is my Medical Home: □ Yes □ No

If yes, please provide the doctor's name: _____

Communication: Do we have your permission to:
Leave a message on your primary phone regarding the student listed above? □Yes □No

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 in this school or until revoked by me in writing, by submitting it to compliance@roguech.org. If revoked, I understand the authorization will not affect any use or disclosure of information that has already occurred.

_____ ___/___/____
Signature Printed Name Date

_____
Relationship to Student/Patient