ESKENAZI HEALTH
Indianapolis, Indiana

CONSENT FOR SCHOOL-BASED, FEE-FOR-SERVICES PROVIDED BY NURSE PRACTIONER OR SOCIAL WORKER RIVERSIDE HIGH SCHOOL

STUDENT'S LEGAL NAME ________________________________ **SCHOOL YEAR** ____________________________

1.) **<u>I give consent for my child to receive school-based services:</u>** My consent will allow my child to receive healthcare services (as listed on item #4) while he/she is a student at Riverside High School. If I change my mind, I must write a letter to the school-based healthcare office stating my intentions. It will also be my responsibility to notify the school-based healthcare office staff about changes in any guardianship, address, phone number, and email address. I am aware the healthcare office cannot take care of all medical needs my child may have. If my child is not already under the care of a doctor, I am aware the healthcare office has the resources to assist me in choosing one.

2.) **<u>Information Policy:</u>** I have had an opportunity to receive and review a detailed copy of the **<u>NOTICE OF PRIVACY PRACTICES</u>** to help me understand Eskenazi Health's policies with regards to my child's personal health information prior to signing this consent. It has been explained to me that the terms of the notice may change from time to time and that the current notice will be posted on the Eskenazi Health website, https://www.eskenazihealth.edu, and that copies will be available for me to take.

3.) **<u>Release of Information:</u>** I understand the services provided by the school-based healthcare office are confidential. The school-based health-care office will use and disclose my child's personal health information to provide treatment and for improvement of healthcare operations. My child's information may be shared with their doctor or primary care physician, school-based healthcare staff, or the social worker for legitimate purposes. I authorize the release of my child's medical information to other physicians and providers who may have my child as a patient. I also authorize the use of information from my child's medical record for purposes of medical care, treatment, clinic administration and evaluation.

4.) **<u>Nurse Practitioner/ Licensed Social Worker Services</u>:** I understand my consent will allow my child to be seen and treated by the Nurse Practitioner and/or the Licensed Social Worker. I am aware these are Fee-For-Service visits and services rendered will be billed to my child's insurance. I also understand that my co-pay will be billed along with any other services not covered by my child's insurance and that I accept all financial responsibility. I am aware that NO money is needed nor will be accepted on the day services are rendered.

There are a wide range of services that can be provided, including, but not limited to the following:

*Headaches	*Eye/Ear pain	*Upper Respiratory/Sinus Infections
*Rashes	*Sore Throat	*Reproductive Health
*Sports Physicals	*Asthma/Allergies	*Mental Health/Counseling Services

Parent/Guardian Signature: ____ **Date:** __________________

Parent/Guardian Print Name: ______________________________________

<u>Insurance Information Required</u>:

Policy Holder's Name ______________________________ **Birth Date** ____________________

Insurance Company ______________________________ **Employer** ____________________

Group number _________________________ **Policy/Member ID** _________________________

****Attach a copy of the front and back of insurance card.**

Submission of signed Eskenazi Health Consent and Assignment form also required for services.

ANY SERVICES OTHER THAN <u>EMERGENCY TREATMENT</u> WILL NOT BE PROVIDED WITHOUT A SIGNED CONSENT AS REQUIRED BY THE INDIANA STATE LAW.