HealthSource of Ohio

HealthSource of Ohio
School Based Health Consent Form
Revised 5/2022

Welcome to HealthSource School Based Health Center

For your convenience, you can complete these documents directly on your computer. You may electronically sign the form or print and sign the forms. You can return them to the health center by:

- Emailing signed forms to **sbhc.consent@hsohio.org**
- Sending printed forms with your student to school OR drop off at the health center
- Printing and Faxing the forms to **513-436-0470**

Please note that documents you send electronically may not be protected until they are received by HealthSource and saved in our system. We recognize these forms ask for private information about you and your child. Please make the choice that is best for you family.

- Scheduling may be delayed if there are missing documents or information is illegible

Patient Information & Consent for Services			
Today's Date:	Patient's Last Name:	Patient's First Name:	Patient's DOB:
Patient's School:		Teacher & Home Room:	Grade:
Patient's Address:		Patient Phone #:	Student ID #:

Insurance Information (please present all insurance cards and a picture ID to the receptionist):						
Medical Insurance:	Policy #:	Group #:	Effective:	Co-Pay:	Policy Holder:	Relationship:
Dental Insurance:	ID:	MMIS#:	Effective:	Co-Pay:	Subscriber:	Subscriber DOB:
Vision Insurance:	Policy #:	Group #:	Effective:	Co-Pay:	Policy Holder:	Relationship:

Is your child a current HSO patient?

☐ YES, my child is a current HSO patient and is seen by _____ at _____.
HSO Clinician HSO Location

Do you give informed consent for your child to participate in HSO school-based services?

☐ YES, I give my informed consent for my child to participate in the following HSO school-based services:

***Please check which services you wish your child to participate in:**

☐Medical ☐Dental ☐Mobile Dental ☐Telehealth services
☐Transportation ☐Vision ☐Mobile Vision ☐All

☐ NO, I do not wish my child to receive any services.

STOP AND SIGN HERE:

_____ _____ _____
Parent/Guardian Signature or Patient/Student Signature (Only if 18 or older) | Parent/Guardian Printed Name or Patient/Student Signature (Only if 18 or older) | Date

Consent to Medical/Dental/Vision/Behavioral Health Treatment

I am seeking medical, dental, vision, and/or behavioral health care and agree to receive this care from HealthSource of Ohio and the providers employed by HealthSource of Ohio. This may include medically necessary diagnostic, medical, dental, vision, or behavioral healthcare services rendered by employed physicians, dentists, and allied health providers, including licensed providers such as social workers, nurse practitioners, and clinical nurse specialists. I understand that:

a. The practice of medicine, dentistry, surgery, and behavioral health is not an exact science and acknowledge that treatment may involve risks such as life-threatening complications, including death, as well as benefits, and that there may be alternatives to recommended treatments. I acknowledge that no guarantees have been made to me about the results of examination and treatment by this office and HealthSource of Ohio.
b. Normally, except under emergency or extraordinary circumstances, no important procedures are performed on a patient unless and until he/she has had an opportunity to discuss them with the provider. Behavioral health patients will have an opportunity to discuss plans of care with the provider.
c. I should always ask my doctor or provider to explain any part of my care or treatment which I do not understand and have the right to have my questions answered to my satisfaction.
d. I have the right to agree or to refuse any recommended procedure or course of treatment.
e. I will not take part in any experimental procedure, treatment or research without complete knowledge and agreement.
f. HealthSource of Ohio is a Federally Qualified Health Center and offers a reduced fee to eligible patients and their families based on family size and income. The physicians, providers, and staff of HealthSource may be considered federal employees under the Federally Supported Health Centers Assistance Act of 1992 and 1995.
g. There may be medical, dental, nursing, behavioral health, and other healthcare personnel at this office who are still in training. I understand that they may be present and participate in my care.
h. I may refuse to sign this if I wish.

Consent for Release of Protected Health Information (PHI) for Treatment, Payment & Operations

I understand that HealthSource of Ohio (HSO) creates, receives, and maintains medical and healthcare information about me, or the patient above, as part of healthcare (PHI). Examples of this information include health history, test results, diagnoses, provider orders for treatment and referrals, and documentation of office visits. This information is used for several purposes, such as:

a. Planning my care & treatment and communicating among the healthcare providers who care for me.
b. Documenting services for billing any insurance or government benefit program (Medicare or Medicaid) for costs of my care and payment for those costs.
c. HSO operations. Including checking on the quality of my care, reviewing the way my providers care for me, and sending data required by federal and state healthcare agencies.

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have been given a copy of HSO's NOTICE OF PRIVACY PRACTICES, which has more information about how HSO uses and discloses my PHI and that I can review this Notice prior to signing this form. Since HSO can change this Notice, I can also request that HSO send me the latest copy of the Notice to review. I may refuse to sign this if I wish.

I consent to the use and disclosure of my PHI by HSO to affiliates, third parties, insurers, government healthcare programs, other healthcare providers and to other organizations to whom disclosure is permitted by the current HIPAA Privacy Rules at 45 CFR Parts 160 and 164f and as amended over time.

I give my permission for HSO to release my PHI to the following common organizations for services, payment for services, to meet government requirements or to assist in my referral for care by another provider. I understand that my health records may contain information about sexually transmitted disease testing and/or conditions, such as human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), substance abuse and behavioral/mental health treatment. I understand that this list does not cover every situation where my PHI may be used or disclosed:

a. Medicare or Medicaid offices and agents
b. My insurance company
c. Physicians, hospitals, home agencies, long-term care and other healthcare facilities and services selected by me
d. School health officials as part of school health programs
e. County/state health departments and public health agencies
f. Women, Infants & Children (WIC) program and Maternal/Child Health Program

I understand that I may revoke (take back) this Consent in writing, by delivering written notice to HealthSource of Ohio at 424 Wards Corner Rd. Suite 200 Loveland, OH 45140, Attn: Privacy Officer. You decision will become effective thirty (30) days after we receive you notice. Information used and disclosed by HSO before your revocation was received is not covered by the revocation.

I acknowledge the consent for treatment form above has been fully explained to me and I understand all the information as it applies to healthcare treatment by HealthSource of Ohio and the providers and staff of this office.

Acknowledgement and Financial Responsibility Statement

1. I understand that I am ultimately responsible for the payment of all healthcare services rendered by HealthSource of Ohio.
2. I hereby authorize assignment of insurance benefits, including Medicare or Medicaid, due and payable for health services rendered to me (or my dependent) be paid directly to HealthSource of Ohio.

Acknowledgement

By signing below, I acknowledge that I have reviewed and understand the information listed below as provided to me by HealthSource of Ohio.

1. Acknowledgement of Receipt of Notice of Privacy Practices
2. Consent to Medical/Dental/Behavioral Health Treatment
3. Consent for release of Protected Health Information (PHI) for Treatment Payment and Operations
4. Acknowledgement and Financial Responsibility Statement
5. Consent to School Based Health Center Services

STOP AND SIGN HERE:

_____	_____	_____
Parent/Guardian Signature or Patient/Student Signature (Only if 18 or older)	Parent/Guardian Printed Name or Patient/Student Signature (Only if 18 or older)	Date

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Patient Information

Today's Date:	Patient's Last Name:	Patient's First Name:	MI:	Nickname:	SSN:	Patient's DOB:

Birth Gender:	Current Gender:	Preferred Language:	Religion:	Marital Status:	Student Status:
☐ Female ☐ Male	☐ Female ☐ Male			☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated	☐ No ☐ Full-Time ☐ Yes ☐ Part-Time

Patient Billing Address (responsible party):

Patient Residence (if different):

Check all that apply:	Receive notifications by:	Check which contact number you prefer:	Parent/Guardian Email Address:
☐ Veteran ☐ Smoker ☐ Hearing Impaired ☐ Visually Impaired	☐ Opt Out ☐ Email ☐ Text ☐ Voicemail	☐ Cell Phone # _____ ☐ Home Phone # _____ ☐ Work Phone # _____	

Emergency Contact Name:	Emergency Contact Relationship:	Emergency Contact Phone #:

List person/persons authorized by you to discuss/receive/access your medical information:

Last Name:	First Name:	Relation to Patient:
Last Name:	First Name:	Relation to Patient:

Statistics Required for Governmental Reporting:

Check all that apply:	Race:	Ethnicity:
☐ Homeless ☐ Migrant Farm Worker ☐ Language Barrier	☐ Black/African American ☐ White/Caucasian ☐ American Indian/Alaska Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ More than one	☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Financial Information – Responsible Party (required for patients <18 and when the guarantor is not the patient):

Last Name:	First Name:	MI:	SSN:	DOB:	Relationship:

Insurance Information (please present all insurance cards and a picture ID to the receptionist):

It is the policy of HealthSource of Ohio to provide essential services to those who have no means or limited means to pay for their medical services (uninsured or underinsured). Discounts will be based on income and family size only. Please complete the following information to determine if you or members of your family are eligible for a discount.

**For the purposes of assistance, family is defined as: a group of two or more people, related by birth, marriage, or adoption and residing together, all such people, including related subfamily members, are considered members of one family.*

Section (a): Total combined income for all persons working in the household.
Section (b): How often do you get paid?
Section (c): Any additional income received in the household.
Section (d): Total number of people the household income supports.

All information will be kept confidential.

(a) Total household income before taxes:	(b) How often do you get paid?	(c) Other Income:	(d) Total # of people supported by income:
	☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly		

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Patient Information			
Today's Date:	Patient's Last Name:	Patient's First Name:	Patient's DOB:
Patient's Primary Care Provider:	Preferred Pharmacy:		Pharmacy Phone #:

Medical Health History	YES	NO	
Do they have any allergies?	☐	☐	If yes, please list medications, foods, plants, etc. AND their reaction to each:
Do they currently take any medications?	☐	☐	If yes, please list any prescription, over-the-counter, or herbal supplements and dosage they take:

Is there a health history of:	Patient Yes	Family Yes		Patient Yes	Family Yes
Asthma	☐	☐	Faint with Exercise	☐	☐
Acid Reflux/GERD	☐	☐	Heart Disease	☐	☐
ADD/ADHD	☐	☐	Heart Murmur	☐	☐
Anemia/Blood Disorder	☐	☐	Kidney Disease	☐	☐
Alcohol Abuse	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	Joint Problems	☐	☐
Anxiety	☐	☐	Mental Illness/Behavior	☐	☐
Cancer	☐	☐	Pneumonia	☐	☐
Chronic Ear Infections	☐	☐	Prematurity	☐	☐
Cholesterol, High	☐	☐	Rheumatic Fever	☐	☐
Concussion, Head Injury	☐	☐	Seizure Disorder	☐	☐
Drug Abuse	☐	☐	Sleep Apnea/Snoring	☐	☐
Depression	☐	☐	Scoliosis	☐	☐
Developmental Delay	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Suicide Attempt	☐	☐
EPI-Pen Needed	☐	☐	Thyroid Disorder	☐	☐
Eczema/Skin Condition	☐	☐	Urinary Tract Infection (frequent)	☐	☐
Environmental Allergies	☐	☐	Weight Issues (under/overweight)	☐	☐

Vision History		
Blurry Vision	☐	☐
Headaches	☐	☐
Trouble with close or distance vision	☐	☐
Glasses/Contacts	☐	☐
Vision Concerns	☐	☐
Date of last eye exam:		

Other, please explain:

Surgical History	YES	NO		YES	NO
Appendectomy	☐	☐	Gall Bladder	☐	☐
Adenoidectomy	☐	☐	Heart	☐	☐
C-Section	☐	☐	Hernia Repair	☐	☐
Dental Surgery	☐	☐	Hysterectomy	☐	☐
Eye Surgery	☐	☐	Tonsillectomy	☐	☐
Ear Tubes	☐	☐	Other:		

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Patient Information			
Today's Date:	Patient's Last Name:	Patient's First Name:	Patient's DOB:

Dental Health History	
Reason for today's visit:	
Previous Dentist:	Date of last dental care:
What was done at that time?	Any complications from the past dental treatment?

Please check if they have or have had any of the following:

☐Bad breath	☐Grinding teeth	☐Sensitivity to cold or sweets
☐Bleeding gums	☐Clicking or popping jaw	☐Sensitivity to heat
☐Broken teeth or fillings	☐Periodontal treatment	☐Sensitivity when biting
☐Food collection between teeth	☐Loose teeth	☐Mouth sores or growths

Dental Health History	YES	NO	
Are they now under the care of a physician?	☐	☐	If yes, please list physician name, phone, and address:
Are they under the care of a pain management specialist?	☐	☐	If yes, please list pain specialist name, phone, and address:
Have they had a serious illness, operation, or been hospitalized in the past 5 years?	☐	☐	If yes, please list with approximate date:
Women Only. Are they pregnant?	☐	☐	If yes, please list number of weeks and due date:
Women Only. Are they nursing?	☐	☐	
Using hormonal birth control (pills, shots, IUD) or hormone replacement?	☐	☐	

Are they allergic or have they had any reaction to:

☐Local anesthetics (numbing medicine)	☐Barbiturates, sedatives, or sleeping pills
☐Aspirin	☐Metals
☐Penicillin, Amoxicillin, Augmentin	☐Latex (rubber)
☐Other antibiotics (specify)	☐Iodine
☐Sulfa drugs (ex: Bactrim)	☐Hay fever/seasonal
☐Codeine or other narcotics	☐Food
	☐Other

If yes to any of the above, please specify and explain reaction:

Subacute Bacterial Endocarditis Prophylaxis

Please check if they have/have had any of the following:

☐Artificial heart valve	☐Previous infective endocarditis
☐Heart transplant recipient with cardiac valvular disease	☐Congenital heart disease

1) repaired completely in last 6 months; 2) repaired CHD with residual defects; 3) unrepaired, cyanotic CHD

** Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

Medical Information	YES	NO	
Joint Replacement: Have they had an orthopedic total joint (hip, knee, shoulder, elbow, ankle) replacement?	☐	☐	If yes, please list date and if any complications were present:
Has your surgeon specifically recommended taking antibiotics before dental treatment?	☐	☐	
Bisphosphonates: Are they taking or scheduled to be taking any form of bisphosphonate?	☐	☐	If yes, please list and the date treatment began or will begin:
Do they use controlled substances (drugs) or do they have a history of drug abuse?	☐	☐	If yes, please specify:
Are they currently taking Suboxone or Subutex?	☐	☐	If yes, please list prescribing doctor and phone:
Do they use tobacco (smoking, snuff, chew)?	☐	☐	
Have they used tobacco products in the past?	☐	☐	If yes, for how many years?
Do they drink alcoholic beverages?	☐	☐	If yes, how many alcoholic drinks do they typically have in one week?