FamilyCare HEALTH CENTERS

Business Office
97 Great Teays Blvd., Suite 6
Scott Depot, WV 25560-9816

SCHOOL-BASED HEALTH CENTER CONSENT/ENROLLMENT

Dear Parent and/or Guardian,

FamilyCare Health Centers is pleased to offer school-based health services at your child's school during the school day. Licensed Healthcare Providers are available at the school to provide expanded medical treatment (illnesses, injuries, vaccinations and physicals) and behavioral health treatment on-site. School-based health services work in conjunction with care provided by your child's regular Primary Care Provider (PCP)/Pediatrician and are not meant to take their place.

All children enrolled in the school-based health program are eligible to receive services regardless of insurance status. FamilyCare Health Centers accepts most insurance plans. Coverage and costs for these services depends upon your insurance coverage. If you do not have insurance, please ask staff about enrolling your child in the WV CHIP program or the FamilyCare Health Centers sliding fee program. We do have staff that can assist with this process.

Parents are welcome to accompany their student for scheduled appointments at the health center. For unscheduled acute care visits, we will attempt to notify the parent if a student needs to be seen by a Provider. If the parent cannot be reached, however, and we have a consent form on file, the student will be treated and given a note to take home to the parent.

Parents are encouraged to actively participate in their child's health care. You are welcome to call or stop by the health center any time. We hope that we can help your child have a healthy and successful school year!

All parts of this Consent/Enrollment form must be completed, signed, and returned to the school before your child can receive services.

CONTACT INFORMATION: **FamilyCare Health Centers**
304-760-6336

***Please keep this page for contact information and return the remaining pages to the school.**

School Name:_____

Student/Patient Information:

Last Name	First Name		MI
Street Address	City	ST	Zip
Phone #	Other Phone #	Email Address	

Sex	DOB	Allergies (meds/foods,etc)	Ethnicity	Race
			☐ Hispanic ☐ Non-Hispanic	☐ American Indian ☐ Pacific Island ☐ Black ☐ Asian ☐ White

Parent/Guardian	Relationship	DOB	Phone #
1)_____	1)_____	1)_____	1)_____
2)_____	2)_____	2)_____	2)_____

Student Lives With: ☐ Mom ☐ Dad ☐ Both ☐ Other: _____

Name of Emergency Contact	Relationship	Phone #

*** Please Supply a Copy of Insurance Cards (Front and Back) ***

Primary Insurance	State Insurance ID Number	Group Number
Insurance Phone Number	Policy Holder Name	
Policy Holder Social Security Number	Policy Holder Date of Birth	Policy Holder Employer

Secondary Insurance	State Insurance ID Number	Group Number
Insurance Phone Number	Policy Holder Name	
Policy Holder Social Security Number	Policy Holder Date of Birth	Policy Holder Employer

Behavioral Health Insurance	State Insurance ID Number	Group Number
Insurance Phone Number	Policy Holder Name	
Policy Holder Social Security Number	Policy Holder Date of Birth	Policy Holder Employer

☐ I Do Not Have Insurance Annual Household Income $_____ Number in Household _____

Please check Yes or No after each statement and sign at the bottom	Yes	No
I give permission for my child to be treated by the school-based health staff (including the administration of any over-the-counter medications deemed necessary). A brief health history will be conducted during initial visit with medical provider.	☐	☐
Services may include Medical Services.	☐	☐
Services may include Behavioral Health Services.	☐	☐
I certify that the information provided is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to the student/patient's health. I will contact school based health staff if any of my child's medical history changes.	☐	☐
I have reviewed FamilyCare Health Centers Notice of Privacy Practices (www.familycarewv.org).	☐	☐
Release of Information and Payment Authorization: I authorize the release of any medical or other information necessary to process my claim. I also authorize payment of medical benefits to FamilyCare Health Centers for services provided.	☐	☐
Consent and Acknowledgement of Privacy Practices: I consent to the use and disclosure of my protected health information by FamilyCare Health Centers to any person or organization for the purpose of carrying out treatment, obtaining payment, or conducting certain healthcare operations. Protected health information used or disclosed by FamilyCare Health Centers may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with West Virginia and Federal law which may require you to provide specific authorization. I understand that how FamilyCare Health Centers will use and disclose my information can be found in FamilyCare Health Centers Notice of Privacy Practices. I understand that this consent is effective as long as FamilyCare Health Centers maintains my protected health information.	☐	☐
Authorization for Exchange of Health & Education Information: I hereby authorize FamilyCare Health Centers to exchange health and education records with my child's school district for the purpose of providing care and treatment to my child, if applicable.	☐	☐

Authorization for Exchange of Health Information: I hereby authorize FamilyCare Health Centers to exchange health care records with my child's PCP (Primary Care Provider) for the purpose of continuity of care and treatment of my child, as needed.

My child's Primary Care Provider/Pediatrician is: _____

This authorization is valid until I revoke this authorization or until my child no longer attends this school. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. Any changes to parent/guardianship, address/phone number, or any change in medical information is my responsibility to inform FamilyCare Health Centers School Based Health Center. I recognize that health records, if received by the school district, may not be protected by the HIPAA Privacy Rules, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA). I agree that a copy of this authorization is as valid as the original.

The School-Based Health Center staff can provide a copy of the Privacy Notice upon request.

By signing below, I understand and acknowledge the following:

1) I have read and understand this consent.
2) I have reviewed FamilyCare Health Centers Notice of Privacy Practices.

Parent or Legal Guardian Signature	Student Signature (If over 18)
Print Name	Date