Boothbay Region School Health Center

Keeping students in school & parents at work

Dear Parents or Guardian,

The Boothbay Region School Health Center (SHC) and AOS 98 are pleased to offer quality health services to all K-12 students and staff. The School Health Center is located in Boothbay Region High School. SHC staff also sees students from BRES, Edgecomb Eddy and Southport Central schools.

The SHC is like a doctor's office at school.

Having medical and behavioral health care at school saves your child from missing time away from school. Your child can get an appointment and be seen in school. It also saves parent's time away from work.

If you have a primary care doctor already, your child can still be seen at the SHC. We will work with your child's doctor.

HOW IT WORKS.

If your child isn't feeling well, first they see the AOS 98 School Nurse. If the School Nurse decides it's needed, she will contact the parent/guardian for permission to send your child to see the SHC staff. **Registration is required to be seen. By filling out the attached forms and returning them to the school. **Note: Forms must be completed each year.**

Payment Options/Fee for SHC Service. (It is free to sign up.)

We will bill MaineCare or your private insurance provider for services provided. Co-pays are billed after the appointment.

If your student does not have health insurance, please feel free to call us at 633-1934 for help.

HOW to Sign Up. It's quick and simple.

1. Complete the Demographic Information and Emergency Information and Insurance. - Please send a copy of your child's insurance card, if you have insurance.
2. Read and sign the Consent to Treat Form.-This is the same type of form you sign when you visit your doctor's office or go to the Hospital.
3. Read and sign the Consent for Expanded Service Form. –Consent for medical and behavioral health services is required for any student under the age of 18.
4. Return completed forms to the School Health Center. – Mail or send with your student to school.

Please call the School Health Center during school hours at 633-1934 if you have any question.

Sincerely,

Anne Barker, APRN-FNP

Carol McClure, Practice Manager

Cynthia Dechenes, MD, Medical Director

Heather Norris, LCSW

Lisa Carbone, LCSW

Kacy Pound, Office Assistant

CONSENT FOR EXPANDED SERVICES AT
BOOTHBAY REGION SCHOOL HEALTH CENTER
SCHOOL YEAR _____

Patient/Student Name_____ Date of Birth: _____
(Please Print) Month/Day/Year

BOOTHBAY REGION SCHOOL HEALTH CENTER
CONSENT TO TREATMENT, ASSIGNMENT OF BENEFITS, AND NOTICE OF PRIVACY PRACTICES

I. **Consent to Treatment and to Release Information to Other Providers**

By signing this section below, I authorize the Boothbay Region (AOS98) School Health Center (SHC) staff to examine me/my student and perform any tests and/or treatments determined to be medically necessary, recommended or appropriate, to care for my/my student's injuries, illness or conditions.

I understand that the healthcare provider responsible for caring for me/my student 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 SHC services are meant to complement, not replace, those provided by my/my student's primary health care provider (PCP), and that all health-related information will be treated in a confidential manner.

I authorize the Boothbay Region School Health Center (SHC) to both release and receive information from my/my student's PCP as necessary to provide care. I also authorize the exchange of medical information between the SHC and the authorized School Personnel (if necessary).

This release of information shall be in effect for 1 (one) school year from authorized signature date unless revoked. This does not include releasing privileged information concerning treatment for drug and alcohol use, sexually transmitted diseases, HIV status, or mental health issues.

_____ _____
Signature of Patient/Staff/Parent, Guardian or Other Legally Authorized Representative Date

II. **Payment and/or Assignment of Benefits**

I understand that I am financially responsible for paying all costs associated with healthcare services rendered to me/my student by the Boothbay Region Student Health Center. If I have health insurance, I understand that I may be financially responsible for copayments, deductibles, healthcare 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 healthcare services rendered to me/my student, directly to the Boothbay Harbor School Health Center and its contracted agents.

III. **Notice of Privacy Practices**

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

IV. **Use and Disclosure of Health Care Information**

I understand that information and records concerning healthcare services provided to me/my student may be used and disclosed to those involved in my/my student's care for treatment and healthcare operations purposes, and to third party payers for payment purposes. I also understand that my/my student's healthcare 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/my student's mental health, substance abuse program and HIV information, unless such disclosure is otherwise authorized by law.

_____ _____
Signature of Patient/Staff/Parent, Guardian or Other Legally Authorized Representative Date

CONSENT FOR EXPANDED SERVICES AT
BOOTHBAY REGION SCHOOL HEALTH CENTER
SCHOOL YEAR _____

Please complete and sign this form if you are a patient or a parent/guardian and would like your student to be eligible for Expanded Medical Services. Please read the consent/payment options carefully included on this form.

Expanded Medical Services

I give consent for_____ (print patient or student's first/last name) to receive medically necessary or recommended Expanded Medical Services from the clinical staff at the Boothbay Region School Health Center.

I understand these services will be available:

- Diagnosis, treatment, and triage of injuries;
- Diagnosis and treatment of illnesses such as strep throat, mono, and ear infections (the nurse practitioner is able to call in prescriptions if needed for treatment);
- Evaluation of recurring symptoms such as headaches or stomach pains;
- Assistance with chronic conditions such as asthma, eating disorders, or diabetes;
- Reproductive health care services including education and counseling, prescription contraception and contraception and contraception management, diagnosis and treatment of sexually transmitted infections, and pregnancy testing;
- Provision of routine lab tests including hemoglobin, cultures, and screenings for mono and strep;
- Medical, mental and/or behavioral health counseling.

Please check below which billing/payment options you choose for Expanded Medical Services.

- ☐ Please bill my Health Insurance for Expanded medical Services (the visit is billed just as a doctor's office visit is billed)
- ☐ I have or my student has Maine Care (Medicaid) Health Insurance; please bill Maine Care for Expanded medical Services.
- ☐ I will pay for any bills.
- ☐ Please send me a Maine Care (Medicaid)/CarePartners application to complete to find out if I quality or my student qualifies.

- I understand that the Health Center provides services that complement (but do not replace) those provided by my/my student's primary health care provider (PCP). If I need or my student needs a service that the Health Center is unable to provide, I understand that Health Center staff will refer me/my student to my/my student's PCP for that service.
- If I do not/my student does not have a PCP, I understand that the Health Center staff will help me in finding one.
- I understand that my/my student's Health Center records will be kept in a confidential manner; however, I acknowledge that the Health Center may disclose information to my/my student's PCP and other healthcare providers (including the school personnel) for treatment or continuity of care purposes in accordance with applicable law.
- I acknowledge that the Health Center may disclose my/my student's health information to third party payers, such as Maine Care, Anthem or other health insurance companies, for billing and payment purposes, in accordance with applicable law.
- I have read and understand the information in this consent form, including the information on confidentiality, and I understand that this consent is valid one (1) school year from authorized signature date.

_____ _____
Signature of Patient/Staff/Parent, Guardian or Other Legally Authorized Representative Date

Write Relationship to student: _____

Boothbay Region (AOS 98) School Health Center
EMERGENCY INFORMATION Form 2020-2021

Please return as soon as possible so that we have **phone numbers** to reach you in case of emergency.

PLEASE PRINT

Demographic Information

Name_____ **Date of Birth** _____ Social Security Number _____-_____-_____ □ M □ F **Grade** _____ (if applicable)

Name and address of parent/guardian with whom student lives: (for school employees please provide your home address)

Name (first/last) _____ Home Phone _____

Mailing Address _____ Town_____ State _____ Zip Code _____

Parent/Guardian information: (If applicable)

Mother/Guardian's name (first/last) _____ Business/Day Phone _____ □ okay to call at work

Cell phone # _____ Pager# _____ Mother Home Phone # _____

Occupation/Business Name _____ Mother e-mail address _____

Father/Guardian's Name (First/last) _____ Business/Day Phone _____ □ okay to call at work

Cell phone # _____ Pager# _____ Father Home Phone # _____

Occupation/Business Name _____ Father e-mail address _____

Medical Information

Please be advised that this information will be shared with school staff on a confidential Medical Alert List.

Explain any medical conditions you/your student have: _____

Please list any allergies you/your studenthave:_____

_____

Please list any medications taken at home/:

_____

Taken at school: _____

Date of last comprehensive physical exam: _____
(Month/day/year)

□ **do not have health insurance.**

Health Insurance Company or MaineCare _____ **Policy/MaineCare #** _____

Subscriber's Name _____ **D.O.B.** _____ **SS#** _____-_____-_____

Mailing Address/Phone # (if different than above) Street/PO: _____ **City** _____

State _____ **Zip Code** _____ **Phone #** _____

Primary Health Care Provider (PCP's) Name: _____ **Phone Number:** _____ □ **do not have a PCP**

Dentist's Name: _____ **Phone Number:** _____ □ **do not have a dentist**

I authorize the designated School Health Center staff or school nurse to administer Acetaminophen or Ibuprofen in the appropriate dosage. □ Yes □ No

I understand this registration consent is valid for one school year from today unless revoked earlier. *

_____ _____

Staff/Parent, Guardian or Other Legally Authorized Representative Signature Date

_____ (write relationship to student) if applicable