FAMILY MEDICAL CENTERS

Just like family, we'll take care of you

Welcome to Rock Hill Family Medical Centers.

The Ironton Lawrence County Area Community Action Organization has partnered with the Rock Hill School System to provide a school-based health center (SBHC). The Rock Hill Family Medical Center offers students and community members access to medical care, oral health care, and behavioral health services in a more convenient manner.

The SBHC will operate year round, including the school year, and offers no cost transportation from the district schools to the health center and back during the school year. The parent/guardian is always welcome at the appointments, but is not required to be present.

The space for the Center is currently being renovated so full services are not yet available. However, we are able to provide Behavioral Health Services that your student may need at this time.

We ask that you complete this enrollment form now so that your student may have access to Behavioral Health services with our licensed professional. The form will go on file so that once the Center is fully opened later this year, the student may also have access to any of the range of services you have selected on the enrollment form.

Once a student's completed consent form and history are received, the student is eligible for appointments for approved services. Parent/guardian will receive a notice of the student's appointment time by phone or by a note from the school. If parent/guardian does not request a change to the appointment, the student will receive services as scheduled.

To enroll a student in the SBHC, the parent/guardian should complete the required documents and return them to the school with the student. Incomplete or illegible forms may result in delayed scheduling. Please feel free to contact us during regular business hours at **(740) 643-8688.**

FAMILY MEDICAL CENTERS
Just like family, we'll take care of you

School Based Health Center Enrollment Packet

STUDENT INFORMATION & CONSENT FOR SERVICES				
Today's Date: / /	Student's Last Name:	Student's First Name:	M.I.	Student's Date of Birth: / /
Student's Current School:	Student's Current Building:	Student Current Grade:	Student's Current School ID #:	

PRIMARY CARE SERVICES

☐ **YES,** I consent for my child to receive **MEDICAL CARE** including well child exams (includes work, daycare, and sports physicals), appropriate immunizations, appropriate behavioral evaluations and treatment for illness or injury including over the counter medications unless emergency services are needed.

☐ **NO,** I do not wish for my child to receive **MEDICAL CARE** at the School Based Health Center.

BEHAVIORAL HEALTH SERVICES

☐ **YES,** I consent for my child to receive **BEHAVIORAL HEALTH SERVICES** including assessments, appropriate behavioral evaluations and treatments.

☐ **NO,** I do not wish for my child to receive **BEHAVIORAL HEALTH SERVICES** at the School Based Health Center.

DENTAL SERVICES

☐ **YES,** I consent for my child to receive **DENTAL SERVICES** at the school based / mobile dental office including preventative care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals, if necessary. Sealants, fluoride, caries arresting medication, and other preventive procedures will also be provided. The treatment plan will be provided and approved by the parents/ guardian PRIOR to starting treatment.

☐ **NO,** I do not wish for my child to receive **DENTAL SERVICES** at the School Based Health Center.

VISION SERVICES

☐ **YES,** I consent for my child to receive **VISION SERVICES,** which may include comprehensive eye examinations (including dilation), vision therapy, and fitting/ dispensing of vision correction.

☐ **NO,** I do not wish for my child to receive **VISION SERVICES** at the School Based Health Center.

TRANSPORTATION SERVICES

☐ **YES,** I consent for my child to be TRANSPORTED/ACCOMPANIED **to** and from the SBHC by a school designee.

I, the parent or guardian of above named student, release Family Medical Centers, its Board members, its employees and authorized agents/representatives from any and all liability to personal injury or damage resulting from the transportation to or from the school for these purposes.

☐ **NO,** I do not wish for my child to be TRANSPORTED/ACCOMPANIED to or from school for these purposes

By signing this consent, I agree to the terms and conditions regarding Payment for Services & Sharing of Health Information as explained in the accompanying Program Description form. I have also received and agree with the Patient Consent for use and Disclosure of Protected Health Information as explained in the Program Description form. I have received the Notice of Privacy Practices. I understand and agree that this consent will remain in effect until I revoke it or until my child is no longer enrolled in a school district where FMC provides services.

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

FAMILY MEDICAL CENTERS
PATIENT REGISTRATION/FINANCIAL FORM

Today's Date Month / Day / Year

PATIENT INFORMATION:

Last Name	First Name	MI	Nickname	Social Security #	Birth Date Month / Day / Year

☑ Birth Gender:
☐ Female
☐ Male

☑ Current Gender:
☐ Female
☐ Male

☑ Gender Identity:
☐ Choose not to Disclose
☐ Female
☐ Female-to-Male (FTM) Transgender Male
☐ Genderqueer, neither exclusively Male or Female
☐ Male
☐ Male-to-Female, (MTF) Transgender Female
☐ Other

☑ Sexual Orientation:
☐ Choose not to Disclose
☐ Bisexual
☐ Don't Know
☐ Lesbian, Gay, Homosexual
☐ Straight, Heterosexual
☐ Other: _____

☑ Preferred Pronoun:
☐ Declined to Answer
☐ Asked but Unknown
☐ He, Him, His
☐ She, Her, Hers
☐ They, Them, Theirs
☐ Ze, Hir
☐ Other

Patient Billing Address (Responsible Party)	City	State	Zip
Patient Residence (if different)	City	State	Zip

☑ Preferred Language:
☐ English ☐ Spanish
☐ French ☐ German
☐ Nepali ☐ Russian
☐ Other: _____

☑ Religion:
☐ Christian ☐ Agnostic ☐ Atheist
☐ Buddhist ☐ Hindu ☐ Jewish
☐ Islamic ☐ Scientology
☐ Other: _____

☑ Marital Status:
☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Life Partner
☐ Other: _____

☑ Student Status:
☐ No
☐ Yes
☐ Full-Time Student
☐ Part-Time Student

☑ All that apply:
☐ Veteran
☐ Smoker
☐ Hearing Impaired
☐ Visually Impaired
☐ None of the Above

Can we send notifications?
☑ All that Apply:
☐ Opt Out
☐ Email ☐ Phone ☐ Text ☐ Voicemail

☑ Which Contact # You Prefer:
☐ Home Phone #
( )
☐ Day/Work Phone #
( )
☐ Cell/Alternate #
( )

Emergency Contact Name	Emergency Contact Relationship	Emergency Contact Phone #
		( )

Patient/Guardian Email Address

PARENT/GUARDIAN EMPLOYMENT INFORMATION:

Employer Name	Occupation	Employer Phone #

STATISTICS REQUIRED FOR GOVERNMENTAL REPORTING:

☑ Tax Filing Status:
☐ Return Not Filed
☐ Single
☐ Married
☐ Head of Household

Is Head of Household:
☐ Male ☐ Female

☑ All that Apply:
☐ Homeless
☐ Migrant Farm Worker
☐ Language Barrier
☐ None of the Above

☑ Race:
☐ White/Caucasian
☐ Black/African American
☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander
☐ Asian
☐ More than One Race

☑ Ethnicity:
☐ Decline
☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown

FOR STAFF USE ONLY

Portal Enrollment Reviewed: ☐ Yes ☐ No *If No, Reason:* ☐ Patient Already Enrolled Other:_____
Reason for No Email: ☐ Declined (refused) ☐ Deferred (Self-Enroll) ☐ No Email

_____ _____ ***Date of Signature*** _____
FMC Staff Name (Print) ***FMC Staff Signature***

FAMILY MEDICAL CENTERS
PATIENT REGISTRATION/FINANCIAL FORM
PARENT/GUARDIAN INFORMATION

Today's Date Month / Day / Year

☐ **FINANCIAL INFORMATION REVIEWED - NO CHANGES**

RESPONSIBLE PARTY (Required for patients less than 18 and whenever the guarantor is not the patient):

Last Name	First Name	MI	Social Security #	Birth Date Month / Day / Year	Relationship

INSURANCE INFORMATION (Please present ALL Insurance Cards and a Picture ID to the receptionist):

Primary Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship
Secondary Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship
Tertiary Insurance	Policy #	Group #	Effective	Co-Pay $	Policy Holder	Relationship

HOUSEHOLD INCOME:

It is the policy of Family Medical Centers to provide essential services to those who have no means, or limited means, to pay for their medical services (Uninsured or Underinsured). Sliding Fee discounts will be based on income and family size, only, as outlined below. Please complete the following information to determine if you or members of your family are eligible for a discount.

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

Section (a): Total combined Income for all persons working in the household. **Section (b):** How often 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) ☑ Frequency:	(c) Other Income:	(d) Total Number of People Supported by Income:
$	☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly	$	

DOCUMENTATION OF NO INCOME:

If you have reported $0 household income in the section above, please explain how you are meeting your daily needs.

_____

_____

ACKNOWLEDGEMENT & CONSENT:

I understand that to determine eligibility for the sliding fee program, I must provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). If Self-employed, I must submit detail of the most recent three months of income and expenses for the business. Family Medical Centers may request additional information before the patient named above is approved for a discount.

I agree to inform Family Medical Centers of any changes in my circumstances that may affect patient's eligibility. Any intentional false or fraudulent information will be grounds for denial of services for the patient. I understand the information above must be updated every twelve (12) months, or if there are any changes in family size or household income.

I have received information explaining the Sliding Fee Scale Program and I agree to follow its terms. I understand that any discount for which I am eligible for will apply to all services received at any of the Family Medical Centers practices, but not those services or equipment that are purchased from outside, including reference laboratory testing, medications, and x-ray interpretation by a consulting radiologist, and other such services.

I certify that all information given by me is true. I consent to any services rendered to me or my dependents by the attending provider/physician. I understand this authorization will also permit the center to release information related to my medical records to other offices to assist in my continuing care. I acknowledge full financial responsibility for services rendered by Family Medical Centers. I authorize the release of information to my insurance carrier and authorize payment directly to Family Medical Centers. I have read and fully understand the above.

_____ _____ _____

Patient Name/Responsible Party (Print) ***Signature of Patient/Responsible Party*** ***Date of Signature***

☐ Patient ☐ Parent ☐ Guardian

*****FOR STAFF USE ONLY*****

Income Documents Received: ☐ Yes ☐ No *If No, Reason:* ☐ One Day Slide ☐ Refused ☐ Other:_____

Documents Scanned: ☐ Yes ☐ No *If No, Reason:* _____

Insurance Card Scanned: ☐ Yes ☐ No *If No, Reason:* _____

_____ _____ _____

FMC Staff Name (Print) ***FMC Staff Signature*** ***Date of Signature***

FAMILY MEDICAL CENTERS (FMC)

Today's date: Month / Day / Year	Student's Last Name:	Student's First Name:	Student's Date of Birth: Month / Day / Year

Acknowledgement Of Receipt Of Privacy Practices

We are required to give each patient a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice and a copy of our patient brochure. You may refuse to sign if you wish.

Please answer the following questions so that we can contact you in the most efficient way possible.

May we send/receive clinical information from health care providers participating in your care? ☐ Yes ☐ No

If you have an answering machine at home, may we leave a message? ☐ Yes ☐ No

May we leave a message at your work for you to call our office? ☐ Yes ☐ No

Is there a person at your house that we mayleave a message with? ☐ Yes ☐ No

If yes, please provide household member's name: _____

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

	Last Name:	First Name:	Relationship to Patient:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

By signing below, I authorize FMC to use/disclose my health information in a manner consistent with that stated in the Notice of Privacy Practices that I have received.

_____
Patient Name (Print)

_____ _____
Guardian's Name (Print) Relationship to Patient

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

☐ Check here if you refuse to sign the acknowledgement of Receipt of Privacy Practices.

Our Privacy Officer can be reached as follows:

Name of Privacy Officer:

Practice Address:

FMS Staff Signature **Date**

_____ _____

FAMILY MEDICAL CENTERS
STUDENT HOME, SCHOOL, & HEALTH HISTORY FORM

Today s date: Month / Day / Year	Student's Last Name:	Student's First Name:	Student's Date of Birth: Month / Day / Year

HOME HISTORY	YES	NO	COMMENTS
Does anyone in the home smoke?			
Has your child been a victim of abuse/ bullied?			
Has your child seen someone abused?			
Do they get enough to eat?			
Is there a gun in the home?			
What activities / hobbies do they enjoy?			

SCHOOL HISTORY	YES	NO	COMMENTS
Are there any learning problems/ disabilities?			
Are they in special classes or have an IEP?			
Have they repeated any grade?			
Do they get into trouble often at school?			
Are any of the responses above different from the past?			
What are their grades?			

MEDICAL/DENTAL/EYE HISTORY	YES	NO	COMMENTS
Date of last physical exam (Head-to-Toe):	**Date of Exam:**		**Provider's Name:**
Do they take any medications currently?			
Have they previously taken medications?			
Are they allergic to any medications?			
Preferred Pharmacy Name:_____ Address _____ Phone _____			
Have they ever been pregnant?			# of Pregnancies: / # of Living Children:
Ever in hospital overnight?			
Any previous surgeries?			
Any previous head injuries?			
Any developmental delays?			
Immunizations up to date?			
Other Medical Concerns?			
Date of last complete dental exam:	**Date of Exam:**		**Provider's Name:**
Any dental pain?			
Do they brush their teeth?	☐ Only morning ☐ Only night ☐ Both morning and night ☐ Rarely ☐ Never		
Do they floss?	☐ Only morning ☐ Only night ☐ Both morning and night ☐ Rarely ☐ Never		
Have they ever had fluoride treatments?			
Have they learned the importance of primary (baby) teeth?			
Other dental concerns?			
Date of last complete eye exam:	**Date of Exam:**		**Provider's Name:**
Have they had glasses in the past?			
If yes, do they still have/wear them?			
Do they have trouble seeing things close?			
Do they have trouble with changing distance?			
Do they have headaches with vision related tasks?			
Other eye concerns?			
Any other information we should be aware of?			

BEHAVIORAL HEALTH HISTORY

Does your child suffer from any of the following? □ Fussiness □ Won't Mind □ Holds Breath □ Jealousy □ Thumb Sucking □ Nail Biting □ Bed Wetting □ Overactive □ Slow Learner □ Bad Temper □ Speech Problems □ Can't Toilet Train □ Miserable/ Withdrawn □ Eats Dirt, Paint, or Glue □ Doesn't Pay Attention □ Other, please explain:

FAMILY MEDICAL CENTERS
STUDENT HOME, SCHOOL, & HEALTH HISTORY FORM

Today s date: Month / Day / Year	Student's Last Name:	Student's First Name:	Student's Date of Birth: Month / Day / Year

Does student or any family member have or had any of following problems?

PROBLEM	STUDENT ☑ YES	FAMILY ☑ YES	PROBLEM	STUDENT ☑ YES	FAMILY ☑ YES	PROBLEM	STUDENT ☑ YES	FAMILY ☑ YES
Asthma/ Wheezing	☐	☐	Eye Trauma	☐	☐	Seizure Disorder	☐	☐
Allergy/Hay Fever	☐	☐	Fainting w/Exercise	☐	☐	Sickle Cell	☐	☐
Allergy/Food	☐	☐	Glaucoma	☐	☐	Sinus issues	☐	☐
Allergy/Pets	☐	☐	Headaches/ Frequent	☐	☐	Sleep apnea	☐	☐
ADHD/ADD	☐	☐	Hearing Loss/Concern	☐	☐	Sleep issues	☐	☐
Anemia/Blood	☐	☐	Heart Disease	☐	☐	Snoring	☐	☐
Anaphylactic R x n	☐	☐	Heart Murmur	☐	☐	Sore Throat/ Frequent	☐	☐
Acne	☐	☐	Kidney Disease/Issues	☐	☐	Speech Issues	☐	☐
Alcohol Abuse	☐	☐	High Blood Pressure	☐	☐	Spinal Curvature	☐	☐
Behavior Issues	☐	☐	HIV/ AIDS	☐	☐	Stomach Ache/Frequent	☐	☐
Bleeding Disorder	☐	☐	Hives	☐	☐	Stroke	☐	☐
Bowel Movements	☐	☐	Hyperactivity	☐	☐	Suicide Attempt(s)	☐	☐
Broken Bones	☐	☐	Joint Problems	☐	☐	Testicle not in Sac	☐	☐
Cancer	☐	☐	Lazy Eye	☐	☐	Toothache/Dental	☐	☐
Cataract	☐	☐	Lead Poisoning	☐	☐	Tuberculosis	☐	☐
Chicken Pox	☐	☐	Learning problems	☐	☐	Twitching Eyelid	☐	☐
Chronic Ear Infections	☐	☐	Leukemia	☐	☐	Underweight	☐	☐
Cholesterol High	☐	☐	Light Sensitivity	☐	☐	Urinary Tract Infections/Frequent	☐	☐
Concussion	☐	☐	Lumps Groin/Breast	☐	☐	Vaginal Discharge	☐	☐
Constipation	☐	☐	Mental Illness	☐	☐	Watery Eyes	☐	☐
Depression	☐	☐	Migraines	☐	☐			
Diabetes	☐	☐	Muscle Problems	☐	☐			
Diarrhea	☐	☐	Nervous Twitch/Tics	☐	☐			
Dizzy/Light Headed	☐	☐	Nose Bleeds/Frequent	☐	☐			
Dry/Burning Eyes	☐	☐	Nightmares	☐	☐			
Eczema/Skin Infection	☐	☐	Obesity	☐	☐			
Eye strain	☐	☐	Rheumatic Fever	☐	☐			

☐ ***By checking this box I am acknowledging that I have reviewed the document and there is no student or family history of the problems listed above.***

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

THE FOLLOWING PAGES ARE FOR YOU

TO REVIEW

AND

KEEP FOR YOUR RECORDS

FAMILY MEDICAL CENTERS
SCHOOL BASED HEALTH CENTER
PROGRAM DESCRIPTION

Welcome to Family Medical Centers' School-Based Health Center. The School-Based Health Center, operated by FMC at participating school districts, makes medical, dental and vision care available to all students in those districts when needed. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, immunizations, routine dental care, or a vision exam they can have it done in the School-Based Health Center. If your child/adolescent develops a dental problem at school, a dentist can see your child without having to take time away from work and minimize the time that your child is out of the learning environment.

How the School-Based Health Center (SBHC) works:

- You must complete the attached consent form and the other information pages and return them to the school nurse or school office.
- You or your child may schedule an appointment in the SBHC if your child is sick or injured. You can also schedule an appointment for physicals, immunizations, required sports or employment physicals, dental care, eye exams, and all associated health care concerns. Any necessary prescriptions will be provided.
- After your child's visit with the provider or dentist, attempts will be made to contact you as necessary.
- **The School-Based Health Center does not take the place of your primary care provider (PCP) and joining the program does not mean you are changing your child's PCP.** You will be encouraged to have any needed follow-up care with that PCP and a summary of your child's visit at the SBHC will be sent to that office. However, if you do not have a regular PCP, we welcome that relationship here and can become your child's PCP. If your child is already a patient of any Family Medical Centers locations, you still have to sign this consent to be a part of the School-Based Health Center.

Patient Rights and Responsibilities:

- Respectful and equal treatment, care, and accommodations are available regardless of race, age, ethnicity, creed, sex; or sexual orientation.
- To have a health care assessment and plan of care and participate in your health care plan.
- To talk to your health care provider openly and privately.
- It is the patient's responsibility to carry out the recommended treatment plan.
- Allow at least 30 days for completion of insurance or disability forms and transfer of treatment records.
- Notify the SBHC if you have received treatment in an Emergency Room or hospital.
- After hours, in case of emergency call 911 or go to the nearest emergency room. If you have an urgent issue and would like to speak with the provider on call, please call **(740) 643-8688**

The PRIMARY HEALTH CARE SERVICES we may provide include:

- Ill visits (for example, for sore throat, rash, an asthma attack) and follow-up for medical problems, including physical examination, tests and treatment/medications as needed.
- Minor injury evaluation, including first aid.
- Routine physical examination (including sports and work physicals) with immunizations, routine tests and treatments as needed.
- Management of chronic conditions such as hypertension, diabetes, and high cholesterol.
- Health education and wellness promotion.
- Referral to outside agencies for further care that cannot be provided at the School-Based Health Center.

The DENTAL HEALTH CARE SERVICES we may provide include:

- Routine dental examination and screenings, including dental health education and preventive services such as cleaning and dental sealants to help stop tooth decay.
- Problem visits (for example, for pain, infection or injury) or visits for urgent or emergency care, to include examination, x-rays, fillings, extractions (the pulling of loose or infected teeth), necessary treatment (including medication) for oral infection or other problems, and/or other procedures (including root canals on front teeth).

Regarding PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate **discounted fee**. However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on the Family Medical Centers' sliding fee scale. This information will be kept strictly confidential.

If you have private insurance, you should contact their customer service department to be sure your insurance pays for services at Family Medical Centers. If your insurance does not cover Family Medical Centers, you will be responsible for the bill at the appropriate discounted fee based on your household income.

- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid. You may stop by our center or call **(740) 532-3534**.
- You may also contact the Lawrence County Job and Family Services Department at 740-532-3324.

Regarding the SHARING OF HEALTH INFORMATION

- The School-Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the School-Based Health Center to your childs PCP.
- Family Medical Centers, the School-Based Health Center and/or the school nurses will share medical information, including immunization records, with each other as needed.
- The child's medical and any other information will only be used in the treatment, payment, and health care operations of the School-Based Health Center. All of your child's information will be kept strictly confidential according to all state and federal laws.
- The school has other community resources available, including mental health. If services for mental health are needed, the health center provider may initiate a referral to the mental health provider at your child's school or a community site. The mental health provider will contact your for consent. The health center provider and the mental health provider will coordinate your child's care as needed. All information will be kept strictly confidential.

Patient Consent for Use and Disclosure of Protected Health Information

- With my consent, School-Based Health Center or Family Medical Centers may use and disclose protected health information, (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Family Medical Centers' Notice of Privacy Practice for a more complete description of such uses and disclosures.
- I have the right to review the Notice of Privacy Practice prior to signing this consent. Family Medical Centers reserves the right to revise its' Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Family Medical Centers at 305 N. 5th Street, Ironton, Ohio 45638.
- With my consent, School-Based Health Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.
- With my consent, School-Based Health Center or Family Medical Centers may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.
- I have the right to request that School-Based Health Center or Family Medical Centers restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
- By signing this form, I am consenting to uses and disclosure of my Protected Health Information to carry out treatment, payment and operation.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the School-Based Health Center may decline to provide treatment to me.

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*Please note that the School-Based Health Center is **completely optional.** School nursing and emergency services will still be provided as always whether you consent to the School-Based Health Center or not.

This consent will remain in effect until your child is no longer enrolled in one of the participating school districts. You **may revoke** this consent for treatment at any time by requesting the School-Based Health Center, in writing, to have your child removed from School-Based Health Center. Please notify us at the number below and in writing for any changes in guardianship.

Please keep this Program Description for your records.

The School-Based Health Center is an excellent way to keep your child healthy and in school. Please let us know if there is anything keeping you from enrolling your child. If you have any questions or need help with the application, please call Family Medical Centers at **(740) 532-3534** or contact your school nurse.