

Consent for Minor's Patient Care



Students Name _____ Date of Birth _____

Students SSN _____ School _____ Grade _____

I give consent for the above named student to receive services at the Student Wellness Center. This may include: Medical Treatment, Behavioral Health, and Chemical Dependency Services. This may also include Medication Evaluation and Treatment through Richard Young Outpatient Clinic, provided at Student Wellness Center or through Telehealth provided at the Student Wellness Center.

MEDICAL RECORDS RELEASE

I give permission for the Student Wellness Center to exchange relevant medical/ behavioral health information in verbal / written form between Student Wellness Center and: school nurses, the students primary care physician, school administration / personnel, probation, diversion, truancy court, or referral facility as needed in order to facilitate evaluation of this student's medical / behavioral health care.

SCHOOL REGISTRATION

I give permission for the Student Wellness Center to utilize the information provided to the school during annual registration. This may include (but not limited to): demographics, emergency contact, doctor, race, ethnicity, and language.

COMMUNICATION CONSENT

I consent to receiving communications from the Student Wellness Center, staff, contractors, collection agents, and others, at any number I provided or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto-dialer or other computer assisted technology, pre-recorded messages, or by any other form of electronic communication. Including (but not limited to) appointments, follow-up care, scheduling, my accounts, assignment of benefits, and/ or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new numbers) if my numbers) change.

HIPPA

I acknowledge receipt of the Student Wellness Center's notice of Privacy Practices received upon request and/ or at the initial registration with the Student Wellness Center. (April 2016)

INSURANCE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the Student Wellness Center to release information regarding treatment to third party payers or others for purposes of billing or program management and evaluations. Additionally, I authorize and request that any payment of benefits due for care provided be paid directly to the Student Wellness Center. I individually obligate myself and the patient to pay the Student Wellness Center account in accordance with the regular rates and payment policy of the Medical Center. **Please provide a copy of your insurance card at the time of the visit. If you believe you may qualify for Charity Assistance, please notify us.**

X _____

SIGNATURE OF PARENT/GUARDIAN

DATE

Insurance Policy Holder Name

Date of Birth

SSN

Insurance Policy Name

Insurance Policy Number

Relationship to student: ☐ Mother ☐ Father ☐ Other (specify) _____

*This consent can be withdrawn at any time with written notification to the Student Wellness Center

*This consent is good only for the current school year.