The Healthcare Connection, Inc.
Viking School-Based Health Center (VSBHC)
Consent for Treatment, Health Information Release, and Privacy Form

______________________________________ ______________________
Print – Student's Legal Name Date of Birth

CONSENT FOR VSBHC SERVICES:
I, the parent/guardian of said student, give consent for my child to receive services at the Viking School-Based Health Center (VSBHC) operated by The HealthCare Connection (THCC). I authorize THCC to provide medical, dental, and behavioral health services. Dental treatment includes the application of fluoride varnish to your students' teeth. Fluoride varnish is an American Dental Association accepted therapy that can reduce dental decay by up to 33%. It is a non-invasive, 20 second treatment. Please check ❑Yes, I give consent or ❑ No, I do not give consent for fluoride varnish application for my child. All health care information is confidential. By signing the consent form, I am giving VSBHC staff, the school nurse, and my child's regular medical provider (if applicable) permission to communicate and share medical information regarding my child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner.

Confidentiality between the student, parents and VSBHC is assured. I do understand by law, some information requires the student's signed consent prior to disclosure to anyone, including parents\guardians; and that VSBHC staff will encourage every student to involve his/her parent/guardian in health care decisions. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above-named child will be shared between the VSBHC and the alternative contact. By signing this consent, I understand and agree to the terms and conditions regarding sharing of health information.

PAYMENT:
I understand there is a charge depending on the service provided and that I will be responsible for payment. When available, my insurance including Medicaid will be billed. The VSBHC may release information regarding treatment to third party payers for billing purposes. I understand no student will be denied access to VSBHC medical services due to inability to pay.

HEALTH INFORMATION RELEASE:
I understand and agree that my health information may be stored in or released through one or more electronic health records systems through which healthcare professionals and facilities and others involved in my care may view and obtain information. I also understand and agree that, once my health information is released in that way, it may be added into other treating providers' medical records and be aggregated with the health information of others and used or disclosed to conduct data analysis, or for any other lawful purpose.

I understand that this Health Information Release Consent applies to information generated prior to the date of this consent and during any subsequent visit while this consent is in effect. This consent is effective on the date of my signature (or the signature of my authorized representative) below. I may revoke this consent in writing, at any time; provided, however, that such revocation will not apply to any uses or sharing of my heath information that occurred prior to the date the written revocation was received.

Acknowledgement of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices. This Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. I am aware that the Notice may be changed at any time. I was given the opportunity to review the Notice and ask questions regarding my privacy rights. I understand that by law, THCC may use or disclose specific information without authorization. Those specific reasons are listed in the Notice. I further understand that my medical information is protected under HIPAA for privacy and confidentiality and cannot be released without my written consent. By signing this form, I am authorizing THCC's use and disclosure of my protected health information as detailed above. However, I may give notice to restrict the use of such information and revoke my consent in writing.

______________________________________ ______________________
Patient Signature Date

____
Signature of Parent or Patient's Representative (if applicable)

THE HEALTHCARE CONNECTION, INC.
ENROLLMENT FORM

Student's Name:____Student's School: ________________________Grade: ______

Address:____Zip Code:__Birthdate:______SS#:______________________

Gender: ❑ Female ❑ Male ❑ Transgender Male ❑ Transgender Female ❑ Other ❑ Choose not to disclose

Sexual Orientation: ❑ Straight ❑ Lesbian/Gay ❑ Bisexual ❑ Something else ❑ Choose not to disclose

RACE/ETHNICITY/LANGUAGE (Please check)

RACE: ❑ Asian ❑ Native Hawaiian ❑ Other Pacific Islander ❑ Black/African American ❑ American Indian/Alaskan Native

❑ White Male ❑ More than one race ❑ Choose not to disclose

ETHNICITY: ❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino **PREFERRED LANGUAGE:** ____________________________

HEALTH CARE SERVICES NEEDED (Please check and complete all that apply)

❑ Annual physical ❑ Sports physical ❑ Work permit ❑ Immunizations ❑ Sick visit: ______________________________

❑ No services needed at this time, please keep consent form on file.

❑ My child regularly goes to another doctor. I would like to use the VSBHC when necessary. I understand my child's doctor will receive reports following visits.

Preferred Drug Store: Name:_________________________Location:_________________________Phone: ____________________

CHILD'S INSURANCE INFORMATION (Please check and complete all that apply)

❑ **No health insurance** ❑ **I wish to apply for a service discount**

❑ **Primary Health Insurance:**

Name of Subscriber (Policy Holder) ____

Birthdate of Policy Holder______________________SS# of Policy Holder _____________________________________

Address (if different from child) ____

Name of Insurance Company ____

Insurance Phone / Fax Number ____

Group & ID Number ____

❑ **Secondary Health Insurance:**

Name of Subscriber (Policy Holder) ____

Birthdate of Policy Holder___________________SS# of Policy Holder _____________________________________

Address (if different from child) ____

Name of Insurance Company ____

Insurance Phone / Fax Number ____

Group & ID Number ____

❑ **Medicaid/HMO:** ❑Buckeye ❑ CareSource ❑ Molina ❑Paramount ❑ United Healthcare ❑ Other: _________________

Member Name:____Birthdate: ______________________________

Medicaid/HMO ID#: ______________________________ MMIS # ____

PARENT/GUARDIAN CONTACT INFORMATION

Name:________________________________Mailing Address:______________________________________ ❑ Same as child

Birthdate:______________________SS#:____________________________Home Phone: ______________________

Cell:______________________Okay to leave a message/voicemail or text? ❑ Yes ❑ No Work Phone: ____________________

Email:______________________________ Okay to email in non-emergency situations? ❑ Yes ❑ No

❑ Parent/Guardian responsible for medical bills

Relationship to student: ❑ Father ❑ Mother ❑ Guardian

ALTERNATE CONTACT

Name:________________________________Mailing Address:______________________________________ ❑ Same as child

Birthdate:______________________SS#:____________________________Home Phone: ______________________

Cell:______________________Okay to leave a message/voicemail or text? ❑ Yes ❑ No Work Phone: ____________________

Email: ______________________________ Okay to email in non-emergency situations. ❑ Yes ❑ No

❑ Parent/Guardian responsible for medical bills

Relationship to student: ❑ Father ❑ Mother ❑ Guardian

CHILD'S HEALTH PROVIDER INFORMATION

Doctor's Name: Address: Phone:

Date of last physical exam: _______________________

❑ My child has not had a physical exam within the last year. If time allows, I would like my child to have a comprehensive physical exam during the school year.

❑ My child regularly goes to a dentist

Dentist's Name: Address: Phone:

Date of last visit: _____________________________

GENERAL INFORMATION

We accept most commercial insurances, Medicaid, and managed care plans, and offer discounts to families based on income and family size. For more information about discounted services, or to apply, parents should call The HealthCare Connection's (THCC) Finance Department at **513-483-3078**. No student is denied services due to the inability to pay.

Staff members are available to assist families without insurance to determine eligibility for Medicaid or the federal health exchange. For more information or to request assistance, parents should call **513-483-3071** to speak with a Resource Advocate.

THE HEALTHCARE CONNECTION, INC.
STUDENT HEALTH HISTORY

Student Name: ____ **Date of Birth:**_____/____/_____

Gender: ❑ Female ❑ Male ❑ Transgender Male ❑ Transgender Female ❑ Other ❑ Choose not to disclose

Sexual Orientation: ❑ Straight ❑ Lesbian/Gay ❑ Bisexual ❑ Something else ❑ Choose not to disclose

Date of last physical exam: __________________ **Date of last dental exam:** __________________

Does your child have any of the following medical problems? Please check.

☐ Diabetes ☐ Depression
☐ Asthma or Wheezing ☐ ADHD
☐ Seizures ☐ Developmental delay (speech, motor, cognitive)
☐ Other ____

Please explain any check marks: ____

____

____

Please list any prescription or over the counter medication your child is taking.

Medication	Dose & Frequency

Is your child allergic to any medications or food (for example, penicillin, eggs, milk)? If so, please list.

____

____

Family Medical History
Please check if anyone in the child's family has any of the following conditions (include only parents, siblings, grandparents, uncles, aunts, 1st cousins):

☐ Asthma ☐ Heart Disease or Attacks ☐ Diabetes

☐ Environmental Allergies ☐ High Blood Pressure

Signature of person completing this form: ____

Date:_____/_____/ _____

Print Name: ____