QUICKmed URGENT CARE

SCHOOL-BASED ON-SITE HEALTH CLINIC CONSENT FORM

_____ partners with QUICKmed Urgent Care to offer School Based Supplemental Health Services. This one form replaces many of the different permission forms required to provide these services for your child. School nursing and emergency services will still be provided as always whether or not you choose to take part in these added services. Some Supplemental Services may not be available at all school buildings. (Check with your school nurse for questions about service ability).

These health services provide quality health care in a friendly and familiar school setting at a time that works for the student and family. We are not trying to replace your regular source of health care.

Student Information (Print all information in ink)

Patient/Student Name (First, Middle, Last) **Student Preferred Name**

Street Address **City** **State** **Zip Code**

(Area Code) Phone Number **Student Date of Birth (Month-Day-Year)** **Grade** **School Name**

Sex: ☐Male ☐Female ☐ Prefer to self-describe: _____ Ethnicity: Hispanic/Latino (check one)☐ Yes☐ No
Race: Please check **all that apply** for your child:☐ Black or African American ☐ White ☐ Asian
☐ Native Hawaiian/Pacific Islander☐ American Indian/Alaskan Native ☐Other: _____

Student's Main Language:☐ English ☐ Spanish☐ Russian Turkish☐ Kinyarwanda☐ French☐ Arabic ☐Other: _____

Consent for Health Services Treatment
I consent to let providers participating in School-Based Supplemental Health Services perform the following services/ treatment for my child: (Check each service that you want to have available for your child.)

1	Care and treatment for injury/illness Physical examinations (well-child or sports) Influenza (flu) immunization	X	7	Dental screening and sealants for 2nd/6th grades (also includes a sealant check next school year and reapplication if needed)
2	Meningococcal immunization (required for 7th & 12th grades)	x	8	Dental exam, dental filings
3	Tdap immunization (required for 7th grade)	x	9	Mental/behavioral health counseling
4	Other immunizations (age-appropriate, following the American Academy of Pediatrics immunization schedule □ DTaP/Td □Polio □Hepatitis B □ MMR □ Varicella □ Hepatitis A □ HPV □ Pneumococcal conjugate □ Hib	X	10	Eye exam, including dilation (drops are used to make the pupil bigger), vision therapy, the fitting and dispensing of eyeglasses and corneal foreign removal (removing something from the clear, protective outer layer of the eye)
5	Well visits and sick visits	x	11	Audiology/Hearing screening and evaluation
6	Sexually Transmitted Infection (STI/STD) testing, Education and/or treatment			

By signing this Consent for Health Services Treatment, I agree to the terms and conditions regarding Authorization to Release Information and Assignment of Insurance Benefits as explained in this consent form. I also acknowledge that I have received information about how to receive Notice of Privacy Practices as explained in this consent. I also have received and understand available services as described in the School-Based Supplemental Health Services Information for Parents & Students handout which is available on the school district website.

I understand that I will be notified of any services my child receives, as well as any abnormal findings and/or further treatment recommendations. I also understand I should contact the school nurse if I have questions about any necessary follow-up care or instructions. For services provided by the Health Centers, I understand I should call the phone number listed on the After Visit Summary which was sent home with my child. I understand this consent will remain valid as long as the child remains a student within Mad River Local Schools unless revoked by me. I may revoke this consent for treatment at any time by requesting in writing that School-Based Supplemental Health Services remove my child from services. I have received this handout, School-Based Supplemental Health Services Information for Parents and Students, which includes the agencies providing services, and I understand the services available. It is my responsibility to notify the school nurse of all updates or changes to my child's health condition(s), immunization records, medications or insurance coverage.

Privacy Practices & Authorization to Release Information

Notice of Privacy Practices Acknowledgement: I have been notified that I can ask for a copy of the Notice of Privacy Practices forms for QUICKmed Urgent Care.

Authorization to Release Information: I hereby authorize QUICKmed and the school district listed on page 1 to exchange information with insurers, compensation carrier, healthcare facility, welfare agency, healthcare provider, the MRLS school nurse(s), school counselor and/or school social worker, for the exclusive purpose of financial assistance, continuity of medical care, or care coordination. Administered immunizations will be entered into the statewide immunization information system (Ohio ImpactSIIS). Release of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987.

No disclosure of information regarding AIDS, HIV testing, or diagnosis of HIV/AIDS will be made. School-Based Supplemental Health Services may use student health records to evaluate the quality of care provided and the effectiveness of offering these services. My child's records are protected and can only be accessed by authorized users with restricted access. I understand this authorization will remain valid as long as the child remains a student within the school district unless revoked by me. I may withdraw this authorization at any time by providing written notice to remove my child from these School-Based Supplemental Health Services.

Insurance Information: Insurance or other health care coverage programs are billed whenever possible to help cover the cost of care. Some School Based Supplemental Health Services are provided at no cost to families whether or not a student has insurance or the ability to pay. I give QUICKmed Urgent Care the right to submit claims for reimbursement under any private health insurance policy, Medicare, Medicaid or any other programs that I identify for which a benefit may be able to pay for services provided to my child through School-Based Supplemental Health Services.

This consent is valid until the child reaches the age of majority, or is no longer a student at a the school district. This consent may be revoked at any time by the parent/guardian authorized to act on behalf of the patient, except to the extent that all organizations have already taken action in reliance on this consent.

I understand that the healthcare organization will not discuss my medical care or billing information with anyone not listed on this consent. Below please list people that we may release information to.

Name Relationship to Student Name Relationship to Student

1._____ 2. _____

3._____ 4. _____

Parent/Guardian Relationship to Student (if student/patient is less than 18 years old): □ Mother □ Father □ Legal Guardian

x	**x**	**x**	
Parent/Guardian *Printed Name*	**Parent/Guardian** *Signature*	Date	
	x	**x**	**x**
OR If student/patient is 18 years or older	**Student/** *Signature*	Date	**Student Phone**

STUDENT NAME_____ **DOB**_____

PATIENT REGISTRATION FORM: (Complete all sections)

PATIENT INFORMATION:						
Last Name	First Name	MI	Nickname	Social Security #	Birthdate	Sex
Billing Address: of Patient or Responsible Party Apt #				City	State	Zip
□ Home Phone ( )		□ Alternate Phone ( )		□ Family Friend ( )		
Email Address:						

RESPONSIBLE PARTY (Required for patients under 18 or whenever the guarantor is not the patient)

Last Name	First Name	MI	Social Security #	Birthdate	Relationship

HEALTH INSURANCE

Please check which insurance carrier covers your child or sign below if you don't think your child has insurance. Most School Based Supplemental Health Services are provided at no cost to families whether or not s student insurance or the ability to pay.

Medicaid Managed Care Plans (check one below):

Managed Care ID# _____

☐ buckeye health plan

☐ CareSource

☐ PARAMOUNT ADVANTAGE | MEDICAID Affiliate of ProMedica

☐ Molina Healthcare

☐ UnitedHealthcare

☐ Ohio Medicaid # _____

☐ **Private Insurance (Other than Medicaid)**

Insurance Company _____

Policy Holder Name _____

Relationship to the Student _____

Date of Birth _____

Effective Date _____

Co-Pay $ _____

Policy # _____

☐ **Secondary Insurance**

Insurance Company _____

Policy Holder Name _____

Relationship to the Student _____

Date of Birth _____

Effective Date _____

Co-Pay $ _____

Policy # _____

New Patient History **STUDENT NAME** _____ **DOB** _____

Primary Care Provider:	Provider Location:
Other Provider:	Other Provider Location
Seen by other Providers for:	
Dentist:	Dentist Location:
Preferred Pharmacy:	Pharmacy Location:

Does your child have any allergies? ☐ Yes ☐ No *(Please check and explain)*

Allergies	Describe Reaction
All Surgeries since birth	

Family History:

Does anyone at home smoke or vape?	☐ Yes ☐ No	Indoors? ☐ Yes ☐ No	Outdoors? ☐ Yes ☐ No

Date of child's last physical or well-child exam _____	My child has not had a physical or well-child exam in the last 12 months ☐

Please list below all medical problems each family member has had.

Mother		Medical problems:
Father		Medical problems:
Grandmother	Mom side / Dad side (circle one)	Medical problems:
Grandfather	Mom side / Dad side (circle one)	Medical problems:
Brother		Medical problems:
Sister		Medical problems:

Medical Problems and Health Concerns (Check "Yes" or "No" for each item and explain below if necessary).

Chicken Pox disease (age: ___)	☐ Yes ☐ No	History of Guillain-Barre Syndrome	☐ Yes ☐ No
Dizziness/fainting/passing out	☐ Yes ☐ No	Seizures (Epilepsy) *Date of last seizure:* _____	☐ Yes ☐ No
Psychological or mood problem*	☐ Yes ☐ No	Brain or nervous system problem*	☐ Yes ☐ No
Development problems	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Surgery or admitted to the hospital In the last year	☐ Yes ☐ No	Cystic Fibrosis	☐ Yes ☐ No
Heart Problem	☐ Yes ☐ No	Lung or breathing problem*	☐ Yes ☐ No
Sickle Cell Disease	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Immune system problem*	☐ Yes ☐ No	GI or stomach problem*	☐ Yes ☐ No
Clotting disorder*	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No
Blood disorder*	☐ Yes ☐ No	Bladder or urinary problem*	☐ Yes ☐ No
Type 1 Diabetes	☐ Yes ☐ No	Pregnant *(girls only)*	☐ Yes ☐ No
Type 2 Diabetes	☐ Yes ☐ No	Other problems/concerns*	☐ Yes ☐ No
Endocrine disorder	☐ Yes ☐ No		
**Please explain any above starred items*			

Person Completing Form (print): _____ Date: _____

Signature: _____ Relationship to Child: _____

Billing Agreement

Health Insurance:

I am aware that it is my responsibility as the patient to give a copy of my insurance information to QUICKmed Urgent Care, LLC

Self-Pay (Uninsured or Underinsured):

QUICKmed will work with the uninsured to obtain access to care.

Co-Pay/Nominal Fee:

I am aware that my co-pay/nominal fee is my responsibility. I may pay cash, check or credit card.

Statements:

I am aware that I will only receive two (2) statements and one (1) past due statement (a total of 3 statements)

Financial Authorization and Release of Information

I authorize payment directly to QUICKmed Urgent Care and/or the physicians or their designees of the benefits herein specified and otherwise payable to me but not to exceed the regular charges.

MEDICARE PATIENTS ONLY – I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I authorize any holder, including the physicians and/or their designees, of medical or other information about me to release to the Social Security Administration and/or the Medicare program any information needed for this or related Medicare claim. IF FOR ANY REASON MEDICARE (OR MY INSURANCE COMPANY) DENIES PAYMENT, I AUTHORIZE CHCGD and FRHC TO ACT ON MY BEHALF TO APPEAL FOR PAYMENT.

My signature, or that of my authorized representative, indicates that I have read, understand and agree the above conditions and this consent for care at QUICKmed UC supersedes any other financial consent that may have been signed.

Student's Name	DOB	Signature of Patient or Legal Representative or Agent	Date	Relationship to Student	Date