



Dear Parent/Guardian,

Effingham Behavior Health Center, in collaboration with Effingham County School District, is pleased to announce a new initiative designed to improve access to mental health services for your child. Effingham Behavioral Health Center is a partnership between Effingham Health System and Curtis V. Cooper in Springfield.

Your child's school has been selected to participate in a **School-Based Behavioral Health Program**, which allows students to receive behavioral health support directly at school during the regular school day.

Our care team includes **physicians, nurse practitioners, licensed clinical social workers, and counselors** who work together to support students' emotional, behavioral, and mental well-being. Some of the conditions our behavioral health team can help manage include, but are not limited to, are:

- Anxiety and stress
- Depression and mood concerns
- Behavioral or attention difficulties
- Adjustment challenges related to family or school changes
- Coping skills and emotional regulation

Behavioral health plays a vital role in a child's overall development and success—both academically and socially. When children learn to identify, express, and manage their emotions in healthy ways, they are better able to focus, build positive relationships, and handle challenges effectively. Addressing behavioral health needs early can prevent small concerns from becoming larger issues and can significantly improve a child's confidence, classroom participation, and long-term well-being.

By providing these services within the school setting, we aim to reduce barriers to care, support students' academic success, and promote overall wellness.

To enroll your child in the program, a completed general consent form is required. Please submit the completed paperwork to Curtis V. Cooper using one of the following methods:

1. **Email:** bhs@cvcphc.com
2. **Fax:** 877-289-2706
3. **Drop-off:** Effingham Behavioral Health, 1451 HWY 21, Suite H, Springfield, GA 31329

These services will be billed to your medical insurance that you will provide to us in the paperwork. If the child does not have medical insurance, we will work with you to provide these services.

If you have any questions or would like more information, please contact your school counselor or Effingham Behavioral Health at 912-999-1586.

We appreciate your partnership in supporting your child's health and success.

Sincerely,

Effingham Health System

Registration and Financial Evaluation Form

Patient/Student Information			
Last Name:	First Name:	Middle Name:	
SSN:	Date of Birth:	Age:	Sex:
Preferred Pharmacy:		Preferred language:	
Address:			
Parent's phone number:			
Parent's secondary phone number:			
Parent's email address:			
Patient's School:		Grade:	
What is your child's race? <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other		Additional Information: Homeless <input type="checkbox"/> Yes <input type="checkbox"/> No Migrant/seasonal worker <input type="checkbox"/> Yes <input type="checkbox"/> No Public Housing <input type="checkbox"/> Yes <input type="checkbox"/> No Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is your child's ethnicity? <input type="checkbox"/> Hispanic, Latin, or Spanish Origin <input type="checkbox"/> Not Hispanic, Latin, or Spanish Origin			
Guarantor Information			
Last Name:	First Name:	Middle Name:	
Relationship to Patient:	Sex:	Phone number:	
Address:			
Email address:			
Insurance Information			
Primary Insurance:	Primary Policy # & Group #:	Primary subscriber name & Date of Birth:	
Secondary Insurance:	Secondary Policy # & Group #:	Secondary subscriber name & Date of Birth:	
Emergency Contact Information			
Name:	Phone number:	Relationship to Patient:	

Parent/Guardian Signature: _____
 Date: _____

CVCPHC Employee: _____
 Date: _____



In collaboration with Curtis V. Cooper and Effingham County School District

Acknowledgement of Receipt of Privacy Notice

Purpose

The Health Insurance Portability and Accountability Act (HIPAA) requires that Effingham Health System and its partnering organizations provide patients and their guardians with a Notice of Privacy Practices. This notice explains how your child's protected health information (PHI) may be used and disclosed, as well as your rights regarding that information.

Your Rights and Our Responsibilities

- You have the right to review our Notice of Privacy Practices before signing this acknowledgment.
- You may request a copy of the Notice at any time, even if you have already signed this form.
- We are required by law to maintain the privacy and security of your child's PHI.
- We will not share your information unless permitted or required by law, or unless you authorize it in writing.

Acknowledgment of Receipt

I acknowledge that I have received and/or been offered a copy of the **Effingham Health System Notice of Privacy Practices**.

I understand that this notice explains how my child's health information may be used, disclosed, and how I can access this information.

Patient (Student) Name: _____

Date of Birth: _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____

Date: _____

Relationship to Patient (Student): _____

FOR OFFICE USE ONLY

If acknowledgment is not obtained, please complete below

Patient/Parent/Guardian declined to sign

Patient/Parent/Guardian unable to sign (reason): _____

Notice mailed on (date): _____

Other: _____

Staff Name/Title: _____

Signature: _____

Date: _____

GENERAL CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION FOR INSURANCE PAYMENT

I, the undersigned or legal guardian, grant permission as indicated below to undergo all necessary tests, treatments, and other procedures or studies required for the diagnosis by the medical staff and other employees of Effingham Health System and Curtis V. Cooper Primary Healthcare, Inc.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment and examination by Effingham Health System and Curtis V. Cooper Primary Healthcare, Inc.

I consent to the release of medical information to other institutions or agencies accepting the patient for medical or institutional care, and consent to the release of medical information to patient's insurer and give permission to release data (both medical and personal) to such government agencies as is required of Effingham Health System and Curtis V. Cooper Primary Healthcare, Inc. by law, rules, regulations, or by consent.

I consent to the release of medical and financial information for auditing purposes.

I consent for my medical records to be shared electronically, securely, and confidentially through electronic medical record systems. I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, health plans, and my other healthcare providers.

I hereby authorize payment to Curtis V. Cooper Primary Healthcare, Inc. of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS, otherwise payable to me, but not to exceed the health center and/or physician regular charges for this period of treatment. I agree that a copy of this authorization is as valid as the original. I understand that if my insurance does not approve the charges for this visit, I am fully responsible to Curtis V. Cooper Primary Healthcare, Inc. for payment.

MEDICARE PATIENTS ONLY: I authorize any holder of medical or other information about me to release to Centers for Medicare and Medicaid (CMS) or its intermediaries or carriers, any information needed for this or any subsequent Medicare claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party that accepts assignment for such claim.

I hereby voluntarily consent to treatment now and during all subsequent visits to the Effingham Health System and Curtis V. Cooper Primary Healthcare, Inc. I voluntarily consent to mental health services as may be ordered and/or recommended by physicians and/or appropriate designee responsible for my medical care.

By signing this document, I attest that all information is true and correct and I will notify Effingham Health System and Curtis V. Cooper Primary Healthcare, Inc., of any changes to my insurance, income, or contact information.

If you have any questions, please contact our Privacy Officer at telephone number (912) 754-0143.

Name of Patient/Student (Print)	CVCPHC Representative (Print)
Signature of Patient/Guardian & Date	CVCPHC Representative's Signature & Date

AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, authorize the **Effingham County Board of Education** (and/or the school the student attends), **Curtis V. Cooper Primary Health Care, Inc.**, and **Effingham Health System** to verbally, electronically, and/or in writing communicate with one another and to mutually release and obtain information regarding my child's case for the purpose of coordinating educational and behavioral health services, ensuring continuity of care, and supporting my child's academic and emotional well-being. A copy of this authorization will be provided to all parties.

My child's name is: _____

Date of Birth: _____ School: _____

The following information is included:

- My child's attendance in therapy
- My child's diagnosis
- My child's treatment plan
- Information relevant to coordinating care
- When treatment is terminated and why
- Other (please explain in detail): _____

I understand that this release is valid for the extent of treatment unless revoked in writing. I further understand that I may revoke this authorization in writing at any time. If you wish this release to be valid for a shorter term, please indicate the date it shall expire on: _____

I understand that information released to the above organizations may be re-disclosed as permitted by law and may no longer be protected by federal privacy regulations.

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information. All information I hereby authorize to be released to or obtained from this agency will be held strictly confidential to the extent permitted by law. I may withdraw this consent at any time.

Signature of Parent/Guardian:	Date:
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