Trotwood-Madison City Schools
School-Based Health Center Enrollment and Lifetime Consent Form

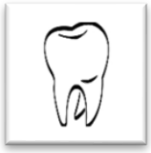
(rev. 11/21)

Trotwood-Madison City Schools (TMCS) partners with many community agencies 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 about service ability. These health services provide quality health care in a friendly, convenient 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 or your current primary care provider.

Patient/Student Name (First, Middle, Last)		Student Preferred Name	
Street Address	City	State	Zip Code
Phone Number (with area code)	Date of Birth (Month/Day/Year)	Grade	School Name

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.)

Medical/ Behavioral Health 	☐	Care and treatment for injury/illness, physical examinations (well-child or sports), Influenza (flu) immunization
	☐	Meningococcal immunization (required for 7th & 12th grades)
	☐	Tdap immunization (required for 7th grade)
		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
	☐	Pregnancy testing
	☐	Sexually Transmitted Infection (STI/STD) testing, Education and/or treatment
	☐	Birth Control
	☐	Mental/behavioral health counseling
Dental 	☐	Free Dental screening and sealants for 2nd and 6th grades and a sealant check next school year and re- application if needed)
	☐	Dental exam, dental filings
Vision 	☐	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)

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 and Five Rivers Health Centers (FRHC) 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 Trotwood-Madison 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.

Person completing form (print): _____ Date: _____

Signature: _____ Relationship to Child: _____

_____

Health Insurance Information

Please circle which insurance carrier shown below covers your child. 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. You may get a bill for some services if not covered by insurance.

Medicaid Managed Care Plans (circle one below):

buckeye health plan CareSource PARAMOUNT ADVANTAGE | MEDICAID Affiliate of ProMedica UnitedHealthcare

Managed Care ID# _____ Ohio Medicaid # _____

Patient information:			
Patient/Student Name (First, Middle, Last)		Student Preferred Name	
Social Security #	Date of Birth		

Responsible party (Required for patients under 18 or whenever the guarantor is not the patient):					
Name (First, Middle, Last)	Social Security #	Date of Birth	Relationship		
Billing Address of Patient or Responsible Party Apt. #	City	State	Zip		
Home Phone ( )	Alternate Phone ( )	Family Friend ( )			
Email Address					

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 # _____

Five Rivers Health Centers is a Federally-Qualified Health Center.
We are required to collect the incomes and other demographic information of our patient population. All information is confidential and we are only required to report numbers, not patient names.

A family size is your immediate family who live in your home that you are legally responsible for and children you pay child support for that do not live in your home. We will ask you to update this information yearly.

Please circle your family size and your family income on the chart below:

Family Size	Annual Income Under	Annual Income Between	Annual Income Between	Annual Income Between	Annual Income Between
1	$12,880	$12,881-$16,100	$16,101-$19,320	$19,321-$22,540	$22,541-$25,760
2	$17,420	$17,421-$21,775	$21,776-$26,130	$26,131-$30,485	$30,486-$34,840
3	$21,960	$21,961-$27,450	$27,451-$32,940	$32,941-$38,430	$38,431-$43,920
4	$26,500	$26,501-$33,125	$33,126-$39,750	$39,751-$46,375	$46,376-$53,000
5	$31,040	$31,041-$38,800	$38,801-$46,560	$46,561-$54,320	$54,321-$62,080
6	$35,580	$35,581-$44,475	$43,476-$53,370	$53,371-$62,265	$62,266-$71,160
7	$40,120	$40,121-$50,150	$50,151-$60,180	$60,181-$70,210	$70,211-$80,240
8	$44,600	$44,601-$55,750	$55,751-$66,900	$66,901-$78,050	$78,051-$89,200

Student Demographic Information

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: _____

Billing Agreement

Student Name _____ DOB_____

Health Insurance:

I am aware that it is my responsibility as the patient to give a copy of my insurance information to Five Rivers Health Centers.

Self-Pay (Uninsured or Underinsured):

I am aware that it is my responsibility to complete the Sliding Fee Application and return my proof of income within 30 days of my visit or I will be responsible for 100% of my bill.

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) before my account is sent out to an outside collection agency. I am aware if Five Rivers Health Centers receives returned mail because I have not supplied a correct/updated billing address, I may be sent to an outside collection agency.

Payment Arrangements:

I am aware that if there is a balance due, I may set up a "Payment Arrangement" if I am unable to pay in full. I am also aware that if I do not set up a payment plan with Five Rivers Health Centers or I do not make my scheduled payments, I may be sent to an outside collection agency.

Collections:

I am aware that if I am sent to an outside collection agency two (2) times that I may be discharged from the practice and I will no longer be able to receive services at FRHC.

Financial Authorization

I authorize payment directly to FRHC and/or the physicians or their designees of the benefits herein specified and otherwise payable to me but not to exceed the regular charges. I understand I am responsible for all charges until the bills are paid in full and/or the balances of charges are not covered by insurance.

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 FRHC supersedes any other financial consent that may have been signed.

_____ _____

Signature of Patient or Legal Representative or Agent | Date | Relationship to Student

Student Name _____ DOB_____

Date of student's last physical or well-child exam	☐ My child has **not** had a physical or well-child exam in the past 12 months
Primary Care Provider	Provider Location
Other Provider	Other Provider Location
Seen by other Provider(s) for	
Dentist	Dentist Location
Preferred Pharmacy	Pharmacy Location
All Surgeries since birth	

Does your child have any allergies? ☐ Yes ☐ No (*If yes, explain below)*

Allergies	Describe Reaction:

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

Family History:

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

Mother:	
Father:	
Grandmother: circle one: Mom side Dad side	
Grandfather: circle one: Mom side Dad side	
Brother(s):	
Sister(s):	

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
Surgery or admitted to the hospital in the last year	□ 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
Dizziness/fainting/passing out	□ 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**			

Privacy Practices & Authorization to Release Information

Student Name _____ DOB_____

Notice of Privacy Practices Acknowledgement: I have been notified that I can ask for a copy of the Notice of Privacy Practices forms for Five Rivers Health Centers at any TMCS building. I know I also can view them online at and www.fiverivershealthcenters.org. Copies of the consent form are available at my child's school and blank forms are also available at www.trotwood.k12.oh.us

Authorization to Release Information: I hereby authorize FRHC or TMCS to exchange information with insurers, compensation carrier, healthcare facility, welfare agency, healthcare provider, the DPS 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 is a student within Trotwood-Madison City Schools unless revoked by me. I may revoke 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 Five Rivers Health Centers 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.

☐ **I AGREE** to allow Five Rivers Health Centers access to my child's individual academic, attendance and behavior records for the current and prior school years, so they can provide better services to my child.

☐ **I DO NOT AGREE** to allow Five Rivers Health Centers access to my child's individual academic, attendance and behavior records for the current and prior school years, so they can provide better services to my child.

This consent is valid until the child reaches the age of majority, or is no longer a student at a Trotwood-Madison City Schools. 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 two organizations 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**

Parent/Guardian (Print)	Parent/Guardian (Signature)	Date
Student/Patient (Print) (if 18 years or older)	Student/Patient (Signature) (if 18 years or older)	Date