REGISTRATION FORM FOR CONSENT TO TREATMENT, ASSIGNMENT OF BENEFITS, AND NOTICE OF PRIVACY PRACTICES

Student Name: ____ **Date of Birth:** ________________________

I. CONSENT TO TREATMENT

By signing this section below, I authorize the Maranacook School-Based Health Center staff, its contracted agents and other individuals involved in my child's care to examine my child and perform any tests and/or treatments determined to be medically necessary, recommended or appropriate, to care for my child's injuries, illness or conditions. I understand that the health care provider responsible for caring for my child will explain the reasons for any tests and treatment, as well as the benefits, the most common risks and available treatment alternatives. I also understand that I have the right to refuse any recommended examinations, tests or treatment. I understand that the Maranacook School-Based Health Center and its contracted agents are dedicated to teaching, and that authorized trainees may observe and assist in the diagnosis and treatment of my child.

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Parent, Guardian or Other Legally Authorized Representative (state relationship to patient) Date

II. PAYMENT AND/OR ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for paying all costs associated with health care services rendered to my child by the Maranacook School-Based Health Center. If I have health insurance, I understand that I may be financially responsible for copayments, deductibles, health care services and charges not covered by my health insurance, consistent with my insurance coverage and state law. I authorize my health insurance carrier(s) or other third party payers, including Medicare and CHAMPUS/ TRICARE that are responsible for paying for my health care, to pay the costs associated with health care services rendered to my child, directly to the Maranacook School-Based Health Center and its contracted agents.

III. NOTICE OF PRIVACY PRACTICES

I understand that the Maranacook School-Based Health Center's Notice of Privacy Practices provides information about how the Health Center may use and disclose my child's protected health information. I understand I have the right to review the Notice before signing this consent. I understand that my child will be given a copy of the Health Center's Notice of Privacy Practices at the time services are rendered, that I may request a copy be mailed to me, and that additional copies are available at the Maranacook School-Based Health Center.

IV. USE AND DISCLOSURE OF HEALTH CARE INFORMATION

I understand that information and records concerning health care services provided to my child may be used and disclosed to those involved in my child's care for treatment and health care operations purposes, and to third party payors for payment purposes. I also understand that my child's health care information may be used or disclosed, without my authorization, when required or permitted by law. I understand that my specific authorization is required to authorize the disclosure of my child's mental health, substance abuse program and HIV information, unless such disclosure is otherwise authorized by law.

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Parent, Guardian or Other Legally Authorized Representative (state relationship to patient) Date