Jordan Valley Health

Lebanon
School Year: _____

Prefer to fill this out online? Scan this code:

Patient Paperwork and Consent to Treat | Mobile and School-Based Care Form

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I am providing consent for my child to participate in the following services provided by Jordan Valley Health School-Based/Mobile Unit Program (please select all that apply)

- ☐ Medical: Sick Visits, Well Visits including Sports Physical, Telehealth
- ☐ Dental: Routine check-up and/or restorative work
- ☐ Vision: Eye exam
- ☐ Behavioral Services
- ☐ All services listed above

In addition to written consent, flouride treatment will also be confirmed via verbal consent at the time of service. If you have any questions about this program, email MobileUnits@JordanValley.org.

Date: _____ Grade: _____

Patient Legal Name: _____ Patient Preferred Name: _____

Social Security Number: _____ Date of Birth (DOB): _____

Sex Assigned at Birth: ☐ Male ☐ Female Preferred Language: _____

Address: _____
City State Zip

Race (check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Multi-racial: _____
- ☐ Other: _____
- ☐ Prefer not to answer

Ethnicity (check all that apply)

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other: _____
- ☐ Prefer not to answer

Housing Status

- ☐ Not homeless
- ☐ Currently not homeless, was in the last 12 months
- ☐ At risk for homelessness

Migrant Seasonal Worker Status

- ☐ Migrant worker
- ☐ Seasonal worker
- ☐ Neither

Number of Adults/Children in Your Household: _____

Annual Income for Household: _____

Insurance

Patient is covered by Medicaid: ☐ No ☐ Yes If yes, Medicaid #: _____

Patient is covered by Other Insurance: ☐ No ☐ Yes

Name of Insurance: _____ Group: _____ Policy #: _____

Name of Policy Holder: _____ Date of Birth: _____

Social Security Number: _____ Relationship: _____

Parent/Legal Guardian Contact

Parent/Legal Guardian Name: _____ Date of Birth: _____

Address: _____

City State Zip

Relationship to Patient: _____ Home Phone #: _____

Work Phone #: _____ Cell Phone #: _____

Social Security Number: _____

Vision

Does your child have vision problems? ☐ No ☐ Yes If yes, what kind of problems is your child experiencing?

☐ Nearsighted ☐ Farsighted ☐ Astigmatism ☐ Other If other, please explain: _____

_____

Has your child ever worn glasses or contacts? ☐ Glasses ☐ Contacts ☐ Neither Glasses nor Contacts

Medical

Does your child have any current or past medical conditions? (Examples: Asthma, Diabetes, Heart Disease, High Blood Pressure, Neurological Conditions, Allergies, etc.) ☐ No ☐ Yes If yes, please list: _____

_____

Has the patient had surgery? ☐ No ☐ Yes If yes, please list the type of surgery or surgeries and date(s):

_____

Please list any medicine and supplements your child is taking: _____

_____

Does the patient have any allergies? ☐ No ☐ Yes If yes, please list: _____

_____

Dental

Has your child ever seen a dentist before? ☐ No ☐ Yes If yes, date of last treatment: _____

Name of your child's dentist: _____

Has your child had any unpleasant experiences in a dental office? ☐ No ☐ Yes

If yes, please describe what happened and how we can make your child more comfortable: _____

_____

_____

Does your child have any medical conditions that may affect or complicate treatment? This may include HEART, BREATHING, BLEEDING, SEIZURE, BEHAVIORAL, ALLERGIES, COMMUNICABLE DISEASE, GENETIC CONDITIONS, and/or IMMUNE DISORDERS.

☐ No ☐ Yes If yes, please list: _____

Consent to Share Protected Health Information

Sharing Your Information

Jordan Valley Health (JVH) uses a tool to electronically submit prescriptions on your behalf to the pharmacy of your choice. Limited information about you and the medication will be securely transmitted to support the prescription order.

JVH will sometimes utilize your contact information including phone, text, email, and mail to send you appointment reminders, information about the clinic, health education, and information which may contain protected health information, or to ask for feedback. Please help us keep your contact information up to date including your phone number, home address, and email.

Limited Verbal Release of Protected Health Information

Jordan Valley Health (JVH) gives you the option to name other persons who can contact JVH to talk to JVH about your (or your dependent's) care, treatment, payment, or appointment schedules. These people cannot make decisions about your (or your dependent's) care. JVH will ask these people to identify themselves before sharing PHI. PHI will not be shared with persons who are not authorized by you.

I authorize limited release of my PHI as told above to the following person(s):

Full Legal Name	Relationship	Date of Birth	Phone
Full Legal Name	Relationship	Date of Birth	Phone

Authorization for Consent to Treat a Minor Form

Unless a child (i.e. minor) has a life-threatening injury or illness, doctors are required by law to have permission from the parent or legal guardian to treat anyone under the age of 18.

This form is necessary when a child under the age of 18 needs care and is not with their parent or guardian. Jordan Valley Health will not provide care for children in the care of a relative or baby-sitter without a written consent from their parent or legal guardian.

Authorization for Consent to Treat a Minor

Child Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Date of Birth: _____

This consent is good for one year from the date of signature. If you wish to change PHI or revoke this consent, please submit it in writing to Compliance@JordanValley.org or contact your local Jordan Valley Community Health Worker (CHW).

I acknowledge the previous information, and I permit limited release of my/or my dependents PHI as described previously.

Print Patient Name	Date
Patient/Legal Guardian/Guarantor Signature	Print Legal Guardian/Guarantor Name (if applicable) Full Legal Name

Consent for Treatment

By signing below, I am giving consent for myself/my ward to receive any treatment or procedure deemed necessary by the professional staff of Jordan Valley Health (JVH) which may include medical, dental, or behavioral health treatment. I acknowledge that my care may be provided by licensed professionals, students, and other healthcare staff while at JVH. By signing below, I hereby state that I am the patient, parent, primary legal custodian, or joint legal custodian of the patient being presented today for treatment. I understand any behavioral health and education services are documented in my electronic medical record and are available for my care providers to view. Additionally, I understand my insurance company may require basic information about me such as diagnosis and how many appointments I have had. Other than this, my information is kept confidential unless I disclose intent to harm myself or another person, or I am suspected of, or aware of abuse to a child, an elderly person, or an otherwise vulnerable adult. These situations will have to be reported to the appropriate authorities.

OCHIN Epic Information Sharing

JVH is part of an organized healthcare arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of JVH, OCHIN supplies information technology and related services to JVH and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by JVH with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the healthcare operations purposes of the organized healthcare arrangement. Healthcare operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive. Personal health information may include past, present, and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent; however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided with a list of entities to which your information has been disclosed.

Notice of Privacy Practices for Tiger Institute Health Information Exchange

JVH participates in a Health Information Exchange provided through the Tiger Institute Health Information Alliance. The Exchange facilitates the transmission of your medical record between providers who are treating you, replacing other types of communication methods such as the telephone. Fax machine, and the US Postal Service. With your written permission, the Exchange permanently stores your data in a secured repository for providers who may treat you in the future, if they have established a treatment relationship with you. The Exchange may also provide critical information about you for other lawful purposes, such as to educate providers who manage the care of others like you, but in doing so will not share your names, address or other information that could identify you.

In those cases where your specific consent or authorization is required by law to disclose your medical records to others, JVH will not disclose that information through the Exchange without first obtaining your written consent.

Print Patient Name	Date
Patient/Legal Guardian/Guarantor Signature	Print Legal Guardian/Guarantor Name (if applicable) Full Legal Name

Acknowledgement of JVH Billing and Payment Practices

Jordan Valley Health (JVH) is committed to providing patients the highest quality of care and pursuing excellence in our services and interactions. We share this information with you to help you understand and prepare for your care and responsibilities as a patient of JVH.

Time of Service Payment: JVH collects payment at time of service including co-pays, deductibles, and/or sliding and other fees that may be due. JVH accepts cash, checks, Visa, Mastercard or Discover card. Past due payments may be referred to a collection agency. JVH offers payment agreements, if needed.

Self-pay and Discounts: JVH offers a pre-paid discount or a sliding fee discount. Full payment is due at the time of service.

Medicaid and Medicare: As applicable, JVH will confirm your current Medicaid or Medicare coverage at each visit. Please provide your current benefits card. If Medicaid or Medicare denies payment for your services, you are responsible for the balance due. I request that payment of authorized Medicare, Medicaid or other insurance company benefits be made either to me or on my behalf to JVH for any services provided to me by that party who accepts assignment. I understand the regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid services or its intermediaries or carriers any information needed for this, or related Medicare or other insurance company claim. I understand billing information relating to services I receive could be released to my insurance provider for payment of services received. I permit a copy of this authorization to be used in place of the original.

Insurance Billing: As applicable, JVH will file a claim for service with your insurance company. Not all health insurance plans are accepted at JVH. We will confirm if your plan is accepted. If your plan fails to provide payment to JVH, you are responsible for paying the balance due. JVH does not file liability insurance, such as motor vehicles or third-party coverage. We also do not file Workers Compensation claims. JVH will share information with you if you choose to file your own claims for this coverage.

Financial Agreement: I agree to pay Jordan Valley Health (JVH) for all billable services rendered to me and/or my ward. I acknowledge payment is due at the time of service and payable upon receipt of a monthly billing statement. If payment is not received within 90 days of the date of service, the balance may be referred to a collection agency. I understand I can enter into a payment agreement with the support of JVH's billing department if I am unable to pay the balance in full at the time of service. I understand that, after 6 months, any unused prepayments or copay amounts will be applied to any outstanding balances on my account before a refund is issued. I acknowledge that access to services at JVH will not be restricted due to my inability to pay amounts owed. However, I agree to work with JVH to establish an appropriate payment plan to address any outstanding balances.

Acknowledgement of Patient Practices

Keeping Your Appointments: It is important you keep to your appointments to stay healthy. If you cannot keep your appointment, please call us right away, but no less than 24 hours before your appointment. If you miss too many appointments, JVH may limit how you can schedule in the future. JVH assures certain rights to patients while asking patients to fulfill certain responsibilities. The Patient Rights and Responsibilities statement is publicly posted in our clinics. You can request a complete print copy of Patient Rights and Responsibilities at any time within our clinics.

Understanding Patient Rights and Responsibilities: JVH assures certain rights to patients while asking patients to fulfill certain responsibilities. The Patient Rights and Responsibilities statement is publicly posted in our clinics. You can request a complete print copy of Patient Rights and Responsibilities at any time within our clinics.

Acknowledgement of Notice of Privacy Practices: JVH may sometimes use or disclose limited protected health information (PHI) about your medical, dental, vision, or behavioral healthcare with other entities to coordinate your care, assure payment for services, or to support healthcare operations. Some examples of this disclosure include submission of electronic prescriptions on your behalf, billing and/or payment data shared with third-party service vendors and contact information for appointment reminders or feedback requests. Additionally, JVH may use or disclose your PHI without authorization when there is an emergency or when JVH is required by law to do so. Other uses or disclosures of your PHI can only be made with your written authorization. The Notice of Privacy Practices statement is publicly posted in our clinics. You can request a complete print copy of Notice of Privacy Practices at any time within our clinics. Review it to learn how protected health information about you may be used and disclosed and how you can get access to this information.

I acknowledge the above notices, and I permit limited release of my PHI as described.

Print Patient Name	Date
Patient/Legal Guardian/Guarantor Signature	Print Legal Guardian/Guarantor Name (if applicable) Full Legal Name