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: Behavioral Health (BH) (**if 14 years or older**)

Self/Student: Medical **(if 15 years or older)** Sex (circle): M F Other: _________________________

All students are eligible for medical services as part of RCH care. Please indicate if you: □Accept □Decline

All students are eligible for Behavioral Health services as part of RCH care. Please indicate if you: □Accept □Decline

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, Ibuprofen, 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. 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: ___________________________ Phone #: ________________________

Communication: Do we have your permission to:

- Leave a message on your primary phone regarding the student listed above? □Yes □No Please Initial: ________________
- As the legal parent/guardian, I hereby consent to the release and exchange of information, including appointment time and location, between the SBHC staff and the school staff members. □Yes □No Please Initial: ________________
- 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 for the life of the student while enrolled in school for Medical services and for approximately 12 months for BH services, or until revoked by me in writing, by submitting it to compliance@roguch.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

Updated 09.2023LL

MRN:____________________

PATIENT REGISTRATION FORM

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Rogue Community Health to use and disclose the health and medical information of ____________________________(patient) for the purposes of Treatment, Payment, and Healthcare Operations.

***Treatment** includes services performed by a provider, nurse, lab personnel, office staff, and other types of healthcare professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other healthcare providers. This consent includes treatment provided by any medical personnel who covers our practice by telephone as the on-call medical personnel.

***Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization of services.

***Healthcare Operations** includes the necessary administrative and business functions of our office. Rogue Community Health is part of an organized health care arrangement including participants in the Oregon Community Health Information Network (OCHIN). Your health information may be shared by Rogue Community Health with other OCHIN participants when necessary for healthcare operations.

***Communications** As a patient of Rogue Community Health, you may be contacted via text or voice messaging to remind you of an appointment, to obtain feedback on your healthcare experience with our medical, dental and/or behavioral health teams, and to provide general reminders. I consent to receiving appointment reminders and other healthcare communications via text or voice message from Rogue Community Health at my preferred telephone number and any number forwarded or transferred to that number. I understand that this request to receive text or voice messages will apply to all future appointment reminders/feedback/health information. I further understand that message/data rates may apply to "sent" messages under my cell phone plan.

You may review Rogue Community Health's **"Notice of Privacy Practices"** for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our **Notice** by initialing here: ______________.

Rogue Community Health reserves the right to change our privacy practices in accordance with the law which may change the terms contained in the **Notice**. A summary of the **Notice** is posted in our waiting room and on our website (www.roguecommunityhealth.org) and includes the effective date of the **Notice** in the upper right-hand corner. We will offer you a copy of the **Notice** on your first visit to us after the effective date of the most current **Notice**. We will also provide you with a copy of the **Notice** upon your request.

As more fully explained in the **Notice**, you have the right to request restrictions on how we use and disclose your protected health information for purposes of treatment, payment, and healthcare operations. **We are not required to agree to your request**. If we do agree with your request, we are required to comply with your request unless the restricted information is needed to provide you emergency treatment. Other medical personnel who provide call coverage for our office are required to use and disclose your protected health information consistent with the **Notice**.

I agree to the terms stated herein and understand that I have the right to revoke this CONSENT provided I do so in writing to the Compliance Director at compliance@roguech.org, except to the extent that Rogue Community Health has already used or disclosed the information based on this CONSENT.

____

Patient or Person Authorized by Law (please print)

____

Signature of Patient (or Signature of Person Authorized by Law) **Date**