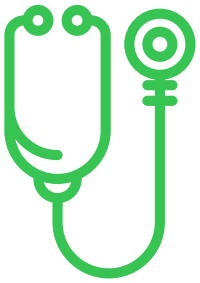
HealthSource of Ohio + Western Brown Broncos

Your SOURCE for School-Based Health

HealthSource School-Based Health Centers keep students in school and ready to learn. Our Clinicians treat acute and chronic health problems immediately and return students to class as soon as possible. With a School-Based Health Center, parents miss less work. The Center can see students and staff members conveniently and easily during the school day.



School- Based Health Services Include:

- Routine physical exams, including wellness checks, sports, and work physicals
- Asthma and other chronic illness diagnosis and management
- Acute illness and injury treatment

Mobile Health Services

HealthSource provides Mobile Health Services to students, including Dental and Vision. The **Mobile Vision Team's** optometrist can see your child during school hours for their vision screening, comprehensive exam, and any potential glasses or eye health needs.

The **Mobile Dental Team's** Dentist provides dental exams for students during school hours, including exams, x-rays, cleanings, sealants, and fluoride.

How does it work?

- Complete the **School-Based Health Permission Form** ***(scan the code below)*** and return completed form to your child's school
- HealthSource **Mobile Dental** will do your child's dental exam when they come to the school
- HealthSource **Mobile Vision** will do your child's vision screening, glasses and fitting if necessary, and a comprehensive eye health exam
- Your child can be seen at the School-Based Health Center for medical issues when needed
- We accept most insurance plans, including Medicaid

To learn more about Mobile Health Services, email: SBHconsent@hsohio.org

Scan the code for the Permission Form

HealthSource of Ohio

HealthSource of Ohio
School Based Health Permission 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 **513-214-2408**

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