Camden Family Health School-Based Health Care Centers

General Consent for Treatment ~ Assignment of Benefits
Patient Responsibility for Payment

I, the undersigned, being either the patient or the patient's legally authorized representative, do hereby:

GENERAL CONSENT FOR TREATMENT

- Consent to routine medical treatment and/or evaluation, including but not limited to laboratory testing. I agree to all services offered by the School-Based Health Care Center and hereby give my consent for my child to receive services at Camden Family Health School-Based Health Center/s.
- I understand that separate consents will be requested for certain special procedures.
- I authorize the release of any information necessary to process claims and for the insurance company to render payment to Camden Family Health.
- I understand that information may be shared with the school nurse or his/her designee and my primary care physician when pertinent to my child's health and also authorize the school and primary care physician to share information with SBHC when pertinent to my child's health.

ASSIGNMENT OF BENEFITS

- I assign all benefits under any insurance, health benefit plan, Medicare, or Medicaid for payment for medical services rendered by Camden Family Health and further agree to remit payment to Camden Family Health within thirty (30) days of any benefits paid directly to me.

PATIENT RESPONSIBILITY

- I accept financial responsibility for any amount not paid by insurance, other health benefit plans, Medicare, or Medicaid.

REQUIRED FORMS

I have received a copy of the "Notice of Privacy Practices" and understand that it is my responsibility to read the information and ask any questions that I may have. I further understand that current copies are posted in the waiting area and a copy is available on request.

I understand this document remains in effect until my child's date of graduation, unless specifically revoked in writing.

_____ _____
Student Name and Date of Birth Date

_____ _____
Parent Signature Date

_____ _____
Legally Authorized Representative Date
(If parent is unable to consent or if the patient is a minor)

I, _____, **DO NOT,** want my child, _____,
(Parent or Guardian) (Student's Name)
to be seen at the Camden Family Health School-Based Health Care Center/s.

Camden Family Health
Insurance Information

****Please provide a copy of the card if possible****

_____ _____

Student's Name (as it appears on insurance card) Date

Private Insurance Information

Insured Parent/Legal Guardian:_____

Birthdate of Card Holder: _____ Social Security Number of Card Holder: _____

Address (if different from child):_____

Place of Employment:_____

Insurance Company and Complete Address: _____

_____

Insurance Company Phone Number: _____

Group Number: _____ Insurance ID Number:_____

From (month/year): _____ To (month/year): _____

Medicaid Information

Please Circle or Write in your child's carrier: (Ex: Molina, Unicare, Aetna Better Health, etc.)

_____

Medicaid ID Number: _____

PCP/HMO Provider: _____ Provider Phone Number: _____

West Virginia Children's Health Insurance Program (WVCHIP)

Name listed on card: _____ Birthdate of card holder: _____

ID Number on card: _____ Group Number: _____

From (month/year): _____ To (month/year): _____

Please list any additional information on your insurance card.

_____

You may send a copy of your card at any time by mail, fax, or drop off.

Camden Family Health
School-Based Health Centers
Parent/Guardian Consent Form

Please read and complete this form so your child can use the School-Based Health Center.

If you want your child to receive health services, please read this form carefully, complete the questions and sign the attached signature sheets.

Name of Student: _____
(Please list child's name as it appears on birth certificate)

_____
Parent/Guardian (Please Print) Relationship to child Date

_____
Mailing Address City State Zip Code

_____ _____ _____
Home Phone Number Work Phone Number Other Phone Number (Cell)

_____
Parent/Guardian (Please Print) Relationship to child Date

_____
Mailing Address City State Zip Code

_____ _____ _____
Home Phone Number Work Phone Number Other Phone Number (Cell)

Student's Birth Date: ___/___/_____ Grade: ____ Social Security Number: _____-____-_____
(It is very important that we have this number)

Sex (Circle): Male Female Race (Circle): White Black Other:_____

Please list an alternate contact: _____ Relationship to Child: _____

Alternate Contact's Phone Number:_____

By signing the attached signature sheet, I authorize my child to be seen at the SBHC. I agree to all services offered by school-based health center and hereby give my consent for my child to receive health services at Camden Family Health School-Based Health Center, operated by Camden on Gauley Medical Center, Inc. I authorize release of information necessary to process insurance claims and I authorize payment of medical benefits to the health care center. I understand that I am responsible for any charges incurred by my child. I understand that information may be shared with the school nurse and/or his/her designee and my primary care physician when pertinent to my child's health and also authorize the school nurse and/or his/her designee and primary care physician to share information with Camden Family Health when pertinent to my child's health. I understand that this consent will be valid until my child leaves school or until I provide the Camden Family Health staff with written directions otherwise.

Children Will Not Be Seen Without Written Consent
Except as permitted by law

Camden Family Health Student Health History Form

Student's Name _____ Current Grade _____ Date _____

The following information will help the healthcare provider evaluate your child's health. Please answer to the best of your knowledge.

Does your child have a family doctor or pediatrician? Yes:____ No:____. If yes, please list your medical provider's Name:_____When did your child have his/her last ***complete*** physical exam?_____

What is your preferred pharmacy for your child? _____
(Pharmacy Name and Location)

____My child has not had a physical exam within the last year. If time allows, I would like my child to get a physical exam during this school year. I understand that I will be notified of the date and time the physical will be given. Afterwards, I will receive a letter explaining the findings and recommendations.

Allergies

Is your child allergic to any medications? Yes____ No____ If Yes, what medications?

Does your child have any other allergies? (Such as foods, pollens, insect bites, etc.) Yes____ No____
If Yes, What?_____

Medications

List any Medication your child is currently taking and the reason for which the medication was given.

Medication/Dose	Reason	How long taking medication
_____	_____	_____
_____	_____	_____

Please check any of the following health conditions that your child has:

___Anemia
___Asthma
___Diabetes
___Headaches/Migraines
___Emotional Disorders
___Depressed or overly nervous
___Frequent Illness
___Scoliosis
___Seizure Disorder
___Stomach or Intestinal Disorders
___Allergies
___Hypertension
___Bladder Infection
___Serious Injuries
___Toothaches
___Other
Please Explain:_____

Please let us know if your child has other important health issues that we should know about:

Dental

How often does your child go to the dentist? At least once a year:___ Only with toothaches:___ Never:___
When was your child's last dental exam?_____ Name of Dentist:_____

Additional Information

In the past year, have there been any changes in your family such as:

___Marriage
___Separation
___Deaths
___Serious Illness
___Loss of job
___Other:_____
___Change in School
___Births
___Moved to a new home
___Divorce

Please attach a copy of your child's Immunization Record

_____ _____
Parent/Guardian Signature Date

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